BlueCare Plus Tennessee

BlueCare Plus MA SNP HMO Provider Administration Manual

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I.

This manual is intended to be used as a practical and informational guide. In the event of a conflict or inconsistency between the Regulatory requirement and this manual, the provisions of the regulatory requirements will control, except with regard to benefit contracts outside the scope of the regulatory requirement.

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BlueCare Plus is a specialized Medicare Advantage Plan (a Medicare "Special Needs Plan"), which means its benefits are designed for people with special health care needs. BlueCare Plus is designed specifically for people who have Medicare and who are also

entitled to assistance from TennCare (Medicaid). Coverage under BlueCare Plus Tennessee includes two plan options: BlueCare Plus Dual Special Needs Plan (DSNP) and BlueCare Plus Choice Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP).

The requirements, policies and processes defined in this Provider Administration Manual (PAM) are a contractual obligation as stipulated in either the stand-alone BlueCare Plus Agreement or a BlueCare Plus Amendment to the BlueCare /TennCare*Select* Agreements.

Changes to this Manual will be communicated to providers at least thirty (30) days prior to implementation (excludes medical policy changes driven by new technology). Such changes will be communicated using one or more of the following resources:

- *BlueAlert* Monthly Provider Newsletter
- Quarterly Provider Manual updates
- Online updates to Medical Policy Manual accessible on company websites, www.bcbst.com or bluecareplus.bcbst.com
- Individual Provider Mailings

No person on the grounds of race, color, religion, national origin, sex, age, or disability shall be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or service provided by BlueCross BlueShield of Tennessee (BCBST), including its licensed affiliate, BlueCare Plus.

Furthermore, no person shall be subjected to any form of retaliation to include, threats, coercion, intimidation or discrimination because of filing a complaint, testifying, assisting or participating in an investigation, proceeding or hearing.

A. BlueCare Plus Statement of Purpose

BUSINESS

BlueCare Plus is designed to meet the needs of people who receive certain TennCare (Medicaid) services.

PURPOSE

Local Solutions, Meaningful Results.

LONG-TERM CORPORATE GOALS

Our Long-Term Corporate Goals are:

- Affordability
- Sustainability
- Outreach

MISSION

BlueCare Plus is designed to serve the unique individual needs of the dual eligible Medicare and Medicaid population while promoting quality of care through coordination of care for members with complex, chronic or catastrophic health care needs. Care coordination support teams works with each member to access the most appropriate services to meet physical, behavioral health, long-term care and social needs.

Collaboration with the Interdisciplinary Care Teams (ICT's) are an important component of the integrated care programs for our members and typically consist of the member, providers, other support professionals, other family members and/or natural supports caregivers, and care coordination teams.

BlueCare Plus is committed to excellence. Customer service is more than answering questions quickly and correctly. Customer service is the very heart of BlueCare Plus, talking personally, individually, to our members, making sure each member receives the particular services needed. We work as a liaison between members and providers, helping customers access their benefits and assisting providers in coordinating and managing members care.

B. Code of Business Conduct

We have built a bond of trust with the people we serve, as well as the vendors and suppliers with whom we do business.

To strengthen that bond of trust, BlueCare Plus adopted a set of policies and Code of Conduct that applies to all employees, officers, contracted vendors, and members of the Board of Directors. We are willing to share our own Code of Conduct, along with related policies and procedures, with our business partners in order to relay our commitment to a corporate culture of ethics and compliance. The Code of Conduct sets an ethical tone for the organization and provides guidelines for how our business partners and BlueCare Plus is expected to conduct business.

We encourage suppliers and third parties with whom we do business to adopt and follow a Code of Conduct particular to their own organization that reflects a commitment to prevent, detect and correct any occurrences of unethical behavior. In addition, we embrace fraud prevention and awareness as essential tools in preserving affordable quality health care and actively work with our business partners and law enforcement agencies to combat health care fraud.

Included in our Code of Conduct are two sections entitled “Conflicts of Interest” and “Dealing with Customers, Suppliers, and Third Parties”. The primary focus of these sections is to help ensure business decisions based on the merit of the business factors involved and not on the offering or acceptance of favors. Additionally, any activity that conflicts or is otherwise incompatible with our professional responsibilities should be avoided. You may review the Code of Conduct in its entirety online at https://bluecare.bcbst.com/forms/vshpcodeofconduct.pdf.

Please share this information with all your employees who interact with our company. If you should have any questions, or wish to report a suspected violation, please call the Confidential Compliance Hotline, 1-888-343-4221 or e-mail us at compliancehotline@bcbst.com.

C. Provider Manual Requirements

BlueCare Plus is required to explain certain categories in the provider manual. A listing of the topics is included below.

Encounter Data Reporting	145	Utilization Management Requirements and Procedures	132
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D. Statutory and Regulatory History

Congress authorized special needs plans (SNPs) as a type of Medicare Advantage (MA) plan designed to enroll members with special needs. The first component of the plan requires an evidence-based model of care with an appropriate network of providers and specialists that meet the needs of the target population.

The second component is an array of care management services that includes: 1) A comprehensive initial assessment and an annual assessment of the members' individual physical, psychosocial, and functional needs; 2) an individualized Plan of Care (POC) and Interdisciplinary Care Team (ICT).

BlueCare Plus MA SNP HMO serves members who are dually eligible for Medicare and Medicaid within the BlueCare Plus service area.

1. The Medicare Improvements for Patients and Providers Act (MIPPA)

The Medicare Improvements for Patients and Providers Act (MIPPA) (Pub. L. 110–275), enacted on July 05, 2008, called upon the Secretary to revise the marketing requirements for Part C and Part D plans in several areas. MIPPA also enacted changes with respect to Special Needs Plans (SNPs), Private Fee-For-Service plans (PFFS), Quality Improvement Programs, the prompt payment of Part D claims, and the use of Part D data. With the exceptions noted in the final rule, MIPPA required that these new rules take effect at a date specified by the Secretary, but no later than November 15, 2008.

Under the Medicare Improvement for Patients and Providers Act of 2008 ("MIPPA") and resulting regulations, CMS requires the SNP provider to enter into an agreement with the State to provide or arrange for Medicaid benefits to be provided to its Dual Eligible enrollees.

The final rule finalized the MIPPA related provisions of the September 18, 2008 IFC (73 FR 54226), November 14, 2008 IFC (73 FR 67406), November 21, 2008 correction notice (73 FR 70598), and one provision on two SNP-related statutory definitions that was finalized with a comment period in the January 16, 2009 final rule with comment period (74 FR 2881).

2. Special Needs Plan

The Dually Eligible Special Needs Plan (DSNP) enrolls members who are entitled to both Medicare (Title XVIII) and Medical Assistance from the State under Title XIX (Medicaid) and offer the opportunity of enhanced benefits by coordinating those available through Medicare and Medicaid. The program is designed to promote the integration and coordination of Medicare and Medicaid benefits through a single managed care organization, while ensuring full access to seamless high quality health care and to make the system as cost effective as possible.

The Affordable Care Act created requirements for DSNPs:

- Provide dual eligible members access to Medicare and Medicaid benefits under a single managed care organization;
- Coordinate delivery of covered Medicare and Medicaid health and long-term care services;
- Possess a valid capitated contract with the State for specified primary, acute, and long-term care benefits consistent with State policy; and
- Comply with CMS and State policy regarding marketing, appeals, quality assurance, and enrollment communication procedures.

Additionally, the Affordable Care Act authorized the creation of Fully Integrated Dual Eligible Special Needs Plans (FIDE SNP). FIDE SNPs provide states with additional authority and flexibility to achieve a higher degree of integration of administrative alignment and integration of Medicare and Medicaid services. FIDE SNPs offer the highest level of benefit and administrative integration.

II. Administrative

Development of the Medicare special needs plans are to provide more focused and specialized healthcare for people who require health benefits tailored to their specific needs and conditions. The plans are available to Medicare and Medicaid members who have chronic, severe or disabling medical conditions. BlueCare Plus is a person-centered approach to coordinated care for special needs members.

The program promotes quality and cost-effective coordination of care for BlueCare Plus members with chronic, complex, and complicated health care, social service and long-term care needs. Care Coordination involves the systemic process of assessment, planning, coordinating, implementing and evaluating care received through fully integrated physical and behavioral health to ensure the care needs of the member are met.

A. General Information

Member Service Line	1-800-332-5762
Provider Service Line	1-800-299-1407
Fax Line	1-800-309-7093
Prior Authorization for Medical	1-866-789-6314
Prior Authorization for Medical Fax	1-866 325-6698
Prior Authorization for Behavioral Health	1-866-789-6314
Prior Authorization for Behavioral Health Fax	1-866-325-6698

1. Interpretation Services

According to federal and state regulations of Title VI of the Civil Rights Act of 1964, translation or interpretation services due to Limited English Proficiency (LEP) is to be provided by the entity at the level at which the request for service is received.

The financial responsibility for the provision of the requested language assistance is that of the entity that provides the service. Charges for these services should not be billed to BlueCare Plus and it is not permissible to charge a BlueCare Plus member for these services. Full text of Title VI of the Civil Rights Act of 1964 can be found online at https://www.fhwa.dot.gov/civilrights/programs/title_vi/guidance.cfm. Providers can use the "I Speak" Language Identification Flash Card to identify the primary language of BlueCare Plus members. The flash card, published by the Department of Commerce Bureau of Census, containing 38 languages can be found online at https://www.lep.gov/sites/lep/files/media/document/2020-02/crcl-i-speak-booklet.pdf

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Additional recommended resources for use when LEP services are needed or providers cannot locate interpreters specializing in meeting needs of LEP clients may include the following:

- Language Line 1-800-874-3972
- AVAZA Language Services 1-800-482-8292
- Institute of Foreign Language 615-741-7579

Providers may also consider:

- Training bilingual staff;
- Utilizing telephone and video services;
- Using qualified translators and interpreters; and

- Using qualified bilingual volunteers.

2. Health Literacy and Cultural Competency Provider Tool Kit

Health Literacy and Cultural Competency are important issues facing health care providers. It is important for organizations to have and utilize policies, trained and skilled employees and resources to anticipate, recognize and respond to various expectations (language, cultural and religious) of members and health care providers.

BlueCare Plus through collaborative efforts with the Division of TennCare offers a Health Literacy and Cultural Competency Provider Tool Kit providing health care professionals additional resources to better manage members with diverse backgrounds. The Tool Kit may be accessed on the company website at **https://bluecare.bcbst.com/forms/Provider%20Forms/Cultural_Awareness.pdf**.

3. Important Contact Information

BCBST produces the BlueAlert newsletter on a monthly basis to communicate important policy and benefit-related news to health care Providers. Also included are helpful tips and reminders on how to file claims and conduct other business more efficiently with BCBST. The newsletters are mailed to all BCBST participating Providers.

Providers are also encouraged to visit the company website, www.bcbst.com to verify member eligibility, benefit coverages and check claims status in a secure area. If you are not registered, go to http://www.Availity.com and click on "Register" in the upper right corner of the home page, select "Providers", click "Register" and follow the instructions in the Availity registration wizard.

Contact	Phone Number	Address or Description
Provider Relations:		
Statewide	1-800-924-7141 – Option 2	Provider Relations 1 Cameron Hill Circle, Chattanooga, TN 37402
Provider Service Line		
Eligibility Claims Status	1-800-AVAILITY 1-800-299-1407	Available Monday - Friday (except between 7p.m. and 9 p.m. when eligibility information is being updated) and Saturday and Sunday from 8 a.m. to 4 p.m. The system is not available on Thanksgiving Day or Christmas Day.

Care Management		
Member Nurse Line	1-888-747-8951	Available 24-hours-a-day, 7-days-a-week
Health Care Counseling	1-800-262-2873	
Inpatient/Outpatient Behavioral Health	1-866-789-6314	All inpatient and some specific outpatient behavioral health care services require prior authorization.
Pharmacy Program – Prior Authorization	1-800-299-1407	
Dental	1-800-332-5762	
Enrollment	1-800-924-7141	
eBusiness Solutions Technical	423-535-5717	
State of Tennessee		
Division of TennCare	1-800-852-2683	Division of TennCare
Division of TennCare Program Integrity	1-800-433-3982	To report suspected fraudulent activity.
Family Assistance Service Center	1-866-311-4287	310 Great Circle Rd., Nashville, TN 37243
Family Assistance Service Center – Nashville	1-615-743-2000	Nashville Area Only
Office of Inspector General	1-800-433-3982	To report suspected fraudulent activity.
Crisis Hotline	1-855-274-7471	To obtain immediate assistance in a crisis.
Medicare	1-800-MEDICARE	
TennCare Connect	1-855-259-0701	Monday through Saturday 7 a.m. – 7 p.m.

B. Compliance

1. Protected Health Information-allowable disclosures under HIPAA

Privacy of medical information is important to all covered entities. New federal regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) may require some changes in the way BlueCare Plus operates, however, it will not prevent us from exchanging the information we need for **treatment**, **payment**, and **health care operations (TPO)**.

BlueCare Plus will continue to conduct business as usual in most circumstances. HIPAA regulations allow disclosure of certain medical information, and BlueCare Plus providers (subject to all applicable privacy and confidentiality requirements) are contractually obligated to make medical records of BlueCare Plus members available to each Physician and/or Health Care Professional treating BlueCare Plus, its agents, or representatives.

Privacy Regulations should not affect patient treatment and quality of care; it is vital for the benefit of our members and your patients that quality of care is not negatively impacted due to misconceptions about allowable exchanges of information for TPO. The following offers examples of TPO, which include, but are not limited to:

- **Treatment** - rendering medical services, coordinating medical care for an individual, or even referring a patient for health care.
- **Payment** - the money paid to a covered entity for services rendered whether it is a health plan collecting premiums, a health plan fulfilling its responsibility for coverage, or a health plan paying a provider for services rendered to a patient.
- **Health care operations** - conducting quality assessment and improvement activities, underwriting, premium rating, auditing functions, business planning and development, and business management and general administrative activities.

For complete TPO definitions and a listing of examples, please review the federal regulations at

www.hhs.gov/ocr/hipaa/finalreg.html.

If you have any questions or concerns regarding privacy matters, you may contact the BlueCross BlueShield of Tennessee Privacy Office at 1-888-455-3824 or e-mail privacy_office@bcbst.com.

2. Fraud and Abuse

A special telephone hotline is available to report possible fraudulent activities involving the delivery or financing of health care. Anyone, whether or not they are a BlueCross BlueShield of Tennessee participating provider or member, can report suspected health care fraud by: calling BlueCross BlueShield of Tennessee Fraud and Abuse Hotline at 1-888-343-4221 or submitting a confidential tip online at www.bcbst.com/fraud/index.page.

3. False Claims Act

The following information pertains to the Federal False Claims Act (Title 31, Section 3729):

Civil Liability for Certain Acts. — A person is liable under the Federal False Claims Act, who—

- Knowingly presents, or causes to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval;

- Knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government;
- Conspires to defraud the Government by getting a false or fraudulent claim allowed or paid;
- Authorized to make or deliver a document certifying receipt of property used, or to be used, by the Government and, intending to defraud the Government, makes or delivers the receipt without completely knowing that the information on the receipt is true;
- Knowingly buys, or receives as a pledge of an obligation or debt, public property from an officer or employee of the Government, or a member of the Armed Forces, who lawfully may not sell or pledge the property; or
- Knowingly makes, uses, or causes to be made or used, a false record or statement to conceal, avoid, or decrease an obligation to pay or transmit money or property to the Government,

Civil Penalties and Damages

- Civil penalty of not less than $5,000 and not more than $10,000,
- Cost of litigation; and
- Damages of 3 times the amount of damages which the Government sustains because of the act of that person, except that the court may assess not less than 2 times the amount of damages which the Government sustains if the court finds that:
  - The person committing the violation furnished officials of the United States responsible for investigating false claims violations with all information known to such person about the violation within 30 days after the date on which the person (defendant) first obtained the information;
  - The person fully cooperated with any Government investigation of the violation; and
  - At the time the person furnished the United States with the information about the violation, no criminal prosecution, civil action, or administrative action had commenced under Title 31 of the United States Code with respect to the violation, and the person did not have actual knowledge of the existence of an investigation into the violation.

Whistleblower

- Whistleblower provision
  - Individuals with original information regarding fraud involving government health care programs may file a lawsuit.
  - As used in this section, Whistleblower – means an employee who discloses suspected fraud or abuse by his/her employer to a government or law enforcement agency.
- Whistleblower successful lawsuit
  - Must meet specific legal requirements.
  - Possibly awarded 15 percent to 30 percent of total recovered.
  - Employee protected from retaliation.
- Whistleblower protection from retaliation
  - Employee must reasonably believe he/she is reporting a violation of the law.
  - Employer cannot discharge, demote, suspend, harass, or in any manner discriminate against the employee whistleblowing.
- Employer Liability for Retaliation Against Whistleblower
  - Reinstatement of job with same seniority status;
  - 2 times back pay, plus interest on back pay;
  - Litigation costs and attorneys' fees; and
  - Any other special damages sustained by the Whistleblower.

Criminal Liability for Certain Acts.

Improper Benefits

A person commits Class E felony who knowingly obtains or attempts to obtain, or aids or abets any person to obtain, by means of a willfully false representation or concealment of a material fact, or by other fraudulent means, an Improper Benefit. As used in this section, "Improper Benefit" refers to:

- Medical assistance benefits provided pursuant to a TennCare rule, law, or regulation that the person is not entitled to receive or that are of a greater value than the person is authorized to receive;
- Benefits the person receives as a result of knowingly making a false statement or concealing a material fact relating to personal or household income that results in the assessment of a lower monthly premium than the person would be required to pay if not for the false statement or concealment of a material fact; and Controlled substances benefits the person receives by knowingly, willfully and with the intent to deceive, failing to disclose to a health care provider that the person received the same or similar controlled substance from another practitioner within the previous 30 days and the person used TennCare to pay for either the clinical visit or for the controlled substance.

False Claims
An entity or person (but not an enrollee or applicant) commits a Class D felony who knowingly obtains or attempts to obtain, or aids or abets a person or entity to obtain, by means of a willfully false representation or concealment of a material fact, or by other fraudulent means, medical assistance payment under TennCare to which the entity or person is not entitled or which are of greater value than that to which the entity or person is entitled.

Misrepresentation of Medical Condition or Eligibility for Insurance.
An entity or person commits a Class D felony who by means of a willfully false statement regarding another person's medical condition or eligibility for insurance to aid the person in obtaining or attempting to obtain medical assistance payments, benefits or any assistance provided under TennCare to which the person is not entitled or which are of greater value than that to which the person is authorized to receive. ("Attempting to obtain" as used in this section includes knowingly making a false claim.)

Obstruction of Investigation.
Any entity or person commits a Class D felony who in connection with any of the above offenses knowingly and willfully falsifies, conceals or omits by any trick, scheme, artifice, or device a material fact; makes a materially false or fraudulent statement or representation; or makes or uses a materially false writing or document.

Criminal Penalties, Restitution, and Sanctions.
- Criminal felony penalties as described above;
- Restitution to TennCare of the greater of the total amount of all medical assistance payments made to all providers, or a managed care entity, related to the services underlying the offense;
- Disqualify the person from participation in TennCare; and
- Report the person or entity to the appropriate professional licensure board or Department of Commerce and Insurance for disciplinary action.

4. Requirements for Reporting Fraud and Abuse

Persons are encouraged to report suspected fraud and abuse. Persons who have knowledge of fraud and abuse are required to report it as follows:

- **Recipient, Enrollee or Applicant Fraud.** Providers, managed care organizations, and others must notify the Office of TennCare Inspector General immediately when there is actual knowledge of TennCare recipient, enrollee or applicant fraud. Call toll-free 1-800-433-3982 or go online to www.tn.gov/finance/fa-oig/fa-oig-report-fraud.html. This obligation does not apply if the knowledge is subject to a testimonial privilege.

- **Provider Fraud.** Providers, managed care organizations, and others must notify the Medicaid Fraud Control Unit immediately when there is actual knowledge of provider fraud. Call toll-free 1-800-433-5454.

- **Failure to Report.** Any person who willfully fails to report fraud shall be subject to a civil penalty of up to $10,000 for each finding of the TennCare Inspector General.

BlueCare Plus will comply with the reporting requirements established by The Centers for Medicare and Medicaid Services (CMS).

5. Education of Employees, Contractors, and Agents

Deficit Reduction Act of 2005

If provider receives or makes annual Medicaid payments of $5 million or more than meets the definition of a "covered entity" under section 6032 of the Deficit Reduction Act of 2005 and shall provide information/education to employees, contractors and agents of the provider about false claims recovery including the following components:

(1) Provide detailed information in written policies applicable to employees, contractors, and agents of the provider about the federal False Claims Act and any State laws that pertain to civil or criminal penalties for making false claims and statements to the Government or its agents.
(2) Provide detailed information about whistleblower protections under such laws, along with the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs.
(3) These written policies must also include detailed information about the provider's policies and procedures for detecting and preventing fraud, waste and abuse.
(4) The provider's employee handbook, if the "covered entity" has one, shall include a specific discussion of the laws, the right of employees to be protected as whistleblowers, and the provider's policies and procedures for detecting and preventing fraud, waste and abuse.
(5) The provider shall have documented instructions on how to report suspected fraud including the telephone number and person to contact within the organization. These instructions shall also tell how to report suspected fraud to external agencies such as the State of Tennessee Comptroller's hot-line *(1-800-232-5454)*, the Tennessee Department of Finance and Administration's Office of Inspector General (OIG) fraud and abuse hot-line (1-800-433-3982) and the Tennessee Bureau of Investigation (TBI) Medicaid fraud hot-line *(*1-800-433-5454*).*
(6) The provider shall have procedure to follow up on suspected fraud including how they report the results of their investigation.

6. Non-Discrimination

BlueCare Plus participating Providers through their contracts with us and in compliance with existing federal and state laws, rules and regulations agree not to discriminate against Members in the provision of services on the basis of race, color, national origin, religion, sex, age or disability.

C. Coordination of Benefits, Medicare Secondary Payer and Third Party Liability

BlueCare Plus includes the provision for Coordination of Benefits (COB), which applies when a member has coverage under more than one group contract or health care benefits plan. Claims should be submitted to the primary payer prior to submission to BlueCare Plus.

All Medicare secondary payer rules apply. These rules can be found in the *Medicare Secondary Payer Manual* located at www.cms.gov/Manuals/IOM/list.asp
Also at www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf Providers should identify primary coverage and provide information to BlueCare Plus at the time of billing.

BlueCare Plus does not pay for services when a third party is required to be the primary payer. This section only covers collections related to the BlueCare Plus program and its responsibility to;

- Identify payers that are primary to BlueCare Plus
- Identify the amounts payable by those payers
- Coordinate its benefits to members with the benefits of the primary payers

In some circumstances, a secondary payer status may arise from settlements and other insurance plans. In some cases coverage for a BlueCare Plus member may depend on the following;

- Whether the enrollee entitlement to Medicare is due to of age or disability;
- Who is the primary beneficiary of the other insurance plan; or
- The size (number of employees) of the sponsoring employer group.

BlueCare Plus may be secondary if the member is 65 years or older and is covered by a Group Health Plan (GHP) as a result of;

- Current employment or
- Employment of a spouse of any age and;
- The employer employs 20 or more employees

When a BlueCare Plus member is disabled and the member is covered by a Large Group Health Plan (LGHP) because of either:

- Current employment or
- A family member's current employment
- The employer employs 100 or more members

The purpose of Coordination of Benefits (COB) is to avoid duplicate payments for covered services. COB is applied when the member is also eligible for other health insurance. Providers should submit claims for payment to the primary plan first. Any amount payable by BlueCare Plus is governed by the amount paid by the primary plan. Follow the guidelines below for correct billing;

- When BlueCare Plus is primary, submit the claim directly to BlueCare Plus
- When BlueCare Plus is secondary, submit to the primary carrier first. Attach the Explanation of Benefits (EOB) with the claim.

Providers generally request additional insurance information from patients at the point of service. Providers should bill the primary payer first. If the probable existence of other insurance exists for a particular member, as determined by BlueCare Plus, then BlueCare Plus may deny and return claims to the provider, with the instruction that the provider should bill the third party payer first. When denying a claim for other insurance, BlueCare Plus must give the provider other insurance data in order that the provider can appropriately submit the claim to the third party or primary payer.

In some situations, the availability of other insurance may not be identified until the provider claim has been processed and adjudicated. The other insurance can be identified by internal or external sources.

- Providers always have the discretion to refund payments they have received from BlueCare Plus or one of its contractors, in order to pursue payment from the primary insurance. Once a provider has refunded a payment received from BlueCare Plus or one of its contractors, the provider may not resubmit another claim to BlueCare Plus or its contractor for the same service furnished to the same enrollee on the same date.

- If BlueCare Plus learns of the availability of primary insurance after it has made payment to the provider, then BlueCare Plus may recover its payment to the provider if all of the following conditions are met. This policy is not intended to affect the ability of BlueCare Plus to recover a duplicate payment when both BlueCare Plus and a third party have paid a claim to the same provider for the same service.

    - Less than nine months have passed since the date of service when there is a commercial insurer or Medicare involved;

    - Prior to recoupment of its payment, BlueCare Plus notified the provider with a refund request letter that included, at a minimum:

        - Identification of BlueCare Plus payment;
        - The name of the provider;

    - The list of claims or a reference to a remittance advice date;
    - The reason for overpayment (Example: “Another commercial insurance carrier was the primary carrier at the time of service”);
    - The identification and contact information of the insurance carrier who was determined to have been primary at the time of service, together with information about the insurance policy so that the provider can bill the insurance carrier;
    - A time period of at least forty-five (45) calendar days in which the provider may return the BlueCare Plus payment and/or appeal the decision;
    - Information about how and where to file an appeal with BlueCare Plus and
    - A request that the provider submit claims to the other insurance if not already done.

When providers choose to appeal the refund request letter from BlueCare Plus, they are given sixty (60) calendar days in addition to the thirty (30) initial calendar days stated in the letter to provide sufficient documentation to BlueCare Plus prior to the BlueCare Plus’ recovery of their payment. Providers should include a copy of a denial from the primary carrier in their appeal, if available.

BlueCare Plus has ensured that there is a separate Service Line or Prompt for provider inquiries regarding these recoveries.

BlueCare Plus may not recoup payments made to a provider when COB is discovered unless all of the above criteria have been met. All appeals should be submitted to the address listed below:

BlueCare Plus
Provider Appeals Ste 0039
1 Cameron Hill Circle
Chattanooga, TN 37402

The Centers for Medicare & Medicaid Services does require that sufficient data will be shared between BlueCare Plus and the state to allow for the coordination and/or integration of Medicare and Medicaid benefits.

III. Member Enrollment

BlueCare Plus Tennessee offers enrollment under two distinct products: BlueCare Plus Dual Special Needs Plan (DSNP) and BlueCare Plus Choice Fully Integrated Dual Eligible Special Needs Plan (FIDE SNP). BlueCare Plus Tennessee enrollment is limited to people that are both Medicare and Medicaid eligible with specific diseases or conditions. Both plans tailor the members' benefits, provider choices and drug formularies (list of covered drugs) to best meet the specific needs of members, in this complex population.

BlueCare Plus is available for individuals that have Medicare Part A (Hospital Insurance), Part B (Medical Insurance) and Medicaid. BlueCare Plus Choice FIDE SNP, is available for individuals that have Medicare Part A, Part B, Standard Medicaid, and Medicaid Long Term Services and Supports (LTSS). Both plans include physical and behavioral health services and prescription drug coverages as well as coordination of all healthcare services for the member.

If an individual joins BlueCare Plus, the following is applicable:

- Member is still in the Medicare program
- Member still has Medicare rights and protections
- Receives Medicare Part A and Part B coverage through BlueCare Plus
- Receives standard Medicaid benefits (either through BlueCare or another Medicaid MCO); BlueCare Plus will provide coordination for Medicaid services and coverage
- Receives Medicare prescription drug coverage through BlueCare Plus
- Additional supplemental benefits are provided through BlueCare Plus

If an individual joins the BlueCare Plus Choice the following is applicable:

- Member is still in the Medicare program
- Member still has Medicare rights and protections
- Receives Medicare Part A and Part B coverage through BlueCare Plus
- Receives standard Medicaid benefits and Medicaid LTSS through BlueCare Plus
- Receives Medicare prescription drug coverage through BlueCare Plus
- Additional supplemental benefits are provided through BlueCare Plus

Beneficiaries can enroll in BlueCare Plus Tennessee through;

- Online Enrollment Center http://bluecare.bcbst.com
- Calling Sales at 1-888-413-9637

Default Enrollment

Default Enrollment permits organizations that offer both a Medicare Advantage (DSNP) plan and a Medicaid program (BlueCare/TennCare*Select*) to seamlessly convert individuals who become Medicare eligible. The individuals who are currently enrolled in BlueCare/TennCare*Select* and are about to become eligible for Medicare (based on age or disability) will receive a letter from the Division of TennCare and BlueCare Plus Tennessee explaining that they will automatically be enrolled in either BlueCare Plus or BlueCare Plus Choice, due to now being eligible for Medicare. These members will automatically be enrolled in one of our plans, unless the beneficiary chooses to opt out.

The Centers for Medicare & Medicaid Services (CMS) offers periods when Medicare beneficiaries can enroll or disenroll from Medicare plans known as election periods. BlueCare Plus Tennessee is a Special Needs Plan and all of our members qualify for the Special Enrollment Period (SEP) every quarter during the first nine (9) months of the year.

The Centers for Medicare & Medicaid (CMS) offer periods when Medicare beneficiaries can enroll or disenroll from Medicare plans. These times are known as election periods. BlueCare Plus is a Special Needs Plan and all of our members qualify for the Special Enrollment Period (SEP) every quarter during the first nine (9) months of the year. A non-qualifying individual that disenrolls from BlueCare Plus may re-enroll if the individual once again meets the specific qualifying characteristic(s) of BlueCare Plus.

A. Special Enrollment Period and Disenrollment

A member can remain enrolled in the BlueCare Plus Tennessee if the member continues to meet the requirements for eligibility for one of our Plus plans. As a MA SNP program, all our members qualify for the Special Enrollment Period (SEP). The Special Enrollment Period constitutes periods outside of the usual enrollment period. The SEP permits our member to enroll or disenroll one time during each of the following Special Enrollment Periods:

- January to March
- April to Jun
- July to September

Members may not use this Special Enrollment Period to end their membership in our plan between October and December. However, all Medicare enrollees can make changes from October 15 to December 7 during the Annual Enrollment Period.

For more information regarding the Special Enrollment Period visit bluecareplus.bcbst.com or www.cms.gov. A member may be disenrolled if the member loses Medicaid eligibility.

A BlueCare Plus member may request a disenrollment during one of the enrollment periods. A member may disenroll by;

- Enrolling in another plan (during a valid enrollment period)
- Giving or faxing a signed written notice to BlueCare Plus
- Calling 1-800-MEDICARE or visiting www.medicare.gov

If a representative is assisting the member with disenrollment the following must occur;

- The representative must attest that he or she has the authority under State law to make the disenrollment request on behalf of the member
- Attest that proof of this authorization, as required by State law that empowers the representative to effect a disenrollment on behalf of the member
- Provide contact information

If a member or provider has any questions about the disenrollment process, please contact BlueCare Plus Member Service line at 800-332-5762 for assistance.

B. Summary of Benefits

State	Physician Services	Hospital and Ancillary Services
Tennessee	Bill TennCare for cost sharing	Bill TennCare for cost sharing

TennCare is obligated to pay for Medicare deductibles and coinsurance for Medicare beneficiaries classified as QMBs and SLMB Plus and other dual eligible recipients. TennCare is not required to pay Medicare coinsurance for non-covered services for SLMB Plus and other dual eligible recipients unless the enrollee is a child under age 21 or an SSI beneficiary. Cost-sharing obligations do not include:

- Medicare premiums that TennCare is required to pay under the State Plan on behalf of dual eligible members
- Payments for any Medicaid services that are covered solely by TennCare
- Any cost sharing for a Part D prescription drug

BlueCare network providers are required to refer dual-eligible members who are QMB Plus or other FBDE recipients to the members' TennCare managed care organization for the provision of TennCare benefits that are not covered by the BlueCare Plus plan.

TennCare offers a broad array of long-term services and supports designed to help meet Members unique needs. Long-Term Services & Supports (LTSS) is a variety of services which help meet both the medical and non-medical need of people with a chronic illness, physical disability and intellectual disability who cannot care for themselves for long periods of time. It is common for long term care to provide custodial and non-skilled care, such as assisting with normal daily tasks like dressing, bathing, and using the bathroom. Increasingly, long-term care involves providing a level of medical care that requires the expertise of skilled practitioners to address the often multiple chronic conditions associated with older populations. Long-term care can be provided at home, in the community, in assisted living or in nursing homes. Long-term services or supports may be needed by people of any age, even though it is a common need for senior citizens.
The Tennessee's CHOICES program provides the elderly (65 years of age and older) & adults with physical disabilities (21 years of age and older) who are eligible for TennCare with needed long term services and supports in the home/community setting or nursing home.
Information about the TennCare Managed Care Organization and available TennCare Program Benefits can be found at the following TennCare Program web sites:

https://www.tn.gov/tenncare/providers.html
https://www.tn.gov/tenncare/members-applicants.html
https://www.tn.gov/tenncare/long-term-services-supports.html

Providers should refer to the Division of TennCare Medicare and Medicaid Crossover Claims directions outlined on the Division of TennCare web site at:
https://www.tn.gov/tenncare/providers/medicare-medicaid-crossover-claims.html.

BlueCare Plus Benefits

Description	Member Cost Sharing
Premium	$0
OOP Maximum **The OOP Max is only accumulated when the member actually pays cost sharing**	$7,550

Inpatient Hospital Coverage	Requires prior authorization $0
Inpatient Mental Health Care	Requires prior authorization $0
Skilled Nursing Facility	Requires prior authorization $0 for 100 days per benefit period
Home Health Care **Part-time or intermittent skilled nursingand home health aide services combined must total fewer than 8 hours per day and 35 hours per week.** **Includes Physical therapy, occupationaltherapy, and speech therapy** (Authorization Rules May Apply)	Zero Cost Sharing
Hospice	Medicare-certified hospice program is paid for by Original Medicare. BlueCare Plus pays for a consultative visit prior to hospice.
Doctor Office Visits **Routine or Specialist**	Zero Cost Sharing

BlueCare Plus Choice Benefits

Description	Member Cost Sharing
Premium	$0
OOP Maximum **The OOP Max is only accumulated when the member actually pays cost sharing**	$7,550
Inpatient Hospital Coverage	Requires prior authorization $0
Inpatient Mental Health Care	Requires prior authorization $0

Skilled Nursing Facility	Requires prior authorization $0 for 100 days per benefit period
Home Health Care **Part-time or intermittent skilled nursingand home health aide services combined must total fewer than 8 hours per day and 35 hours per week.** **Includes Physical therapy, occupationaltherapy, and speech therapy** (Authorization Rules May Apply)	Zero Cost Sharing
Hospice	Medicare-certified hospice program is paid for by Original Medicare. BlueCare Plus pays for a consultative visit prior to hospice.
Doctor Office Visits **Routine or Specialist**	Zero Cost Sharing

***BluePerks -** Created exclusively for BlueCross BlueShield of Tennessee members, BluePerks features discounts of up to 50 percent on a wide variety of alternative medical procedures – such as massage therapy, acupuncture and more. Plus, BluePerks also includes savings on health and wellness services, such as fitness centers, spas, personal trainers, Tai Chi classes and vitamins.

****Silver&Fit** - A basic fitness center membership at a participating location near you with access to the basic amenities; Custom designed, low impact classes designed to improve your body's strength and flexibility; On-site advisors to act as your contact for information and personalized service; and Social events.

*****MD Live -** This is a valuable resource for you should your BlueCare Plus patients have non-emergency health service questions or concerns after your office hours. The number to call is 1-888-747-8951. Should a member have a serious health concern, such as chest pain, they should call 911.

C. Member ID Cards

BlueCare Plus and BlueCare Plus Choice members should receive an Identification card (ID) prior to the effective date. However, if a member does not receive the ID card you can access member eligibility information on the BlueCare Plus Website at bluecareplus.bcbst.com or contacting the BlueCare Plus customer service line at 1-800-332-5762.

Presentation of the ID card does not guarantee eligibility. The card is for identification purposes only. Eligibility should be verified at the time services are received. The process of verifying eligibility is essential to avoid the following circumstances:

- Member may no longer be eligible
- Benefits may be altered
- Fraudulent use may occur

BlueCare Plus Member ID Card (DSNP)

BlueCare Plus Choice Member ID Card (FIDE SNP)*

*BlueCare Plus Choice Member ID card is applicable to all Medicare, Medicaid and pharmacy services for the BlueCare Plus Choice member.

D. Primary Care Provider (PCP)

PCPs are responsible for the overall health care of BlueCare Plus members assigned to them. Responsibilities associated with the role include, but are not limited to:

- Coordinating the provision of initial and primary care;
- Providing or making arrangements for all medically necessary and covered services;
- Initiating and/or authorizing referrals for specialty care;

- Collaboration with the care coordinator and the Interdisciplinary Care Team (ICT);
- Monitoring the continuity of member care services;
- Routine office visits for new and established members;
- Counseling and risk intervention, family planning
- Immunizations and other preventive services
- Administering and interpreting a members health risk assessment results;
- Medically Necessary X-ray and laboratory services;
- In-office test/procedures as part of the office visit;
- Maintaining all credentials necessary to provide covered Member Services including but not limited to admitting privileges, certifications, 24-hour call coverage, possession of required licenses and liability insurance ($1,000,000 individual and $3,000,000 aggregate), and compliance with records and audit requirements; and
- Adhering to the Access and Availability Standards (outlined in Section VII. Member Policy in this Manual).

BlueCare Plus PCPs have agreed to fulfill special roles and responsibilities associated with the management and care of BlueCare Plus members. In return for the additional efforts in caring for BlueCare Plus members, PCPs receive a higher reimbursement rate for participation in the Model of Care (MOC) Training and Interdisciplinary Care Team (ICT).

The Membership Listings are available electronically via Availity. If you have not registered for Availity, visit https://www.bcbst.com/providers/availity.page. If you need assistance, contact our eBusiness Service Center at 423-535-5717 or email Ecomm_TechSupport@bcbst.com.

There are four report selections available:

- Added Members Since Last Report
  - Lists information about newly assigned members reflected on the current listing. These members should not be listed on any previous membership listings for the provider.
- Current Members
  - Lists information about members assigned to the provider on the previous membership listing
- Members Transferred from Provider
  - Lists information about members transferred to another PCP or MCO
- Dropped Members
  - Lists information about members who have either changed MCOs or are no longer eligible for TennCare

The legend below describes fields on the PCP Membership Listing:

Field	Description
Date	Date the member listing report was created
Pay To	Address where the PCP's payment was sent
Member Name	Member last name, first name and middle initial
Effective with PCP	Date member assigned to PCP. The names are listed alphabetically, last name first.
Member Address	Address of assigned member
DOB/Sex/SSN	Date of birth, gender of assigned member and his/her Social Security Number

ID Number/Old Member	New identification number, old Social Security Number
Effective Date of Coverage	Date the member became eligible for BlueCare Plus
Future Disenroll Date	Date member will be disenrolled from the BlueCare Plus program. This date will change if the Division of TennCare notifies us of eligibility status change
Effective with PCP	Date member became effective with PCP

The Primary Care Provider change considered initiated when:

- A member calls in a PCP change request to BlueCare Plus Customer Service line;
- A member mails in a written PCP change request to BlueCare Plus Customer Service
- A member mails a postage-paid PCP Change Card to BlueCare Plus (cards are available in the Member's BlueCare Plus Directory and BlueCare Plus Member Handbook or
- PCP Change Form faxed to BlueCare Plus are only accepted if the member is:
    - New to BlueCare Plus or in need of help submitting the change.
    - Reflect reason for change in the form.
- PCP change requests are made effective on the date of the request.
  Miscellaneous PCP Assignment Information
- When a member requests a new PCP, the member must fall within the PCP's stated patient accept criteria
- If a PCP wants to change his/her patient accept criteria, he/she must submit a written request to the Provider Management Department. This request can be submitted on a Primary Care Provider Change Form or on the PCP's letterhead and mail to:

BlueCare Plus
1 Cameron Hill, Circle Ste 0002
Chattanooga, TN 37402-9025

Fax to BlueCare Plus PCP Department
Attention: PCP Change Team
1-855-876-1481

BlueCare Plus
Tennessee

Primary Care Provider (PCP)
Change Request Form

Fill out this form and mail to:
BlueCare Plus | 1 Cameron Hill Circle, Suite 0039 | Chattanooga, TN 37402
When you choose a new PCP, we'll send you a letter to let you know we made the change.

Member Information

Your Name: _____
First Last MI

Your Address: _____

City: _____ State: _____ Zip: _____

Your Member ID number: _____ Your Birth Date: ____ / ____ / ____
(Your Member ID number can be found on your BlueCare Plus member card.) Month Day Year

Phone Number: ( ) _____
Area Code

PCP 1st Choice

Name of PCP you want: _____
First Last

Office Address: _____

Telephone Number: ( ) _____
Area Code

PCP 2nd Choice

Name of PCP you want: _____
First Last

Office Address: _____

Telephone Number: ( ) _____
Area Code

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IV. Provider Requirements

A. Provider Networks

Participation in BlueCross BlueShield of Tennessee/Volunteer State Health Plan, dba BlueCare Plus (BlueCare Plus) Provider Networks requires satisfaction of applicable network participation and credentialing requirements.

Providers interested in expanding their participation in BCBST/BlueCare Plus Provider Networks or needing to communicate any changes in their practice may call their local Provider Network Manager.

1. Network Participation Criteria

BlueCross BlueShield of Tennessee has established Network Participation Criteria detailing the terms and conditions for participation in in one of our Provider Networks. These Terms and Conditions will be consistently applied to all Providers regardless of participation status. These Terms and Conditions will apply to any Provider who:

- is a Network Provider;
- is recruited by the Plan;
- requests participation or re-applies for participation;
- re-applies following voluntary or involuntary termination of Provider's participation;
- has a significant change in practice, or other intervening event or activity, which initiates a re-application and/or reconsideration of the Provider's current participation status.

2. Changes in Practice

Certain federal and state regulations may require BCBST/BlueCare Plus contracted Providers to timely notify us of any changes to their street address, telephone numbers, office hours, and any other changes that impact availability.

If you have moved, acquired an additional location, changed your status for accepting patients, or made other changes to your practice:

- E-mail a completed Provider Change Form to https://www.bcbst.com/providers/forms/Practitioner_Change_Form.pdf and any attachments to us at PNS_GM@bcbst.com; and
- Update your Provider profile on the Council for Affordable Quality Healthcare (CAQH®) website at http://proview.caqh.org/Login/Index?ReturnUrl=%2f.

Taking these steps will confirm that all information for contracting and credentialing is correct and help ensure Provider directories utilized by Members contain the most current and correct information about their practice.

The following may require reconsideration for continued participation of a currently contracted Provider, immediate termination of a contracted Provider, review of the initial application by a non-contracted Provider, or re-application for participation by a non-contracted Provider.

BCBST and BlueCare Plus reserves the right to interpret and apply these criteria in its sole discretion and judgment. Any Provider adversely affected by BCBST/BlueCare Plus's application of these criteria will be entitled to the appropriate appeals procedure set

forth in the Provider Dispute Resolution Procedure or set forth in this Manual. In the event of a change of ownership mentioned below, Provider is required to adhere to the change of ownership policy in Attachment I.

Practitioner

Including but not limited to:

- Change in practice locations;
- Change in practice specialty;
- Entering into or exiting from a group practice;
- Change in ownership;
- Entering into or exiting from a group practice;
- Change in hospital privileges;
- Change in insurance coverage;
- Disciplinary or corrective action by licensing agency, federal agency (DEA, Medicare, Medicaid, etc.) or peer review committee;
- Malpractice claim(s) and/or judgment(s);
- Indictment, arrest, conviction or moral turpitude allegation;
- Adverse or adversarial relationship with BCBST/BlueCare Plus;
- Any material change, which affects the Practitioner's ability to perform its obligations to Members and/or BCBST/BlueCare Plus;
- Any material change in the information submitted on the pre-application or application.

Institutional, Ancillary Providers or Group Practice

Including but not limited to:

- Change in ownership;
- Malpractice claim(s) and/or judgment(s);
- Change in insurance coverage;
- Disciplinary or corrective action by licensing agency, federal agency (DEA, Medicare, Medicaid, etc.) or peer review committee. Disciplinary action includes (without Limitation) any change in license status, such as probation, or any extraordinary conditions or training mandated by any licensing agency, federal agency, or peer review committee beyond those normal educational requirements for all Providers to maintain a license.
- Adverse or adversarial relationship with BCBST/BlueCare Plus;
- Any material change which affects the organization's ability to perform its obligations to Member(s) and/or BCBST/BlueCare Plus;
- Any material change in the information submitted on the pre-application or application.

3. Providers Denied Participation

Providers denied participation in a BCBST/BlueCare Plus Provider Network for other than network need, may not be considered for reapplication for a minimum of one (1) year from the date of denial. Providers will be given reason for denial as well as notice when they may reapply to networks as determined by and at the Provider Participation Status Committee's (PPSC) sole discretion.

This requirement may be waived by BCBST/BlueCare Plus in its sole discretion.

4. Removal of Providers from BCBST/BlueCare Plus Provider Network

The PPSC will review and take action on all requests for removal of Providers from BCBST/BlueCare Plus Provider Networks including, but not limited to, lack of minimum participation standards, no malpractice insurance, aberrant billing practice, pattern of out of network referrals, or Providers that have (1) been arrested or indicted (2) been convicted of a crime (3) committed fraud or (4) been accused or convicted of any offense involving moral turpitude in any jurisdiction, in addition to the other reasons set forth in the Provider's Agreement. If the PPSC determines a Provider falls within any of these termination reasons, a Provider may be immediately terminated from the BCBST/BlueCare Plus Networks or BCBST/BlueCare Plus may refuse participation in any BCBST/BlueCare Plus Networks.

The PPSC may also address any contractual breach of contracts that can lead to terminating a network Provider. In either event, Provider shall not be considered, at the discretion of BCBST/BlueCare Plus, for network participation for a minimum of two (2) years after the date of the resolution of the offense or allegation, except as otherwise provided by applicable laws. Provider's initial or continued participation shall not be considered, at the discretion of BCBST/BlueCare Plus, unless the charges are dismissed or otherwise resolved in the Provider's favor.

The PPSC has delegated the responsibility for initiating administrative terminations to the Provider Network Operations (PNO) Department. If the PNO staff confirms all BCBST/BlueCare Plus policies and procedures were followed related to such administrative terminations, notice of termination may be sent without committee review. If the PNO staff determines there are unique circumstances that warrant a committee level review, the termination action will be brought to the PPSC. A list of the reasons for administrative termination of a provider's participation include, without limitation:

- Loss of License
- Loss of DEA Registration, if applicable
- Medicare/Medicaid or CHIP Sanctions
- Failure to submit all required information necessary to complete the BCBST/BlueCare Plus Credentialing or Recredentialing process
- Lack of Network Specific Admitting Privileges (or provision of coverage by a BCBST/BlueCare Plus participating Provider)
- Lack of Network Specific 24 Hour Coverage
- Retired/Deceased/Moved out of State
- Excluded from participation in the Medicare/Medicaid and/or CHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TennCare program
- Advocacy revoked by the Tennessee Medical Foundation
- Lack of Electronic Funds Transfer
- Lack of Paperless Claims Filing
- No Claims Activity Within 12 Consecutive Months (Provider NPI does not appear on claims in previous 12 months)
- Appearance on the Medicare Opt-Out List
- Appearance on the CMS Preclusion List
- Termination of Medicaid ID/participation by TennCare (if applicable)

A report will be submitted to the PPSC reflecting administrative terminations at least quarterly. Providers that are removed from a BCBST Participating Network may reapply in accordance with the Network Participation Criteria or the timeframe set forth in the Provider termination notice.

In those cases where a Provider is removed from all BCBST/BlueCare Plus Networks, credentials will be suspended the effective date of contract termination. Upon exhaustion of the contract termination appeal process, credentials will be discontinued.

5. Provider Termination Appeal Process

Except as set forth herein, Providers whose network participation has been terminated pursuant to the terms of their contract may be entitled to the procedural remedies set forth below.

- All notices concerning Provider Network Management contract terminations with cause or without cause are communicated according to the provisions in the Provider's contract.
- Termination notices sent to Providers will include instructions on appealing the termination decision.
- Providers (except as set forth in Paragraph 3 below) whose network participation has been terminated without cause may take any dispute concerning this termination to binding arbitration as set forth in section 1(c) below.

1. APPEAL OF WITH CAUSE TERMINATION OF A PARTICIPATING PROVIDER
    a. Reconsideration
        i. The Provider may request a reconsideration of BCBST's decision by submitting a request in writing within thirty (30) days of the date of the notice of termination to the Provider. Failure to meet this requirement will result in a waiver of the right to appeal the termination. PPSC will send to Provider a response to this request for reconsideration.
    b. Appeal
        i. If Provider is not satisfied with BCBST's response to Provider's reconsideration request, Provider may request an appeal by telephonic hearing. Provider must request in writing a telephonic hearing no later than fourteen (14) days of BCBST's decision on Provider's request for reconsideration. Failure to meet this requirement will result in a waiver of the right to a telephonic hearing.
        ii. Following receipt of a written request for a telephonic hearing from a Provider pursuant to section 1.b.i, BCBST will contact the Provider to establish a mutually acceptable date and time for the telephonic hearing, which generally shall be conducted within the thirty (30) day period following receipt of the written request. If the Provider fails to appear at the hearing without good cause, the right to schedule another hearing is forfeited.
        iii. For Practitioners, telephonic hearings shall be conducted by a panel chosen by BCBST.
        iv. For Institutional and Ancillary Providers, telephonic hearings shall be conducted by a hearing officer chosen by BCBST.
        v. Formal rules of evidence or legal procedure will not be applicable during any telephonic hearing.
        vi. In addition to any procedure adopted by the Panel/Hearing Officer, for telephonic hearings:
            1. The Provider has the right to be represented by an attorney or other representative. If the Provider elects to be represented, such representation shall be at his or her own expense.
            2. The hearing may be recorded by a court reporter at BCBST's discretion.
            3. The Provider and BCBST must provide the other party with a list of witnesses expected to testify on their respective behalf during the hearing and any documentary evidence that it expects to present during the hearing, as soon as possible following issuance of the notice of hearing. Either party may amend that list at any time not less than ten (10) working days before the date of the hearing.
            4. Each party has the right to inspect and request copies of any documentary information that the other party intends to present during the hearing, at the inspecting party's expense upon reasonable advance notice.
            5. During the hearing, each party has the right to:
                a. Call witnesses
                b. Cross-examine opposing witnesses
            6. Following the hearing, each party may obtain copies of any record of the hearing, upon payment of the charges for that record.
        vii. The Panel/Hearing Officer will send BCBST and the Provider a written response within sixty (60) days of the date of the telephonic hearing. The Panel's/Hearing Officer's decision will be reviewed by the PPSC and BCBST's final decision will be sent to the Provider.
    c. Binding Arbitration

i. If the Provider is not satisfied with BCBST's final decision, the next and final step is binding arbitration. The Provider may make a written demand that the matter be submitted to binding arbitration pursuant to Section XIV(B) – Provider Dispute Resolutions Procedure.

2. APPEAL OF DENIAL OF APPLICATION OF AN APPLICANT
    a. Written Appeal
        i. A Provider may appeal by submitting a written statement of his/her position within thirty (30) days of the notice of the denial of application. The written appeal will be reviewed by the PPSC. A written response will be sent to the Provider within sixty (60) days of our receipt of the written appeal.
    b. Binding Arbitration
        i. If the Provider is not satisfied with the PPSC's decision, the next and final step is binding arbitration. The Provider may make a written demand that the matter be submitted to binding arbitration pursuant to Section XIV(B) – Provider Dispute Resolution Procedure.

3. APPEAL OF TERMINATION BY A PARTICIPATING PHYSICIAN IN BLUECARE PLUS NETWORKS
    a. Physicians terminated with or without cause from BCBST's BlueCare Plus networks shall be afforded the procedural rights set forth in subsection 1 above.

6. Participation in BlueCare Plus Networks

Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCross BlueShield of Tennessee, Inc. and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.

	Network Attribute	DSNP
I.	**Tennessee/Contiguous Counties**	Required
II.	**State License**	
	1. License to practice is Current and Valid	Required
	2. License to practice is Unrestricted as to services performed	Required
	3. If the Provider's medical license has been revoked, suspended or not renewed (a license "revocation") by any jurisdiction, for cause, or the Provider has surrendered or agreed to surrender license to avoid such a revocation, Provider will be considered for participation at a minimum of one (1) year after the date that Provider's license was re-instated, except as otherwise provided by applicable laws. If such a license revocation action is pending or initiated against a Provider, Provider's participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider maintains licensure.	Required
III.	**Malpractice Insurance**	$1 million/$3 million unless State employee
IV.	**Accept Terms of Contract**	Required
V.	**Board Certified/Eligible**	Required
VI.	**Must be able to meet Credentialing and Re-credentialing Requirements**	Required
VII.	**Successful Site Evaluation**	Required for Primary Care and High Volume Specialists
	Factors reviewed at site visit are: Accessibility/appearance, Risk Management Polices/Procedures, access/availability of medical services, medical records administration, and valid certification for regulated services and personnel.	
VIII.	**Admitting Privileges**	
	Maintain admitting privileges (*or provision for coverage* by a BCBST participating Provider) with a BCBST network hospital*	Required
IX.	**Availability Standards**	
	Network participation is dependent on the business needs of BlueCross BlueShield of Tennessee, Inc. and its affiliates	
	1. Primary Care	No limits to size. Must meet Network Availability Standards

	2. Hospital Based	Affiliated with Participating Hospital
	Anesthesiology (*includes CRNAs)*	Fee Schedule
	Pathology	Fee Schedule
	Radiology	Fee Schedule
	Emergency Room	Fee Schedule
	Hospital required to deliver	Yes
	3. Specialists	No limits to size; Must meet Network Availability Standards
X.	**Member Access Standards**	
	1. Agrees to provide care to members within BCBST standards	Required
	2. Demonstrates a practice history, which BCBST deems consistent and comparable with Providers' ability to comply with these standards.	Required
	2.1 Regular: Routine Examination, TENNderCARE, Preventive Care, Physical Exam	**Adult** - Annual; Within a year of the last scheduled physical after coverage becomes effective, or if last physical is greater than one year, within 3 months. **Children** - According to the American Academy of Pediatrics periodicity schedule
	2.2 Prenatal Care:	
	First Trimester	To be seen in the first trimester, ≤ 6 weeks of woman's questioning pregnancy
	Second Trimester	If the first appointment is beyond the 1st trimester, ≤ 15 days
	2.3 Urgent Care (Adult & Child)	≤ 48 hours
	2.4 Emergency Care (Adult & Child)	Immediate - refer to facility-based providers
	2.5 Specialty Care (Adult & Child)	As practitioner deems appropriate for condition or follow-up
	2.6 Wait Times	

	1) Office Wait Time (including lab and X-ray)	≤ 45 minutes

	2) Member Telephone Call (during office hours):	
	Urgent	<15 minutes
	Routine	24 hours
	3) Member Telephone Call (after office hours):	
	Urgent	≤ 30 minutes
	Routine	≤ 90 minutes
	2.7 7Day/24 Hour Coverage through Par Providers	Required
	3. Open Practice	No
	4. Service Area Definition	TN & Contiguous Counties
XI.	**Reimbursement**	
	1. Agrees to the price and reimbursement schedule for the Network	Required
	2. Agrees to the reimbursement methodology:	Required
	3. Agrees not to balance bill member	Required
	4. Delegation	Subject to minimum criteria and approval by Delegated Oversight Committee
	5. Administrative Services Only (ASO) Available	Yes
	6. Acceptance of Electronic Funds Transfer (EFT)	Required
	7. Electronic Claims Submission	Required
XII.	**Quality Improvement/Utilization Review/Medical Management Program**	
	1. Cooperate with BCBST QI & UM Programs	Required
	2. Maintain a QI/UM Plan	Required
	3. Demonstrate practice style and history, which BCBST deems consistent and comparable with BCBST quality management program standards and practices.	Required

	4. Meet BCBST acceptable practice pattern analysis performance parameters related to quality of care, patient satisfaction and cost efficiency.	Required
XIII.	**General Provisions**	
	1. Meet member satisfaction standards - Based on member complaints, grievances, and satisfaction survey	Required
	2. Demonstrate willingness to cooperate with other Providers, hospitals and health care facilities	Required
	3. Agree to participate in exclusive arrangements	
	4. Satisfactory record on fraud and abuse and billing practices	Required
	5. Practice style which is consistent with current standards of medical delivery	Required
	6. Prescribing pattern, which is consistent with BCBST's quality management program.	Required
	7. If the Provider's Drug Enforcement Administration Certificate, Controlled Dangerous Substances Certificate, or any schedules thereof have been revoked, suspended or not renewed (a "revocation") by any jurisdiction, for cause, or surrendered to avoid imposition of such revocation, Provider shall not be considered for participation at a minimum of one (1) year after the date that Provider was re-issued a certificate or schedule, except as otherwise provided by applicable laws. If such a certificate or schedule revocation action is pending or initiated against a Provider, Provider's participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider retains certification or schedules.	Required
	8. If the Provider has: (1) been indicted; (2) been convicted of a crime; (3) committed fraud; or (4) been accused or convicted of any offense involving moral turpitude in any jurisdiction, Provider may be immediately terminated from the BCBST Networks or BCBST may refuse participation in any BCBST Networks. In either event, Provider will be considered, at the discretion of BCBST for participation for a minimum of two (2) years after the date of the resolution of the offense or allegation, except as otherwise provided by applicable laws. Provider's initial or continued participation shall not be considered, at the discretion of BCBST, unless the charges are dismissed or otherwise resolved in the Provider's favor.	Required

	9. Not currently excluded from Medicare, Medicaid or Federal Procurement and Non-Procurement Program(s), or SCHIP.	Required
	10. Term of Contract	Minimum 180 Day Termination
	11. Abide by Terms of BCBST Provider Dispute Resolution Procedure	Required
	12. Exclusivity Allowed	No
	13. Defined Service Area	Statewide
	14. If Provider has established an adversarial relationship with BCBST, members or participating Providers that might reasonably prevent the Provider from acting in good faith and in accordance with applicable laws or the requirements of BCBST's agreements with that Provider, other Providers, members or other parties. Provider may not be considered for initial or continued participation in BCBST Networks. As examples, such adversarial relationships include, but are not limited to: credible evidence of making defamatory statements about BCBST; initiating legal or administrative actions against BCBST in bad faith; BCBST's prior or pending termination of the Provider's participation agreement for cause; or prior or pending collection actions against members in violation of an applicable hold harmless requirement. This participation criterion is not intended to prevent the Provider from fully and fairly discussing all aspects of a patient's medical condition, treatment or coverage (i.e. to "gag" the Provider from discussing relevant matters with members). Involving Members or third parties in disputes with BCBST prior to receiving a final determination of that dispute in accordance with BCBST's Provider Dispute Resolution Procedure may be deemed, however, to constitute an adversarial relationship with BCBST.	Required Required
	15. Provider's network participation agreement has not been terminated, for other than administrative reasons, within the past year. Examples of administrative terminations are failure to complete the credentialing process, failure to maintain hospital privileges at a network hospital, or no claims activity in previous 12 months. For administrative terminations, Provider may reapply upon cure of the deficiency.	Required

Minimum Institutional Provider Network Participation Criteria

Acute Care Hospitals, Ambulatory Surgical Facilities, Birthing Centers, Dialysis Centers, Inpatient Rehabilitation, Outpatient Rehabilitation, Skilled Nursing Facilities**, Mobile X-ray Labs,** and Sleep Centers**.**

Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BCBST and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.

	Network Attribute	DSNP
I.	**Tennessee/Contiguous Counties**	Required
II.	**State License**	
	1. License is Current and Valid.	Required, as applicable (See Exhibit B-1)
	2. License is Unrestricted as to services performed.	Required, as applicable (see Exhibit B-1)
	3. If the Provider's license has been revoked, suspended or not renewed (a license "revocation") by any jurisdiction, for cause, or if the Provider has surrendered license or agreed to surrender license to avoid such a revocation, the Provider will be considered for participation at a minimum of one (1) year after the date that license was re-issued, except as otherwise provided by applicable laws. If such a license revocation action is pending or initiated against a Provider, the Provider's participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider retains license.	Required
III.	**Malpractice Insurance**	$1 million/$3 million unless State employee
IV.	**Medicare Certification Requirements**	Required, as applicable (see Exhibit B-1)
V.	**Accreditation Requirements**	Required, as applicable (see Exhibit B-1)
VI.	**Accept Terms of Contract**	Required
VII.	**Meet Credentialing and Recredentialing Requirements**	Required
VII.I	**1.** Institutional Providers	No limits to size. Must meet Network Availability Standards.
IX.	**Member Access Standards**	
	1. Agrees to provide care to members within BCBST standards	Required
	2. Demonstrates a medical delivery history, which BCBST deems consistent and comparable with Providers ability to comply with these standards.	Required
	3. Service Area Definition	TN & Contiguous Counties

	Network Attribute	DSNP
	4. Hospitals that are contracted in out-of-state counties which are contiguous to Tennessee must meet the minimum criteria to justify commercial network participation. Minimum criteria includes but is not limited to satisfaction of minimum claim volume and membership thresholds as well as market impact analysis	Required
X.	**Reimbursement**	
	1. Agrees to the price and reimbursement schedule for the Network	Required
	2. Agrees to the reimbursement methodology:	Required
	3. Agrees not to balance bill member	Required
	4. Delegation	Subject to minimum criteria and approval by Delegated Oversight Committee
	5. Administrative Services Only (ASO) Available	Yes
	6. Acceptance of Electronic Funds Transfer (EFT)	Required
	7. Electronic Claims Submission	Required
XI.	**Quality Improvement/Utilization Review/Medical Management Program**	
	1. Cooperate with BCBST QI & UM Programs	Required
	2. Maintain a QI/UM Plan	Required
	3. Demonstrate medical delivery style and history, which BCBST deems consistent and comparable with BCBST quality management program standards and practices.	Required
XII.	**General Provisions**	Required
	1. Meet Member satisfaction standards – Based on member complaints, grievances, and satisfaction survey	Required
	2. Demonstrate willingness to cooperate with other Providers, hospitals and health care facilities	Required
	3. Agree to participate in exclusive arrangements	
	4. Satisfactory record on fraud and abuse and billing practices	Required
	5. Medical Delivery style which is consistent with current standards of medical delivery	Required

	Network Attribute	DSNP
	6. Claims filing method	CMS-1450
	7. If any person who has an ownership interest of the Provider has: (1) been indicted (2) been convicted of a crime (3) committed fraud or (4) been accused or convicted of any offense involving moral turpitude in any jurisdiction, Provider may be immediately terminated from the BCBST Networks or BCBST may refuse participation in any BCBST Networks. In either event Provider will be considered, at the discretion of BCBST, for participation for a minimum of two (2) years after the date of the resolution of the offense or allegation, except as otherwise provided by applicable laws. Provider's initial or continued participation shall not be considered, at the discretion of BCBST, unless the charges are dismissed or otherwise resolved in the Provider's favor.	Required
	8. Not currently excluded from Medicare, Medicaid or Federal Procurement and Non-Procurement Program(s) or SCHIP.	Required
	9. Term of Contract	See Exhibit B-1
	10. Abide by Terms of BCBST Provider Dispute Resolution Procedure	Required
	11. Exclusivity Allowed	No
	12. Defined Service Area	Statewide
	13. Provider has not established an adversarial relationship with BCBST or its affiliates, members or participating Providers that might reasonably prevent the Provider from acting in good faith and in accordance with applicable laws or the requirements of BCBST's agreements with that Provider, other Providers, members or other parties. As examples, such adversarial relationships include, but are not limited to: creditable evidence of making defamatory statements about BCBST; initiating legal or administrative actions against BCBST in bad faith; BCBST's prior or pending termination of the Provider's participation agreement for cause; or prior or pending collection actions against members in violation of an applicable hold harmless requirement. This participation criterion is not intended to prevent the Provider from fully and fairly discussing all aspects of a patient's medical condition, treatment or coverage (i.e. to "gag" the Provider from discussing relevant matters with members). Involving Members or third parties in disputes with BCBST prior to receiving a final determination of that dispute in accordance with BCBST's Provider Dispute Resolution Procedure may be deemed, however, to constitute an adversarial relationship with BCBST.	Required
	14. Provider's network participation agreement has not been terminated, for other than administrative reasons, within the past year. Examples of administrative terminations are failure to complete the credentialing process. For administrative terminations, Provider may reapply upon cure of the deficiency.	Required

Exhibit B-1

Minimum Institutional Provider Network Participation Criteria

Network Attribute	DSNP
State License Requirements	
Acute Care Hospitals	**TN**: Licensed as an Acute Care Facility **Contiguous**: Licensed in accordance with that state's licensing law
Ambulatory Surgical Facility (ASF)	**TN**: Licensed as an Ambulatory Surgery Facility **Contiguous**: Licensed in accordance with that state's licensing laws
Ambulatory Surgical Facility, Birthing Center	**TN: Licensed as a Birthing Center** **Contiguous: Licensed in accordance with that state's licensing laws**
Dialysis Center	**TN**: Licensed as a Dialysis Center
Inpatient Rehabilitation	**TN**: Licensed as an Inpatient Rehabilitation Facility **Contiguous**: Licensed in accordance with that state's licensing laws
Outpatient Rehabilitation	**TN**: Does not license Outpatient Rehabilitation Facilities **Contiguous**: Licensed in accordance with that state's licensing laws
Skilled Nursing Facility (SNF)	**TN**: Licensed as a Skilled Nursing Facility **Contiguous**: Licensed in accordance with that state's licensing laws
Sleep Labs/Centers	TN: **Does not license Sleep Centers** Contiguous: Licensed in accordance with that state's licensing laws
Mobile X-ray Lab	TN: **Does not license Mobile X-ray Labs** **Contiguous: Licensed in accordance with that state's licensing laws.**
Pain Management Centers	TN: **Licensed as an Ambulatory Surgery Facility** Contiguous**: Licensed in accordance with that state's licensing laws.**

Network Attribute	DSNP
Accreditation and/or Certification Requirements	
Acute Care Hospital	JC, AOA, CHAP or ACHC and Medicare A or State Site Survey
Ambulatory Surgical Facility (ASF)	JC, AOA, AAAHC, or AAAASF, and Medicare B
Ambulatory Surgical Facility, Birthing Center	JC, AOA, CHAP, ACHC or Medicare B
Dialysis Center	Medicare A
Inpatient Rehabilitation	JC, CARF or AOA and Medicare A
Outpatient Rehabilitation	Medicare A or Mental Health License
Skilled Nursing Facility	Medicare A
Sleep Labs/Centers	AASM and Medicare B
Mobile X-ray Lab	Medicare Part B
Pain Management Centers	CARF or American Academy of Pain Management
Term of Contract	
Acute Care Hospital	3 years initially; annually thereafter, 120 day notification prior to expiration of 3 year term
Ambulatory Surgical Facility (ASF)	Annual; 120 days prior to anniversary of effective date
Ambulatory Surgical Facility, Birthing Center	Annual; 120 days prior to anniversary of effective date
Dialysis Center	Annual; 180 day clause
Inpatient Rehabilitation	Annual; 180 day clause
Outpatient Rehabilitation	Annual; 180 day clause
Skilled Nursing Facility (SNF)	Annual; 180 day clause
Sleep Labs/Centers	Annual; 180 day clause
Mobile X-ray Lab	Annual; 180 day clause

Network Attribute	DSNP
Pain Management Centers	Annual, 120 days prior to anniversary of effective date

Minimum Ancillary Provider Network Participation Criteria

Home Health, Home Infusion, Durable Medical Equipment (includes Specialty DME and Prosthetic/Orthotic DME), Hospice and Independent Laboratory

Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCross BlueShield of Tennessee, Inc. and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.

	Network Attribute	DSNP
I.	**Tennessee/Contiguous Counties**	Required
II.	**State License**	
	1. License to practice is Current and Valid	Required, as applicable (see Exhibit B-1)
	2. License to practice is Unrestricted as to services performed.	Required, as applicable (see Exhibit B-1)
	3. If the Provider's license has been revoked or not renewed (a license "revocation") by any jurisdiction, for cause, or surrendered to avoid such a revocation, Provider will be considered for participation a minimum of one (1) year after the date that license was re-issued, except as otherwise provided by applicable laws. If such a license revocation action is pending or initiated against a Provider, the Provider's participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider retains license.	Required
III.	**Minimum Insurance Requirements**	Required, as applicable (see Exhibit B-1)
IV.	**Medicare Certification Requirements**	Required, as applicable (see Exhibit B-1)
V.	**Accreditation Requirements**	Required, as applicable (See Exhibit B-1)
VI.	**Accept Terms of Contract**	Required
VII.	**Meet Credentialing and Recredentialing Requirements**	Required

VIII.	**1.** Ancillary Providers	Limited Network. Must meet Network Availability Standards.
IX.	**Member Access Standards**	
	1. Agrees to provide care to members within BCBST standards	Required
	2. Demonstrates a medical delivery history, which BCBST deems consistent and comparable with Providers' ability to comply with these standards.	Required
	3. Service Area Definition	TN & Contiguous Counties
X.	**Reimbursement**	
	1. Agrees to the price and reimbursement schedule for the Network	Required
	2. Agrees to the reimbursement methodology:	Required
	3. Agrees not to balance bill member	Required
	4. Delegation	Subject to minimum criteria and approval by Delegated Oversight Committee
	5. ASO Available	Yes
	6. Acceptance of Electronic Funds Transfer (EFT)	Required
	7. Electronic Claims Submission	Required
XI.	**Quality Improvement/Utilization Review/Medical Management Program**	
	1. Cooperate with BCBST QI & UM Programs	Required
	2. Maintain a QI/UM Plan	Required
	3. Demonstrate medical delivery style and history, which BCBST deems consistent and comparable with BCBST quality management program standards and practices.	Required
	4. Agrees to Rapid Response Requirement	Required, as applicable (See Exhibit B-1)
XII.	**General Provisions**	
	1. Meet Member satisfaction standards – Based on member complaints, grievances, and satisfaction survey	Required

	2. Demonstrate willingness to cooperate with other Providers, hospitals and health care facilities.	Required
	3. Agree to participate in exclusive arrangements	Required/Negotiated
	4. Satisfactory record on fraud and abuse and billing practices	Required
	5. Medical Delivery style which is consistent with current standards of medical delivery	Required
	6. Claims filing method	Required, as applicable (See Exhibit B-1)
	7. Must provide all services	No
	8. Services must be available in all counties of a CSA (subcontracting permitted)	No
	9. CLIA Certificate	Required for Independent Labs only
	10. Valid contract with CAREMARK®	Required for Home Infusion only
	11. If any person who has an ownership interest of the Provider has: (1) been indicted (2) been convicted of a crime (3) committed fraud or (4) been accused or convicted of any offense involving moral turpitude in any jurisdiction, Provider may be immediately terminated from the BCBST Networks or BCBST may refuse participation in any BCBST Networks. In either event Provider will be considered, at the discretion of BCBST, for participation for a minimum of two (2) years after the date of the resolution of the offense or allegation, except as otherwise provided by applicable laws. Provider's initial or continued participation shall not be considered, at the discretion of BCBST, unless the charges are dismissed or otherwise resolved in the Provider's favor.	Required
	12. Not currently excluded from Medicare, Medicaid or Federal Procurement and Non-Procurement Program(s), or SCHIP.	Required
	13. Term of Contract	See Exhibit B-1
	14. Abide by Terms of BCBST Provider Dispute Resolution Procedure	Required
	15. Exclusivity Allowed	No
	16. Defined Service Area	Statewide

	17. Provider has not established an adversarial relationship with BCBST, members or participating Providers that might reasonably prevent the Provider from acting in good faith and in accordance with applicable laws or the requirements of BCBST's agreements with that Provider, other Providers, members or other parties. As examples, such adversarial relationships include, but are not limited to: credible evidence of making defamatory statements about BCBST; initiating legal or administrative actions against BCBST in bad faith; BCBST's prior or pending termination of the Provider's participation agreement for cause; or prior or pending collection actions against members in violation of an applicable hold harmless requirement. This participation criterion is not intended to prevent the Provider from fully and fairly discussing all aspects of a patient's medical condition, treatment or coverage (i.e. to "gag" the Provider from discussing relevant matters with members). Involving Members or third parties in disputes with BCBST prior to receiving a final determination of that dispute in accordance with BCBST's Provider Dispute Resolution Procedure may be deemed, however, to constitute an adversarial relationship with BCBST.	Required
	18. Provider's network participation agreement has not been terminated, for other than administrative reasons, within the past year. Examples of administrative terminations are failure to complete the credentialing process. For administrative terminations, Provider may reapply upon cure of the deficiency.	Required

Exhibit B-1

Minimum Ancillary Provider Network Participation Criteria

Network Attribute	DSNP
State License Requirements	
Home Health	**TN**: Licensed as a Home Health Provider **Contiguous**: Licensed in accordance with that state's licensing laws
Home Infusion Therapy	**TN**: Licensed as a Home Health Provider **Contiguous**: Licensed in accordance with that state's licensing laws

Durable Medical Equipment	**TN**: Licensed as a Home Infusion Therapy Provider **Contiguous**: Licensed in accordance with that state's licensing laws
Prosthetic/Orthotic Durable Medical Equipment Suppliers	**TN**: does not license Prosthetic/Orthotic Durable Medical Equipment Suppliers **Contiguous**: Licensed in accordance with that state's licensing laws
Specialty Durable Medical Equipment Suppliers *(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)*	**TN**: does not license Prosthetic/Orthotic Durable Medical Equipment Suppliers **Contiguous**: Licensed in accordance with that state's licensing laws
Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)	
Hospice	**TN**: Licensed as a Hospice Provider
State License Requirements (cont'd)	
Independent Laboratory	**TN**: Licensed as a Medical Laboratory **Contiguous**: Licensed in accordance with that state's licensing laws
Minimum Insurance Requirements	
Malpractice Insurance	$1 million/$3 million unless State employee
Comprehensive Insurance (DME Only)	$1 million/$3 million unless State employee
Product Liability (Breast Prosthesis Only)	$500,000
Medicare Certification Requirements	
Home Health	Medicare Part A
Home Infusion Therapy	Medicare Part B
Durable Medical Equipment	Medicare Part B
Prosthetic/Orthotic Durable Medical Equipment Suppliers	Medicare Part B

Specialty Durable Medical Equipment Suppliers *(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)*	Medicare Part B
Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)	Medicare Part B
Hospice	Medicare Part A
Independent Laboratory	Medicare Part B
Accreditation Requirements	
Home Health	N/A
Home Infusion Therapy	N/A
Durable Medical Equipment	JC or CHAP or AAAHC, BOC, The Compliance Team, ABC, NBAOS, CARF, HQAA, ACHC
Prosthetic/Orthotic Durable Medical Equipment Suppliers	N/A
Specialty Durable Medical Equipment Suppliers *(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)*	JC or CHAP or AAAHC, if applicable
Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)	N/A
Hospice	N/A
Independent Laboratory	N/A
Agrees to Rapid Response Requirement	
Home Health	Yes
Home Infusion Therapy	Yes
Durable Medical Equipment	Yes
Prosthetic/Orthotic Durable Medical Equipment Suppliers	N/A
Specialty Durable Medical Equipment Suppliers *(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)*	N/A
Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)	N/A
Hospice	N/A

Independent Laboratory	N/A
Claims Filing Method	
Home Health	CMS-1450
Home Infusion Therapy	CMS-1500
Durable Medical Equipment	CMS-1500
Prosthetic/Orthotic Durable Medical Equipment Suppliers	CMS-1500
Specialty Durable Medical Equipment Suppliers *(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)*	CMS-1500
Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)	CMS-1500
Hospice	CMS-1450
Independent Laboratory	CMS-1500
Must Provide all Services	
Home Health	N/A
Home Infusion Therapy	N/A
Durable Medical Equipment	N/A
Prosthetic/Orthotic Durable Medical Equipment Suppliers	N/A
Specialty Durable Medical Equipment Suppliers *(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)*	N/A
Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)	N/A
Hospice	N/A
Independent Laboratory	N/A
Services must be available in all counties of a CSA (*subcontracting permitted)*	
Home Health	N/A
Home Infusion Therapy	N/A

Durable Medical Equipment	N/A
Prosthetic/Orthotic Durable Medical Equipment Suppliers	N/A
Specialty Durable Medical Equipment Suppliers *(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)*	N/A
Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)	N/A
Hospice	N/A
Independent Laboratory	N/A
Term of Contract	
Home Health	180 days
Home Infusion Therapy	180 days
Durable Medical Equipment	180 days
Prosthetic/Orthotic Durable Medical Equipment Suppliers	180 days
Specialty Durable Medical Equipment Suppliers *(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)*	180 days
Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)	180 days
Hospice	180 days
Independent Laboratory	60 days

7. Provider Identification Number Process

Before submitting claims to BlueCare Plus, a Provider must request and be assigned an individual provider identification number or contact us to register their National Provider Identifier (NPI). The purpose of this number is to identify the Provider and ensure accurate distribution of payments, remittance advices (Explanation of Payments (EOPs), and 1099 forms. **The assigned provider number or NPI in no way signifies that the Provider participates in any or all BlueCross BlueShield of Tennessee/BlueCare Plus networks.**

Inquiries regarding the need for a new provider number or to register their NPI should be directed to:

- BlueCare Tennessee Provider Service line, 1-800-468-9736, and say “Contracts” when prompted.

8. Provider Rights and Responsibilities

BlueCare Plus Network Providers have a right to:

- Receive information about the managed care organization, its services, and its members' rights and responsibilities.
- Be treated with respect and recognition of their dignity and right to privacy.
- Require that Members follow the plans and instructions for care that they have agreed upon with their Providers.
- Be involved in the adoption of clinical practice guidelines.
- Discontinue treatment of a member with whom the Provider feels he/she cannot establish or maintain a professional relationship in accordance with the Contractor Risk Agreement.
- Specify the functions and/or services to be provided in order to ensure that these functions and/or services to be provided are within the scope of his/her professional/technical practice.
- Be paid upon receipt of a clean claim properly submitted by the Provider within the required time frames as specified in T.C.A. 56-32-226 and Section 2-9.g. of the Contractor Risk Agreement.

BlueCare Plus Network Providers have the responsibility to:

- Recognize and abide by all applicable state and federal laws, regulations, and guidelines.
- Assist in such reviews including the provision of complete copies of medical records.
- Provide Members and their representatives with access to their medical records.
- Treat Member with respect and recognition of their dignity and right to privacy.
- Allow Member participation in decision-making regarding their health care.
- Discuss Medically Appropriate or Medically Necessary treatment options for their conditions, regardless of cost or benefit coverage.
- Provide, to the extent possible, information that the managed care organization needs in order to provide quality care and service to members.
- Participate in the development and implementation of specific quality management activities, including identifying, measuring, and improving aspects of care and service.
- Serve as a conduit to the Practitioner community regarding the dissemination of quality and other health care information.
- Abide by the accessibility and availability standards as set forth in the Physician Contract or Agreement.
- Provide Covered Services on 24-hour-a-day, 7-days-a-week basis with call coverage through Network BlueCare Plus Practitioners.
- Be capable of providing comprehensive health care services, in accordance with the network adequacy criteria for time/distance/patient volume, to their BlueCare Plus members. Comprehensive services shall include, but not be limited to:
    - Preventive health services;
    - Primary care services;
    - Home health care services;
    - Practitioner services; and
    - Hospital services, including emergency services.
- Be responsible for supervising or coordinating the provision of initial and primary care to Members; for initiating specialty care; and for monitoring the continuity of Member care services.

B. Provider Credentialing

1. Introduction

The BlueCross BlueShield of Tennessee/BlueCare Tennessee Credentialing Program was established August 1, 1995. The Credentialing Program is designed around goals that reflect the BCBST/BlueCare Tennessee mission, as well as regulatory and accrediting requirements.

In order to establish consistent standards for network participation, and to meet regulatory requirements, BlueCare Plus developed Network Participation Criteria. Practitioners applying for network admission are asked to complete an application through the Council for Affordable Quality Healthcare (CAQH) for individual professionals. BlueCare Plus partners with CAQH Solutions, which offers Providers a single point of entry for application information. Organizational Providers will utilize the BCBST Facility application information. Utilizing the CAQH application or Organizational Provider application, BCBST/BCT conducts a preliminary evaluation for network participation. Practitioners must complete the application in its entirety, submit the required documentation, and complete the credentialing process prior to network participation.

Verifying credentials of Practitioners, Organizational Providers, and other Health Care Professionals/Providers is an essential component of an integrated health care system. The Credentialing process incorporates an ongoing assessment of the quality-of-care services provided by those Practitioners, Organizational Providers, and other Health Care Professionals/Providers who wish to participate in the BCBST/BCT/BCP networks. Major components of the credentialing program include:

- Credentialing Committee
- Policies and Procedures
- Initial Credentialing Process
- Recredentialing Process
- Delegated Credentialing Activities

The Credentialing Committee (the Committee) is a peer review committee and is subject to the rights and privileges set forth in TCA Section 63-1-150. The Committee shall conduct peer review of those cases meeting the Exception Criteria of the Credentialing and Recredentialing of Practitioners policy (and other situations that involve peer review functions) and will evaluate each case individually.

The Committee may, in its discretion, allow credentialing or continued credentialing of certain Practitioners or Organizations who fall within the exception criteria and deny credentialing or terminate credentials of other Practitioners or Organizations who also fall within the exception criteria. It shall be within the Committee's discretion to assess and evaluate the facts of each individual case and determine whether it is in the best interest of BlueCare Plus members and BCT for a Practitioners or Organizations to be credentialed or credentialing continued. In its discretion, the Committee may deny all Practitioners or Organizations who fall within a certain exception criteria if the Committee determines that the health and welfare of BlueCare Plus members could be jeopardized by credentialing such Practitioners or Organizations, or continuing their credentialing (Credentialing Committee Discretion Policy).

Practitioners or Organizational Providers have the right to review information (received from outside sources excluding peer review protected information) submitted with their application; correct erroneous information within thirty (30) days of receipt of completed application by contacting us at the address, phone number and/or email address listed below; or be informed of the status of their credentialing/recredentialing application upon request. Inquiries regarding the Credentialing process and/or Credentialing applications should be addressed to the following:

Mailing Address:	**Telephone Inquiries:**	
BlueCross BlueShield of Tennessee	(Toll Free)	1-800-357-0395
Attn: Credentialing Department	(Fax)	1-423-535-8357
1 Cameron Hill Circle, Ste 0007	(Fax)	1-423-535-6711
Chattanooga, TN 37402-0007		

E-mail: Credentials@bcbst.com

Note: For denial/appeal process refer to the Medical Management Corrective Action Plan in Section XI. Quality Improvement Program in this Manual for detailed description of appeal rights.

2. Credentialing Application

Credentialing applications are used to uniformly identify and gather specific information for all Practitioners and Organizational Providers that wish to participate with BlueCare Plus. BlueCare Plus Credentialing standards apply to all licensed independent Practitioners or Practitioner groups who have an independent relationship with BlueCare Plus. The BlueCare Plus Credentialing Program determines whether Practitioners, Organizational Providers, and other Health Care Professionals, licensed by the State and under contract to BlueCare Plus, are qualified to perform their services and meet the minimum requirements defined by National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS), and the TennCare Risk Agreement. Verification of all required credentials is imperative.

Once Practitioners and Organizational Providers have completed the credentialing process, they will receive written notification within ten (10) days from BlueCare Plus's Credentialing Department. Note: This notification does not guarantee acceptance in BlueCare Plus networks; Practitioners and Organizational Providers are not considered participating in BlueCare Plus networks until they receive an acceptance letter from BlueCare Plus' Contracting Department. Our goal is to complete credentialing and contracting a Provider within thirty (30) days of receiving a completed application.

CAQH APPLICATIONS SHOULD REFLECT THE FOLLOWING, ALONG WITH THEIR STANDARD REQUIREMENTS TO BE CONSIDERED COMPLETE:

- Detailed Explanation of any malpractice suit within the last five (5) years (NPDB reports or self-reported)
- Detailed Explanation of any question(s) answered, "Yes" on the application
- Letter of agreement signed by admitting Physician when Practitioner does not have current Hospital Privileges (If applicable)
- Copy of Certificate from Nationally Recognized Accrediting Body -- NP & PA (ANCC, AANP, if applicable)
- Ownership and Disclosure of Interest Statement
- Group Grid
- Other Supporting Documentation sent to Provider from BCT

Letter for NPs and PAs must include:

- The name and address of supervisory Physician
- APN License (NP only).

Electronic Funds Transfer (EFT):

Providers are required to enroll in the EFT process. For enrollment, information is available on the CAQH Solutions website at https://solutions.caqh.org.

If you're newly enrolling EFT/ERA information or making a change to your former information, you'll need to enroll with Change Healthcare's Payer Enrollment Services portal at payerenrollservices.com. After your information is verified, they'll send it to BlueCross. We encourage providers to start this process as soon as possible to allow plenty of time for verification. Most changes will be processed within 14 days.

The applying Provider will receive notification from BlueCare Tennessee when all documents have been received and the review process has begun. If all necessary documentation is not received within thirty (30) days of the documentation request date, the application will be closed as incomplete. The Provider has the right to correct erroneous information within thirty (30) days of receipt as well as check the status of application at any time during the credentialing/recredentialing process.

If you have any questions or need assistance, contact Provider Service line at 1-800-924-7141 and say "Credentialing and Contracting" when prompted.

3. Credentialing Policies

BlueCross BlueShield of Tennessee/BlueCare Tennessee has written policies and procedures for both the initial and credentialing process of Practitioners and Organizational Providers. The following policies are subject to change and should only be referenced as a guideline. Final determination of credentialing status is a decision of the BlueCare Plus Corporate Credentialing Committee. For specific assistance, or you need a copy of the actual policy, please contact your Provider Relations Consultant (see Section I for specific telephone numbers) or call the BlueCare Plus Credentialing Department at 1-800-357-0395.

Note: Primary Care Practitioner and OB/GYN office site visits are performed by BlueCare Plus within six (6) months of the credentialing event.

1. Credentialing Process for Practitioner:

The following information is required and/or must be verified for Practitioners:

- A current, valid, full, unrestricted license to practice in the state of jurisdiction.
- History of, or current license probation will be subject to peer review.
- Current, valid, unrestricted Prescriptive Authority with all schedules (ability to prescribe medication in accordance with State Law). Providers without all listed schedules (2, 2N, 3, 3N, 4, & 5) will be submitted to the Credentialing Committee for review.
- Work history for the last five years with documented gaps in employment over 90 days.
- Malpractice coverage in amounts of not less than $1,000,000 per occurrence and $3,000,000 aggregate (exceptions made for State Employees).
- Clinical privileges in good standing at a licensed facility designated by the Practitioner as the primary admitting facility. (Any exceptions to this will be determined by the BlueCare Plus Credentialing Committee).
- National Practitioner Data Bank (NPDB) report or Claims History Report from all malpractice carriers for the last five (5) years.
- Board certification verification if the Practitioner indicates certified on application

- BlueCare Plus recognizes the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Academy of Pediatrics (AAP), American Dental Association (ADA), and the American Board of Podiatric Surgery (ABPS) for recognized specialty designation.
- Absence of history of federal and/or state sanctions (Medicare, Medicaid, or TennCare).

- Verification of a current, valid, unrestricted state license is sufficient for a Practitioner's degree. Verification of board certification or highest level of education is necessary for specialty designation.
- History of, or criminal conviction or indictment will be subject to peer review.
- Current Clinical Laboratory Improvement Amendments (CLIA) Certificate, if applicable.
- Twenty-four (24) hour, seven (7)-day-a-week call coverage or arrangements with a BlueCare Plus credentialed Practitioner.
- Statement from applicant regarding:
    - Current or past physical or mental problems that may affect ability to provide health care;
    - Current or past substance use disorder
    - History of loss of license and or felony convictions
    - History of loss or limitation of privileges or disciplinary activity; and
    - An attestation to correctness/completeness of the application.
- Office site visit to each potential Primary Care Practitioner's and OB/GYN's office including documentation of a structured review of the site and medical record maintenance process. (See below section D. Practice Site Evaluations/Medical Record Practices.)
- Verification the Physician is physically at the offices where treatment is being rendered and is interacting and overseeing the NP/PA as specified in the Rules and Regulations for the State in which they practice;
- Verification that Protocol exists and is located at the premises where NP/PA practices as required by state law.

Specific requirements for specialties listed:

Acupuncturist

- Licensed as an Acupuncturist.
- Proof of current diplomat status in acupuncture from NCCAOM and proof of completion of a 3-year post-secondary acupuncture training program or college acupuncture program that is ACAOM accredited.
- DEA certificate not required; however, if applicant has a DEA, it must be verified
- Call coverage not required.
- Hospital privileges not required.

Addictionologist (non-Psychiatrist)

- Certified by the American Society of Addition Medicine (ASAM) as an addition specialist.

Addictionologist (Buprenorphine – Based Therapy for medication assisted treatment of substance abuse)

- DEA certificate with additional buprenorphine endorsement
- Certified by the American Society of Addition Medicine (ASAM) as an addition specialist.
- Certified in buprenorphine therapy in the state where practice is to occur.

Anesthesiologist

- If Credentialing is required:
    - Credentialing is required for Office based Providers (Services occur in an office setting). Credentialing is not required for Hospital based Providers (Services occur in a hospital setting

- Credentialing is required for Office based Providers (Services occur in an office setting). Credentialing is not required for Hospital based Providers (Services occur in a hospital setting)
- Hospital privileges required (may be Allied Health)
- DEA Required
- Call Coverage required

Audiologist:

- Current Licensure in State of Tennessee in Specialty will verify education.
- If not practicing in Tennessee, education may be verified by certificate from:
  - American Occupational Therapy Certification Board;
  - American Speech-Language-Hearing Association;
  - Physical Therapist Certificate of Fitness, if applicable; **or**
  - Verification of highest level of education in specialty requested.
- Call coverage not required.
- Clinical privileges not required.
- DEA certificate not required; however, if applicant has a DEA, it must be verified

Behavior Analyst (CBA)

- Provider must be a Board Certified Behavior Analyst-Doctoral (BCBA D) by the Behavior Analyst Certification Board (BACB)

Note: Acceptable TennCare equivalents

- Currently licensed in the State of Tennessee for the independent practice of psychology, or
- Currently a Qualified Mental Health Professional licensed in the State of Tennessee with the scope of practice to include behavior analysis, and Credential verification by the Managed Care Organization.
- Master's or Doctorate degree from an accredited university that must be conferred in behavior analysis, education, or psychology or in a degree program in which the candidate completed a Behavior Analyst Certified Board approved course sequence.
- Certified by (BCBA).

Chiropractor:

- Clinical privileges not required.
- DEA certificate not required; however, if applicant has a DEA, it must be verified

Chiropractor performing Acupuncture

- If the State license has Acupuncture listed at the bottom, practitioner has met the State's educational requirements to perform Acupuncture

CRNA:

- If credentialing is required, call coverage and hospital privileges are required.
  - Credentialing is required for Office based Providers (Services occur in an office setting). Credentialing is not required for Hospital based Providers (Services occur in a hospital setting).
  - DEA certificate not required, however, if applicant has a DEA it must be verified.

***Dentist – Endodontics; Periodontist; Prosthodontics*:**

- Licensed as a Dentist
- Verify Residency or license to have one of the above specialties
- DEA required
- 24/7 Call Coverage required

Dentist/Pediatric Dentist:

- Clinical privileges not required.
- Call coverage not required.
- DEA certificate not required, however if applicant has a DEA, it must be verified.

Dentist - Orthodontics:

- Clinical privileges not required.
- License will show specialty of Orthodontics and Dentofacial Orthopedics.
- Call coverage not required.
- DEA certificate not required, however if applicant has a DEA, it must be verified.

Dietitian/Nutritionist:

- Licensed as a Dietitian/Nutritionist.
- Minimum of a BA degree from an accredited U.S. college or university, with course approved by the American Dietetic Association's Commission for a Didactic Program in Dietetics.
- Must undergo a 6- to 12-month practice program or internship at a healthcare facility, community agency, or food service corporation, or do the equivalent in combination with their undergraduate course work.
- Completion of a Commission on Accreditation of Dietetics Education (CADE) accredited Didactic Program in Dietetics and pass the national board examination administered by the Commission on Dietetic Registration (CDR).
- Clinical privileges not required.
- Call coverage not required.
- DEA certificate not required; however, if applicant has a DEA, it must be verified

Hospice & Palliative Care Practitioner

- Clinical privileges not required.
- Call coverage required.

Hospital Based (i.e. Hospital Medicine / Emergency Medicine):

- If credentialing is required.
    - Credentialing is required for Office based Providers (Services occur in an office setting). Credentialing is not required for Hospital based Providers (Services occur in a hospital setting).
- Hospital privileges required (may be Allied Health).
- DEA required if MD/DO.
- Call coverage required.

Lactation Specialist

- Licensed as a Registered Nurse at a minimum.
- Certification with IBCLC: Global Certification for Lactation Consultant.

- Clinical privileges not required.
- Call coverage not required.
- DEA certificate not required; however, if applicant has a DEA, it must be verified

Licensed Clinical Social Worker (LCSW)

- Master's degree or higher from a graduate school or social work accredited by the Council on Social Work Education (CSWE).
- All provider applicants must have a minimum of three (3) year's post-licensure clinical experience in a mental health/substance abuse setting providing direct patient care

Marriage and Family Therapist

- Master's degree or higher in a mental health discipline.
- State licensed or certified at the highest level of independent practice in the state where practice is to occur, OR certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT) OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).
- All provider applicants must have a minimum of three (3) year's post-licensure clinical experience in a mental health/substance abuse setting providing direct patient care.

Neuropsychologist (Ph.D):

- Clinical privileges not required.
- License must specify "Health Services Provider".
- Ph. D., PsyD, or EdD degree required.
- DEA certificate not required, however if applicant has a DEA, it must be verified
- Twenty-four (24) hour, seven (7) day-a-week call coverage or arrangements. Answering machine/cell phone is acceptable

Nurse Practitioners or Nurse Mid-Wife:

- RN License.
- Advanced Practice Nurse (APN) certificate in TN and applicable prescriptive authority for contiguous states.
- Certification most applicable to the nurse specialty from one of the following bodies:
  - American Nurses Credentialing Center *(Internal Medicine, Pediatrics etc, and ABMS/AOA/AAP specialty)*
  - American Association of Critical Care Nurses (AACN)

    American Academy of Nurse Practitioners *(Family Practice, Pediatrics etc, and ABMS/AOA/AAP specialty)*
  - American College of Nurse-Midwives Certification Council
  - National Certification Corporation of Obstetric and Neonatal Nursing Specialties
  - National Certification Board of Pediatric Nurse Practitioners and Nurses *(Pediatrics and/or any AAP specialty list)*
  - The name and address of the supervising Practitioner
  - If practicing in a setting other than Family Medicine or OB/GYN, must provide a detailed scope of practice. Application will be considered adverse

Exclusion:

- Clinical privileges not required (must have an arrangement with a credentialed Practitioner who has clinical privileges at a credentialed hospital facility).
- DEA certificate not required, however if applicant has a DEA it must be verified.

Nurse Practitioner – Masters Clinical Nurse Specialist/Psychiatric Nurse

- Certification most applicable to the nurse specialty
- Name and address of the supervising Physician
- Verification that the physician is responsible for the care and treatment rendered by the NP
- Verification that the physician is physically at the offices where treatment is being rendered and is interacting and overseeing the NP as specified in the Rules and Regulations for the State in which they practice.
- Verification that a Protocol exists and it's located at the premises where the NP practices as required by state law.
- Clinical privileges are not required (must have a practitioner that admits for them).
- DEA not required; however, if applicant has DEA, it must be verified

Obstetrics & Gynecology

- If Provider is office based (Services occur in an office setting only) – Hospital privileges not required – admitting arrangement is acceptable.

Optometrist:

- State license must contain Therapeutic Certification.
- Hospital privileges not required.
- DEA certificate not required, however if applicant has a DEA, it must be verified
- Call coverage not required

Oral & Maxillofacial Surgeon

- Hospital privileges are required. If provider does not have their own privileges, an admitting physician can be listed.

Pathologist

- If credentialing is required.
    - Credentialing is required for Office based Providers (Services occur in an office setting). Credentialing is not required for Hospital based Providers (Services occur in a hospital setting).
- Hospital privileges not required.
- DEA certificate not required, however if applicant has a DEA, it must be verified.
- Call coverage required.

Pharmacist - Clinical:

- BlueCare Plus staff Pharmacists (and PBM Management).
- Collaborative agreement between Pharmacy and Physician.
- Certificate of accredited program.

Exclusion:

- Clinical privileges not required.
- Call coverage not required.

Pharmacist – Disease Management:

BlueCare Plus staff Pharmacists (and PBM Management).

- Copy of certificate for successful completion disease management program(s), if applicable.

Exclusion:

- Clinical privileges not required.
- Call coverage not required.

Pharmacist - Immunizing:

BlueCare Plus staff Pharmacists (and PBM Management).

- Certification of accredited immunizing program.

Exclusion:

- Clinical privileges not required.
- Call coverage not required.

Physical Therapist/Occupational Therapist/Speech Therapist

- Current Licensure in State of Tennessee in Specialty will verify education. If not practicing in Tennessee, education may be verified by certificate from: American Occupational Therapy Certification Board, American Speech-Language-Hearing Association, Physician Therapist Certificate of Fitness, if applicable or Verification of highest level of education in specialty requested.

Exclusion:

- Call coverage not required
- Clinical privileges not required
- DEA certificate not required, however, if applicant has a DEA, it must be verified.

Physician Assistant:

- Certificate from the National Commission on Certification of Physician Assistants (NCCPA), if applicable.
- The name and address of the supervising Physician.
- If practicing in a setting other than Family Medicine or OB/GYN, must provide a detailed scope of practice. Application will be considered adverse.

Exclusion:

- Clinical privileges not required (must have an arrangement with a credentialed Practitioner who has clinical privileges at a credentialed hospital facility).
- DEA certificate not required, however, if applicant has DEA, it must be verified.

Physician Assistant-Surgical Assist:

- PA must be licensed, meet all other general Provider requirements.
- Supervising Surgeon must be credentialed with BCBST in a surgical specialty. (General, Urology, Neurology, Orthopedics, etc.)
- PA must meet all State practice protocol requirements as verified with attestation.
- PA's Hospital and ASF privilege criteria must be verified.
- PA must provide proof of graduation from an accredited PA program.

- PA Surgical Assist must maintain ongoing certification by the NCCPA (which will include satisfactory completion of the NCCPA examination and all other ongoing certification requirements) and completion of NCCPA examination/certification.

Podiatrist

- Clinical privileges not required unless, current privileges are indicated, they must be verified.

Professional Counselors (Includes Genetic Counselors, Alcohol and Drug Counselors, Mental Health Counselors, Pastoral Counselors, Licensed Substance Use Disorder Treatment Professionals, Senior Psychological Examiner (SPE), and Employee Assistance Professional Counselor (EAP))

- Master's degree or higher
- State licensed or certified at the highest level of independent practice in the state where practice is to occur.
- Provider must work in a facility. (No stand-alone practitioners.)
- Admitting privileges not required.
- Twenty-four (24) hour, seven (7)-day-a-week call coverage or arrangements. Answering machine/cell phone is acceptable.
- DEA certificate not required, however, if applicant has DEA, it must be verified

Psychologists or Psychoanalyst (includes Clinical and Child & Adolescent)

- DEA certificate not required; however, if applicant has DEA, it must be verified
- Doctoral degree (PhD, EdD, PsyD) in clinical psychology or counseling psychology from an accredited college or university and meet one of the following:
- Doctorate degree received from a college or university program on the American Psychological Association (APA) accredited list of counseling psychology or clinical psychology programs, or
- Completion of a pre-doctoral APA approved clinical internship at the time of graduation, or
- Listed in the National Register of Health Services Providers in Psychology, or
- Diplomat of the American Board of Professional Psychology (ABPP) under the cinical psychology or counseling psychology categories

Radiologist (For Diagnostic Radiology, Refer to PAM or Policies/Procedures)

If credentialing is required

- Credentialing is required for Office based Providers (Services occur in an office setting). Credentialing is not required for Hospital based Providers (Services occur in a hospital setting).

- Hospital privileges not required.
- DEA certificate not required, however if applicant has a DEA, it must be verified.
- Call coverage required.

Diagnostic Radiology

Minimum and Exception criteria apply with the exception of:

- DEA certificate not required, however if applicant has a DEA, it must be verified.
- DEA is not required.
- Hospital privileges not required.

Interventional Radiology

Minimum and Exception criteria apply with the exception of:

- DEA is required.
- Hospital privileges are required.

Sleep Medicine

- This specialty is designated only for Medical Doctors and Doctors of Osteopathy.

Speech Language Pathologist

- Certificate of Clinical Competence – Speech Language Pathology (CCC-SLP) from American Speech-Language-Hearing Association (ASHA) – Not Required. **However, if applicant has ASHA Certificate, it must be verified. If certificate has expired, certificate must be verified by previous certificate verification.**

Urgent Care Physician

- Clinical privileges not required.
- Call Coverage not required.
- Site Visit if provider is PCP.

Exception:

- When urgent care/retail clinic Providers request PCP status, verify practice site is complete and indicate not all Practitioners at an Urgent Care will have PCP status.

2. Credentialing Process for Medical and Behavioral Health Practitioners/Providers

Obtaining valid/current copies of the following information as submitted with the credentialing application is essential to ensure that decisions are based on the most accurate, current information available. The following types of Medical and Organizational Providers require verification of specific requirements to be considered by the Credentialing Committee. The following pages list these requirements:

Organizational Providers must be recredentialed every thirty six (36) months to meet federal and state regulatory guidelines. During the recredentialing process, the initial credentialing information must be resubmitted.

The following information is the minimum criteria required and/or must be verified for Organizational Practitioners:

- Licensed in the State of Tennessee. Providers receive a new license each year and is considered proof of compliance; therefore, no site visit is required.
- Professional liability coverage of $1,000,000 per case/ $3,000,000 aggregate.
- General liability insurance
- Malpractice claims history for past five (5) years. NPDB reports or self-reported.
- Accreditation by: AAAAS, AAAHC/URAC, AAASF, AAPM, AASM, ABCOP, ACHC, AOA, CABC, CARF, CHAP, CIHQ, COA, CORF, CUC, DNV-GL, HFAP, HQAA, National Association of Boards of Pharmacy, NBAOS, SAMHSA, The Joint Commission (TJC), If not accredited, a site visit review or copy of state site visit.
- Certification from Medicare, Medicaid, TRICARE or state agencies if applicable CLIA certificate, if applicable
- DEA certificate, if applicable.
- CLIA certificate, if applicable
- History of federal and/or state sanctions (Medicare or TennCare)
- Staff roster for outpatient mental health and/or substance use disorder clinics.
- An attestation to the correctness and completeness of the application

Acute Care Facility Hospital

- TN: Licensed as Acute Care Facility

- Other States: Licensed in accordance with that state's licensing laws
- DEA certificate, if applicable
- CLIA certificate, if applicable
- Medicare certification (new facilities which have not obtained subject to Committee exception)
- TJC or AOA or CHAP or AAAHC, CIHQ, or Det Norske Veritas (lack of accreditation subject to Committee exception)
- If not accredited, copy of State Site Survey required
- Leapfrog Compliance, if available

Ambulatory Infusion Center (AIC)

- TN: Licensed as an Ambulatory Infusion Center
- Other States: Licensed in accordance with that state's licensing laws
- Medicare Certification
- Accredited by BCBST/BCT approved accrediting body as an AIC
- Medical Director credentialed by BCBST/BCT

Ambulatory Surgical Facility

- TN: Licensed as Ambulatory Surgery Facility
- Other States: Licensed in accordance with that state's licensing laws
- Medicare Certification with copy of site audit
- CLIA certificate, if applicable
- Accredited by TJC, AOA, CHAP, AAAHC, AAAASF, or CHHQ
- Medical Director credentialed by BCBST/BCT

Applied Behavior Analysis (ABA)

Note: Services will be provided at an Outpatient Mental Health Clinic level of intensity.

- Must receive oversight from a licensed behavioral health or BACB (Behavior Analyst Certification Board) certified professional.
- All non-licensed/ non-BACB certified staff must have direct clinical supervision by Qualified licensed staff with an Autism Spectrum Disorder (ASD) specialty or BACB certification in accordance with BACB recommended clinically appropriate supervision (i.e., a minimum of 1.5 hours for every 10 hours of direct service).
- BCaBA® (Board Certified Assistant Behavior Analyst®) staff must be supervised by BCBA® (Board Certified Behavior Analyst®) or BCBA-D® (Board Certified Behavior Analyst-Doctoral®) supervisors in accordance with BACB requirements.
- All non-licensed staff (paraprofessionals/tutors/therapists) must have completed criminal background checks, drug screening (including random testing), and confirmation of required ABA specific training.

Birthing Centers

- TN: Licensed as Birthing Center
- Other States: Licensed in accordance with that state's licensing laws
- CLIA Certificate, if applicable
- TJC, AOA, CHAP,AAAHC, or CIHQ or Medicare certification

Community Mental Health Center

- Licensed as a Mental Health Outpatient Facility.
- Formal CMS designation.

Note: If a site review is required (Acute Care Facility, Home Health Agency, Ambulatory Surgery Center, or Skilled Nursing Facility) and the CMS or State audit is not available, the file will be referred to the Credentialing Committee as an exception.

Behavioral Health Organizational Providers (facilities and programs) must be evaluated at credentialing and recredentialing. Those who are accredited by an accrediting body accepted by BCBST/BCT must have their accreditation status verified. In addition, non-accredited organizational providers must undergo a structured site visit to confirm that they meet BCBST/BCT standards. Standing with state and federal authorities and programs will be verified.

Crisis Stabilization Unit

- Program must be part of a TJC accredited hospital or health care organization that provides psychiatric services or accredited by AOA, TRICARE, CARF or COA or accredits the program itself as an observation/holding bed program that provides psychiatric services.
- Formal written agreement with TJC accredited provider for emergency psychiatric, substance use disorder, or medical care if not available on site.
- Must meet state licensure/certification and Medicaid requirements, as applicable.
- Must meet all applicable federal, state, and local laws and regulations.
- Combination of licensed mental health professional, mental health workers and other appropriate paraprofessional staff.

Dialysis Facility

- State of Tennessee End Stage Renal Diseases (ESRD) Facility License
- Other States: Licensed in accordance with that state's licensing laws
- Medicare certification
- CLIA Certificate

DME Providers

- TN: Licensed as a DME Provider
- Other States: Licensed in accordance with that state's licensing laws
- Medicare certification required
- DEA certificate, if applicable
- Pharmacy License, if applicable
- TJC, CHAP, AAAHC, BOC, The Compliance Team or ABC, NBAOC, CARF, CIHQ, HQAA or ACHC required

Health Department

- State Tort Insurance
- CLIA Certificate

Home Infusion Therapy Providers

- TN: Licensed as a Home Infusion Therapy Provider (Pharmacy License - Required, however can be from anywhere within the state)
- Other States: Licensed in accordance with that state's licensing laws
- Medicare certification
- DEA certificate, if applicable
- TJC, CHAP, CIHQ, or AAAHC, collect but not required

Home Health Agency

- TN: Licensed as a Home Health Provider
- Other States: Licensed in accordance with that state's licensing laws
- Medicare certification
- CLIA Certificate, if applicable
- TJC, CHAP, AAAHC, or CIHQ, collect but not required
- If not accredited, copy of state or CMS site audit

Hospice Provider

- TN: Licensed as a Hospice Provider
- Other States: Licensed in accordance with that state's licensing laws
- Medicare certification
- CLIA Certificate, if applicable
- TJC, AOA, CHAP, CAP, CIHQ, or AAAHC, collect but not required

Independent Lab

- TN: Licensed as a Medical Laboratory Facility
- Other States: Licensed in accordance with that state's licensing law.
- Medicare certification
- TJC, CAP, CIHQ; collect if applicable but not required
- CLIA Certificate, Draw Station – CLIA not required

Inpatient Detoxification/Inpatient Substance Abuse Disorder Rehabilitation

- Must have 24 hours/7-days-week skilled nursing staff.
- Oversight from a Medical Director.
- Must have an Addictionologist on staff or contracted or Medical Director must have three (3) years' experience treating patients with substance use disorder.

Inpatient Psychiatric/ Residential Psychiatric or Substance Abuse Disorder

- 24 hour/7-days-a-week skilled nursing staff.
- Oversight from a Medical Director.

Inpatient Rehabilitation Facility

- TN: Licensed as an Inpatient Rehabilitation Facility
- Other States: Licensed in accordance with that state's licensing laws
- Not currently sanctioned by Medicare/Medicaid
- .
- Medicare certification
- CLIA certificate, if applicable
- DEA certificate, if applicable
- TJC or CARF or AOA or CIHQ accreditation (no exception)

Intensive Outpatient (Psychiatric or Substance Abuse Disorder)

- Must have the supervision of a licensed clinician.
- Must provide services at least three (3) hours per day, 2-4 days per week.

Non-Licensed DME Providers (Non-motorized equipment only e.g., walker canes, crutches)

- Medicare certification
- TJC, CHAP, or AAAHC, if applicable but not required

Orthotic/Prosthetic Supplier

- American Board for Certification in Orthotics and Prosthetics Accreditation OR Medicare B Certification
- $1 million/$3 million Malpractice (exception for Breast Prosthetic suppliers ONLY to have product liability coverage $500 thousand) and claims history. NPDB reports or self-reported.

Opioid Treatment Program:

- TN: Licensed as an Opioid Treatment Program (OTP)

- Other States: Licensed in accordance with that state's licensing laws
- DEA certification
- CLIA certification, if applicable
- Certification by SAMHSA, TJC, CARF, COA (lack of accreditation subject to committee exception)

Outpatient Diagnostic

- Medicare certification
- CLIA certification, if applicable

Outpatient Mental Health and/or Substance Abuse Disorder Clinic

- Must have a governing body and an organized professional staff.
- Must have, or have a formal contract with, a multi-disciplinary staff that includes at least one licensed psychiatrist, one licensed psychologist (psychologist must also be licensed to perform psychological testing), and at least one licensed masters- or doctoral-level mental health clinician.
- Must have written credentialing criteria for all clinical staff.
- All non-licensed staff must have direct clinical supervision by licensed staff; non-licensed staff may not provide the predominant portion of any major intervention modality, other than educational services.
- Must receive oversight from a licensed behavioral health professional.

Outpatient Mental Health Facility

- Licensed by the Tennessee Department of Mental Health and Substance Abuse Services
- Medicare certification, collect but not required

Outpatient Rehabilitation Facility

- Medicare certification (If Provider is licensed under the Tennessee Department of Mental Health and Developmental Disabilities and provides services to pediatric patients, evidence of the State License site audit)
- TJC, CORF, or CIHQ, collect but not required.
- CLIA required if onsite laboratory.

Pain Management Center

- TN: Licensed as an Ambulatory Surgical Facility
- Other States: Licensed in accordance with that state's licensing laws
- DEA certificate, if applicable
- Accredited by CARF or AAPM

Partial Hospitalization (Psychiatric or Substance Abuse Disorder)

- Must operate 3-5 days per week and at least 4-6 hours per day.
- Oversight from a Medical Director or licensed Program Director.
- Must be under the supervision of a Physician.

Professional Support Services Licensure (PSSL)

- TN: Licensed as a Professional Support Service
- Medicare certification
- Member of DIDS (Division of Intellectual Disability Services)

Skilled Nursing Facility (No Swing Beds)

- TN: Licensed and Certified as a Nursing Home
- Other States: Licensed in accordance with that state's licensing laws
- Medicare certification
- CLIA, if applicable
- DEA certificate, if applicable
- Accredited by TJC, CHAP, AAAHC, AOA or CIHQ, collect but not required
- If not accredited, copy of state or CMS site audit

Sleep Labs

- Medicare certification
- Accredited by AASM, TJC or CIHQ
- Medical Director who is a Diplomat of the ABSM, or Board Certified by ABMS or AOA in Sleep Medicine.
- Medical Director who is a Diplomat of the American Board of Sleep Medicine

Urgent Care Centers

- State Business License
- Oversight by a Medical Director that is currently credentialed by BCBST/BCT
- Accreditation by Urgent Care Association of America (UCAOA), Joint Commission, AAAHC, or a certificate from Certified Urgent Care (CUC) Program

Note: If a site review is required (Acute Care Facility, Home Health Agency, Ambulatory Surgery Center, or Skilled Nursing Facility) and the CMS or State audit is not available, the file will be referred to the Credentialing Committee as an exception.

Behavioral Health Organizational Providers (facilities and programs) must be evaluated at credentialing and recredentialing. Those who are accredited by an accrediting body accepted by BLUECARE PLUS must have their accreditation status verified. In addition, non-accredited organizational providers must undergo a structured site visit to confirm that they meet BLUECARE PLUS standards. Standing with state and federal authorities and programs will be verified.

4. Recredentialing Process

All Medical or Behavioral Health Practitioners will be recredentialed every thirty-six (36) months.

In addition to the information that will be verified by primary or secondary sources, BLUECARE PLUS will include and consider collected information regarding the participating Practitioner's performance within the health plan, including information collected through the health plan's quality management program.

Recredentialing will begin approximately three (3) to six (6) months prior to the expiration of the credentialing cycle. Providers are sent a letter stating their file will be placed in a recredentialing status and BCT will retrieve their application from CAQH to begin the recredentialing process. To help ensure the recredentialing process is handled expediently with no interruptions in network participation we encourage the Practitioner to visit the CAQH ProViewTM website, https://proview.caqh.org, to update their information.

Failure to comply with the request may result in immediate disenrollment from the Provider network. Credentialing information that is subject to change must be re-verified from primary sources during the recredentialing process. The Provider must attest to any limits on his/her ability to perform essential functions of the position and attest to absence of current illegal drug use.

Organizational Providers must be recredentialed every thirty-six (36) months to meet federal and state regulatory guidelines. During the recredentialing process the initial credentialing information must be resubmitted.

5. BlueCross BlueShield of Tennessee/BlueCare Tennessee Approved Specialties

BlueCross BlueShield of Tennessee/BlueCare recognizes and maintains the current list of specialties of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), American Academy of Pediatrics (AAP), the American Board of Podiatric Surgery (ABPS), and the American Dental Association (ADA) Boards or others as deemed necessary by peer review to support business needs.

Providers must designate a specialty on the credentialing application. To be listed in any BLUECARE PLUS Provider directory in the specialty requested, the Provider must meet one of the following requirements:

- Recognized Board Certification, or
- Practitioners: Successful completion of residency or fellowship in the applied specialty.
- Other Health Care Professionals: Licensure and additional certification, if applicable in the field of specialty.

American Board of Medical Specialties (ABMS)

I. American Board of Allergy and Immunology

A. Allergy and Immunology

B. Clinical and Laboratory Immunology

II. American Board of Anesthesiology

A. Anesthesiology

B. Critical Care Medicine

C. Pain management

III. American Board of Colon and Rectal Surgery

A. Colon and Rectal Surgery

IV. American Board of Dermatology

A. Clinical and Laboratory Dermatological Immunology

B. Dermatology

C. Dermatopathology

D. Pediatric Dermatology

V. American Board of Emergency Medicine

A. Emergency Medicine

B. Medical Toxicology

C. Pediatric Emergency Medicine

D. Sports Medicine

E. Undersea-Hyperbaric Medicine

VI. American Board of Family Practice

A. Family Practice

B. Geriatric Medicine

C. Sports Medicine

VII. American Board of Internal Medicine

A. Adolescent Medicine
B. Cardiovascular Disease
C. Clinical & Laboratory Immunology
D. Clinical Cardiac Electrophysiology
E. Critical Care Medicine
F. Endocrinology, Diabetes, and Metabolism
G. Gastroenterology
H. Geriatric Medicine
I. Hematology
J. Infectious Disease
K. Internal Medicine
L. Interventional Cardiology
M. Medical Oncology
N. Nephrology
O. Pulmonary Disease
P. Rheumatology
Q. Sports Medicine

VIII. American Board of Medical Genetics, Inc.

A. Clinical Biochemical Genetics
B. Clinical Cytogenetics
C. Clinical Genetics
D. Clinical Molecular Genetics
E. Molecular Genetic Pathology
F. PHD Medical Genetics

IX. American Board of Neurological Surgery

A. Neurological Surgery

X. American Board of Nuclear Medicine

A. Nuclear Medicine

XI. American Board of Obstetrics and Gynecology

A. Critical Care Medicine
B. Gynecologic Oncology
C. Gynecology
D. Maternal Fetal Medicine
E. Obstetrics

F. Obstetrics and Gynecology

G. Reproductive Endocrinology

XII. American Board of Ophthalmology

A. Ophthalmology

XIII. American Board of Orthopedic Surgery

A. Hand Surgery

B. Orthopedic Surgery

XIV. American Board of Otolaryngology

A. Otolaryngology

B. Otology/Neurotology

C. Pediatric Otolaryngology

D. Plastic Surgery within the head and neck

XV. American Board of Pathology

A. Anatomic & Clinical Pathology

B. Anatomic Pathology

C. Blood Banking Transfusion Medicine

D. Chemical Pathology

E. Clinical Pathology

F. Cytopathology

G. Dermatopathology

H. Forensic Pathology

I. Hematology

J. Medical Microbiology

K. Molecular Genetic Pathology

L. Neuropathology

M. Pediatric Pathology

XVI. American Board of Pediatrics

A. Adolescent Medicine

B. Clinical & Laboratory Immunology

C. Developmental-Behavioral Pediatrics

D. Medical Toxicology

E. Neonatal-Perinatal Medicine

F. Neurodevelopmental Disabilities

G. Pediatric Cardiology

H. Pediatric Critical Care Medicine
I. Pediatric Emergency Medicine
J. Pediatric Endocrinology
K. Pediatric Gastroenterology
L. Pediatric Hematology-Oncology
M. Pediatric Infectious Disease
N. Pediatric Nephrology
O. Pediatric Pulmonology
P. Pediatric Rheumatology
Q. Pediatrics
R. Sports Medicine

XVII. American Board of Physical Medicine and Rehabilitation

A. Pain Management
B. Pediatric Rehabilitation Medicine
C. Physical Medicine and Rehabilitation
D. Spinal Cord Injury Medicine

XVIII. American Board of Plastic Surgery, Inc.

A. Hand Surgery
B. Plastic Surgery
C. Plastic Surgery within the head and neck

XIX. American Board of Preventive Medicine

A. Aerospace Medicine
B. Medical Toxicology
C. Occupational Medicine
D. Preventive Medicine
E. Undersea and Hyperbaric Medicine

XX. American Board of Psychiatry and Neurology

A. Addiction Psychiatry
B. Child and Adolescent Psychiatry
C. Clinical Neurophysiology
D. Forensic Psychiatry
E. Geriatric Psychiatry
F. Neurodevelopmental Disabilities
G. Neurology

H. Neurology with special qualification in Child Neurology

I. Pain Management

J. Pediatric Neurology

K. Psychiatry

XXI. American Board of Radiology

A. Diagnostic Radiology

B. Neuroradiology

C. Nuclear Radiology

D. Pediatric Radiology

E. Radiation Oncology

F. Radiological Physics

G. Radiology

H. Vascular & Interventional Radiology

XXII. American Board of Surgery

A. Hand Surgery

B. Pediatric Surgery

C. Surgery

D. Surgical Critical Care

E. Vascular Surgery

XXIII. American Board of Thoracic Surgery

A. Thoracic Surgery

XXIV. American Board of Urology, Inc.

A. Urology

American Osteopathic Association Boards (AOA)

I. American Osteopathic Board of Anesthesiology

A. Addiction Medicine

B. Anesthesiology

C. Critical Care Medicine

D. Pain Management

II. American Osteopathic Board of Dermatology

A. Dermatology

B. Dermatopathology

C. MOHS-Micrographic Surgery

III. American Osteopathic Board of Emergency Medicine

A. Emergency Medical Services

B. Emergency Medicine

C. Medical Toxicology

D. Sports Medicine

IV. American Osteopathic Board of Family Practice

A. Addiction Medicine

B. Adolescent And Young Adult Medicine

C. Family Practice

D. Geriatric Medicine

E. Sports Medicine

V. American Osteopathic Board of Internal Medicine

A. Addiction Medicine

B. Allergy/Immunology

C. Cardiology

D. Clinical Cardiac Electrophysiology

E. Critical Care Medicine

F. Endocrinology

G. Gastroenterology

H. Geriatric Medicine

I. Hematology

J. Hematology/Oncology

K. Infectious Disease

L. Internal Medicine

M. Medical Oncology

N. Nephrology

O. Oncology

P. Pulmonary Disease

Q. Rheumatology

R. Sports Medicine

VI. American Osteopathic Board of Neurology and Psychiatry

A. Addiction Medicine

B. Child And Adolescent Neurology

C. Child And Adolescent Psychiatry

D. Neurology

E. Neurology/Psychiatry

F. Psychiatry

G. Sports Medicine

VII. American Osteopathic Board of Neuromusculoskeletal Medicine

A. Neuromusculoskeletal Medicine

B. Osteopathic Manipulative Medicine

C. Sports Medicine

VIII. American Osteopathic Board of Nuclear Medicine

A. In Vivo and In Vitro Nuclear Medicine

B. Nuclear Cardiology

C. Nuclear Imaging and Therapy

D. Nuclear Medicine

IX. American Osteopathic Board of Obstetrics and Gynecology

A. Gynecologic Oncology

B. Gynecology

C. Maternal And Fetal Medicine

D. Obstetrics

E. Obstetrics And Gynecologic Surgery

F. Obstetrics And Gynecology

G. Reproductive Endocrinology

X. American Osteopathic Board of Ophthalmology and Otorhinolaryngology

A. Facial Plastic Surgery

B. Ophthalmology

C. Otorhinolaryngology

D. Otorhinolaryngology and Facial Plastic Surgery

XI. American Osteopathic Board of Orthopedic Surgery

A. Orthopedic Surgery

XII. American Osteopathic Board of Pathology

A. Anatomic Pathology

B. Anatomic Pathology and Laboratory Medicine

C. Blood Banking Transfusion Medicine

D. Chemical Pathology

E. Cytopathology

F. Dermatopathology

G. Forensic Pathology

H. Hematology

I. Laboratory Medicine

J. Medical Microbiology

K. Neuropathology

XIII. American Osteopathic Board of Pediatrics

A. Adolescent and Young Adult Medicine

B. Neonatology

C. Pediatric Allergy and Immunology

D. Pediatric Cardiology

E. Pediatric Endocrinology

F. Pediatric Hematology/Oncology

G. Pediatric Infectious Disease

H. Pediatric Intensive Care

I. Pediatric Nephrology

J. Pediatric Pulmonary Medicine

K. Pediatrics

L. Sports Medicine

XIV. American Osteopathic Board of Preventive Medicine

A. Occupational Medicine

B. Preventive Medicine/Aerospace Medicine

C. Preventive Medicine/Occupational-Environmental Medicine

D. Public Health/General Preventive Medicine

XV. American Osteopathic Board of Proctology

A. Proctology

XVI. American Osteopathic Board of Radiology

A. Angiography and Interventional Radiology

B. Body Imaging

C. Diagnostic Radiology

D. Diagnostic Ultrasound

E. Neuroradiology

F. Nuclear Radiology

G. Pediatric Radiology

H. Radiation Oncology

I. Radiation Therapy

J. Radiology

XVII. American Osteopathic Board of Rehabilitation Medicine

A. Rehabilitation Medicine

B. Sports Medicine

XVIII. American Osteopathic Board of Surgery

A. General Vascular Surgery

B. Neurological Surgery

C. Plastic and Reconstructive Surgery

D. Surgery

E. Surgical Critical Care

F. Thoracic Cardiovascular Surgery

G. Urological Surgery

American Board of Dental Sleep Medicine

A. Dental Sleep Medicine

American Academy of Pediatrics (AAP)

A. Pediatric Heart Surgery

B. Pediatric Neurosurgery

C. Pediatric Orthopedics

D. Pediatric Urology

American Board of Oral and Maxillofacial Pathology

A. Oral Pathology

American Board of Oral and Maxillofacial Surgery

A. Oral and Maxillofacial Surgery

B. Oral Pathology

American Board of Orthodontics

A. Orthodontics

American Board of Pain Management

A. Pain Management

American Board of Pediatric Dentistry

A. Pediatric Dentistry

American Board of Periodontology

A. Periodontology

American Board of Podiatric Orthopedics & Primary Podiatric

A. Podiatry (DPM)

American Board of Podiatric Surgery

A. Podiatry (DPM)

American Board of Prosthodontics

A. Prosthodontics

American Chiropractic Neurology Board, Inc.

A. Chiropractic Neurology

Other Health Care Professionals:

I. Acupuncturist
II. Audiology
III. Addictionologist (Non Psychiatrist)
IV. Associate Behavior Analyst
V. Certified Behavior Analyst
VI. Certified Registered Nurse Anesthetist (CRNA)
VII. Chiropractor (DC)
VIII. Chiropractor Neurologist
IX. Dietitian
X. Employee Assistance Professional Counselor
XI. Endodontist
XII. Family Practice with Obstetrical Fellowship
XIII. General Dentistry
XIV. General Practice
XV. Licensed Clinical social Worker (LCSW)
XVI. Licensed Professional Counselor
XVII. Licensed Senior Psychological Examiner (LSPE)
XVIII. Marriage and Family Therapist
XIX. Mental Health Counselor/Licensed Substance Abuse Treatment Professionals
XX. Midwife (CNM)
XXI. Neuropsychology (Ph.D.)
XXII. Nurse (RN)
XXIII. Nurse Clinician
XXIV. Nurse Practitioner
XXV. Nurse Practitioner, Acute Care
XXVI. Nurse Practitioner, Adult Health
XXVII. Nurse Practitioner, Family Practice
XXVIII. Nurse Practitioner, Gerontology and Adult Health

XXIX. Nurse Practitioner, Neonatal
XXX. Nurse Practitioner, Pediatrics
XXXI. Nurse Practitioner, Psychological/Mental Health
XXXII. Nurse Practitioner, Women's Health
XXXIII. Nutrition
XXXIV. Occupational Therapy (OT)
XXXV. Optometry
XXXVI. Pastoral Counselor
XXXVII. Pediatric Anesthesiology
XXXVIII. Pediatric Genetics
XXXIX. Pediatric Ophthalmology
XL. Pediatric Plastic Surgery
XLI. Pharmacist - Clinical
XLII. Pharmacist – Immunizing
XLIII. Physical Therapist (PT)
XLIV. Physician Assistant (PA)
XLV. Physician Assistant – Surgical Assist
XLVI. Professional Counselor
XLVII. Prosthetist/Orthotist
XLVIII. Psychiatrist
XLIX. Psychologist or Psychoanalyst
L. Psychology (Ph.D.)
LI. Speech Pathology/Speech Therapy (ST)
LII. Therapeutic Optometry
LIII. Urgent Care

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6. BlueCare Plus Recognized Accrediting Bodies

- Accreditation Association for Ambulatory Health Care (AAAHC)
- Accreditation Commission for Health Care, Inc. (ACHC)
- American Academy of Nurse Practitioners (AANP)
- American Academy of Pain Management (AAPM)
- American Academy of Sleep Medicine (AASM)
- American Accreditation HealthCare Commission/URAC (AAHCC/URAC)
- American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)

- American Association for Marriage and Family Therapy (AAMFT)
- American Association of Critical Care Nurses (AACN)
- American Board of Medical Specialties (ABMS)
- American Board of Certification in Orthotics, Prosthetics, and Pedorthics (ABC)
- American Board of Professional Psychology (ABPP)
- American College of Nurse – Midwives Certification Council
- American Medical Association (AMA)
- American Nurse Credentialing Center (ANCC)
- American Osteopathic Association (AOA)
- American Society of Addiction Medicine (ASAM)
- American Speech-Language-Hearing Association (ASHA)
- Board for Orthotist/Prosthetist Certification (BOC)
- Commission for the Accreditation of Birth Centers (CABC)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Community Health Accreditation Program (CHAP)
- Comprehensive Outpatient Rehabilitation Facilities (CORF)
- Council on Accreditation (COA)
- Council on Social Work Education (CSWE)
- Det Norske Veritas Germanischer Lloyd (DNV GL)
- Division of TennCare or Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- HealthCare Quality Association on Accreditation (HQAA)
- International Board of Certification of Lactation Consultants (IBCLC)
- National Association of Boards of Pharmacy
- National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties (NCC)
- National Commission on Certification of Physician Assistants (NCCPA)
- National Committee for Quality Assurance (NCQA)
- The Center for Improvement in Healthcare Quality (CIHQ)
- The Joint Commission (TJC)
- The National Board of Accreditation for Orthotic Suppliers (NBAOS)
- Tricare
- Urgent Care Association of America (UCAOA)
- Certified Urgent Care Program (CUC)

Practice Site /Medical Record Standards

Practice Site Standards

BlueCross BlueShield of Tennessee/BlueCare Tennessee has adopted practice site standards for all credentialed Practitioners that provide ambulatory care to Members. These standards were developed to assure Members have access to care in a clean, safe, organized and physically accessible environment.

Clinical Risk Management (CRM) monitors Member complaints received regarding the quality of office sites. Practitioners will be advised in writing of specific complaints received about the quality of the office site. Credentialed Practitioners with two (2) office quality complaints within a six (6) month period, that include but is not limited to complaints about physical accessibility, adequacy of waiting area and cleanliness of site, will be referred to Clinical Quality Assurance Department to request an onsite review for compliance with the standards listed below within sixty (60) days of 2nd Member complaint. CRM investigates the severity of all complaints received. BlueCross BlueShield of Tennesee/BlueCare Tennessee may act on one complaint if it is determined necessary.

Primary Care Provider (PCP) practice sites and OB/GYN sites not previously reviewed and currently occupied by a network Practitioner will be evaluated prior to, or within sixty (60) days of initial credentialing.

Practitioners will receive site review results with suggestions for improvement, if applicable, at the conclusion of the audit. Non-compliant sites will be reported to Clinical Risk Management Committee and re-audited within six (6) months.

Sites non-compliant on re-audit will be reviewed by Clinical Risk Management for placement on a Practice Improvement Plan and a 2nd re-audit planned within six (6) months.

The following current established site review standards have been adopted by BLUECARE PLUS. Compliance with all required elements noted with an asterisk (*), and an overall score of 80 percent achieved is required to meet these site review standards. These standards are subject to change and revisions will be posted in quarterly updates.

Site Review Standards

*1.	The office is to be handicap accessible.
*2.	The office is to be clean, and organized, with adequate examining room and waiting room space.
*3.	The office should have adequate lighting in waiting room and treatment area.
*4.	Examining rooms should be designed for patient privacy.
5.	There should be evidence of compliance with BlueCross BlueShield of Tennessee/BlueCare Tennessee appointment availability standards for routine and urgent care.
*6.	Appropriate procedures should be in place for after-hours coverage. Voice mail messaging/answering machines should include instructions for reaching the Practitioner on call.
*7.	There should be an individual medical record for each patient.
*8.	Current medical records should be available at the site where services are provided and readily accessible.
*9.	Medical records should be kept in a secure location. Sites with Electronic Medical Records should provide evidence of a secure off site record retention/recovery process.
*10.	There should be evidence of a medical record confidentiality plan/policy that includes Protected Health Information (PHI).
*11.	There should be evidence of a fire safety/emergency action plan with evidence of staff education. This plan must be written at locations with 10 or more employees. Pathways to doors should be clear and well marked.

*12.	Emergency Supplies and procedures should be available for scope of practice. Minimum requirements include: o Epinephrine and O2 for PCP sites o Delivery kit for OB/GYN o Crash cart and O2 at sites that perform stress test or services that require sedation.
*13.	The office has infection control procedures that include appropriate disposal of bio-hazardous material. Hand washing facilities should be in/near treatment rooms and OSHA standards and MSDS/SDS information should be available to staff.
*14.	There should be a process for the appropriate disposal of needles and other sharps.
15.	There should be a process for inventory control of all stock and sample medications.
*16.	There should be evidence of an inventory control process for dispensing controlled substances and disposal of expired or unused portions of drugs.
*17.	Controlled substances must be maintained in a locked area.
*18.	Evidence of CLIA registration with site-specific address is required for any practice location where lab is performed.
*19.	If radiology services are provided, a current state inspection compliance notice should be posted with the date of the last inspection.
20.	Radiology technique should be posted near the radiology equipment if not generated by radiology equipment.
*21.	For Physician Extenders, there should be a protocol on site and evidence of supervising Physician oversight, as required by practice type and state regulations.
22.	There should be a sign posted that Physician Extenders may provide care, where applicable.
23.	Professional staff should be licensed appropriately with evidence of licensure on file.
24.	Member rights and responsibilities should be posted or otherwise made available to Members.

Comprehensive Medical Record Standards

Network Practitioners are expected to maintain medical records in detail consistent with good medical/professional practice, which permits effective internal/external review and/or medical audit and facilitates appropriate care and treatment by any health care Practitioner.

Practitioner performance will be evaluated against the standards listed below through random solicitation of records for review, and evaluation of records obtained as part of routine health plan operations and quality of care reporting processes.

Clinical staff will schedule onsite medical record reviews for no less than five (5) percent of credentialed Primary Care Practitioners annually to evaluate against published standards. Suggestions for improvement will be documented and shared with Practitioner or Practitioner representative if applicable. In addition, medical record reviews will be performed during the annual HEDIS® project and analysis performed to identify Practitioners with educational needs.

Random comprehensive medical record reviews may also be performed for any credentialed Practitioner upon request of the Clinical Risk Management Department.

Practitioners with illegible records and those with appropriateness of care or potential utilization of care concerns noted during review will be referred to the Clinical Risk Management Department for further review.

Medical record data is utilized to evaluate potential coordination of care concerns and to provide supplemental data for internal/external quality reports.

Medical Record Keeping Practices

- Medical records should be legible.
- Member identification is to be on each page of the record.
- Each recorded chart entry is to be dated and identified by the author. Stamped signatures are not acceptable.
- The medical records should be readily accessible to the Practitioner during normal office hours.

Documentation

- All medical records are to contain a current Member problem list, which addresses chronic and significant recurrent/acute conditions.
- All medication allergies, absence of allergies, and/or adverse reactions are to be consistently documented and prominently displayed in all medical records.
- An initial history and physical examination should be documented for new patients within 12 months of Member first seeking care or within 3 visits, whichever occurs first. Past medical history that includes behavioral health history, serious accidents, illnesses and surgeries, and gestational and birth history for pediatric patients under age 6 should be documented.
- Each medical record is to contain an updated list of medications the Member is taking, or documentation that the Member is presently not taking any medications.
- Each medical record is to contain tobacco, alcohol, and/or substance use history (for Members 12 years and over and seen three (3) or more times).
- The medical record of all Members age 18 years and over should contain documentation of whether a medical advance directive has been executed for Medicaid/Medicare Members.
- If the Member has executed an advance directive, a copy should be on file within the office.

Appropriateness of Care

- Each visit should include documentation of Member's chief complaint or purpose for visit. Clinical assessment and physical examination should be documented and correspond to Member's stated complaint or visit purpose and/or ongoing care for chronic illnesses.
- Working diagnosis or medical impressions that logically follow from the clinical assessment and physical examination should be recorded.
- Rationale for treatment decisions should appear Medically Appropriate and be substantiated by documentation in the record, with laboratory tests performed at appropriate intervals.
- Records should substantiate the Member's clinical problems and treatment in a manner such that another Practitioner can determine the Member's overall clinical course under the reviewed Practitioner's management.

Continuity and Coordination of Care

- There should be documentation of unresolved problems from past visits, and abnormal consults or diagnostic tests through follow-up phone calls or return office visits.
- Medical records should contain documentation of appropriate use of consultants, which includes Behavioral Health Providers, and documentation of medical services performed by a referral specialist/Practitioner.
- If diagnostic and/or therapeutic ancillary services were performed, there should be a copy of the written report of the service in the record.

Education & Preventive Care

- Each medical record should contain evidence that age/sex appropriate preventive screenings/immunizations are offered in accordance with *Clinician's Handbook of Preventive Services or* the American Academy of Pediatrics, as applicable.
- Care for high-risk conditions should be documented in accordance with BlueCross BlueShield of Tennessee's Clinical Practice Guidelines (CPG's).
- There should be documentation of Member education/instructions.

Facility Site Standards

Non-accredited facilities applying for initial credentialing with BlueCare Plus networks must meet and maintain compliance with the site standards listed below.

Non-compliant sites for currently credentialed Providers will be referred to the BlueCare Plus Clinical Risk Management Committee for review. The credentialing process will be halted for all non-credentialed Providers until BlueCare Plus facility site standards are met.

Physical Assessment

- The facility is to be handicap accessible.
- The facility should be clean and organized with adequate lighting and work space in treatment rooms to conduct patient exams effectively.

After Hours Coverage

- Appropriate procedures should be in place for after-hours coverage, where applicable.

Medical Record Keeping

- There should be an individual medical record for each Member.
- Medical records should be kept in a secure location.
- There should be evidence of a medical record confidentiality plan/policy that includes Protected Health Information (PHI).
- Medical records should be legible and maintained in detail consistent with good medical/professional practice, which permits effective internal/external review and/or medical audit and facilitate follow-up treatment.

Safety

- Emergency supplies and procedures should be available for the scope of practice.
- Policy and procedures should be available and reviewed annually regarding administrative, operational, safety, disaster management and infection control.
- There should be evidence of staff education to include safety, disaster management and infection control.
- There should be infection control measures consistent with OSHA guidelines.
- There should be a Quality Improvement plan monitoring all aspects of performance of care/services with evidence of staff review.
- Evidence of CLIA registration is required if lab is performed in the facility.
- If radiology services are provided, a current state inspection compliance notice should be posted with the date of the last inspection.
- Radiological technique should be posted near the radiology equipment.
- There should be a process for inventory control of all stock and sample medications and medical supplies.
- There should be evidence of an inventory control process for dispensing controlled substances and disposal of expired or unused portions of drugs.
- Controlled substances must be maintained in a locked area.
- The facility should maintain equipment in a safe manner consistent with the manufacturer's recommendations.
- Member Rights and Responsibilities should be posted, or available in the facility.
- Professional staff should be licensed appropriately with evidence of licensure on file.
- The facility should have a defined process to ensure professional performance of its staff by:

- Completing credentialing process for independent Practitioners.
- Completing credentialing functions according to state, federal and NCQA standards.
- Utilizing the current license, relevant training and experience, current competence and privileges at a hospital in the credentialing process.

If needed, the facilities' files will be audited by a BlueCare Plus Clinical Quality Assurance Representative to ensure the credentialing process meets the above criteria.

C. Electronic Data Interchange (EDI)

All network providers are required to submit claims electronically rather than by paper format. Submitting claims electronically ensures compliance with the terms of the Minimum Practitioner Network Participation Criteria as well as lower costs and streamline adjudication. Additional information regarding electronic claims is available here.

All network providers are required to receive payment by Electronic Funds Transfer (EFT) to remain in compliance with the terms of the Minimum Practitioner Network Participation Criteria. More information regarding Electronic Funds Transfer (EFT) is available here.

BlueCare Plus accepts claims electronically in the ANSI 837 format additional information is available here.

BCBST accepts electronic funds transfer (EFT) enrollment through Change Healthcare who offers a universal enrollment tool for providers that provides a single of entry for adopting EFT and ERA. The Change Healthcare process facilitates compliance with CAQH Core III requirements, eliminates administrative redundancies and creates significant time and cost savings. Enrollment information is available on the Change Healthcare website at payerenrollservices.com.

To view/print a copy of your remittance advices, ensure you have access to Availity, BCBST's secure area on its websites, www.bcbst.com and https://bluecare.bcbst.com.

For more information regarding the EFT program process, or for assistance with Availity, please call eBusiness Service at 800-924-7141 and follow the prompts to eBusiness support or email eBusiness_service@bcbst.com.

Payer Enrollment Services is the new name for the Change Healthcare EFT and ERA enrollment tool.

Phone: 800-956-5190 Monday through Friday, 8 a.m. to 5 p.m. (Central)

Website: payerenrollservices.com

Submission of professional charges are on the CMS-UB04/ANSI-837 Professional Transaction and institutional charges on the CMS-UB04 /ANSI-837 Institutional Transaction. Claims data should be complete and filed for all services both covered and non-covered. Billed services for the same patient, same date of service (DOS), same place of service (POS), must be billed on a single claim submission. Claims data is vital to report measurements and statistics needed for the Healthcare Effectiveness Data and Information Set (HEDIS) and URAC requirements.

The start date for determining the timely filing period is the date of service or "From" date on the claim. For institutional claims (Form CMS-1450, the UB-04 and now the 837I that includes span dates of service (i.e., a "From" and "Through" date span on the claim), the "Through" date on the claim is used for determining the date of service for claims filing timeliness. For professional claims (Form CMS-1500 and 837P) submitted by physicians and other suppliers that include span dates of service, the line item "From" date is used for determining the date of service for claims filing timeliness. (This includes DME supplies and rental items.)

BlueCare Plus timely filing period is 1 year from the date of service or, for facilities, within **1 year** from the date of discharge.

If the provider has documented evidence the member did not provide BlueCare Plus insurance information, the timely filing provision shall begin with receipt of insurance information, subject to the limitations of the member's benefit agreement.

The Health Care Claim Acknowledgement Report

The Health Care Claim Acknowledgement Report supplies providers with one comprehensive report of all claims received electronically. The provider should maintain this report for proof of timely filing. A provider submitting claims electronically either directly or through a billing service/clearinghouse will automatically receive claims receipt reports in their electronic mailbox.

To learn more about retrieving your electronic reports, contact eBusiness Solutions at 423-535-5717, Monday through Thursday, 8 a.m. to 6:00 p.m. (ET) and Friday, 9 a.m. to 6:00 p.m. (ET).

Note: Submission dates of claims filed electronically that are **not** accepted by BlueCare Plus due to transmission errors are not accepted as proof of timely filing.

1. Filing Electronic Claims

The electronic claims processing system used by BlueCare Plus is in compliance with Federal Health Insurance Portability and Accountability Act of 1996-Administrative Simplification (HIPAA-AS). This system is for processing of American National Standards Institute (ANSI) 837 claims and other ANSI transactions, and to verify HIPAA compliancy of those transactions. BlueCare Plus business edits are modified to recognize the required ANSI formats. These edits apply to electronic claims.

Provider Number/National Provider Identifier (NPI) Number for Electronic Claims:

Claims submitted electronically must include the provider's appropriate individual BlueCare Plus provider number and/or NPI in the required data elements as specified in the Implementation Guide. This guide is available online via theX12.org website at https//x12.org/products. You may access additional companion documents needed for BlueCross BlueShield of Tennessee electronic claims submission at Digital Resources for Providers | BCBS of Tennessee (bcbst.com).

Note: BlueCross BlueShield of Tennessee follows the Centers for Medicare & Medicaid Services (CMS) guidelines for filing the National Provider Identifier (NPI) Number.

2. Electronic Enrollment and Support

Enrollment of new providers, changes to existing provider or billing information (address, tax ID, provider number, NPI, name), or any changes of software vendor should be communicated to eBusiness Solutions via the *Provider Electronic Profile* form. The provider Electronic Profile form is accessible through Availity or visit our website here for additional details.

For technical support or enrollment information, call, fax, or e-mail:

Technical Support call:	423-535-5717
E-mail:	www.ecomm_support@bcbst.com
Enrollment call:	1-800-924-7141
Fax:	423-535-7523
E-mail:	www.ecomm_contracts@bcbst.com

HIPAA standards require Covered Entities to transmit electronic data between trading partners via a standard format (ANSI X12). EDI allows entities within the health care system to exchange this data quickly and securely. Currently, BlueCross BlueShield of Tennessee uses the ANSI 837 version. BlueCross BlueShield of Tennessee accepts the ANSI 837 version, 5010 formats. American

National Standards Institute has accredited a group called “X12” that defines EDI standards for many American industries, including health care insurance. Most electronic standards mandated or proposed under HIPAA are X12 standards.

3. Secure File Gateway (SFG)

The Secure File Gateway allows trading partners to submit electronic claims and download electronic reports using multiple secure managed file transfer protocols. Submit claim files through SFG. How to use SFG can be found here.:

ANSI 837 (Version 5010)

The ANSI 837 format is set up on a hierarchical (chain of command) system consisting of loops, segments, elements, and sub-elements and is used to electronically file professional, institutional and/or dental claims and to report encounter data from a third party*. For detailed specifics on the ANSI 837 format, providers should reference the appropriate guidelines found in *the National Electronic Data Interchange Transaction Set Implementation Guide*. This guide is available online via the x12.org website here.. Additional companion documents needed for BlueCross BlueShield of Tennessee electronic claims submission can be accessed at here under Electronic Data Interchange..

*Coordination of Benefits (COB) is part of the ANSI 837, which provides the ability to transmit primary and secondary carrier information. The primary payer can report the primary payment to the secondary payer. For detailed specifics on the ANSI 837 format, providers should reference the appropriate guidelines found in *the National Electronic Data Interchange Transaction Set Implementation Guide*. This guide is available online via the Washington Publishing Company website at http://www.wpc-edi.com. Additional companion documents are available for BlueCross BlueShield of Tennessee electronic claims submission at: http://www.bcbst.com/providers/ecomm/technical-information.shtml .

4. Electronic Enrollment Forms

Electronic enrollment just got easier. The Electronic Provider Profile replaces all our previous registration forms, contracts and addendums. And original signatures have been eliminated. For questions call (800) 924-7141 and speak "Enrollment”.

To enroll in electronic claims filing, to add a provider to an existing electronic practice or make any changes in your electronic filing process you must complete an Electronic Provider Profile Form.

Access the Electronic Provider Profile Form on Availity ***for all Providers.***

If you would like to make changes to your current electronic mailbox(s), or migrate to the SFG, you must complete the SFG Request for Access form through Availity.

5. Security Information

In order to protect your secure access to our systems, each individual who will be accessing our systems is required to submit the Provider Account Security Form located on our website under Electronic Data Interchange (EDI).

D. Provider Resources

1. BlueCare Plus Provider Website

BlueCare Plus Tennessee integrates self-service and electronic communication technologies as an efficient, cost-effective means to distribute BlueCare Plus provider information, education, and assistance. We take every opportunity to educate our providers about and encourage the use of our self-service technologies. Our site is located at bluecareplus.bcbst.com.

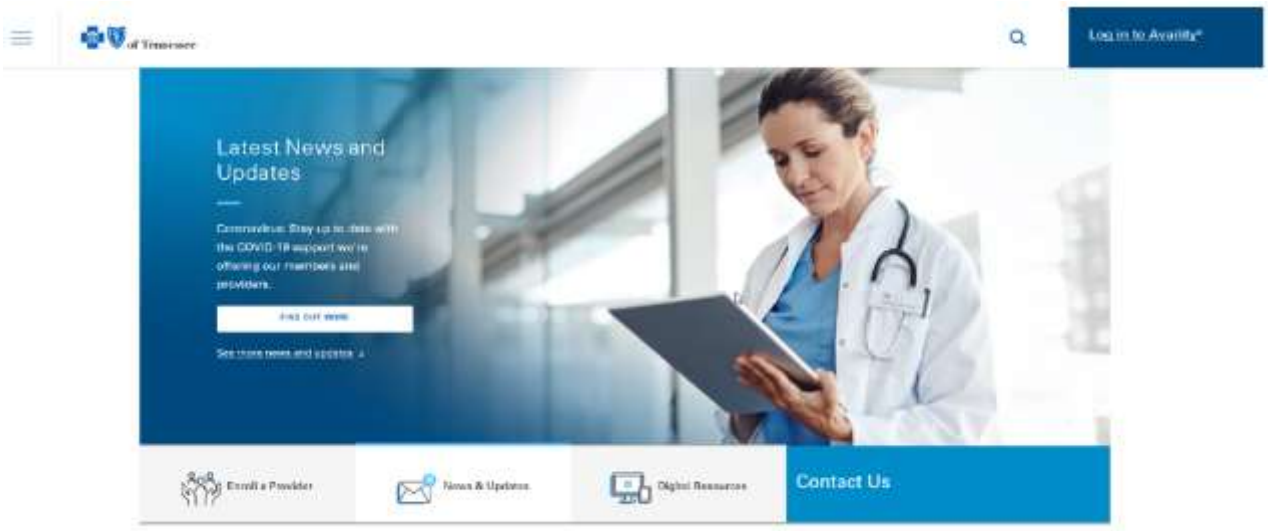
The Website design offers a user-friendly experience for both members and providers in seeking information and assistance regarding the Medicare and Medicaid program. The Website presents appropriate, clear and accessible information to both members and providers, with effortless access to information while adhering to all 508 accessibility, NCQA, URAC and BCBST standards, policies and procedures. Our primary goal is to provide healthcare information in an easy-to-use platform with self-service technology and to improve the user experience..

BlueCare Plus Homepage

The following provider resource sections are available on bluecareplus.bcbst.com.

- **Provider Administration Manual**
  The Provider Administration Manual (PAM) offers information about our programs, and how we work with our members and providers.
- **Provider Education and Resources**
  The Provider Education and Resources section offers timely and accessible information, including additional education to review at your convenience. We offer a Provider Resource page to assist you with day-to-day operations for providing services to our members.
- **Electronic Data Interchange**
  Electronic enrollment just got easier. The Electronic Provider Profile replaces all our previous registration forms, contracts and addendums.
- **Clinical Practice Guidelines**
  BlueCare Plus follows the Clinical Practice Guidelines (CPGs) that have been adopted by BlueCross BlueShield of Tennessee. BlueCare Plus may also follow modified Practice Guidelines based on conditions relevant to our member population, TennCare, CMS and/or nationally recognized standards in which there is not a supporting corporate guideline.

Provider Resource Page



A number of reference materials are also available online giving you access to current administrative processes, and medical policies. The website contains a “find” feature making it convenient for providers to locate specific information, (e.g., billing requirements, UM guidelines, preventive care guidelines, upcoming medical policies and much more).

We invite you to visit the website often. Information and new features and timely information are added regularly.

2. Availity

Availity enables you to view the following in real time:

- Up-to-date policy
- Medical and behavioral health claim information
- Eligibility and coverage
- Prior authorizations
- View and/or print your remittance advice

Additional services are available

- PCP Membership Rosters
- Provider Fee Schedules
- Quality Care Rewards (QCR)s

Availity includes e-Health Services® (benefits, claims and authorization information), as well as access to Primary Care Provider member rosters, provider remittance advices and much more. First time users must register to access these online services. Visit Provider Contact Us | BCBS of Tennessee (bcbst.com) to find your contact for Availity technical support.

V. General Guidelines for Benefits

The scope of the benefits under Medicare Part A and Medicare Part B is defined in the Social Security Act. The scopes of Part A and Part B are discussed in sections 1812 and 1832 of the Act, respectively, while section 1861 of the Act lays out the definition of medical and other health services. Specific health care services must fit into one of these benefit categories or supplemental benefit categories, and not be otherwise excluded from coverage under the Medicare program (see §1862 for exclusions).

BlueCare Plus coverage and payment is contingent upon the following:

1. A service must be a covered benefit in a member's Evidence of Coverage;
2. A service must not be excluded; and
3. A service must be appropriate and medically necessary.

BlueCare Plus uses the following hierarchy of references to determine coverage:

- The law (Title 18 of the Social Security Act);
- The regulations (Title 42 Code of Federal Regulations (CFR) Parts 422 and 476);
- National Coverage Determinations (NCDs) Manual Publication 100-03 of Medicare's Internet Only Manuals;
- Benefit Policy Manual Publication 100-02 of Medicare's Internet Only Manuals;
- Local Coverage Determinations (LCDs);
- Coverage guidelines in Interpretative Manuals (Medicare's Internet Only Manuals, sub-manuals) including:
    - Claims Processing Manual Publication 100-04;
    - Program Integrity Manual Publication 100-08;
    - Quality Improvement Organization Manual Publication 100-10;
    - Medicare Managed Care Manual Publication (100-16)
- Durable Medical Equipment Medicare Administrative Contractor (DMEMAC);
- Associated Program Safeguard Contractor (PSC) Local Coverage Determinations;
- MCG criteria;
- BlueCross Utilization Guidelines;
- U.S. Food and Drug Administration approved indications for medications;
- Supplemental benefits and limitations as outlined in a member's Evidence of Coverage;
- BCBST Policy; and
- Other major payor policy and peer reviewed literature.

BlueCare Plus is a MA SNP HMO for beneficiaries enrolled in Medicare and receiving full Medicaid benefits and/or assistance with Medicare premiums or cost sharing through one of the Medicare Saving programs categories that are offered to help members with Medicare pay Medicare cost sharing:

Qualified Medicare Beneficiary (QMB): Helps pay Medicare Part A and Part B premiums, and other cost sharing like deductibles, coinsurance, and copayments. Some people with QMB are also eligible for full TennCare (Medicaid) benefits (QMB+).

Specified Low-Income Medicare Beneficiary Plus (SLMB+): Helps pay Part B premiums and are also eligible for full TennCare (Medicaid) benefits.

BlueCare Plus confirms eligibility, including both Medicare eligibility and Medicaid eligibility prior to enrollment.

A BlueCare Plus member's eligibility for enrollment is based on his/her eligibility for Medicaid. Medicaid eligibility is subject to changes due to variation in the enrollee's income from one month to another or to changes in the State's criteria for eligibility. Thus, a dual eligible enrollee of BlueCare Plus may become ineligible for the plan due to the loss of his/her Medicaid eligibility for a period of time that may be one, or many months in duration. When a BlueCare Plus member loses Medicaid eligibility, BlueCare Plus will provide assistance to re-establish a member's Medicaid status. However, the expected period of loss of eligibility cannot exceed six months.

Please refer to the BlueCare Tennessee Provider Administration Manual for Medicaid benefits for BlueCare Plus Choice members. The manual is located at:
http://bluecare.bcbst.com/providers/news-manuals.html.

A. Emergent and Urgently Needed Care

An **emergency medical condition** is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency medical condition status is not affected if a later medical review found no actual emergency present.

Emergency services are covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services; and
- Needed to evaluate or treat an emergency medical condition.

Urgently-needed services are covered services that:

- Are not emergency services as defined above but are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition;
- Are provided when a member is temporarily absent from the BlueCare Plus service area and unable to obtain needed services from a network provider or when a member is in the service area, but the network is temporarily unavailable or inaccessible; and
- It was not reasonable given the circumstances to wait to obtain the services from his/her regular network provider after the member returns to the service area or a network provider becomes available.

BlueCare Plus does not require prior approval of emergency or urgently-needed covered services.

Stabilization of an Emergency Medical Condition

A physician treating a member is responsible for deciding when the member may be considered stabilized for transfer or discharge.

Post Stabilization Care Services
Post stabilization care services are covered services that are:

- Related to an emergency medical condition;
- Provided after a member is stabilized; and
- Provided to maintain the stabilized condition, or under certain circumstances, to improve or resolve the member's condition.

Member Protections Related to Plan-Directed Care
In accordance with Medicare Managed Care Manual Chapter 4, CMS considers a contracted provider an agent of BlueCare Plus. As an agent for us, it is the responsibility of contracted providers to know whether specific items and services are covered in our BlueCare Plus plan. Additionally, contracted providers are expected to coordinate care/services with other contracted providers and ensure the member is receiving medically necessary services. Providers should contact BlueCare Plus' UM Department at 1-866-789-6314 or fax clinical information supporting the need for services to be provided by a non-contracted provider to 1-866-325-6698 **prior** to rendering the service. This does not apply to emergency or urgently-needed services as described above.

B. Services, Supplies and Durable Medical Equipment (DME)

Durable Medical Equipment (DME) is equipment which:

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of illness or injury; and
- Is appropriate for use in the home.

All requirements of the definition must be met before an item can be considered to be DME. Although an item may be classified as DME, it may not be covered in every instance. Coverage in a particular case is subject to the requirement that the equipment be necessary and reasonable for treatment of an illness or injury, or to improve the functioning of a malformed body member.

Medical supplies of an expendable nature, such as incontinent pads, lambs wool pads, catheters, ace bandages, elastic stockings, surgical facemasks, irrigating kits, sheets, and bags are not considered "durable" within the meaning of the definition. There are other items that, although durable in nature, may fall into other coverage categories such as supplies, braces, prosthetic devices, artificial arms, legs, and eyes.

For purposes of rental and purchase of DME a member's home may be his/her own dwelling, an apartment, a relative's home, a home for the aged, or some other type of institution (such as an assisted living facility, or an intermediate care facility for individuals with intellectual disabilities (ICF/IID)). However, an institution may not be considered a member's home if it:

- Meets at least the basic requirement in the definition of a hospital, i.e., it is primarily engaged in providing by or under the supervision of physicians, to inpatients, diagnostic and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, and sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons; or
- Meets at least the basic requirement in the definition of a skilled nursing facility, i.e., it is primarily engaged in providing to inpatients skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons.

1. Medical Equipment

Equipment presumptively constituted as medical equipment includes:

- Hospital beds
- Wheelchairs
- Hemodialysis equipment (also covered as a prosthetic device)

- Iron lungs
- Respirators
- Intermittent positive pressure breathing machines
- Medical regulators
- Oxygen tents
- Crutches
- Canes
- Trapeze bars
- Walkers
- Inhalators
- Nebulizers
- Commodes
- Suction machines
- Traction equipment

Special Exception Items
Specified items of equipment may be covered under certain conditions even though they do not meet the definition of DME because they are not primarily and customarily used to serve a medical purpose and/or are generally useful in the absence of illness or injury. These items would be covered when it is clearly established that they serve a therapeutic purpose in an individual case and would include:

- gel pads and pressure and water mattresses (which generally serve a preventive purpose) when prescribed for a patient who had bed sores or there is medical evidence indicating highly susceptible to ulceration; and
- heat lamps for medical therapy where the need for heat therapy has been established.

Continuous Glucose Monitors Covered Under Part B
Continuous glucose monitors are covered under Part B with a prior authorization. Continuous glucose monitoring systems supplied only through the pharmacy and not a DME provider include Dexcom G6 and Abbott Freestyle Libre 14-day and Libre 2 products. DME such as insulin pumps with integrated adjunctive CGMs require authorization

Repair, Maintenance, and Replacement of Medically Required DME Repairs
Repairs to equipment a member owns are covered when necessary to make the equipment serviceable after damage or wear. See Non-Covered Benefits section below related to repair, maintenance or replacement of equipment in frequent and substantial servicing or oxygen equipment.

A new Certificate of Medical Necessity (CMN) and/or physician's order is not needed for repairs.

Maintenance
Extensive maintenance which, based on the manufacturers' recommendations and performed by authorized technicians, is covered as repairs for medically necessary equipment which a member owns. This might include, for example, breaking down sealed components and performing tests which require specialized testing equipment not available to the beneficiary.

A new CMN and/or physician's order is not needed for covered maintenance.

Replacement
Equipment a member owns or is a capped rental item may be replaced in cases of loss or irreparable damage to a specific accident or a natural disaster such as fire or flood.

A physician's order and/or new Certificate of Medical Necessity (CMN), when required, is needed to reaffirm the medical necessity of the item.

Coverage of Supplies and Accessories

Supplies that are necessary for the effective use of DME are covered. Such supplies include drugs and biologicals which must be put directly into the equipment in order to achieve the therapeutic benefit of the DME or to assure the proper functioning of the equipment, e.g., tumor chemotherapy agents used with an infusion pump or heparin used with a home dialysis system. However, the coverage of such drugs or biologicals does not preclude the need for a determination that the drug or biological itself is reasonable and necessary for treatment of the illness or injury or to improve the functioning of a malformed body member.

Preferred DME product or brand is available on the BlueCare Plus Website in members' Evidence of Coverage document.

2. Prosthetics

Prosthetic devices (other than dental) which replace all or part of an internal body organ (including contiguous tissue) or replace all or part of the function of a permanently inoperative or malfunctioning internal body organ are covered when furnished on a physician's order. Examples include:

- Artificial limbs
- Parenteral and enteral nutrition and accessories and/or supplies
- Cardiac pacemakers
- Prosthetic lenses
- Breast prostheses including surgical brassiere post mastectomy
- Maxillofacial devices
- Devices replacing all or part of the ear or nose
- Urinary collection and retention system with or without a tube to replace bladder function in case of permanent incontinence
- Foley catheter for permanent urinary incontinence
- Colostomy and other ostomy bags, necessary accessories required for attachment, irrigation/flushing equipment, and other items/supplies directly related to ostomy care, whether the attachment of a bag is required
- Back braces

Prosthetics Replacement

Replacement of a prosthetic device that is an artificial limb, or replacement part of a device is covered if the ordering physician determines that the replacement device or part is necessary because of any of the following:

- a change in the physiological condition of the patient;
- an irreparable change in the condition of the device, or in a part of the device; or
- the condition of the device, or the part of the device, requires repairs and the cost of such repairs would be more than 60 percent of the cost of a replacement device, or, as the case may be, of the part being replaced.

Prosthetic Supplies, Repairs, Adjustments, and Replacement

Supplies are covered that are necessary for the effective use of a prosthetic device (e.g., the batteries needed to operate an artificial larynx). Adjustment of prosthetic devices required by wear or by a change in the patient's condition is covered when ordered by a physician. General provisions relating to the repair and replacement of DME as described above for the repair and replacement of prosthetic devices are applicable.

Adjustments to an artificial limb or other appliance required by wear or by a change in the patient's condition are covered when ordered by a physician.

C. Chiropractic Services

Manual manipulation and manual devices (i.e., those that are hand-held with the thrust of the force of the device being controlled manually) may be used by chiropractors in performing manual manipulation of the spine. However, no additional payment is available for use of the device, nor does Medicare recognize an extra charge for the device itself.

D. Part B Drugs

In order for Part B drugs to be considered for benefits, the service must be Medically Necessary and Medically Appropriate to the treatment of the Member's illness or injury according to National Coverage Determinations and/or Local Coverage Determinations.

Part B drugs include:

• Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services

• Drugs you take using durable medical equipment (such as nebulizers) that were authorized

Certain Part B drugs may be subject to Step Therapy requirements for Members who are new to start the medication. These drugs are identified with "ST" for Step Therapy. The list of drugs requiring prior authorization and Step Therapy can be found at

https://www.bcbst.com/docs/providers/MA-DSNP-Specialty-Pharmacy-List.pdf.

You can also find all Part B Step Therapy requirements at

https://www.bcbst.com/docs/providers/Part_B_Step_Therapy_Provider_Reference_Guide.pdf.

Certain Part B drugs may be subject to Step Therapy requirements for Members who are new to start the medication. These drugs are identified on the Preferred Formulary for Step Therapy. The list of drugs requiring prior authorization and Step Therapy can be found at
https://www.bcbst.com/docs/providers/MA-DSNP-Specialty-Pharmacy-List.pdf.

Certain formulary drugs may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make a determination.

BlueCross' Medicare Advantage uses MagellanRx for Part B Specialty Pharmacy medication authorizations. Authorization requests can be initiated by phone at 1-800-924-7141, or online through Availity, BlueCross' secure portal on its website, www.bcbst.com.

Note: New drugs may be periodically added to the Specialty Pharmacy list and those products requiring authorization are subject to change. Changes will be communicated via BlueAlert newsletter or updates to this Manual. Current and archived BlueAlert issues can be viewed on the company website under the News and Updates section at
http://www.bcbst.com/providers/newsletters/index.page

E. Hospice

Original Medicare, rather than BlueCare Plus, pays for hospice services for a member who has elected hospice. BlueCare Plus will continue to pay for non-hospice and supplemental benefit services.

F. Out of Area Renal Dialysis Services

A member may select a qualified dialysis provider for medically necessary dialysis services if the member is temporarily absent from BlueCare Plus service area and cannot reasonably access the BlueCare Plus contracted providers. Prior authorization is not required in this situation.

G. Referral Guidelines

In BlueCare Plus, members will choose or be assigned a Primary Care Physician (PCP) for their health care needs. The PCP is responsible for the coordination of BlueCare Plus members' healthcare and routine health care needs.

BlueCare Plus does not require referrals from a PCP to a contracted specialist. If a member needs to obtain services from a non-contracted provider a prior authorization is required.

Members may receive services such as those listed below without prior approval from their PCP.

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as provided from a contracted provider.
- Flu shots, Hepatitis B vaccinations, and pneumonia vaccinations as long as provided from a contracted provider.
- Emergency services from contracted providers or from non-contracted providers.
- Urgently needed care from contracted providers or from non-contracted providers when contracted providers are temporarily unavailable or inaccessible, e.g., when a member may be temporarily outside of the BlueCare Plus service area.
- Kidney dialysis services that a member may receive at a Medicare-certified dialysis facility when the member is temporarily outside the plan's service area.

H. Therapy Caps and Exceptions

The statutory Medicare Part B outpatient therapy cap is an annual per beneficiary therapy cap amount determined for each calendar year. Exceptions to the therapy cap are allowed for reasonable and necessary therapy services. The annual update is published on The Centers for Medicare and Medicaid, Therapy Services page. Prior authorization is for required for therapy services.

The therapy cap applies to all Part B outpatient therapy settings and providers including:

- Therapists' private practices
- Offices of physicians and certain non-physician practitioners
- Part B skilled nursing facilities
- Home health agencies (Type of Bill (TOB) 34X)
- Rehabilitation agencies (also known as Outpatient Rehabilitation Facilities-ORFs)
- Comprehensive Outpatient Rehabilitation Facilities (CORFs)
- Hospital outpatient departments (HOPDs)

I. Behavioral Health Services

BlueCare Plus offers a fully integrated physical and behavioral model designed to serve the needs of its members. Our system of care eliminates the separation of physical and behavioral health and social needs and prevents the fragmentation of services. The cornerstone of this model is the Care Team, which is led by the Primary Care Provider (PCP) and is unique to the member's health care needs. The Care Team is comprised of all individuals responsible for the care of the member, including health care providers, family, state and community resources, and BlueCare Plus Care Facilitators. The composition of the Care Team may change over time, or remain static depending on the needs of the member. Members of the Care Team may be permanent for a member who may have chronic pathology or behavioral health needs. The expectation is that behavioral health providers will be active members of this team ensuring the member's needs are met across time. We believe for managed care to be effective, the delivery of care must occur in an environment where the major participants are working together to achieve the same purpose. An active partnership is essential for significant health improvements to occur in the BlueCare Plus population. BlueCare Plus strongly believes that members, providers, and our organization are all intertwined by four common interests:

- promoting recovery, resiliency and wellness
- achieving outcomes
- managing resources
- managing care

Our care management programs are designed to support effective and efficient integration of PCP and behavioral health services through a variety of joint coordination mechanisms within our Utilization Management program and Case Management programs.

1. Care Management

BlueCare Plus Care Management Program helps members stay healthy, address health risks, and manage their chronic conditions, such as schizophrenia, bipolar disorder, and major depressive disorder. BlueCare Plus Care Management services include outreach, health education, care coordination, case management, and more. Services are available to BlueCare Plus members at no extra cost.

BlueCare Plus Care Management evaluates our entire member population for risk factors (not disease categories) to identify members who may benefit from particular Care Management services. We encourage providers to refer members for care management services, as needed. To refer members, please call 1-877-715-9503.

2. Case Management

The BlueCare Plus Case Management program identifies and assesses members who may benefit from community-based management services. BlueCare Plus Case Management may contact behavioral health providers to facilitate care coordination for high-risk members.

3. Covered Services

Outpatient/Inpatient Behavioral Health Services
Benefits are available for clinical assessment, diagnosis, and referral, as well as inpatient and outpatient services for treatment of behavioral health disorders (mental health and substance use disorders).

The following grid lists behavioral healthcare Covered Services for BlueCare Plus members:

Service	Benefit Limit/Requirement
Psychiatric inpatient hospital services, including CSU* (including physician services)	As Medically Necessary
Outpatient mental health services (including physician services)	As Medically Necessary
Inpatient, residential & outpatient substance use disorder benefits*	As Medically Necessary
Partial Hospitalization (substance abuse and psychiatric)	As Medically Necessary
Psychological/Neuropsychological Testing	As Medically Necessary
Electroconvulsive Therapy	As Medically Necessary
Psychiatric Consult on a medical floor	As Medically Necessary
Transcranial Magnetic Stimulation	As Medically Necessary
Medication Assisted Treatment**	As Medically Necessary

*Inpatient, CSU and residential SUD benefits are limited to services located in an Inpatient facility.
**Effective 1/1/20 Medication Assisted Treatment includes Buprenorphine, Naltrexone and Methadone provided through a network eligible OTP (Opioid Treatment Provider).

4. Prior Authorization

Inpatient and higher levels of care, including Crisis Stabilization Unit, require prior authorization. A prior authorization may be retroactively denied if BlueCare Plus subsequently determines that (1) the healthcare services rendered were not included as Covered Services under the applicable Benefit Plan; (2) such services were not Medically Necessary; (3) the member was ineligible for such services at the time the services were rendered; or (4) the information submitted with the prior authorization request was not accurate or complete.

The following behavioral health levels of care require prior authorization:

- Psychiatric inpatient hospital services
- Inpatient (detox), residential substance use services
- Partial hospitalization (psychiatric only)
- Electroconvulsive Therapy
- Psychological/Neuropsychological Testing
- Transcranial Magnetic Stimulation Therapy

Prior Authorization services for physical and behavioral health services can be arranged by calling the Utilization Management Department Monday through Friday, 8 a.m. to 6 p.m. (ET) at the statewide telephone number listed below:

1-866-789-6314

Requests for urgent services are received and processed telephonically 24 hours a day, 7 days a week. Urgent services are considered:

- Psychiatric inpatient hospital services
- Inpatient substance abuse services (detox)

Providers can submit requests for outpatient services via fax at 1-866-325-6698.

Authorization requests for elective inpatient behavioral health services like residential treatment and any outpatient services requiring prior authorization should be submitted twenty-four (24) hours prior to admission.

Prior authorization requests for urgent inpatient Behavioral Health admissions should be submitted within twenty-four (24) hours or one (1) business day after services have started is suggested in order to facilitate referrals for transition of care.

When a request for an authorization of a procedure, admission/service is denied, the penalty for not meeting authorization guidelines will apply to both the facility and the practitioner rendering the care for the day(s) or service(s) that have been denied. BlueCare Plus' non-payment is applicable to both the facility and practitioner rendering the care.

5. Medical Necessity Determinations

BlueCare Plus considers the individual needs of each member when making Medical Necessity determinations for Covered Services. We also consider availability of appropriate service alternatives that exists within the region.

BlueCare Plus determines Medical Necessity on a case-by-case basis using established and approved criteria for behavioral health disorders. Timeframes for determining Medical Necessity are based on National Committee for Quality Assurance (NCQA), and State of Tennessee timeliness standards. Providers who do not submit requested medical information for the purposes of making a Medical Necessity determination for a service shall not be entitled to payment for that service. BlueCare Tennessee can impose financial penalties on a Provider who does not comply with an information request for appeals.

Second Opinions
BlueCare Plus provides benefits for a second opinion (in any situation where there is a question concerning diagnosis) when requested by a member, parent, or legally appointed representative.

6. Provider Network Participation

Please be aware not all disciplines described are eligible for participation in the BlueCare Plus networks. In addition to network participation criteria that applies for all provider networks, providers must also be enrolled in Medicare and Medicaid and complete a Disclosure of Ownership and Control Interest statement in order to receive reimbursement for treating BlueCare Plus members.

If you have questions about network eligibility, please contact your assigned regional BlueCare Plus Provider Network Manager, email ProviderSupport@bcbst.com or call Provider Network Services at 1-800-924-7141 and select either touchtone (Option 1) or voice (say "voice").

7. Credentialing Process for Behavioral Health Providers

All providers who participate in BlueCare Plus Provider Network must be credentialed/re-credentialed according to BlueCare Plus requirements. For a detailed listing of credentialing requirements for practitioners and facilities, visit http://www.bcbst.com/providers/contracting-credentialing.page?. Among these requirements is primary source verification of the following information:

- Current, valid license to practice as an independent provider at the highest level certified or approved by the state for the provider's specialty or facility/program status
- License current and valid and not encumbered by restrictions, including but not limited to probation, suspension and/or supervision and monitoring requirements
- Clinical privileges in good standing at the institution designated as the primary admitting
- facility, with no limitations placed on the provider's ability to independently practice in his/her specialty
- Graduation from an accredited professional school and/or highest training program applicable to the academic degree, discipline or licensure
- Current Board certification, if indicated on the application
- A copy of a current DEA and CDS Certificate, as applicable
- No adverse professional liability claims which result in settlements or judgments paid by or on behalf of the provider which disclose an instance of, or pattern of, behavior which may endanger members
- No exclusion or sanctions from government programs (i.e. Medicare/Medicaid)
- Current specialized training as required for providers
- Current and adequate malpractice insurance coverage
- An appropriate work history for the provider's specialty (practitioner only)
- No adverse record of failure to follow BlueCare Plus policies, procedures or Quality Management activities.
- No adverse record of provider actions that violate the terms of the Provider Agreement
- No adverse record of indictment, arrest or conviction of any felony or any crime indicating member endangerment
- No criminal charges filed relating to the provider's ability to render services to members, and
- No action or inaction taken by provider that, in BlueCare Plus sole discretion, results in a threat to the health or well-being of a member or is not in the member's best interest

Behavioral Health Providers (facilities and programs) must be evaluated at credentialing and re-credentialing. Those who are accredited by an accrediting body accepted by BlueCare Plus including The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF), Commission on Accreditation (COA), American Osteopathic Association (AOA), Healthcare Facilities Accreditation Program (HFAP), Accreditation Association for Ambulatory Health Care (AAAHC) DetNorske Veritas (DNA), or Community Health Accreditation Program (CHAP) must have their accreditation status verified. In addition, non-accredited organizational providers may undergo a structured site visit to confirm they meet BlueCare Plus standards standing with state and federal authorities and programs will be verified. BlueCare Plus will not reimburse a provider if a service is a non-credentialed and/or non-contracted non-covered benefit. All practitioner locations where services are rendered or that fall under the same tax identification number will be considered a part of the BlueCare Plus Network.

NOTE: Behavioral Health practitioner disciplines currently recognized for all Medicare programs and eligible for participation in BlueCare Plus are limited to physicians, advanced practice nurses, psychologists, and social workers.

8. Treatment Record Requirements

Outpatient Program providers are expected to develop an initial treatment plan within thirty (30) days of the start date of service and update it every six (6) months or more frequently, as clinically appropriate. Evidence of an individualized treatment plan includes, but is not limited to, the following documentation:

A. A Case Formulation Statement that hypothesizes the Member's primary problem(s), states the desired treatment outcomes, describes the therapeutic approach to treatment, and proposes interventions toward desired outcomes;
B. Identified problems for which the Member is seeking treatment;
C. DSM diagnoses, primary and secondary;
D. Measurable, attainable, age-appropriate goals and objectives related to the identified problems;
E. Target dates for completion of goals/objectives;
F. Information regarding the Member's strengths used to develop strengths-based plan;
G. Services to be used for each goal or objective (e.g., medication management, therapy, community-based treatment services);
H. Evidence of Member's involvement in treatment planning. (*Fulfilling this requirement means that each initial treatment plan and subsequent treatment plan review is signed by a Member, family member, or legally appointed representative*.)
I. Progress notes for each service contact documenting the date and time of service, the type of service provided, a summary of treatment interventions used, the treatment plan goals and objectives addressed in the session, and the name and credentials of service Provider.
J. Documentation of coordination of care efforts and communications with PCPs, other outside Providers, agencies, judicial system, Member support system, or any other person or entity involved in the Member's treatment.
K. Evidence of discharge planning activities to include discharge plans, dates of follow-up appointments, and referrals to other Providers.
L. A discharge summary completed and documented following discharge from services (see program description for time frame requirements).
M. For Providers of multiple services, one comprehensive treatment plan is acceptable as long as at least one goal is written and updated as appropriate, for each of the different services provided to the Member.
N. Providers should screen for health issues and provide appropriate referrals and coordination of care as needed following this screening. Screening for physical health issues and coordination with primary care physicians should be completed on intake and annually thereafter for each member.

All treatment records must be legible, maintained in a detailed and organized manner, and available at the site where covered services are rendered. Treatment records for ALL LEVELS OF CARE must contain:

Identifying Member Information:

A. Member name and at least one other piece of identifying information on every page or electronic screen of treatment record. (date of birth, Member ID#, address)
B. Member contact information including address and phone number
C. Employment or school information
D. Marital status
E. Legal status (including state custody)
F. Guardianship and/or conservatorship, if applicable

Consent Forms Signed by Member/Parent/Guardian:

A. Consent for treatment
B. Informed consent for prescribed medications
C. Release of information forms, updated annually, for Member's PCP, for other behavioral health Providers, and for any other Providers or agencies relevant to coordination of care
D. For Members with no PCP, documentation must reflect efforts to help a Member to obtain a PCP
E. Release of information form for MCO or payer, communicating to member that Provider will share service participation and treatment progress with MCO
F. Acknowledgement of review of patient rights and responsibilities

Likewise, when voluntary inpatient treatment is being considered for adults, BlueCare Tennessee expects Providers to inform them or their legally appointed representative of all their options for residential and/or inpatient placement, alternatives to residential and/or inpatient treatment, and the benefits, risks, and limitations of each.

Providers of behavioral health services will adhere to all standards and regulations set forth by their licensing and accreditation entities. Providers of behavioral health services will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and treatment records will comply with those standards. All applicable Tennessee state mandated requirements of the Tenn. Code Ann. § 56-7-2367 (2016) 56-7-2367 for Autism Spectrum Disorders are also followed by BlueCross BlueShield of Tennessee.

Additional resources that provide specific treatment expectations and best practices can be found below:

https://publications.tnsosfiles.com/rules/0940/0940-05/0940-05-45.20081110.pdf
http://mcg/milliman/milliman20/bhg/index.htm

Medication Information Documenting:

A. All medications prescribed (psychotropic medications as well as medications for other physical health conditions), the dosages of each, and the dates of initial prescription and refills;
B. If medications are prescribed by an outside Provider, the prescriber is identified;
C. Any medication allergies or adverse reactions are clearly noted; and
D. For Members being considered for psychotropic treatments, documentation must reflect evidence of informing the Member and parent or guardian of the benefits, risks, and side effects of the medication, alternate medications, and other forms of treatment.

Current Medical Information and Medical History:

A. A health assessment that includes medical history, screening for current medical problems, currently prescribed medications, and medication history;
B. Medication allergies, adverse reactions, and relevant medical conditions are clearly documented as present or absent; and

Psychiatric Information and Psychiatric History:

A. Identification of previous Providers and treatment services;
B. Approximate dates of service for previous Providers and treatment services;
C. Information regarding outcomes of previous treatment services;
D. A mental status evaluation;
E. A DSM diagnosis consistent with current symptoms;
F. Information addressing Member-specific cultural considerations;
G. Information regarding the Member's list of strengths;
H. A substance use assessment that screens for frequently used over-the-counter medications, alcohol, tobacco, and other drugs and history of prior alcohol and drug treatment episodes (recommended screening tools are available at http://bluecare.bcbst.com);
I. Current risk assessment (imminent risk of harm, suicidal or homicidal ideation/intent, elopement potential) clearly documented and updated according to written protocols; and
J. A crisis plan relevant to Member's risk potential that includes individualized steps for prevention or resolution of crisis. This plan should include, but is not limited to:

    1. Identifying crisis triggers;
    2. Steps to prevent, de-escalate, or defuse crisis situations;
    3. Names and phone numbers of contacts who can assist Member in resolving crises; and

4. The Member's preferred treatment options in the event of a crisis.

Additional record requirements apply to SPECIFIC LEVELS OF CARE, as follows:

Outpatient Service Providers:

A. An intake, initial evaluation, or diagnostic assessment completed within the first thirty (30) calendar days of initiation of services
B. An initial treatment plan completed within the first thirty (30) calendar days of initiation of services, and an updated treatment plan at least every six (6) months
C. A progress note completed for each service contact
D. Documentation of communication with Member's PCP and other behavioral health Providers within two (2) weeks of the intake/diagnostic assessment; annual updates to those Providers, and notification of discharge from services to those Providers; all communication to other Providers must include a summary of treatment services, including medications, and any changes to treatment since the previous communication
E. A discharge/transfer summary that includes Member's condition at the time of discharge/transfer, the reason for discharge/transfer, aftercare recommendations or appointments as applicable, and the signature of person preparing the summary

Substance Use Disorder Services Providers (Inpatient, Residential, & Outpatient):

A. For detoxification services, documentation of supervision by a Tennessee-licensed Physician with a minimum of daily re-evaluations by a Physician or a registered nurse.

Behavioral Health Quality Management

One of the primary goals of Behavioral Health Quality Management is to continually improve care and services. Through data collection, measurement, and analysis, aspects of care and service that demonstrate opportunities for improvement are identified and prioritized for quality improvement activities. Data collected for quality improvement activities are frequently related to key industry measures of quality that tend to focus on high-volume diagnoses or services and for high-risk or special populations. Data collected are valid, reliable and comparable over time. Behavioral Health Quality Management takes the following steps to ensure a systematic approach to the development and implementation of quality improvement activities:

A. Monitoring clinical quality indicators;
B. Review and analyze data from indicators;
C. Identify opportunities for improvement;
D. Prioritize opportunities to improve processes or outcomes of behavioral healthcare delivery based on risk assessment, ability to impact performance, and resource availability
E. Identify the at-risk population within the total membership
F. Identify the measures to be used to assess performance
G. Collect valid data for each measure and calculate the baseline level of performance
H. Establish performance goals or desired level of improvement
I. Develop interventions that impact performance, and
J. Analyze results to determine where performance is acceptable and, where it is not, identify barriers to improving performance.

Complaints and Quality of Care Concerns

One method of identifying opportunities for process improvement is to collect and analyze the content of Member complaints and other reported quality of care concerns. Behavioral Health Quality Management investigates and/or reviews all reported complaints and quality of care concerns as appropriate. Data from these investigations are compiled, tracked, and reported to internal committees for analysis and determination of further action or resolution.

Reporting Adverse Occurrences to BlueCare Plus

Participating Providers are required to report all adverse events involving Members to Behavioral Health Quality Management. Providers must report adverse events to Behavioral Health Quality Management within twenty-four (24) hours. Adverse events are defined as occurrences that represent actual or potential serious harm to the well-being of Members or to others by a Member who is in behavioral health treatment in Inpatient or Residential levels of care. Report all adverse occurrences to Behavioral Health Quality Management using the TennCare Adverse Occurrence Report (AOR) form found at http://bluecare.bcbst.com/forms/Provider%20Forms/provider-notification-AOR.pdf.

Examples of reportable adverse occurrences include, but are not limited to the following:

- Suicide death
- Non-suicide death
- Death cause unknown
- Homicide
- Homicide attempt with significant medical intervention*
- Suicide attempt with significant medical intervention*
- Allegation of abuse or neglect including peer-to-peer (physical, sexual, verbal)
- Medical emergency occurring in residential, inpatient or CSU treatment settings requiring significant medical intervention* (e.g., myocardial infarction, medically unstable Member.)
- Accidental injury with significant medical intervention*
- Use of restraints/seclusion (physical, chemical, mechanical) requiring significant medical intervention*
- Treatment complications, including (medication errors and adverse medication reactions requiring significant medical intervention)
- Elopement (specific to inpatient and residential services only)
- Sexual behavior with other patients or staff, whether consensual or not, while in a behavioral health treatment setting
- Other occurrences representing actual or potential serious harm to a member not listed above

***Significant medical intervention**: An event requiring medical intervention that cannot be provided in the behavioral health treatment facility such as an event requiring an ER visit or inpatient hospital stay.

Behavioral Health Quality Management may undertake an investigation based on the circumstances of each occurrence, or on any identified trend of adverse occurrences. As a result, Providers may be asked to furnish records, and/or to engage in corrective action to address quality of care concerns and any identified or suspected deviations from a reasonable standard of care. Providers may also be subject to disciplinary action through BCBST Clinical Risk Management, Provider Participation Sub Committee, or the BCBST Credentialing Committee, or all.

Site Visits for Quality Reviews and Treatment Record Audits

Behavioral Health Quality Management, or its designee, conducts site visits at Provider facilities or offices to monitor compliance with regulatory and contractual standards. An onsite quality review visit can be scheduled or unscheduled. The visit can be conducted as part of monitoring an investigation stemming from a member complaint, adverse occurrence, or other quality issue.

Treatment record audits are conducted regularly to monitor compliance with treatment standards. Providers will be notified prior to the scheduled audit and will be provided with a copy of the audit tool as well as a detailed Member list of charts that will be audited.

Following the site visit, the Provider will receive feedback which may require an action plan to help Providers comply with relevant standards and to provide quality care and service to BlueCare Plus Members.

9. Contact Us

Providers can locate valuable information, tools and resources on our company websites, bluecareplus.bcbst.com and www.bcbst.com. The websites offer access to comprehensive information and practical recommendations related to addiction and recovery, mental and behavioral health, medications, life events, and daily living skills.

Providers having questions or needing to arrange behavioral health/substance abuse services for BlueCare Plus members should either call the Prior Authorization phone line at 1-866-789-6314, Monday through Friday, 8 a.m. to 6 p.m. (ET), or utilize the Prior Authorization fax line 1-866-325-6698.

In the event of a crisis, BlueCare Plus members and providers can call the State of Tennessee crisis hotline at 1-855-274-7471 for direction to their local crisis team for assistance. For urgent situations, members will be referred to providers in their community that can see them within forty-eight (48) hours.

J. Dental

In addition to $5,000 annual coverage limit for supplemental dental services, BlueCare Plus also covers Medicare-covered dental services which are limited to surgery of the jaw or related structures that would be provided by a physician. Covered services are limited to:

- Surgery of the jaw or related structures
- Setting fractures of the jaw or facial bones
- Extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease
- Services that would be covered when provided by a physician

Preventive Services

Exams

Covered: Standard exams, including comprehensive, periodic, detailed/extensive and periodontal oral evaluations (exams). Emergency exams, limited oral evaluations (exams).

Limitations: No more than one periodic exam every 6 months. No more than one emergency exam every 12 months. No more than one comprehensive, detailed/extensive or periodontal exam every 36 months.

Exclusions: Re-evaluations and consultations.

Cleanings, Fluoride Treatment

Covered: Adult and child prophylaxis (cleaning). Child and adult fluoride treatments performed with or without a cleaning.

Limitations: No more than one cleaning or periodontal maintenance procedure every 6 months. Periodontal maintenance procedures are subject to additional limitations listed below under Basic Periodontics found under Coverage B. No more than one fluoride treatment every 12 months for members under age 19. Fluoride must be applied separately from cleaning paste.

X-rays

Covered: Full mouth series, intraoral and bitewing radiographs (X-rays).

Limitations: No more than one full mouth set of X-rays every 36 months. A full mouth set of X-rays is either an intraoral complete series or panoramic X-ray. Benefits provided for either include all necessary intraoral and bitewing films taken on the same day. No more than four bitewing films ever 12 months. Bitewing films must be taken on the same date.

Exclusions: Extraoral, skull and bone survey, sialography, TMJ, and tomographic survey X-ray films, cephalometric films and diagnostic photographs.

Other Preventive Services

Covered: Some preventive services, including sealants, space maintainers.

Limitations: No more than one recementation every 12 months.
Exclusions: Nutritional and tobacco counseling, oral hygiene instructions.

Basic Restorative Services
Covered: Amalgam restorations, silver fillings, resin composite restorations (tooth-colored fillings), stainless steel crowns. Emergency pain relief. Repair of full and partial dentures.
Limitations: No more than one amalgam or resin restoration per tooth surface every 12 months. Replacement of existing amalgam and resin composite restorations covered only after 12 months from the date of initial restoration. Replacement of stainless-steel crowns covered only after 36 months from the date of initial restoration. No more than one repair per denture every 24 months.
Excluded: Gold foil restorations.

Basic Endodontics
Covered: Pulpotomy, pulpal therapy. The benefits for basic endodontic treatment include X-rays, pulp vitality tests and sedative fillings provided with basic endodontic treatment.
Limitations: For primary teeth only. Not covered when performed with major endodontic treatment.
Exclusions: Pulpal debridement.

Major Endodontics
Covered: Root canal treatment and re-treatment, apexification, apicoectomy services, root amputation, retrograde filing, hemisection, pulp cap. The benefits for major endodontic treatment include X-rays, pulp vitality tests, pulpotomy, pulpectomy and sedative filings, and temporary filing material provided with major endodontic treatment.
Limitations: No more than one root canal treatment, re-treatment or apexification per tooth every 60 months. No more than one apicoectomy per root per lifetime.
Exclusions: Implantation, canal preparation and incomplete endodontic therapy.

Basic Periodontics
Covered: Some non-surgical periodontics, including periodontal scaling and root planning, full mouth debridement and periodontal maintenance.
Limitations: No more than one periodontal scaling and root planning per quadrant every 24 months. No mImmunizatore than one full mouth debridement per lifetime. No more than one cleaning or periodontal maintenance procedure every 6 months. Cleanings are subject to additional Limitations listed under Preventive Services and may be subject to a different coverage level under your EOC. Benefits for periodontal maintenance are provided only after active periodontal treatment (surgical or non-surgical), and no sooner than 90 days after completion of the treatment. Benefits for periodontal scaling and root planning, full mouth debridement, periodontal maintenance and prophylaxis are not provided if more than one of these procedures is performed on the same day.
Exclusions: Provisional splinting, scaling in the presence of gingival inflammation, antimicrobial medication and dressing changes.

Major Periodontics
Covered: Some surgical periodontics, including gingivectomy, gingivoplasty, gingival flap procedure, crown lengthening, osseous surgery, and bone and tissue grafting. Benefits provided for major periodontics include services related to 90 days of postoperative care.
Limitations: No more than one major periodontal surgical procedure every 36 months.
Exclusions: Tissue regeneration and apically positioned flap procedure.
Basic Oral Surgery
Covered: Some non-surgical or simple extractions. Benefits provided for basic oral surgery include suturing and postoperative care.
Exclusions: General anesthesia or intravenous sedation when performed with basic oral surgery.

Major Oral Surgery

Covered: Some surgical extractions (including removal of impacted teeth and wisdom teeth) and other oral surgical procedures. Benefits provided for major oral surgery include local anesthesia, suturing and postoperative care.
Limitations: Benefits for general anesthesia or intravenous (IV) sedation are provided only with major oral surgery procedures and only when provided by a dentist licensed to administer them.
Exclusions: Oral surgery typically covered under a medical plan, including but not limited to, excision of lesions and bone tissue, treatment of fractures, suturing, wound and other repair procedures, TMJ and related procedures. Orthognathic surgery and treatment for congenital malformations.

Major Restorative Services
Covered: Some single tooth restorations, including crowns (resin, porcelain, ¾ cast and full cast), inlays and on-lays (metallic, resin and porcelain) and veneers.
Limitations: Only for the treatment of severe carious lesions or severe fracture on permanent teeth and only when the teeth can't be adequately restored with an amalgam or resin composite restoration (filling). For permanent teeth only. Replacement of single tooth restorations covered only after 60 months form the date of initial placement.
Exclusions: Provisional restorations and crowns. Cast crowns or laminate veneers for members age 11 and under.

Prosthodontic Services
Covered: Complete, immediate and partial dentures.
Limitations: While constructing a denture, if the member and dentist decide on a personalized restoration or to use a special technique, the benefits will only cover the standard procedure or materials. Replacement of removable dentures covered only after 60 months from the date of initial placement.
Exclusions: Interim (temporary) dentures.

Other Major Restorative and Prosthodontic Services
Covered: Some crown and bridge services, including core build-ups, post and core, recementation and repair. Denture services, including adjustment, relining, rebasing and tissue connecting. Implants are covered once per lifetime. Implant supported prosthesis is limited to 1 in 60 months. The benefits provided for crown preparation, temporary or prefabricated crowns, impressions and cementation.
Limitations: Benefits won't be provided for a core build-up separate from those provided for crown construction, except in circumstances where benefits are provided for a crown because of severe carious lesions or a fracture so extensive retaining the crown wouldn't be possible. Post and core services are covered only when performed with a covered crown or bridge. Crown and bridge repair and recementation are covered separately only after 12 months from the date of initial placement. Denture adjustments are covered separately from the denture only after 6 months from the date of initial placement. No more than one denture re-line or rebase every 36 months.
Exclusions: Other major restorative services, including sedative filings and coping. Other prosthodontic services, including overdenture, precision attachments, connector bard, stress breakers and coping metal.

Other Exclusions from Coverage
Regardless of any other reference, benefits are not provided for any of the following:

1) Dental services received from a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor union, trustee or similar person or group.
2) Charges for services performed by you or your spouse, or you or your spouse's parent, sister, brother or child.
3) Services rendered by a dentist beyond the scope of his or her license.
4) Dental services which are free, or for which you aren't required or legally obligated to pay for, or for which no charge would be imposed if you had no dental coverage.
5) Dental services to the extent that charges for such services exceed the charge that would have been made and collected if no coverage existed hereunder.

6) Dental services covered by any medical insurance coverage, or by any other non-dental contract or certificate issued by BlueCare Plus Tennessee or any other insurance company, carrier, or plan. For example, removal of impacted teeth, tumors or lip and gum, accidental injuries to the teeth, etc.;
7) Any court-ordered treatment, unless benefits are otherwise payable.
8) Courses of treatment started before you became covered under this plan.
9) Any services performed after you're no longer covered by this plan.
10) Dental care or treatment not specifically listed I your Evidence of Coverage as being covered.
11) Any treatment or service that the plan determines isn't necessary dental care, that doesn't offer a favorable prognosis, that doesn't meet generally accepted standards of professional dental care, or that is experimental in nature.
12) Services or supplies for the treatment of work-related illness or injury, regardless of the presence or absence of workers' compensation coverage. This exclusion doesn't apply to injuries or illnesses or an employee who is (1) a sole proprietor of the group; (2) a partner of the group; (3) a corporate officer of the group, provided the officer filed an election not to accept Workers' Compensation with the appropriate government department.
13) Charges for any services rendered in a hospital or other surgical treatment facility and any additional fees charged by a dentist for treatment in any such facility.
14) Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes. This doesn't exclude those services provided under orthodontic benefits (if applicable).
15) Replacement of tooth structure lost from wear or attrition.
16) Dental services resulting from loss of theft of a denture, crown, bridge or removable orthodontic appliance.
17) Diagnosis for, or fabrication of, appliances or restorations necessary to correct bite problems, or to restore the occlusion or correct temporomandibular joint dysfunction (TMJ) or associated muscles.
18) Adjunctive dental services, including all local and general anesthesia, sedation, and analgesia (except as provided under major oral surgery).
19) Charges for the treatment of desensitizing medicaments, drugs, occlusal guards and adjustments, mouthguards, microabrasion, behavior management and bleaching.
20) Charges for the treatment of professional visits outside the dental office or after regularly scheduled hours for observation.

K. Therapeutic Shoes for Diabetics

BlueCare Plus provides benefits for the following when the need for therapeutic shoes is certified by a physician:

- One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.

L. Preventive Services

BlueCare Plus covers preventive services including:

- Abdominal aortic aneurysm one-time screening for individuals at risk
    - The plan only covers this screening if they have certain risk factors and if they get a referral for it from their physician, physician assistant, nurse practitioner, or clinical nurse specialist
- Alcohol misuse counseling
- Annual wellness visit
    - If member had Part B for longer than 12 months, they can get an annual wellness visit to develop or update a personalized prevention plan based on their current health and risk factors. This is covered once every 12 months.

Note: Their first annual wellness visit can't take place within 12 months of their "Welcome to Medicare" preventive visit. However, they don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after they've had Part B for 12 months

- Bone mass measurement every 24 months for individuals at risk or more frequently if medically necessary
- Breast cancer screening (mammogram)
    - One baseline mammogram between ages 35 and 39
    - One screening mammogram every 12 months for women age 40 and older
    - Clinical breast exam once every 24 months
- Cardiovascular disease screening
    - One visit per year with PCP for risk reduction
    - Blood testing to detect cardiovascular disease once every five years (60 months)
- Cervical and vaginal cancer screening
    - Pap tests and pelvic exams once every 24 months
    - Pap test every 12 months for any one of these:
        - High risk of cervical or vaginal cancer
        - Childbearing age
        - Had an abnormal Pap test within the last three years
- Colorectal screening
    - Age 50 or older flexible sigmoidoscopy or barium enema every 48 months
    - Guaiac-based fecal occult blood test or fecal immunochemical test every 12 months
    - DNA based colorectal screening every three years
    - High risk of colon cancer - Screening colonoscopy or barium enema every 24 months
    - Not at high risk of colon cancer – screening colonoscopy every 10 years (120 months) but not within 48 months of screening sigmoidoscopy
- Depression screening one per year in a primary care setting than can provide follow-up treatment and/or referrals
- Diabetes screening including fasting glucose test for any of the following risk factors:
    - Hypertension
    - History of dyslipidemia
    - Obesity
    - History of high blood glucose
    - Based on results of these screenings, member may be eligible for up to two diabetes screenings every 12 months
- Hepatitis C screening
    - We cover a one-time Hepatitis C screening test. We also cover repeat screening annually for certain people at high risk.
- HIV screening
    - Individuals who ask for screening test or at high risk for HIV infection one screening exam every 12 months
    - Women who are pregnant up to three screening exams during pregnancy
- Immunizations, including influenza, hepatitis B and pneumococcal
    - Covered Medicare Part B services include:
        - Pneumonia vaccine •
        - Flu shots, once each flu season in the fall and winter with additional flu shots if medically necessary
        - Hepatitis B vaccine if they are at high or intermediate risk of getting Hepatitis B • COVID-19 vaccine
        - Other vaccines if they are at risk and they meet Medicare Part B coverage rules
    - We also cover some vaccines under our Part D prescription drug benefit.
        - Tdap (Tetanus, Diphtheria and Pertussis (Whooping Cough))
        - Shingles
- Medical nutrition therapy services for individuals with any of the following:
    - Diabetes
    - Renal disease not on dialysis
    - Post kidney transplant
- Medicare Diabetes Prevention Program

- MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle
- Obesity screening and counseling
- Prostate cancer screenings (PSA)
  - For men age 50 and older, covered services include the following:
    - - once every 12 months:
      - • Digital rectal exam
      - • Prostate Specific Antigen (PSA) test
- Screening and counseling to reduce alcohol misuse
  - We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If the members screen positive for alcohol misuse, they can get up to 4 brief face-to-face counseling sessions per year (if they're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.
- Screening for lung cancer with low dose computed tomography (LDCT)
  - Eligible members ages 55-77 who have no sign of lung cancer but history of smoking at least 30 packs per year and currently smoke or have quit in the past 15 years
  - Once every 12 months
- Sexually transmitted infections (STI's) and counseling to prevent STI's
  - We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.
- Tobacco use cessation counseling
- Welcome to Medicare preventive visit (one-time)

Additional requirements may be required for some screenings. Refer to the Evidence of Coverage located at bluecareplus.bcbst.com for additional information.

M. Hearing Services

Diagnostic hearing and balance evaluations performed by providers to determine if members need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. Benefit includes routine hearing exams, hearing aid fittings and evaluations, hearing aids and batteries and hearing aid repairs and adjustments.
There is no coinsurance, copayment or deductible for each Medicare-covered hearing exam.
Plan-covered $2,500 annual allowance for supplemental hearing services. The annual allowance is a coverage limit

N. Over the Counter (OTC)

There is no coinsurance, copayment or deductible for covered OTC items. The maximum combined coverage amount for covered OTC/Healthy Food items is $100 every month. Any unused amount will expire at the end of each month.

Over-the-counter (OTC)/Healthy Food
We provide a debit card that gives members a fixed dollar amount each month to buy certain OTC products and healthy food at participating retail locations. Members can also place an order for OTC products online, over the phone, or by mail through the OTC

catalog that will be sent to them. Their items will ship directly to them. This card is used for both benefits and provides a combined monthly allowance.

Over-the-counter (OTC) items (Supplemental)
Coverage includes non-prescription OTC health and wellness items like vitamins, sunscreen, pain relievers, cough and cold medicine, and bandages. Members can order: Online – visit BlueCarePlusOTC.com By Phone – call an OTC Advocate toll-free at (855) 243- 1186 (TTY/TDD: 711), Monday to Friday, 8 a.m. to 11 p.m. (Eastern Standard Time), excluding holidays By Mail – fill out and return the OTC Order Form in the OTC Product Catalog By Mobile Application (Mobile App) – download our OTC-Anywhere mobile app and access the app from their smartphone or tablet to place their order. There is no charge to download or use the app. This app works on mobile devices using Apple or Android operating systems. Retail Payment Card - Members will receive a retail payment card to purchase OTC allowed items at participating retail locations. The card will be mailed with instructions for use. Their OTC order will be shipped to the address given when ordering. Shipping will not cost anything. Refer to the 2022 OTC Product Catalog for a complete list of plan-approved OTC items or call an OTC Advocate for more information. Members will find important information (order guidelines) in the 2022 OTC Product Catalog. Healthy Food: Their coverage may include healthy food like fruits, vegetables, and select canned goods. They will qualify for the healthy food benefit if they have certain qualifying conditions. Members will be notified if they are eligible. They will receive a debit card to purchase approved healthy food items at participating retail locations. Healthy Food retail purchase information will be mailed with their debit card. The monthly allowance cannot be used to purchase firearms, ammunition, weaponry, tobacco or alcohol.

O. Podiatry Services

Covered services include:

- Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs)
- Routine foot care for members with certain medical conditions affecting the lower limbs

P. Cardiac Rehabilitation Services

Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. Two one-hour sessions per day for up to 36 sessions per service per year are covered.

Q. Pulmonary Rehabilitation Services

Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a doctor's order from the treating physician. BlueCare Plus covers 36 sessions with an additional 36 sessions if medically necessary.

R. Transportation

BlueCare Plus (DSNP)
Our plan provides transportation for 150 one-way plan-approved medical, vision, dental, hearing appointments, pharmacy and fitness visits and non-emergency ambulance rides that are not covered by the member's Medicaid plan every year within 50 miles from pick-up location.

BlueCare Plus Choice (FIDE)
Our plan provides transportation for 100 one-way plan-approved vision, dental, hearing appointments, pharmacy and fitness visits and non-emergency ambulance rides every year within 50 miles from pick-up location. This plan provides transportation for unlimited plan-approved non-emergent medical appointments within 90 miles from pick-up location.

Transportation services are available weekdays only. To schedule a pick-up, please call 1-855-681-5032 (TTY/TDD: 711), Monday through Friday from 8 a.m. to 5 p.m., excluding holidays. Request for pick-up should be made at least 3 days in advance of the appointment. Travel is limited to 50 miles from pick-up location.

There is no coinsurance, copayment, or deductible for plan-approved transportation.

S. Vision Services

In addition to $400 annual coverage limit for glasses and/or contact lenses and fittings, BlueCare Plus members have coverage for:

- Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.
- For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older
- For people with diabetes, screening for diabetic retinopathy is covered once per year
- One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens (If they have two separate cataract operations, they cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. You are also covered for the following routine vision benefits:
- 1 routine eye exam per year

T. Health and Wellness

Our health and wellness programs are available to all members at no additional cost. They are designed to assist members with improving healthy behaviors.

- **Health Education:**
    - Wellness Services: Interactive wellness services include general preventive education and reminders for certain preventive screening tests appropriate for age, sex, and claims history. This is through web-based coaching and telephonic based coaching provided by population health staff.
- **Fitness Membership**:
    - The Silver&Fit® Healthy Aging and Exercise Program As a member, they have the following choices available at no cost to them: • Fitness center membership: They can go to a Silver&Fit participating fitness center near them. • A customized program for their exercise of choice, including instructions on how to get started and suggested online workout videos. • On-demand videosthrough the website digital library. • Online Health Aging classes
- **Enhanced Disease Management**:

- If they have CHF, COPD, diabetes, hypertension, hypercholesterolemia, or Stage 4 or 5 chronic kidney disease, they may have access to enhanced disease management. In this program, members are assessed and coached by certified case management nurses in compliance with their doctor's plan of care and educated in ways to control and manage their chronic diseases. Members are monitored relative to prescription medication compliance, ER and inpatient utilization and PCP/Specialist visits. This information is shared with the treating provider as it is necessary to help coordinate services.

- **Remote Access Technology**:

  - Nurse Hotline: They have access to a 24-hour telephonic nurse hotline, where an R.N. level nurse can assist with general health information, referral guidance to a local clinician or triage some conditions for immediate evaluation versus next day follow-up with your PCP or specialist.

  - Tele-Monitoring: Home-based monitoring when medically necessary for members with chronic conditions who are participating in condition management programs and are at increased risk for medical interventions or hospitalization. Frequency of monitoring is based on condition severity. Abnormal results are appropriately shared with the treating physician, while normal results are shared monthly. This monitoring does not include blood glucose monitoring devices covered by Original Medicare.

VI. Non-Covered Benefits

A. General Exclusions

General exclusions from coverage for certain items or services for which BlueCare Plus cannot pay claims include:

- Not reasonable and necessary
- No legal obligation to pay for or provide (will be paid by other entity)
  - Automobile insurance;
  - No-fault insurance;
  - Liability insurance; or
  - Workers' Compensation (WC) law or plan of the U.S. or a State.
- Paid for by governmental entity
- Not provided within United States
- Resulting from war
- Personal comfort
  - Items that do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member
  - Examples: Items such as radio, television, telephone, air conditioner, and beauty and barber services
- Routine services and appliances unless covered as a supplemental benefit and described above in the coverage section
- Custodial care*
  - Personal care that does not require continued attention of trained medical or paramedical personnel
  - Assistance in walking, getting in and out of bed, bathing, dressing, feeding, using toilet, preparation of special diets, and supervision of medications that usually can be self-administered
- Cosmetic surgery and expenses incurred in connection with cosmetic surgery

- Charges by immediate relatives or members of household*
- Paid or expected to be paid under worker's compensation
- Non-physician services related to and required as a result of services which are not covered under Original Medicare
- Excluded foot services and supportive devices for feet
    - Treatment of flat foot
    - Routine foot care such as removal of corns or calluses
    - Orthopedic shoes unless for a member with diabetes or if an integral part of a leg brace
- Excluded investigational devices
- Self-administered drugs - BlueCare Plus adheres to the Cahaba Government Benefit Administrators, LLC Self-Administered Drug (SAD) Exclusion List.

**Note: These services can be considered under BlueCare Plus Choice.*

The non-covered benefits listing contained in this section is not an all-inclusive list. It is intended to be a general summary and does not take place of regulations and plan requirements. Refer to IOM Medicare Benefit Policy Manual Publication 100-02 Chapter 16.

B. Services and Supplies Denied as Bundled or Included in the Basic Allowance of another Service

Services and supplies that are bundled or included in the basic allowance of another service will not be paid.

- Fragmented services included in the basic allowance of the initial service;
- Prolonged care (indirect);
- Physician standby services;
- Case management services (e.g., telephone calls to and from the beneficiary); and
- Supplies included in the basic allowance of a procedure.

VII. Pharmacy

In addition to the drugs covered by Medicare, some prescription drugs are covered for BlueCare Plus members under Medicaid benefits. The member may contact Medicaid for more information about drugs covered under their Medicaid coverage.

BlueCare Plus will generally cover drugs under these basic rules:

- The member must have a network provider write the prescription
- The member must use a network pharmacy to fill prescriptions
- The drug must be on the plan's *List of Covered Drugs* (Formulary)
- The drug must be used for a medically accepted indication.
    - Approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
    - *Or* -- supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

BlueCare Plus offers a "List of Covered Drugs (Formulary)" available on the BlueCare Plus Website at https://bluecareplus.bcbst.com/docs/2022_bluecare_plus_formulary.pdf.

The drugs on the list are selected by the plan with the help of a team of doctors and pharmacists. The meets requirements set by Medicare. Medicare has approved the plan's Drug List.

A. Prior Authorization

Certain drugs with special indications require authorization. These drugs are noted on the formulary. For BlueCare Plus the prescribing practitioner, enrollee, or enrollee representative is responsible for obtaining the necessary authorization. Prior authorization must be obtained before the drug is dispensed. You may request prior authorization by contacting the following:

Member Services Line:	1-800-332-5762 (TTY Users Call: 711)
Provider Services Line:	1-800-299-1407
Provider Services Fax:	423-591-9514
Website:	http://bluecareplus.bcbst.com

Quantity Limits or Maximum Drug Limitation

Some medications have a quantity limit for a given time period. These drugs are noted on the formulary. Greater quantities require practitioner request for Medical Necessity.

Member Services Line:	1-800-332-5762 (TTY Users Call: 711)
Provider Services Line:	1-800-299-1407
Provider Services Fax:	423-591-9514
Website:	http://bluecareplus.bcbst.com

Redetermination

If BlueCare Plus has made an adverse determination and denied a member's request for coverage of (or payment for) a prescription drug, a member or the member's physician has the right to ask for a redetermination (appeal) of our decision. A member or the member's physician has 60 days from the date of the Notice of Denial of Medicare Prescription Drug Coverage to ask for a redetermination. Redetermination requests must be in writing or by fax. Urgent requests for redetermination may be requested by phone.

Member Services Line:	1-800-332-5762 (TTY Users Call: 711)
Provider Services Line:	1-800-299-1407
Provider Services Fax:	423-591-9514
Website:	Request for Redetermination of Prescription Drug Denial
Mailing Address:	BlueCross BlueShield of Tennessee Medicare Part D Coverage Determinations and Appeals 1 Cameron Hill Circle, Suite 51 Chattanooga, TN 37402-0051

Who May Make a Request: The member or any prescriber may ask for an appeal on the member's behalf. If a member wants another individual (such as a family member or friend) to request an appeal for the member, that individual must be the member's representative. Contact us to learn how to name a representative.

Peer to Peer

At any time, prescribers may request a peer to peer review for Medicare pharmacy reviews. To initiate a peer to peer review,please contact provider services at 1-800-299-1407.

Pharmacy Directory

The BlueCare Plus Pharmacy Directory is available on the BlueCare Plus Website. Please log in to BlueAccess, hover your mouse over the "Find Care" tab, and click "Find a Doctor." Then, select "Pharmacy" in the drop down menu, and click the magnifying glass to find in-network pharmacies close to you.

Formulary Exceptions
An exception is a type of coverage determination that is unique to the Part D benefit. A member, member's authorized representative or member's prescribing physician may request a Formulary Exception.

Formulary Exception

Ensures that members have access to medically necessary Part D drugs that are not included on the BlueCare Plus formulary. This request also permits members to request an exception to a quantity or dose limitation or a requirement that the member try another drug before BlueCare Plus will pay for the requested drug.

The Physician's supporting statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be as effective because:

- All covered Part D drugs of the BlueCare Plus formulary would not be as effective for the member as the non-formulary drug, and/or would have adverse effects;

- The number of doses available under a dose restriction for the prescription drug:
    - Has been ineffective in the treatment of the member's disease or medical condition or,
    - Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the member, and known characteristics of the drug regimen, the on-formulary amount of the drug is likely to be ineffective or adversely affect the patient or patient's compliance; or

- The prescription drug alternative(s) listed on BlueCare Plus is required to be used in accordance with step therapy requirements:
    - Has been ineffective in the treatment of the member's disease or medical condition or, based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or

    - Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause and adverse reaction or other harm to the member.

B. Identification Card (ID)

Every BlueCare Plus and BlueCare Plus Choice plan member receives an ID card reflecting the benefit plan and product for the member enrolled. The member ID includes all information necessary for all benefits, including pharmacy. Please refer to Chapter III, Section C for more information regarding member ID cards.

VIII. Model of Care (MOC) D-SNP

BlueCare Plus offers a Special Needs Plan (SNP) for our dually eligible members that have Medicare Part A and Part B and are Medicaid qualified.

A. SNP Target Population

The BlueCare Plus Tennessee Model of Care (MOC) is designed to serve the unique individual needs of the dual eligible Medicare and Medicaid population while promoting quality of care and cost effectiveness through coordination of care for members with complex, chronic or catastrophic health care needs. Coverage under BlueCare Plus Tennessee includes two plan options: BlueCare Plus Dual Special Needs Plan (DSNP) and BlueCare Plus Choice Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP).

The Dual eligible population includes those individuals with diverse needs, and requires a blend of medical, long-term care, behavioral health and social services. This population will receive fully integrated physical and behavioral health services designed to serve the individual needs of this population. Medicare and Medicaid eligible members will receive a seamless continuum of care through BlueCare Plus' Care Coordination process.

B. Model of Care Overview

Our Model of Care is designed to serve the unique individual needs of the dual eligible Medicaid and Medicare population while promoting quality of care and cost effectiveness through coordination of care for members with complex, chronic or catastrophic health care needs.

Our Model of Care focuses on:

- Case Management across settings and providers and seamless transitions of care and coordination with Medicaid MCOs for Medicaid services
- Inpatient care coordination with an emphasis on effective discharge planning and post-discharge follow-up to reduce the likelihood of readmissions
- Behavioral health and health related social supports care coordination
- Nursing facility care coordination including services for members receiving inpatient hospice and in long-term care facilities
- Home and Community-Based Services care coordination including long-term home health and private duty nursing services
- Services for members with complex chronic conditions with a concentration on evidence-based care, medication management and monitoring access to care
- Preventive and health promotion services
- Health outcomes
- Social Determinants

Our model of care includes:

- A member centric Interdisciplinary Care Team (ICT) consisting of health plan medical and behavioral health clinical professionals, members and his or her caregivers, Primary Care Physicians (PCP), specialty physicians, and other providers caring for frail and chronically ill members. The ICT will be the primary facilitator of care management to ensure efficiency and continuity of services. The comprehensive team of health care professionals will develop and implement an individualized care plan to address a member's medical, behavioral health, psychosocial and long-term care needs.

- A Care Coordination Team to improve care coordination and care transitions and are responsible for engaging members to participate in his or her ICT and developing an individualized plan of care.
- Clinical programs built on evidence-based medicine and proven programs within our health plan that have well-planned outcomes reporting for continuous quality improvement.
- A structured Model of Care training program for network providers to ensure application of integrated care management strategies.

In addition, the Special Needs Population may receive the following interventions as indicated by their Individualized Care Plan (ICP):

- Initial assessment and other assessments done annually
- Coordination of multiple services, such as home health, PT, OT, wound care, DME and specialty services.
- Referral for health coaching or disease management.
- Surveillance for potential status changes such as ER visits, hospitalizations and claims data.
- Care Coordinator in contact at a minimum of monthly and more frequently as indicated by member needs and/or care plan goals
- Case management/ICT follow-up and care plan update with member/natural supports caregiver as needed when there are any status changes.

C. Staff Structure and Care Management Roles

Staffing for BlueCare Plus Tennessee includes BlueCare Tennessee staff dedicated solely to the DSNP program, BlueCare staff that support both the DSNP program and administer our Medicaid product, as well as BCBST corporate staff to support central functions such as Enterprise Information Technology, credentialing, provider network contracting and provider relations. BCBST Medicare Advantage enrollment staff support BlueCare Plus Tennessee enrollment processes. Staff structure and roles are organized to perform administrative, clinical, and combined administrative/clinical oversight functions to support our dual eligible population.

BlueCare Plus has a multi-disciplinary Care Coordination Team who administers case management activities. The non-clinical staff coordinates benefits, plan information, conducts member outreach, and obtains data from members and network providers. Registered nurses and licensed behavioral health staff performs clinical functions; maintaining a coordinated care management process, education and clinical care. Both non-clinical and clinical staff monitors the Model of Care compliance, assuring statutory and regulatory compliance and monitoring care management effectiveness to provide a coordinated plan of care for each member.

In addition to the Care Coordination Team, BlueCare Plus has a Member Education and Outreach team that conducts health education and direct outreach aimed to enhance the member's health and well-being. All new members receive a welcome call from this team, and outreach is conducted to members throughout the year to complete the health assessment and help members address gaps in care. Additionally, this team conducts provider outreach to assist in gap closure, medication adherence, and obtain necessary medical records.

D. Specialized Provider Network

Coordinating the MOC and case management requires a specialized provider network. BlueCare Plus ensures providers are actively licensed and competent. As well as informed of statutory and regulatory compliance and participating in the Interdisciplinary Care Team (ICT) for the BlueCare Plus members to deliver specialized services in a timely and quality manner, providers are expected to

use evidence-based clinical practice guidelines and nationally recognized protocols. For additional information for participating in BlueCare Plus visit our website,
bluecareplus.bcbst.com.

The specialized provider network expertise may include, but is not limited to, primary care, internal medicine, endocrinologists, cardiologists, oncologists, facilities, ancillaries, and mental health specialists. We monitor the provider network to identify if other specialists are needed to address and manage the needs of the SNP's target population. BlueCare Plus maintains a comprehensive network of primary care providers, facilities, specialists, and ancillary services to meet the needs of SNP members with chronic disease, such as diabetes, cardiac, respiratory, musculoskeletal and neurological disease and behavioral health disorders. with a full range of providers and vendors including acute care hospitals, home health care companies, infusion therapy and dialysis companies, durable medical equipment vendors, outpatient surgery facilities, radiology/imaging centers, skilled nursing facilities, acute and sub-acute rehabilitation facilities, mental health/chemical dependency providers, laboratory services, and outpatient pharmacies allow SNP members to obtain the services they need at a convenient location. The BlueCare Plus website also has a user-friendly search function for members to locate providers and specialists in their area.

Credentialing occurs initially during the application process for any provider applying to participate in the BlueCare Plus Network. Once a provider is approved to participate in the network, they must be re-credentialed based on the service types each provider provides. The credentialing process assures that licensed physicians, organizations, and other health care practitioners within the provider network are qualified to provide health care services to BlueCare Plus members.

Network providers are educated on the coordination of Medicare and Medicaid benefits for which members are eligible. Providers are contractually required to complete the Model of Care (MOC) training. BlueCare Plus offers a self-study and attestation through the BlueCare Plus Website. The attestation must be submitted for verification of the annual MOC training. Annual MOC training will be in print form and available through Provider Resources section of the BlueCare Plus Website. If additional training is identified, the Corporate Provider Relations Network Managers and/or BlueCare Plus' Provider Representative through telephonic outreach will conduct the training or face-to-face provider visits.

BlueCare Plus will not interfere with health professional advice to members regarding member's care and treatment options, as documented and communicated to providers in the BlueCare Plus Provider Administration Manual.

BlueCare Plus encourages open patient communication regarding appropriate treatment alternatives. Providers are not penalized for discussing medically necessary or medically appropriate care with patients.

E. New Provider Orientation and Training

New provider orientation and training will be provided after the completion of contracting and credentialing. The provider will be sent a welcome letter with the effective date and the network manager assigned. The welcome letter includes online resources and a link to this Provider Administration Manual. This manual serves as a source of information for BlueCare Plus.

Network physicians are contractually required to complete Model of Care (MOC) training. In addition, BlueCare Plus offers the training to out of network providers. The MOC training is updated annually and offered via provider self-study and attestation on the BlueCare Plus provider website. Providers are encouraged to take the training at initial contracting and annually thereafter at the beginning of each calendar year.

BlueCare Plus offers training that is tailored to the needs of those providers and billing staff that provide services to the dually eligible members. The training offers fundamental Medicare policies, programs, and procedures and with a concentration on and information on billing BlueCare Plus.

F. Provider Education and Ongoing Training

BlueCare Plus offers a provider service program to assist providers in understanding and complying with the operational processes, policies and billing procedures for the dually eligible population. The outreach program serves to strengthen and enhance ongoing efforts to continuously improve provider satisfaction through timely delivery of accurate and consistent information. The provider outreach will enable providers to understand, manage and bill BlueCare Plus correctly thus reducing the paid claims error rate and improper payments.

The provider outreach area utilizes a variety of strategies and methods to offer providers a broad range of information regarding the BlueCare Plus program. Methods include print, the provider resources section of the website at bluecareplus.bcbst.com, face to face instruction, web based training and presentations.

Additional training is provided in partnership with BCBST for the All Blue Workshops, Tennessee Medical Association (TMA) and other associations throughout the state of Tennessee. The venues include program overview and feature resource centers with one-on-one consultations with staff members from providers' offices.

BlueCare Plus (HMO DSNP)℠ updates and/or changes are communicated through the BlueAlert Newsletter published monthly and/or the quarter Provider Administration Manual (PAM releases).

G. Health Needs Assessment

At enrollment, BlueCare Plus identifies a member's health status through an initial health needs assessment (HNA) completed for each member within 90 days of enrollment, at least annually thereafter, and with any change in the member's health status. Using a person centered approach, the assessment identifies the medical, psychosocial, functional, behavioral, and cognitive needs of the member. BlueCare Plus Care Coordination Teams use this information to analyze and stratify a member's risk level, and then develop an individualized medical Plan of Care (POC). For members receiving LTSS, the HNA and POC will incorporate the Comprehensive Needs Assessment (CNA) and Person-Centered Support Plan (PCSP) using a person-centered approach.

This information is shared with the member's individual Interdisciplinary Care Team (ICT) for further analysis and stratification. The ICT should include the Primary Care Provider (PCP) and other treating providers to facilitate collaboration with all providers who are treating that member. See **section J** for additional ICT information.

H. Individualized Care Plan (ICP)

The ICP includes prioritized goals (short and long-term) that consider self-management goals, healthcare preferences, and level of involvement in the case management plan.

Each BlueCare Plus member has an individualized care plan. A written plan of care is mailed to a member's PCP for input and revision to the member's ICP. Any revisions to the ICP should be returned to BlueCare Plus via telephone, writing or fax. The written ICP prepared by BlueCare Plus and submitted to a PCP is intended to assist the PCP in obtaining necessary information and helping to coordinate and manage his or her member.

The member and/or caregiver will receive a copy of the care plan as well; our hope is that this single document reflects the entire continuum of the member's health care needs and services. Additionally, as applicable, other treating providers will be issued a copy of the written ICP.

For members enrolled in BlueCare Plus Choice, all individualized care plans are developed through home visits and documented in the Person-Centered Support Plan (PCSP) and the Members Plan of Care, as required in the State Medicaid Agency Contracts (SMAC).

For members who declined to participate in care management or failed to return a written assessment with their specific needs and preferences, claims and pharmacy data are used to develop their ICP.

I. Interdisciplinary Care Team (ICT)

Each member will have his or her own personal Interdisciplinary Care Team (ICT). A member's PCP is a crucial component of the member's ICT. At the center of the ICT are the member and/or caregiver(s), the PCP, Care Coordinator, and based on the members' expressed needs, preferences, clinical condition, and/or living situation, the ICT expands to include appropriate specialists, professionals and community supports.

PCP/providers and other ICT participants, if applicable, may participate through the methods listed below:

- Return of the Patient Assessment and Care Planning Form (PACF)
- Medical records submitted in response to the PACF
- Medical records obtained during care management activities
- Receipt of the member's individualized ICP
- Returned response to mailed ICP
- Face to face with a member during a physician office visit
- Information obtained by the Care Coordination Team during a conversation with a provider's office or a facility discharge coordinator
- Information obtained by the embedded Patient Center Medical Home Care Coordinator
- Medication reconciliation post-discharge

The purpose of the ICT is to ensure appropriate communication related to a member's health and health care needs that results in:

- Better coordination of services for the member
- Enhanced member understanding
- Informed decision-making
- Safer medication practice
- Better adherence to prescribed medication
- Better self-management of chronic disease
- Reduced hospitalizations or readmissions

BlueCare Plus will reimburse the PCPs $54 for each ICT they participate in via one of the methods described above. PCPs may use the following codes for claims submission for ICT participation.

99366 - Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by non-physician qualified health care professional
99367 - Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by physician
99368 - Medical team conference with interdisciplinary team of health care professionals, patient and/or family not present, 30 minutes or more; participation by non-physician qualified health care professional

If the PCP participates and the patient is in the office, the PCP should also bill the appropriate office visit evaluation and management code (e.g., 99211 through 99215).

The BlueCare Plus Medical Director and Care Coordinators conduct case rounds at least monthly to evaluate the health status of members who need immediate attention or have complex health issues and to discuss health care options. PCPs and other treating providers may be contacted to participate in case rounds if necessary, and that participation also counts as an ICT.

J. Performance and Health Outcome Measurement

The overall quality performance improvement plan evaluates that appropriate services are being delivered to the special needs of the BlueCare Plus members by analyzing a comprehensive set of utilization, access, satisfaction and clinical measures to evaluate improvement and effectiveness of the Model of Care in order to identify areas for improvement. The Quality Improvement (QI) Program operates in a systematic, coordinated, and continuous manner to improve the health of the dual eligible member. The evaluation processes include assessing trends and establishing improvement actions to improve the outcome of identified problems. The Model of Care has structures and processes to continuously improve the quality of care, safety, and appropriateness of services provided to the BlueCare Plus members. The MOC is continually reviewed for performance improvement opportunities and utilizes evidence based best practices.

BlueCare Plus collects, evaluates, analyzes and reports performance and outcome measurements for the D-SNP program. Internal quality specialists continually review the outcomes to enhance and improve the MOC. Communication of these improvements and updates are published through the BlueAlert, BlueCare Plus Website, Provider Quality newsletters and announcements. BlueCare Plus utilizes an electronic messaging system and the Provider website to keep providers up to date with changes and enhancements. Additionally, BlueCare Plus will include the Medicare Health Outcomes Survey (HOS), the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, the Healthcare Effectiveness Data and Information Set (HEDIS) and The Center for Medicare & Medicaid STARS to measure in evaluating, analyzing and improving the BlueCare Plus program.

Established quantitative measures evaluate performance for issues identified in the HRA, Individualized Care Plan (ICP), Interdisciplinary Care Team (ICT) and the MOC. Each measure is objective, quantifiable based on current scientific knowledge and has an established goal and/or benchmark. These measures may include Health Effectiveness Data and Information Set (HEDIS) Effectiveness of Care measures; Use of Services measures; measurement of outcomes related to approved plan clinical practice guidelines or chronic condition management systems, or other issues that are relevant to the population. This provides BlueCare Plus an objective means to help identify special populations, geographical needs, identify trends and help prioritize opportunities. BlueCare Plus will continue to review performance and outcomes to enhance the Health Risk Assessment and Model of Care to improve and strengthen the program. For additional information and updates visit http://bluecareplus.bcbst.com/provider-resources.

K. Integrated Communication Network

BlueCare Plus coordinates the delivery of services and benefits through integrated systems of communication among plan personnel, providers, and members. Our communication structure includes; web-based network, audio conferencing and face-to-face meetings. Included in the provider resources is a request form for additional training. Training is provided as feasible through different methods; web conferencing, telephone conferencing and on site as permitted. The website will be the preferred method of communication for updates and changes for both the member and provider.

L. Measurable Goals

Measurable goals are identified and reviewed for optimum care for BlueCare Plus members. BlueCare Plus has outlined the goals below in accordance with The Centers for Medicare & Medicaid (CMS) guidelines for program management:

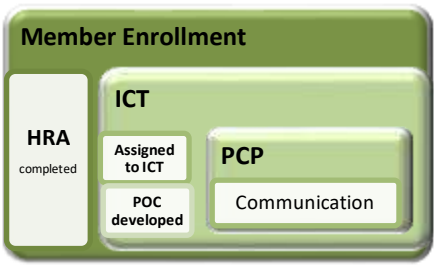
- Improving access to essential services such as medical, mental health, and social services;
- Improving access to affordable care;
- Improving coordination of care through an identified point of contact;
- Improving seamless transitions of care across healthcare settings, providers, and health services;
- Improving access to preventive health services;
- Ensuring appropriate utilization of services; and
- Improving beneficiary health outcomes.

BlueCare Plus uses evidence-based guidelines to structure and achieve care management goals and the structure of the Care Management program was designed based on the SNP structure and process measures developed by the National Committee for Quality Assurance (NCQA) and CMS' Special Needs Plans model and requirements.

BlueCare Plus periodically analyzes and evaluates the rate of progression toward goals by identifying and addressing any barriers impeding goal achievement and identifying opportunities for improvement. The program was designed to assure members have access to essential, affordable and cost effective care based on continual assessment and measurable outcomes.

The key indicators are evaluated and reported annually in the Model of Care evaluation to determine whether further actions are required to meet the needs of the BlueCare Plus's dual membership.

M. Model of Care Process Summary



In summary, The BlueCare Plus Tennessee Model of Care (MOC) is designed to serve the unique individual needs of the dual eligible Medicare and Medicaid population while promoting quality of care and cost effectiveness through coordination of care for members with complex, chronic or catastrophic health care needs. Coverage under BlueCare Plus Tennessee includes two plan options: BlueCare Plus Dual Special Needs Plan (DSNP) and BlueCare Plus Choice Fully Integrated Dual Eligible Special Needs Plan (FIDE-SNP).

Following enrollment of the member with BlueCare Plus plan, a health needs assessment will be conducted, and the information will be used to design coordinated care for special needs members through an interdisciplinary care team (ICT) and an individualized plan of care.

The purpose of the ICT is to consistently collaborate to solve a member's health care problems that may be complex to provide for efficient health care. As a health care provider for a BlueCare Plus member, you will be required to participate in an individual member's ICT on an annual basis. The ICT is responsible for analyzing the results of the initial and annual health risk assessments and incorporating those findings into an individualized plan of care, collaborating to develop and, at least annually, update the member's plan of care, and managing the physical and behavioral health, functional and social support needs of the member. BlueCare Plus will make every effort to have the member participate in his or her ICT, if feasible.

To contact BlueCare Plus for additional information call the numbers below:

Provider Contact	1- 800 299-1407
Members Contact	1- 800 332-5762

IX. Care Management

The BlueCare Plus Care Management Program, promote member empowerment regarding health care decisions, education on health conditions and options, as well as the tools and resources necessary to assist the member/family when making health care decisions. The BlueCare Plus Care Management Program also offer quality and cost-effective coordination of care for members with complicated care needs, chronic illnesses and/or catastrophic illnesses or injuries.

The Care Management Program managed by the BlueCare Plus Department, provides the following services for both the DSNP and FIDE SNP programs:

- Discharge/transition management
- Care Coordination: services including Medicare, Medicaid and Long Term Support Services
- Condition-specific management programs such as congestive heart failure, chronic obstructive pulmonary disease and end stage renal disease.
- Telemonitoring for members with congestive heart failure or chronic obstruction pulmonary disease and on oxygen
- Complex Case Management
- Transplant Case Management
- End of Life Planning
- Catastrophic Care Management
- Maternity Case Management

Catastrophic Care Management focus on the most vulnerable members who:

- Are frail with functional limitations
- Have mental, cognitive or physical disabilities
- Have end-stage renal disease
- Are near end of life
- Have multiple and chronic medical conditions complicated by mental health issues, such as depression, bipolar disorder, schizophrenia or dementia, or social disparities such as homelessness, or lack of adequate supports

A. Referrals and Triage

Members, family and/or caregivers, practitioners and providers are encouraged to initiate referrals for any of the above listed programs and services. A Case Management team member, such as a registered nurse or behavioral health clinician will contact the designated person upon receipt of the referral.

B. Discharge Planning/Transition of Care

Transition of Care (TOC) is a member-centric program collaborating with facilities and Providers to assure
safe transition of Members to appropriate levels of care for better health and optimal outcomes. Members have the option to choose a telephonic or digital participation method of communication. Dedicated staff will assist facility discharge planners, Physicians, and Members with understanding requirements, benefits, and options for discharge.

The role of the Care Management team is to assist the PCP or other treating providers manage transitions by coordinating follow-up care and services, assuring timeliness of services throughout the transition process, conduct medication reconciliation, ensure a member has a post-admission follow-up physician visit, educate the member on self-management activities and tips to avoid re-hospitalization, and set up meals post discharge as needed.

Routine rounds are held with the Medical Director to discuss complex medical care needs and concerns. The Care Coordination team will perform post-discharge calls to the Members that include review of discharge instruction, medication reconciliation, confirmation of, or assistance with Physician appointment scheduling, collaboration with community services, and review of home safety to maximize opportunities for positive health outcomes and help decrease readmissions.

CMS requires BlueCare Plus to assist with discharge planning and transition of care for all members transitioning to a different setting. BlueCare Plus prioritizes its focus on assisting with transitions for inpatient services including:

- Medical and Behavioral Health inpatient admissions
- Long-term Acute Care admissions
- SNF admissions
- Inpatient Rehabilitation admissions

The Division of TennCare also requires BlueCare Plus to perform specific transition activities for CHOICES members in an acute inpatient facility.

It is extremely important for BlueCare Plus Care Management Department to be notified of discharge plans and the discharge date for all BlueCare Plus members for timely intervention by the BlueCare Plus Case Manager upon discharge.

If during a transition of care, a member needs Medicaid services, the BlueCare Plus Care Management team will coordinate with the Medicaid MCO Care Coordinator to arrange for those services. BlueCare Plus also sends electronic notification to each Medicaid MCO regarding BlueCare Plus acute inpatient admissions.

As required by CMS, as a result of a transition, a member's ICP will be updated related to the condition for which he or she was in the hospital and a copy will be mailed to the member or caregiver, PCP, and other treating providers as necessary.

C. Case Management

Case management services involve the full spectrum of care coordination. Case management is intended to stabilize members' health condition/disease, promote self-management by providing tools and education to allow them to make informed decisions about their health care, encourage and provide tools for active participation in managing their condition(s), and assist with arranging for care in the most appropriate setting and care that is necessary for self-management. Providers are encouraged to make referrals to the program.

Case management assist with the determination for admission and need for concurrent review (as explained under the Concurrent Review section of this Program Description) for any Skilled Nursing Facility (SNF), as needed. As with the Utilization Management Program, this Health Management program adheres to CMS Medicare Advantage rules and regulations promulgated in 42 CFR-422, CMS Internet Only Medicare Managed Care Manual and NCQA's Special Needs Plans Structure and Process Guidelines.

The Care Manager collaborates with multiple internal and external sources to develop an individualized care plan for the Member. The Care Manager may work with the Social Worker to obtain resources for the Member and caregiver. Routine rounds are held with the Medical Director to discuss medical care needs and concerns. Pharmacy and Behavioral Health clinicians are also utilized for consultation according to the Member's needs.

The coordination of members' care is essential for healthy outcomes. If you are the Primary Care Provider (PCP), remember to ask the member if they have been seen by any other providers since they were last seen, encourage the member to discuss treatment plans received elsewhere as well as requesting the information from the other provider.

If you are the member's specialist or other treating provider, obtain the name of the member's PCP and share medical assessments, prescriptions, or treatment provided by the member's PCP.

D. Condition-Specific Management Programs

Condition-specific management programs involve the same concepts as case management; however, it is disease specific. It is a system of coordinated health care interventions and communications for the population's members with conditions in which patient self-care efforts are significant. These programs emphasize prevention of exacerbations and complications through education and monitoring, and evaluation of clinical outcomes on an ongoing basis with the goal of overall health.

The Condition Specific Management Program takes a holistic approach recognizing that members face a wide variety of healthcare issues and concerns. The Care Coordination team provide support across a broad spectrum of health conditions and needs to actively engage Members in better management of their overall care.

The disease states managed within this program are coronary artery disease, diabetes, congestive heart failure, chronic obstructive pulmonary disease and asthma (subject to change based on analysis). The primary goal is to stabilize the member's health condition/disease and assist them with tools, education and care necessary for self-management. The program promotes member and caregiver's active participation in management of the disease process resulting in an increased knowledge of the disease process, prevention and treatment. Additionally, the member increases their knowledge of healthy lifestyle changes and co-morbid management. The treating Physician's involvement is an integral part of the program and development of an individualized plan of care and desired outcomes. The program supports the Physician by reinforcing education, monitoring and reporting. Providers identifying members with these diagnoses are requested to contact Case Management for referral into the program.

E. Telemonitoring

The purpose of the telemonitoring program is to reduce condition exacerbation, and unnecessary emergency room visits, inpatient admissions and readmissions. Telemonitoring for members with CHF includes monitoring daily weight gain due to fluid retention, and blood pressure and heart rate monitoring. Telemonitoring for members with COPD includes daily pulse oximetry readings and heart rate monitoring. This is a service provided for our most vulnerable members only. The Care Management team will work with the member and/or caregiver for setup and training on telemonitoring equipment and will monitoring daily measures.

F. Complex Case Management

Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost-effective outcomes. Members with complex health care needs, unstable multi-disease states, and conditions where a longer period of management will be required are managed through Complex Case Management. Complex and catastrophic conditions such as multiple chronic conditions, trauma, AIDS, extensive burns, frequent emergency department utilization, and frequent inpatient admissions are intensively managed by continually assessing, planning, coordinating, implementing and evaluating care. By using this approach, multiple health and psychosocial needs of the member are met.

The Case Management team works with the member, treating practitioners, family members, and other members of the health care team to coordinate and facilitate an individualized plan of treatment, evaluate the member's progress and facilitate referrals to a less intensive health management program.

G. Transplant Case Management

Transplant Care Management focuses on the entire spectrum of transplant care. The care of the member is managed from time of the evaluation for a transplant until services are no longer needed. BlueCare Plus helps its members in need of stem cell or solid

organ transplants receive quality care by directing them to national transplant centers of excellence. The facilities within this network and the associated Practitioners have been specifically selected for their expertise and quality outcomes in transplant cases.

Attention to assisting and educating the members about acquisition and use of needed drugs prescribed by their Physician, with special emphasis on the Part B benefit for anti-rejection drugs is provided. It is critically important, Case Management be contacted as soon as the provider identifies the member may need an evaluation for transplant.

H. End of Life Planning

End of Life planning provides education to a member and the member's family related to end-of-life choices and advance directives through the Care Management team and is available to all BlueCare Plus members. All members are educated on end-of-life choices and advance directives but due to the complexity and chronic illnesses of our most vulnerable members, this program may be utilized more frequently by this sub-population.

Upon identification that a member may need assistance with end of life planning a member of the Care Management team will contact the member/caregiver and will educate the member on end-of-life planning including hospice services and provide support to the member and their PCP when making a decision to enroll the member into hospice. The Case Manager will collaborate closely with a social worker to address the needs of members participating in this program. If the member has decided to execute an advance care plan, the social worker assists the member in completing the appropriate forms. The intent of the program is to empower members to make decisions about their health care and improve their quality of living at the end of life.

I. Maternity Case Management

The program provides prenatal health education and resources to expectant mothers during their pregnancy. Members have the option to choose a telephonic or digital participation method of communication. The focus of the program is to encourage comprehensive and timely prenatal care, as well as supportive Care Management and resources to reduce the incidence of premature deliveries and associated inpatient neonatal intensive care unit (NICU) days. Care Managers with maternity experience outreach no less than monthly, during each trimester, with more frequent interactions in the third trimester and postpartum period. Emphasis is placed on the follow-up care, assessing for depression, and providing additional support as needed.

J. Contact/Referrals to Above Case Management Programs Information

Practitioners/providers are encouraged to initiate referrals for any of the health management programs by contacting BlueCare Plus Case Management.

Phone: 1-877-715-9503
Fax: 1-866-325-6694

Referral requests should include the following information:

- Requesting provider's name and telephone number;
- Contact person and telephone number (if different from requesting provider);
- Member name;
- Member ID number and telephone number;
- Diagnosis and current clinical information;
- Current treatment setting (e.g., hospital, home health, rehabilitation, etc.);

- Reason for referral; and
- Level of urgency.

A Case Management registered nurse or behavioral health professional will contact the requesting provider upon receipt of the program referral.

K. Nursing Facility Diversion Program

BlueCare Plus and BlueCare Plus Choice have a Nursing Facility Diversion program to help allow these members to continue living safely in the community and to delay or prevent placement in a nursing facility. Through this program, our case management staff will coordinate with Medicaid Managed Care Organizations to facilitate home and community-based services for members who would otherwise qualify for nursing home placement.

Through case management, our Case Managers identify "at risk" members for nursing home placement by assessing to determine if a member has one or more of the following on an ongoing basis:

- Transfer – incapable of transfer to and from bed, chair or toilet unless physical assistance is provided 4 or more days per week
- Mobility – requires physical assistance 4 or more days per week. Mobility is defined as the ability to walk, use mobility aids such as a walker, crutch or can or the ability to use a wheelchair if walking is not feasible
- Eating – requires gastrostomy tube feedings or physical assistance from another person to place food/drink into the mouth
- Toileting – requires physical assistance to use the toilet or to perform incontinence care, ostomy care or indwelling catheter care 4 or more days per week
- Expressive and Receptive Communication – incapable of reliably communicating basic needs and wants, such as the need for assistance with toileting or the presence of pain, using verbal or written language or the member is incapable of understanding and following very simple instructions and commands such as dressing or bathing without continual intervention
- Orientation – disoriented to person or place
- Medication Administration – not mentally or physically capable of self-administering prescribed medications despite the availability of limited assistance such as reminders when to take medications, encouragement to take medication, reading medication labels, opening bottles, handing to the member and reassurance of correct dose
- Behavior – requires persistent intervention due to an established and persistent pattern of dementia-related behavioral problems such as aggressive physical behavior, disrobing or repetitive elopement
- Skilled Nursing or Rehabilitative Services – requires certain daily skilled nursing or rehabilitative services at a greater frequency, duration or intensity than, for practical purposes, would be provided through a daily home health visit

Our Case Managers conduct thorough assessments of members' functional and cognitive status as well as social supports, home environment, financial status and medication administration abilities. Close monitoring of transition of care activities is crucial in preventing unnecessary nursing facility stays. Community resources are essential in keeping a member in the community as well as ongoing assessment of the caregiver to determine efficacy for managing the member's home needs.

X. Utilization Management

A. Utilization Management Guidelines

BlueCross BlueShield of Tennessee's Utilization management (UM) Program is committed to providing cost-effective healthcare services to its members. The UM program is designed to manage, evaluate, and improve the quality, appropriateness, and accessibility of healthcare services while achieving Member and Provider satisfaction.

BlueCare Plus adheres to CMS' Medicare Advantage rules and regulations promulgated in 42 CFR § 422 and CMS' Part C & D Grievances, Organization/Coverage Determinations, and Appeals Guidance (released January 2020). CMS' requirements for Medicare Part C vary from the requirements for Original Medicare.

These utilization management strategies are additional effective mechanisms for identifying members who may benefit from Case Management. The Utilization Management program follows the CMS hierarchy for both decisions and references in making Medical Necessity determinations.

BlueCare Plus coverage and payment is contingent upon the following:

1. A service must be a covered benefit in a member's Evidence of Coverage;
2. A service must not be excluded; and
3. A service must be appropriate and medically necessary.

BlueCare Plus uses the following hierarchy of references to determine coverage:

- The law (Title 18 of the Social Security Act);
- The regulations (Title 42 Code of Federal Regulations (CFR) Parts 422 and 476;
- National Coverage Determinations (NCDs) Manual Publication 100-03 of Medicare's Internet Only Manuals;
- Benefit Policy Manual Publication 100-02 of Medicare's Internet Only Manuals:
- Local Coverage Determinations (LCDs);
- Coverage guidelines in Interpretive Manuals (Medicare's Internet Only Manuals, sub-manuals) including:
  - Claims Processing Manual Publication 100-04;
  - Program Integrity Manual Publication 100-08;
  - Quality Improvement Organization Manual Publication 100-10;
  - Medicare Managed Care Manual Publication 100-16;
- Durable Medical Equipment Medicare Administrative Contractor (DMEMAC);
- Associated Program Safeguard Contractor (PSC) Local Coverage Determinations;
- MCG criteria;
- BlueCross Utilization Guidelines;
- U.S. Food and Drug Administration approved indications for medications:
- Supplemental benefits and limitations as outlined in a member's Evidence of Coverage:
- BCBST Policy; and
- Other major payer policy and peer reviewed literature.

Please refer to BlueCare Tennessee's Provider Administration Manual for Medicaid coverage guidelines for BlueCare Plus Choice members located at:
http://bluecare.bcbst.com/providers/news-manuals.html.

Behavioral Health Services provided by an Institution, Physician, or other Providers that are required to identify or treat a TennCare Enrollee's illness or disease should be ordered/recommended by a licensed Physician or other licensed health care Provider practicing with the scope of his or her license who is treating the Member. The order/recommendation may be found in various locations in the record, such as a referral from the higher level of care, in the recommendations on the intake, or on the treatment plan as applicable for the service.

BlueCare Plus' UM decision-making is based only on appropriateness of care and service and existence of coverage. The Organization does not reward Practitioners or other individuals for issuing denials of coverage or care and financial incentives for UM decision-makers do not encourage decisions that result in underutilization.

The program is directed, guided and monitored by our Medical Director who actively seeks input from network-participating Practitioners and other regulatory agencies.

B. Organization Determination

As it related to UM processes, CMS defines an organization determination as a decision made by the plan, or its delegated entity, on a request for coverage (payment or provision) of an item, service, or drug.. Organization determinations include:

- Advance determinations
- Prior authorization determinations
- Retrospective review determinations

C. Advance Determination

A member or provider can seek a determination of coverage of services *that do not require prior authorization* before receiving or providing services by requesting an Advance Determination. Advance Determinations are performed to render Medical Necessity and Appropriateness determinations before services are rendered rather than during claims processing. However, claims submitted for services that were not reviewed prospectively may be reviewed retrospectively for medical appropriateness to determine coverage and reimbursement. Providers can request an Advance Determination by phone or fax. A reference number is issued when care and treatment are determined to be medically necessary and medically appropriate.

D. Prior Authorization

Participating providers are responsible for obtaining the appropriate prior authorizations/advance determinations. Members or their representatives may also request authorizations or advance determinations. It is not the member's responsibility for obtaining prior authorization determinations.

If the Provider chooses to render services that have not received prior authorization, or that do not meet Medical Necessity criteria according to BlueCare Plus' Clinical Decision Process, the member is not financially liable for the charges.

Prior authorization for coverage and Medical Necessity for BlueCare Plus and BlueCare Plus Choice members is required for:

- All acute care facility, skilled nursing facility and rehabilitation facility inpatient admissions
- Mental health acute inpatient admissions
- Substance Use Disorder inpatient admissions
- Select musculoskeletal surgical procedures
- Part B and specialty pharmacy medications
- Durable medical equipment if the purchase or rental price is greater than $500
- Orthotics and prosthetics if the purchase price is greater than $200
- Home Health Services to include all therapies, nursing visits and psychiatric visits
- Outpatient speech, occupational and physical therapy
- High tech imaging
- Non-emergent out-of-network services
- Non-preferred brands of diabetic testing supplies
- Non-emergency ambulance transportation
- Home ventilator devices
- Wearable defibrillator devices
- Psychiatric Partial Hospitalization Program (PHP) (excludes substance use disorder PHP which no longer requires prior authorization)
- Electroconvulsive Therapy (both inpatient and outpatient)
- Neuropsychological Testing and Psychological Testing
- Transcranial Magnetic Services
- Proton beam therapy

Additional prior authorization requirements for **BlueCare Plus Choice members** include:

- Private Duty Nursing if a member:
    - Is ventilator dependent for at least twelve (12) hours each day with an invasive patient end of the circuit (i.e., tracheostomy); or
    - Is ventilator dependent with a progressive neuromuscular disorder or spinal cord injury, and is ventilated using noninvasive positive pressure ventilation (NIPPV) by mask or mouthpiece for at least twelve (12) hours each day in order to avoid or delay tracheostomy (requires medical review); or
    - Has a functioning tracheostomy requiring suctioning and need other specified types of nursing.
- Home Health Aide visits and services
- All services performed by a plastic specialist, including but not limited to:
    - Abdominoplasty/Panniculectomy
    - Blepharoplasty
    - Breast Reduction
    - Reconstructive Repair Pectus Excavatum
    - Vein Ligation
- All food supplements and substitutes, including formulas taken by mouth.
- Incontinence diaper supplies >200 per member per month

Observation stays require notification to the UM Department to support required TennCare reporting and initiate the transition of care process.

E. Prior Authorization Review

A member, designated member advocate, practitioner or facility may requests a prior authorization review. However, it is ultimately the facility and practitioner's responsibility to contact BlueCare Plus to request an authorization and to provide the clinical and demographic information that is required to complete the authorization.

Scheduled admissions/services must be authorized at least twenty-four (24) hours prior to admission. Authorization requests should be submitted as quickly as possible after a procedure is planned.

Prior authorization requests for emergency admissions must be submitted within twenty-four (24) hours or one (1) business day after services have started in order to facilitate referrals for transition of care.

Failure to comply within specified authorization timeframes will result in a denial or reduced benefits due to non-compliance, and BlueCross participating Providers will not be allowed to bill Members for Covered Services rendered.

When a request for an authorization of a procedure, admission/service is denied, the penalty for not meeting authorization guidelines will apply to both the facility and the practitioner rendering the care for the day(s) or service(s) that have been denied. BlueCare Plus' non-payment is applicable to both the facility and practitioner rendering the care.

The Practitioner and/or the facility are notified via telephone and/or electronically/fax of the determination. In the event of an adverse determination, written confirmation to the Practitioner, facility and member follows. Timeframes begin with receipt of the UM requests and include the issuance of the notification of the decision.

Nurse reviewers refer potential denials or questionable cases to a Medical Director for review. If a BlueCross BlueShield of Tennessee Medical Director denies a request for prior authorization, the Provider or member may appeal the decision.

Concurrent/extended stay reviews are performed for inpatient admissions and concurrent/extended service reviews are performed for ancillary services. Approval of the admission or an initial length of stay is assigned upon admission to a facility and an initial length of service is assigned upon onset of ancillary service. However, to receive payment beyond the initial length of stay or length of service, additional medical information, which meets criteria and/or demonstrates Medical Necessity, must be submitted by the facility/Practitioner contacting the Utilization Management Department either by telephone, fax or electronically with the additional information to support the request.

BlueCare Plus Providers can submit authorization requests for inpatient and 23-hour observation via telephone, facsimile or e-Health Services® via Availity, the secure area on the company website, www.bcbst.com. If you have an urgent case in need of an urgent response, you must telephone the request to the Utilization Management Department at 866-789-6314. A voicemail line will be available after business hours and on weekends/holidays for Providers to contact BlueCross BlueShield of Tennessee regarding concurrent or urgent information. Providers submitting requests via facsimile should utilize the authorization request form located on the company website at https://provider.bcbst.com/tools-resources/documents-forms and fax to 866-325-6698.

Medical Review Requirements

Requests requiring prior authorization must contain adequate information for review. Requests for authorization where additional information is requested but not received by the end of the next calendar day may be denied for lack of information. Covered Services that have not been authorized may not be billed to the member.

The following describes specific medical review guidelines:

1. **Inpatient Admission**

   a. **Acute Care Facility**

   All inpatient stays for planned procedures require prior authorization. Authorization will be issued when care and treatment are determined to be Medically Necessary and Appropriate in an inpatient setting. Scheduled inpatient stays require admission the morning of a procedure in nearly all instances.

   Basic information needed for processing a prior authorization request:

   - Member's identification number and name;
   - Patient's name and date of birth;
   - Practitioner's name, provider number and/or National Provider Identifier (NPI), address, telephone number and caller's name;
   - Hospital/Facility's name, provider number and/or NPI, address, telephone number, caller's name.

   Clinical information required for prior authorization:

   - Procedure/Operation to be performed, if applicable;
   - Diagnosis with supporting signs/symptoms;
   - Vital signs and abnormal lab results;
   - Elimination status;
   - Ambulatory status;
   - Hydration status;
   - Co-morbidities that impact patient's condition;
   - Complications;
   - Prognosis or expected length of stay;
   - Current medications.

   b. **Skilled Nursing Facility (SNF)**

   All inpatient stays require prior authorization. Authorization will be issued when care and treatment are determined to be Medically Necessary and Medically Appropriate in an inpatient setting. Skilled services are services requiring the skills of qualified technical or professional health personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, and/or audiologists. Skilled services must be provided directly by or under the general supervision of technical or professional healthcare personnel.

   Basic information needed for processing a prior authorization request:

   - Member's identification number and name;
   - Patient's name and date of birth;
   - Practitioner's name, provider number and/or NPI, address, telephone number and caller's name;
   - Hospital/Facility's name, provider number and/or NPI, address, telephone number, caller's name;
   - Initial review, concurrent review or reconsideration request with admission date, admitting diagnosis, symptoms, treatment; and
   - Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care that would influence the Medical Necessity determination.

   If a covered benefit, SNF admission may be approved for Members with all the following:

   - A condition requiring skilled nursing services or skilled rehabilitation services on an inpatient basis at least daily;
   - A Practitioner's order for skilled services;
   - Ability and willingness to participate in ordered therapy;

- Medical Necessity for the treatment of illness or injury (this includes the treatment being consistent with the nature and severity of the illness or injury and consistent with accepted standards of medical practice); and
- Expectation for significant reportable improvement within a predictable amount of time.

Evaluation and Plan of Care

- Evaluation of the member must be submitted including the following as appropriate:

  - Primary diagnosis
  - Ordering Practitioner and date of last visit
  - Date of diagnosis onset
  - Baseline status
  - Current functional abilities
  - Functional potential
  - Strength
  - Range of Motion
  - Circulation and sensation
  - Gait analysis
  - Cooperation and comprehension
  - Developmental delays (pediatric patients)
  - Other therapies or treatments
  - Patient's goals
  - Medical compliance
  - Support system

- Plan of care must be submitted including the following as appropriate:

  - Short- and Long-term goals
  - Discharge goals
  - Measurable objectives
  - Functional objectives
  - Home program
  - Proposed admission date
  - Frequency of treatment
  - Specific modalities, therapy, exercise
  - Safety and preventive education
  - Community resources

Therapy Services

Therapy services appropriate for skilled nursing facilities include occupational therapy, physical therapy and speech therapy not possible on an outpatient basis. Specific therapy services that may be appropriate for a SNF include, but are not limited to the following:

- Complex wound care requiring hydrotherapy;
- Preventing complications and the start or revision of the member's maintenance therapy plan; and
- Gait evaluation and training to restore function in a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality.

Nursing Services

Nursing services appropriate for skilled nursing facilities include skilled nursing services not possible on an outpatient basis. Specific nursing services that may be appropriate for a SNF include, but are not limited to the following:

- Intramuscular injections or intravenous injections or infusions;
- Burns;
- Open lesions;
- Widespread skin disorder treatments;
- Initiation of and training for care of newly placed

- Tracheostomy
- Pain Management
- In-dwelling catheter with sterile irrigation and replacement
- Colostomy
- Gastrostomy tube and feedings

- Complex wound care involving medication application and sterile technique
- Ulcer treatment with any Stage 3 or 4 pressure ulcer or 2 or more ulcers

Nursing and Therapy Services Not Requiring SNF Placement

Skilled nursing facility placement is not necessary for the services listed below. This list is **not** all- inclusive.

- Administration of routine oral, intradermal or transdermal medications, eye drops, and ointments;
- Custodial services, e.g., non-infected postoperative or chronic conditions;
- Activities or programs primarily social or diversional in nature;
- General supervision of exercises in paralyzed extremities, not related to a specific loss of function;
- Routine care of colostomy or ileostomy;
- Routine services to maintain functioning of in-dwelling catheters;
- Routine care of incontinent patients;
- Routine care in connection with braces and similar devices;
- Prophylactic and palliative skin care (i.e., bathing, application of creams, or treatment of minor skin problems);
- Duplicative services - Physical therapy services that are duplicative of Occupational Therapy services being provided or vice versa;
- Invasive procedures (i.e., iontophoresis involving needle);
- General supervision of aquatic exercise or water-based ambulation;
- Heat modalities (hot packs, diathermy or ultrasound) for pulmonary conditions or wound treatment, or as a palliative or comfort measure only (whirlpool and hydrocollator);
- Hot and cold packs applied in the absence of associated modalities;
- Diagnostic procedures performed by a Physical Therapist (i.e., nerve conduction studies); and

- Electrical stimulation for strokes when there is no potential for restoration of functional improvement. Nerve supply to the muscle must be intact.

Extension of Services

Extension of services requires the following documentation:

- Clinical progress in meeting goals
- Updated goals
- Compliance & participation with any ordered therapy
- Discharge plans & target date

c. Rehabilitation Facility

All inpatient stays require prior authorization. Authorization will be issued when care and treatment are determined to be Medically Necessary and Medically Appropriate in an inpatient setting. Inpatient Rehabilitation provides multidisciplinary, structured, intensive therapy for Members meeting criteria.

Rehabilitation goals are to prevent further disability, to maintain existing ability, and to restore maximum levels of functioning within the limits of the Member's impairment.

Potential inpatient rehabilitation admissions include Members with recent CVA, head trauma, multiple trauma, or spinal cord injury.

Basic information needed for processing a prior authorization request:

- Member's identification number and name;
- Patient's name and date of birth;
- Practitioner's name, provider number and/or NPI, address, telephone number and caller's name;
- Hospital/Facility's name, provider number and/or NPI, address, telephone number, caller's name;
- Initial review, concurrent review or reconsideration request with admission date, admitting diagnosis, symptoms, treatment, frequency of therapies, Member's ability to participate in treatment;
- Member is ventilator dependent or not; and
- Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care that would influence the Medical Necessity determination.

If a Covered Service, inpatient rehabilitation admission may be approved for Members with all the following:

- Rehabilitative potential, to include assessment and/or Current Functional Status from illness or injury and premorbid condition;
- Ability and willingness to actively participate in a minimum of 3 hours of daily therapy, 5-days-per- week, or therapy at least 15 hours per week (7 consecutive days);
- A condition requiring 24-hour rehabilitation nursing and 24-hour availability of a Practitioner with special training in the field of rehabilitation;
- A requirement for at least 2 therapies and a multidisciplinary team approach;
- Medical Necessity for the treatment of illness or injury (this includes the treatment being consistent with the nature and severity of the illness or injury, and consistent with accepted standards of medical practice);
- Acute medical condition stabilized;

- Reasonable and reportable goals in a written plan of care submitted with the request for admission; and
- Documented family commitment to the rehabilitation program (where family involvement will eventually be required).

In addition, a request for an additional inpatient rehabilitation admission for a Member previously admitted to inpatient rehabilitation for essentially the same condition needs to be carefully assessed. The date and length of previous rehabilitation, along with the improvement attained, need to be carefully considered. Alternatives in these cases may be outpatient rehabilitation, home therapy or therapies, or skilled nursing facility (SNF) placement.

Evaluation and Plan of Care

- Evaluation of the Member must be submitted including the following as appropriate:

  - Ordering Practitioner and date of last visit
  - Primary diagnosis
  - Date of diagnosis onset
  - Baseline status
  - Current functional abilities
  - Functional potential
  - Strength
  - Range of Motion
  - Gait analysis
  - Circulation and sensation
  - Cooperation and comprehension
  - Developmental delays (pedia patients)
  - Other therapies or treatments
  - Patient's goals
  - Medical compliance
  - Support system

- Plan of care must be submitted including the following as appropriate:

  - Short- and Long-term goals
  - Discharge goals
  - Measurable objectives
  - Functional objectives
  - Home program
  - Proposed admission date
  - Frequency of treatment
  - Specific modalities, therapy, exerc
  - Safety and preventive education
  - Community resources

Extension of Services

Extension of services requires the following documentation:

- Clinical progress in meeting goals
- Updated goals
- Compliance & participation with therapy
- Demonstrating measurable practical improvement in function with evaluation of current level of functioning
- Discharge plans & target date
- Team conference reports (at least every two weeks or with any significant change in the Member's condition)

Note: A sample copy of the Skilled Nursing Facility/Inpatient Rehabilitation form is available on the BlueCross Provider page on the company website, www.bcbst.com.

Emergency Admission

In-network Providers are responsible for contacting BlueCare Plus within 24 hours or next business day.

Although emergency procedures do not require prior authorization, benefits are subject to verification for eligibility of coverage.

In the event that an emergency hospital admission or emergency outpatient service occurs after normal office hours, you may submit the information via our website, www.bcbst.com, for registered users, or contact the Utilization Management Department within 24 hours or next business day.

If the Member is still admitted at that time, an admission review will be initiated. If the Member has been admitted and discharged, or has already received an emergency outpatient service, a retrospective review will be completed.

Observation Stays

Observation for elective services, direct admissions from the Physician's office, or a transfer from another facility require prior authorization.

The goal of observation stays is to either complete treatment, e.g., hydration, or rule out need for inpatient stays; (e.g., chest pain is not caused by an acute myocardial infarction). Members in this status may advance to admission status if the clinical situation warrants. Admissions need to be reported to the Utilization Management Department before a scheduled admission or within the next business day if unscheduled. For conversion to inpatient admission, submission of adequate clinical to determine Medical Necessity and Medical Appropriateness will be required.

Cosmetic Surgery

Cosmetic surgery is not a Covered Service. However, breast reconstructive and symmetry surgery following a mastectomy is a Covered Service.

Reconstructive breast surgery, in all stages, on the diseased breast as a result of a mastectomy (not including a lumpectomy) is considered Medically Necessary.

Hospice Services

Hospice services are for terminally ill Members where life expectancy is six (6) months or less and is covered by traditional Medicare.

Ambulatory Surgeries (Appropriateness Review), Diagnostic & Other Procedures

Some outpatient surgical/diagnostic procedures may require prior authorization. These procedures may be performed in outpatient surgical facilities, hospital outpatient departments, outpatient diagnostic centers, and in Practitioners' offices. Providers may call Customer Service at the phone number listed on the Member's ID card to determine prior authorization requirements. Some procedures do not require prior authorization if performed on an outpatient basis; however, if performed as 23-hour observation or on an inpatient basis, a prior authorization is required for the hospitalization. Non-emergency elective procedures should be submitted up to thirty (30) days, but not less than 24 hours prior to the scheduled procedure. Failure to obtain prior authorization will result in denial of payment for Covered Services.

Prior authorization is required for the following procedures performed in an inpatient or outpatient setting:

- Blepharoplasty/Browplasty (if Covered)
- Vein ligation
- Bariatric procedures (if Covered)
- Hysterectomy
- Breast Augmentation/Reduction
- Panniculectomy
- Endometrial Ablation
- Hyperbaric Treatments
- Gender Reassignment Surgery (if Covered)

Covered Services that have not been authorized may not be billed to the member if rendered by a BlueCare Plus network Provider.

Providers should call the BlueCross Provider Service line, 1-800-924-7141, or visit e-Health Services® on www.Availity.com to determine prior authorization requirements.

Specialty Pharmacy Medications

Certain high-risk/high-cost specialty pharmacy medications administered in any setting other than inpatient hospital requires prior authorization. This authorization requirement applies to all Provider types including home infusion therapy Providers, specialty pharmacies, hospitals providing outpatient infusions, and injections.

If the Provider is supplying a Provider-Administered drug that requires prior authorization, they must call BlueCross Utilization Management department at 1-800-924-7141 and choose the "Specialty Pharmacy" authorization option or submit the request via Availity, BCBST's secure portal on bcbst.com. This will route to Magellan RX Management, our Specialty Pharmacy Network vendor, who may request additional information if required to complete the review process.

Home Infusion Therapy

Home Infusion Therapy (HIT) is the administration of medications, nutrients or other solutions intravenously, subcutaneously, epidurally, intramuscularly or via implanted reservoir while in the Member's private residence. A request for HIT originates with prescription from a qualified Practitioner to achieve defined therapeutic results. HIT must be provided by a licensed pharmacy. Home nursing for patient education, medication administration, training, and monitoring are handled directly by a qualified home health agency.

When an authorization is needed, specific information is required. Authorizations are valid for the dates approved; any break in service requires a new authorization. HIT Providers requesting approval of HIT services should submit the following information:

- Member name, address, date of birth, sex, ID number;
- Practitioner name, address, phone number;
- HIT agency name, address, phone number, HIT-related provider number and/or National Provider Number (NPI) and a contact person;
- Type of request: initial prior authorization, extension of services or change of services;
- Type of therapy (e.g., palliative, long-term therapy, short-term antibiotic therapy) should include dosage, frequency, date and length of service, including NDC number, HCPCS code and grams

of protein for TPN;

- Primary and HIT diagnosis;
- Clinical documentation (e.g., lab values, cultures, X-rays) to support reason and need for HIT services; and
- A Practitioner's verbal or signed medical order.

The administration of intramuscular (IM) drugs (Rocephin, Phenergan, Procrit, etc.) is not considered HIT and therefore, should not receive HIT benefits. If nursing is required to administer the drug and/or conduct teaching for the member, these services may require prior authorization under Home Health guidelines. If the HIT Provider is dispensing the drug, they are required to follow BlueCare Plus' requirements for prior authorization. All self-administered drugs must be authorized and billed through the Member's appropriate PBM.

Authorization decisions will be phoned, faxed, sent electronically, or mailed to the HIT Provider, the prescribing Practitioner and member. Adverse decisions are rendered if Medical Necessity and Medical Appropriateness are not shown.

Durable Medical Equipment

Durable Medical Equipment (DME) purchases, rentals, or repairs require prior authorization for purchase items more than $500 and all rental items. DME may be subject to retrospective review for Medical Necessity.

DME may be covered if it is determined to be Medically Necessary and Medically Appropriate for the member's condition. The following guidelines and documentation requirements apply to DME whether equipment is purchased or rented:

- The Member's diagnosis should substantiate the need and use of the equipment in the medical record.
- Documentation of the member's capability to be trained in the appropriate use of the equipment.
- Rental equipment is generally considered equipment that requires frequent and substantial servicing and maintenance and/or estimated period of use is finite.
- Certain rented DME is purchased after the equipment has been rented for a total of ten (10) months.
- Documentation for customized equipment should specify the need for the custom equipment versus standard equipment.

Reimbursement may be determined for a more cost-effective alternative if medical necessity and appropriateness for the equipment is not demonstrated in the documentation submitted for review.

Information that needs to be submitted with the claim and/or prior authorization (when applicable) request:

- Practitioner's order (if not submitted with the claim, it may be requested at any time and payment recouped if unavailable);
- Member's diagnosis and expected prognosis;
- Estimated duration of use;
- Limitations and capability of the Member to use the equipment;
- Itemization of the equipment components, if applicable;
- Appropriate HCPCS codes for equipment being requested; and
- The Member's weight and/or dimensions (needed to determine coverage of manual or power wheelchairs), if available.

The following guidelines apply to reimbursement for repair of DME equipment:

- Equipment less than one (1) year old requires documentation related to the warranty coverage. Repairs that are covered by the warranty will not be reimbursed by BlueCross BlueShield of Tennessee;
- Documentation supporting need for services and/or items being billed; initial purchase date of equipment should be included, if available; and
- Prior authorization may be required for DME repairs. BlueCare Plus will only provide benefits for Medically Necessary and Medically Appropriate Equipment. Requests for extraordinary items require justification.

BlueCare Plus will not provide benefits for Investigational Durable Medical Equipment.

Advanced Imaging/High Tech Imaging

Prior authorization* is required for select advanced imaging radiology procedures performed in an outpatient setting. Prior authorization reviews for these cases are processed by our High Tech Imaging vendor on behalf of BlueCare Plus. Prior authorization is not required for imaging procedures performed during an inpatient admission or emergency room visit.

Procedures requiring prior authorization include, but are not limited to:

- Computed tomography (CT)
- Computed tomography angiography (CTA)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Positron emission tomography (PET)
- Magnetic resonance spectroscopy (MRS)

- Nuclear cardiology

To request prior authorization for any of the previously listed radiology procedures, call our High Tech Imaging vendor at 1-888-693-3211.

Second Surgical Opinion

BlueCare Plus will pay for any second surgical opinion requested by a Member. This includes not only major surgery, but also other procedures (e.g., pacemakers, ambulatory surgery procedures, etc.).

The following guidelines apply to Second Surgical Opinions:

- A surgeon (one who is not in the same group or practice as the Practitioner who rendered the first opinion) must render the second opinion.
- The Practitioner rendering the second surgical opinion must be in a BlueCare Plus network.

Non-Emergent Air Ambulance Transportation

- Prior authorization is required for non-emergent air ambulance transportation.
- Prior authorization is NOT required for emergency air ambulance transportation (e.g., from the scene of an accident when ground transport is not appropriate or would pose a threat to the Member).
- To request prior authorization for non-emergent air transportation for a BlueCare Plus Member, call 1-800-299-1407 from 8 a.m. to 6 p.m. (ET).

Molecular and Genomic Testing

Prior authorization is required for select molecular and genomic testing.

Radiation Oncology

Prior authorization is required for oncology/radiation therapy procedures.

Investigational Services

Investigational services are those services that do not meet BlueCross BlueShield of Tennessee's definition of Medical Necessity. New and established technologies are researched and evaluated by BlueCross BlueShield of Tennessee's Medical Policy Research & Development Department and are assessed using sources that rely upon evidence based studies.

Providers can view the criteria used in making determinations as to whether a service is considered to be Investigational or Medically Necessary via the Medical Policy Manual in the Manuals, Policies and Guidelines section on the company website, www.bcbst.com and are informed of new and revised medical policies via monthly BlueCross Provider e-mail notification message. Newly approved medical policies may be viewed on BlueCross' Upcoming Medical Policies web page located on the company website, www.bcbst.com.

Medically Necessary and Medically Appropriate Policy

BlueCare Plus covers Medically Necessary and Medically Appropriate healthcare services not otherwise excluded under BlueCare Plus healthcare benefits plans.

Medically Necessary or Medical Necessity

"Medically Necessary" refers to procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical Practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
- not primarily for the convenience of the patient, Physician or other healthcare Provider; and
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician specialty society recommendations, and the views of medical Practitioners practicing in relevant clinical areas and any other relevant factors.

Medically Appropriate

"Medically Appropriate" refers to services, which have been determined by BlueCross BlueShield of Tennessee in its discretion to be of value in the care of a specific Member. To be Medically Appropriate, a service must meet all of the following:

1. Be Medically Necessary.
2. Be consistent with generally accepted standards of medical practice for the Member's medical condition.
3. Be provided in the most appropriate site and at the most appropriate level of service for the Member's medical condition.

4. Not be provided solely to improve a Member's condition beyond normal variation in individual development, appearance and aging.
5. Not be for the sole convenience of the Provider, Member or Member's family.

BlueCare Plus may request medical records when the complexity of a case requires a review of the medical records in order to determine if a service is Medically Necessary and Medically Appropriate.

Note: According To Contract, BlueCare Plus Will Not Reimburse For Photocopying Expenses. BlueCare Plus encourages open Practitioner/patient communication regarding appropriate treatment alternatives.

F. UM Contact Information

Notification and authorization requests should be submitted to BlueCare Plus.

Authorization, requests, advance determination requests, and observation notification may be submitted to BlueCare Plus via the following methods:

- Telephone: 1-866-789-6314
- Online: www.bcbst.com/Availity
- Fax: 1-866-325-6698
- Mail: BlueCare Plus Utilization Management Department
  One Cameron Hill Circle, Ste 0005
  Chattanooga, TN 37402-0005

Fax forms are available on the BlueCare Plus website at: http://bluecareplus/provider-resources/

HH Aide and PDN Missed Visit Reminder

Please send information on the HH Aide and PDN missed visit form located on the Provider portal on the BlueCare Plus website at : https://provider.bcbst.com/tools-resources/documents-forms/.

Refer to BlueCare Tennessee's Provider Administration Manual for Medicaid Prior Authorization and Notification Request related to BlueCare Plus Choice members located at: https://bluecare.bcbst.com/providers/news-manuals

G. CMS Guidance for Outreach to Support Coverage Decisions

CMS requires Medicare Advantage plans to conduct appropriate outreach to obtain the necessary clinical information in order to conduct a review for medical necessity and appropriate. If clinical information is not adequate or a Medical Director has additional questions, BlueCare Plus will follow this process:

- Conduct outreach 3 times by phone and fax to obtain information
- If information was not provided during those outreach, BlueCare Plus Medical Director will issue an "Intent to Deny" fax to provide an additional opportunity to provide the information before a denial is issued
- If information is received, it will be reviewed to determine medical necessity and appropriateness and an approval or denial will be issued as appropriate

- If information is not received after the Medical Director outreach notifying provider of intent to deny, the request will be reviewed by the Medical Director using the information available to BlueCare Plus

All four (4) outreaches will be conducted with the appropriate review timeframes for standard preservice and expedited organization determinations described in section J.

H. Non-Compliance with Prior Authorization Requirements

A contracted provider is required by contract to follow utilization management processes and must obtain authorization prior to scheduled services or request authorization in the timeframes described above for unplanned services. Failure to comply within specified authorization timeframes will result in a contractual “non-compliant” denial. A request for authorization will not be reviewed if the request is “non-compliant” unless:

- A member does not provide the provider with BlueCare Plus identification card nor notify the provider he or she has a BlueCare Plus plan; or
- BlueCare Plus has not issued a coverage identification card prior to a member needing a service; or
- A coverage issue existed.

If one of the above situations occurred and a provider can provide written evidence of this, a provider can request an appeal through the Provider Dispute Resolution Procedure (PDRP) including a copy of the medical record relevant to the admission or services and the face sheet at the time of the service. At that point, a medical necessity review will be conducted. The PDRP is further described in section L.

BlueCare Plus providers cannot bill members for covered services denied due to non-compliance by the provider.

I. Retrospective Review

Prior to claims payment, select codes may require a review for medical necessity. These reviews will be performed using CMS’ hierarchy or TennCare’s hierarchy and an approval or denial of medical necessity will be issued.

J. Review Timeframes

Organization determinations are reviewed as expeditiously as a member’s health condition requires.

Organization determination types:

Standard *preservice* organization determination – A determination will be made no later than fourteen (14) calendar days of receipt of request.

Standard *preservice* organization determination for Part B drugs – A determination will be made no later than 72 hours of receipt of request.

Expedited organization determination – Upon request by a physician, member or member's authorized representative a determination will be made within 72 hours of receipt of request. This does not apply to services already rendered – those type requests will be handled as a standard organization determination.

Expedited organization determination for Part B drugs – Upon request by a physician, member or member's authorized representative a determination will be made within 24 hours of receipt of request. This does not apply to services already rendered – those type requests will be handled as a standard organization determination.

Excluding Part B drugs, both standard and expedited review requests may be extended up to fourteen (14) calendar days if a member requests and extension or if BlueCare Plus justifies a need for additional information and that it is in the interest of the member to extend the timeframe.

Standard *retrospective* organization determinations – within thirty (30) calendar days of receipt of request

K. Mandated Notices

A. Important Message from Medicare (IM):
Hospitals **are responsible** to deliver the Important Message from Medicare (IM) to any BlueCare Plus member who is a hospital inpatient to inform a member of hospital discharge appeal rights.

CMS requires within two (2) calendar days of admission to a hospital to:

- Issue IM to member or member's authorized representative
- Explain a member's right as a hospital patient including discharge appeal rights
- Obtain signature of member or authorized representative and provide a copy to the member/representative

CMS requires within two (2) calendar days of discharge to a hospital to:

- Deliver a copy of the signed notice to the member/representative

B. Detailed Notice of Discharge (DN):
CMS requires a Detailed Notice of Discharge (DN) be distributed to a member or authorized representative requesting an appeal of discharge from an inpatient facility or when BlueCare Plus no longer intends to continue coverage of an authorized hospital inpatient admission. **BlueCare Plus delegates to providers the responsibility for developing and delivering the DN for provider discharge determinations and for delivery of DN for BCBST discharge determinations.** CMS requires the DN to be delivered as soon as possible, but no later than noon of the day after the QIO's notification or BlueCare Plus' request for delivery. Providers are required to fax a signed copy of the

DN to HMO D-SNP Plus UM Department at 1-866-789-6314. Providers must be able to demonstrate compliance with the delivery of the DN in accordance with applicable CMS regulations.

C. Notice of Medicare Non-Coverage (NOMNC):
Home Health Agencies (HHA), Skilled Nursing Facilities (SNF), and Comprehensive Outpatient Rehabilitation Facilities (CORF) are responsible for delivering Notices of Non-Coverage (NOMNC) to the member or the authorized member representative in accordance with applicable CMS regulations to notify a member how to request an expedited determination and provide an opportunity for such a request.

The NOMNC should be delivered at least two (2) days prior to the member's HHA, SNF, or CORF previously approved/authorized services ending as per CMS requirements. If the member's services are expected to be fewer than two (2) days in duration, the HHA, SNF, or CORF must provide the NOMNC to the member at the time of admission to the provider. A model NOMNC form is located on The CMS Website. Providers are required to fax a signed copy of the NOMNC to BlueCare Plus UM Department at 1-866 325-6698.

D. Detailed Explanation of Non-Coverage (DENC):
CMS requires a Detailed Explanation of Non-Coverage (DENC) be distributed to a member or authorized representative requesting an appeal of discharge from a SNF, HHA, or CORF or when BlueCare Plus no longer intends to continue coverage. BlueCare Plus delegates to providers the responsibility for developing and delivering the DENC for provider discharge determinations and for delivery of the DENC for BlueCare Plus discharge determinations. CMS requires the DENC to be delivered as soon as possible, but no later than close of business the day of the QIO's notification or BlueCare Plus' request for delivery. Providers are required to fax a signed copy of the DENC to BlueCare Plus UM Department at 1-866 325-6698. Providers must be able to demonstrate compliance with the delivery of the DENC in accordance with the applicable CMS regulations. Providers are required to inform BlueCare Plus members that a request for denial notice must be submitted to BlueCare Plus by the member, in the event that the member believes that he/she is being denied service.

E. Medicare Outpatient Observation Notice (MOON)
Hospitals and critical access hospitals are required to provide a MOON to Medicare Advantage beneficiaries receiving observation services for more than 24 hours to inform them they are outpatients receiving observation services and are not patients of a hospital or critical access hospital.

- Written MOON must be provided no later than 36 hours after observations services an outpatient began
- Oral notification must consist of an explanation of the MOON
- Member or authorized representative must sign and date the MOON

L. Provider Appeal

This section applies to the provider appeal process for utilization management review of a denied authorization request for medical necessity. The Provider Dispute Resolution Procedure (PDRP) for claims payment is explained in section XIV – B.

Peer-to-Peer and Re-Evaluation Processes

In accordance with guidance from the Centers for Medicare & Medicaid Services (CMS) and our accreditation through the Utilization Review Accreditation Commission (URAC) the following Peer-to-Peer and Appeal processes are applicable.

When there is insufficient clinical documentation to support an Organization Determination, clinical information is requested a minimum of three (3) times using at least two (2) different notification methods over at least two (2) different days and if insufficient clinical documentation exists, an intent to deny fax will follow. The Plan Medical Director may make an additional outreach directly to the requesting Physician to perform a peer-to-peer discussion. If we still do not receive the needed clinical information within one (1) business day, we will issue the adverse determination for insufficient clinical documentation. There are then no additional peer-to-peer options for the requesting Physician on this specific request if it is for a pre-service denial. Documents submitted after the Organization Determination will be treated as a member appeal (reconsideration) according to CMS regulations.

Concurrent Inpatient Review – An adverse determination for inpatient days coverage from the current date forward will be treated as a member appeal as long as the member is still confined on inpatient status as this would be a pre-service denial. An adverse determination for dates which have already occurred, and the member is still inpatient OR the member has discharged, will be treated as a Provider appeal as this is a post-service denial.

When an adverse Organization Determination is rendered and there is sufficient clinical information, the requesting Provider can request a peer-to-peer discussion with a Medical Director for post-service denials only. Alternately, the requesting Provider can submit additional clinical documentation relative to the basis for the original denial. If the services have not yet been rendered or if the Member has additional financial responsibility from an adverse determination, then the additional information will be reviewed under the Member appeal process.

An adverse determination for Ancillary Services (Home Health, DME, outpatient/HH therapies), Pre-Service or from current date forward requesting an Organization Determination will be treated as a member appeal. An adverse determination for dates, which have already occurred, will be treated as a Provider appeal. Providers can also request a peer-to-peer discussion with a plan Medical Director on adverse decisions as they related to post-service denials.

When requests are treated as member appeals, only the member and treating Physician acting on the behalf of the member have appeal rights per CMS regulations. Everyone else needs to have an Appointment of Representative (AOR) form on file before the appeal can be reviewed. This includes third-party companies acting on behalf of a facility for adverse

determinations appealed while the member is still in the hospital.

When services were already rendered and there was no additional member financial responsibility, these will be processed as Provider appeals. One (1) peer-to-peer conversation and one (1) level of Provider written appeal are permitted during this process, followed by binding arbitration. This process includes inpatient services with adverse determinations and the Member was discharged from the hospital. A peer-to-peer will not be scheduled if a written appeal has been submitted concurrently.

The Utilization Management Department reviews Provider appeals that are received from the provider within 60 calendar days of the provider's receipt of a denial. Mail Provider appeal requests to:

BlueCare Plus Utilization Management Department
1 Cameron Hill Circle, Ste 0005
Chattanooga, TN 37402-0005

Or fax to: 866-325-6698

M. Reopening

A reopening is a remedial action taken to change a final determination or decision even though the determination or decision was correct based on the evidence of record.

There must be new material evidence that was not available or known at the time of the determination or decision, and may result in a different conclusion; or the evidence that was considered in making the determination or decision clearly shows on its face that an obvious error was made at the time of the determination or decision. BlueCare Plus has the authority to determine if a request will be reopened.

The following are guidelines for a reopening request:

- May be made verbally or in writing;
- Should include the specific reason for requesting the reopening (a statement of dissatisfaction is not grounds for a reopening, and should not be submitted); and
- Must be made within timeframes permitted for reopening.

Additional information related to reopening can be found in CMS' Part C & D Grievances, Organization/Coverage Determinations, and Appeals Guidance (released February 2019).

Medical Policy Manual

The Medical Policy Manual contains medical policies approved by BlueCross BlueShield of Tennessee. Medical policies address specific new medical technologies or pharmaceutical agents.

Medical policies are based upon evidence-based research using published studies and/or prevailing Tennessee practice. Determinations with respect to technologies are made using criteria developed by the BlueCross BlueShield Association's Technology Evaluation Center. The criteria are as follows:

- The technology must have final approval from the appropriate governmental regulatory bodies.
- The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
- The technology must improve the net health outcome.
- The technology must be as beneficial as any established alternatives.
- The improvement must be attainable outside the investigational settings.

The medical policies specifically state whether a technology is considered Medically Necessary, Not Medically Necessary, Investigational, or Cosmetic. Definitions of these terms are found within the Medical Policy Manual Glossary. Providers may view the BlueCross BlueShield of Tennessee Medical Policy Manual in its entirety on the company website at https://provider.bcbst.com/tools-resources/manuals- policies-guidelines.

Many policies also contain a Medical Appropriateness section. This section contains the criteria used in determining whether a particular technology is appropriate in a particular case (i.e., for a specific individual).

Medical Policy Appeals

BlueCross BlueShield of Tennessee network Providers may appeal a draft or active medical policy. A medical policy appeal is a formal notice from a network Provider stating dissatisfaction with any medical policy determination. The dissatisfaction could be questioning the Investigational status of a medical policy or the Medical Appropriateness criteria contained in a medical policy. Published, peer-reviewed studies supporting the appealing Providers position must be submitted with each medical policy appeal.

The medical policy appeal process of an active medical policy:

- Provider submits a written request for appeal of a medical policy, along with full-text copies of supporting documentation to the Provider Appeals Department.
- Provider Appeals Coordinator sends the request to the division representative for the Medical Policy Research & Development Department.
- Medical Policy Research & Development Department reviews the appeal and supporting documentation.

- The appeal decision is returned to the Provider Appeals Department with a detailed response for the Provider.
- A written response is sent via registered mail to the network Provider.
- Network Providers may submit a written medical policy appeal along with supporting documentation to:

Provider Appeals Coordinator Provider Network Management BlueCross BlueShield of Tennessee 1 Cameron Hill Circle, Ste 0039

Chattanooga, TN 37402, 0039

Administrative Services Policies

Administrative Services Policies contain corporate positions and/or criteria that reflect BCBST business decisions. These documents are often associated with a Member's benefit plan (i.e., Evidence of Coverage) and they may be used in the adjudication of claims and requests for medical, dental, vision and/or pharmacy related services. Providers may view BlueCare Plus Administrative Services Policies on the company website at https://provider.bcbst.com/tools-resources/manuals-policies-guidelines.

XI. Quality Improvement Program

The BlueCare Plus Quality Improvement Program provides the framework for the evaluation of the delivery of healthcare services and other services provided to members. The QI Program provides a formal process to systematically monitor and objectively evaluate the quality, appropriateness, efficiency, effectiveness and safety of care and service provided to BlueCare Plus members. The QI Program is a three-tiered system of performance improvement that meets the following criteria:

Tier one consists of data for quality and health outcomes that are collected and analyzed to allow beneficiaries to compare and select from the available health coverage options. The data includes selected HEDIS® measures, STARs measures, Satisfaction measures, and other structure and process measures. Each year, CMS provides guidance on HEDIS and STARs measures that health plans are required to report on for the contract year.

Tier two is made up of collection, analysis, and reporting data that measure the performance SNP Model Of Care (MOC).

Tier three consists of monitoring of the implementation of care management through the collection and analysis of selected data that measure the effectiveness of SNP MOCs.

BlueCare Plus must provide for the collection, analysis, and reporting of data that measure health outcomes and indices of quality pertaining to the dually eligible members special needs population.

A. HEDIS Measures

The Medicare Advantage (MA) / Part D Contract and Enrollment Data section serves as a centralized repository for publicly available data on contracts and plans, enrollment numbers, service area data, and contact information for MA, Prescription Drug Plan (PDP), cost, Program of All-inclusive Care for the Elderly (PACE), and demonstration organizations.

HEDIS® is a product of NCQA. MAOs meeting CMS's minimum enrollment requirements must submit audited summary-level HEDIS® data to NCQA. Contracts with 1,000 or more members enrolled as reported in the July Monthly Enrollment by Contract Report (which can be found at

http://www.cms.hhs.gov/MCRAdvPartDEnrolData/MEC/list.asp#TopOfPage).

BlueCare Plus must collect and submit HEDIS® data to CMS. Closed cost contracts are required to report HEDIS® as long as they meet the enrollment threshold in the reporting year. Patient-level data must be reported to the CMS designated data contractor. Information about HEDIS® reporting requirements is posted on the HPMS webpage. During the contract year, if an HPMS contract status is listed as a consolidation, a merger, or a novation, the surviving contract must report HEDIS® data

for all members of the contracts involved. If a contract status is listed as a conversion in the data year, the contract must report if the new organization type is required to report.

CMS collects audited data from all benefit packages designated as SNPs and contracts with ESRD Demonstration Plans that had 30 or more members enrolled as reported in the SNP Comprehensive Report (which can be found at http://www.cms.hhs.gov/MCRAdvPartDEnrolData/SNP/list.asp#TopOfPage).

The data collection methodologies for HEDIS® are either the administrative or the hybrid types. The administrative method is from transactional data for the eligible populations and the hybrid method is from medical record or electronic medical record and transactional data for the sample.

B. Consumer Assessment of Health Providers and Systems (CAHPS)

The CAHPS survey is a CMS driven member survey evaluating multiple areas that impact members including provider encounters. The CAHPS survey collects information on the quality of health services provided by insurance plans. Consumer evaluations of health care and prescription drug services, such as those collected through the CAHPS surveys, measure important aspects of a patient's experience that cannot be assessed by other means.
CMS offers a listing of reports from the annual CAHPS surveys on its website at: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS.

The CAHPS Module divides the following sections based on the various CAHPS surveys CMS sponsors:

- Fee for Service CAHPS (FFS CAHPS)
- Hospital CAHPS (H CAHPS)
- In Center Hemodialysis CAHPS (ICH CAHPS)
- Medicare Advantage CAHPS (MA CAHPS)
- Nursing Home CAHPS (NH CAHPS)

C. STARS

CMS uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the health care system including providers in the healthcare system. The rating system applies to all Medicare Advantage (MA) lines of business: Health Maintenance Organization (HMO), Preferred Provider Organization (PPO), Private Fee-for-Service (PFFS) and prescription drug plans (PDP). **BlueCare Plus is a 4-STAR plan.**

The program is a key component in financing health care benefits for MA plan members. In addition, the ratings are posted on the CMS consumer website, https://www.medicare.gov, to provide information for beneficiaries choosing an MA plan in their area.

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STARS will help promote quality improvement and performance measures. These ratings strengthen beneficiary protections and allow CMS to distinguish stronger health plans and remove consistently poor performers.

How are Star Ratings Derived?

Health plans are rated based on measures in five categories:

- Members' compliance with preventive care and screening recommendations
- Chronic condition management
- Plan responsiveness, access to care and overall quality
- Customer service complaints and appeals
- Clarity and accuracy of prescription drug information and pricing

Benefits to Providers

- Improved patient relations
- Improved health plan relations
- Increased awareness of patient safety issues
- Greater focus on preventive medicine and early disease detection
- Strong benefits to support chronic condition management

Benefits to Members

- Improved relations with their doctors
- Greater health plan focus on access to care
- Increased levels of customer satisfaction
- Greater focus on preventive services for peace of mind, early detection and health care
- Matches their individual needs

BlueCare Plus is strongly committed to providing high-quality Medicare health coverage that meets or exceeds all CMS quality benchmarks. The structure and operations of the CMS Stars rating system will ensure that resources are used to protect, or in some cases, to increase benefits and keep member premiums low. BlueCare Plus encourages members to become engaged in their preventive and chronic-care management through outreach and screening opportunities. Providers are an important partner in these efforts.

TIPS FOR PROVIDERS

- Encourage patients to obtain preventive screenings annually or when recommended.
- Create office practices to identify patients that appear to be non-adherent at the time of their appointment.
- Submit complete and correct encounters/claims with appropriate codes.
- Submit clinical data such as lab results to BlueCare Plus and/or BlueCare Plus Quality Care Rewards portal.
- Communicate clearly and thoroughly; ask:
  - What questions do you have?
  - Have you seen a specialist or been an inpatient in the hospital since your last visit?
  - Have you been in the emergency room since your last visit?
  - May we review your current medications?
- Understand each measure you as a provider impact.

- Review the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey to identify opportunities for you or your office to have an impact: https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS.

CMS has created the **Health & Drug Plan Quality and Performance Ratings 2020 Part C & Part D Technical Notes,** to review this document in its entirety follow this link.

This document describes the methodology for creating the Part C and D Plan Ratings displayed in the Medicare Plan Finder (MPF) tool on http://www.medicare.gov/. These ratings are displayed in the Health Plan Management System (HPMS) for contracts and sponsors. In the HPMS Quality and Performance section, the Part C data can be found in the Part C Performance Metrics module in the Part C Report Card Master Table section. The Part D data are located in the Part D Performance Metrics and Report module in the Part D Report Card Master Table section. All of the health/drug plan quality and performance measure data described in the document are reported at the contract level. Table 1 lists the contract year 2020 organization types and whether they are included in the Part C and/or Part D Plan Ratings.

The Plan Ratings strategy is consistent with CMS' Three-Part Aim (better care, healthier people/healthier communities, and lower costs through improvements) with measures spanning the following five broad categories:

- Outcomes: Outcome measures focus on improvements to a beneficiary's health as a result of the care that is provided.
- Intermediate outcomes: Intermediate outcome measures help move closer to true outcome measures. Controlling Blood Pressure is an example of an intermediate outcome measure where the related outcome of interest would be better health status for members with hypertension.
- Patient experience: Patient experience measures represent members' perspectives about the care they have received.
- Access: Access measures reflect issues that may create barriers to receiving needed care. Plan Makes Timely Decisions about Appeals is an example of an access measure.
- Process: Process measures capture the method by which health care is provided.

D. Quality Incentive Program

BlueCare Plus offers primary care providers a Quality Incentive Program which includes variable reimbursement for closing specific quality gaps in care linked to the CMS STAR program for Medicare Advantage plans, completion of the Provider Model of Care training, and returning defined medical records during the performance year. Providers who are participating in this program have a quality contract amendment outlining how the results impact your base reimbursement.

For performance year 2022, the quality measures included in the Quality Incentive Program are:

2022 Measurement Year Scorecard - BCP VBC & BCP Choice	
Measure	**Weight**
Comprehensive Diabetes Care (CDC) HbA1c Control <9%	3
Controlling High Blood Pressure (CBP)	3
Medication Adherence for Cholesterol (Statins)	3
Medication Adherence for Hypertension (RAS Antagonists)	3
Medication Adhrence for Non-insulin Diabetes Medications (OAD)	3
Plan All-Cause Readmissions (PCR)	3
Breast Cancer Screening (BCS)	1
Colorectal Cancer Screening (COL)	1
Comprehensive Diabetes Care (CDC) - Eye Exam	1
Osteoporosis Management in Women Who Had a Fracture (OMW)	1
Statin Therapy for Patients with Cardiovascular Disease - Received Statin Therapy (SPC)	1
Statin Use in Persons with Diabetes (SUPD)	1
Transitions of Care (TRC)	1
Care for Older Adults (COA)--Medication Review	1
Care for Older Adults (COA)--Pain Assessment Review	1
Measures for Monitoring Status Only	
Annual Wellness Exam (AWV)	0
Provider Assessment Coordination Form (PACF)	0
Osteoporosis Management in Women Who Had a Fracture (OMW) 2023	0
Member Experience - CAHPS (HMS Mock Survey)	0
Member Experience - HOS (HMS Mock Survey)	0
Polypharmacy - Multiple Anticholinergic Medications (Poly-ACH)	0
Polypharmacy - Multiple CNS Medications (Poly-CNS)	0
Kidney Health Evaluation for Patients With Diabetes (KED)	0
Follow-Up After Emergency Department Visit for People With Multiple High-Risk Chronic Conditions (FMC)	0

Detailed information related to each quality measure can be found in the 2022 Quality Program Information Guide located on our website at: https://www.bcbst.com/docs/providers/quality-initiatives/Quality_Partnerships_Program_Guide.pdf.

E. Health Outcomes Survey (HOS)

The Medicare Health Outcomes Survey (HOS) is the first outcomes measure used in Medicare managed care and the largest survey effort ever undertaken by the Centers for Medicare & Medicaid Services (CMS). The goal of the Medicare HOS program is to gather valid and reliable health status data in Medicare managed care for use in quality improvement activities, plan accountability, public reporting, and improving health. Managed care plans with Medicare Advantage (MA) contracts must participate. CMS has provided a website for review located at www.cms.gov/research-statistics-data-and-systems/files-for-order/limiteddatasets/hos.html This website is designed to provide current information on the progress of the HOS program, as well as house the full spectrum of Medicare HOS related data and reports.

The Veterans RAND 12-Item Health Survey (VR-12), supplemented with additional case-mix adjustment variables and four HEDIS® Effectiveness of Care measures, will be used to solicit self-reported information from a sample of Medicare beneficiaries for the HEDIS® functional status

measure, HOS. This measure is the first "outcomes" measure for the Medicare managed care population. Because it measures outcomes rather than the process of care, the results are primarily intended for population-based comparison purposes, by reporting unit. The HOS measure is not a substitute for assessment tools that BlueCare Plus currently uses for clinical quality improvement.

XII. Billing and Reimbursement

A. Claims Processing

BlueCare Plus electronic claims processing system is in compliance with federal Health Insurance Portability and Accountability Act of 1996-Administrative Simplification (HIPAA-AS) requirements. This system is used for processing American National Standards Institute (ANSI) 837 claims and other ANSI transactions, and to verify HIPAA compliancy of those transactions. Business edits have been modified to recognize the new ANSI formats. These edits apply to both electronic and scannable paper claims.

BlueCare Plus providers contracted with Medicare and Medicaid lines of business, serving the BlueCare Plus members will be able to take advantage of single-claim submissions. Claims submitted to BlueCare Plus will be processed under Medicare benefits through BlueCare Plus and then will automatically process under Medicaid benefits through the appropriate program.

1. Provider Number for Electronic Claims

Claims submitted electronically must include the provider's appropriate National Provider Identifier (NPI), and the required data elements as specified in the Implementation Guide. This guide is available online via the Washington Publishing Company website at http://www.wpc-edi.com. Additional companion documents needed for BlueCare Plus electronic claims submission can be accessed at http://www.bcbst.com/providers/ecomm/technical-information.shtml.

2. Electronic Enrollment and Support

Enrollment of new providers, changes to existing provider or billing information (address, tax ID, Provider number, NPI, name), or any changes of software vendor should be communicated to e-Commerce via the Provider Electronic Profile form. The Provider Electronic Profile form can be downloaded at, www.bcbst.com or obtained upon request. Failure to submit a Provider Electronic Profile form when changes to electronic submission information occur can result in delays in claims payment or disruption of electronic claims submissions. Mail or Fax Provider Electronic Profile forms to:

BlueCross BlueShield of Tennessee
Attn: Provider Network Services
1 Cameron Hill Circle, Ste 0007
Chattanooga, TN 37402-0007
Fax 423-535-7523

For technical support or enrollment information, call, fax, or e-mail:

Technical Support	call: 423-535-5717 fax: 423-535-1922 e-mail: www.ecomm_support@bcbst.com
Enrollment	call: 1-800-924-7141 fax: 423-535-7523 e-mail: www.ecomm_contracts@bcbst.com

3. Electronic Data Interchange (EDI)

HIPAA standards require Covered Entities to transmit electronic data between trading partners via a standard format (ANSI X12). EDI allows entities within the health care system to exchange this data quickly and securely. Currently, BlueCare Plus uses the ANSI 837 version, 5010 format. American National Standards Institute has accredited a group called "X12" that defines EDI standards for many American industries, including health care insurance. Most electronic standards mandated or proposed under HIPAA are X12 standards.

4. Secure File Gateway (SFG)

The Secure File Gateway allows trading partners to submit electronic claims and download electronic reports using multiple secure managed file transfer protocols. The SFG provides the ability to transmit files to BlueCross BlueShield of Tennessee using HTTPS, SFTP, and FTP/SSL connections. The below grid reflects a short description of each protocol:

Protocol	Description
HTTPS Website, https://mftweb.bcbst.com/myfilegateway	The BlueCross BlueShield of Tennessee secure website allows individuals to login with their secure credentials and submit electronic claims or download electronic reports.
SFTP (server mftsftp.bcbst.com)	The BlueCross BlueShield of Tennessee SFTP server allows trading partners to automate their processes to submit electronic claims or download electronic reports.
FTP/SSL (server mftsftp.bcbst.com)	The BlueCross BlueShield of Tennessee FTP/SSL server is an additional option to allow trading partners to automate their processes to submit electronic claims or download electronic reports.

5. ANSI 837 (Version 5010)

The ANSI 837 format is set up on a hierarchical (chain of command) system consisting of loops, segments, elements, and sub-elements and is used to electronically file professional, institutional and/or dental claims and to report encounter data from a third party*. *Coordination of Benefits (COB) is part of the ANSI 837, which provides the ability to transmit primary and secondary carrier

information. The primary payer can report the primary payment to the secondary payer. For detailed specifics on the ANSI 837 format, providers should reference the appropriate guidelines found in the National Electronic Data Interchange Transaction Set Implementation Guide. This guide is available online via the Washington Publishing Company website at Additional companion documents needed for BlueCare Plus electronic claims submission can be accessed at eBusiness Technical page or the eBusiness User Guide for additional information.

6. Submission of Paper Claims

All network providers are required to submit claims electronically rather than by paper format. Submitting claims electronically will ensure compliance with the terms of the Minimum Practitioner Network Participation Criteria as well as lower costs and streamline adjudication. This effort is consistent with the health care industry's movement toward more standardized and efficient electronic processes.

Note: Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated.

Key advantages to submitting electronically are:

- Earlier payments;
- More secure submission process;
- Reduced administrative costs
- Less paper storage.

More information regarding submitting electronic claims can be found on the Providers Resource page on the BlueCare Plus Website. For assistance with Availity, please contact eBusiness Service at 423-535-5717, Option 2, Monday through Thursday, 8 a.m. to 6:00 p.m., Friday 9 a.m. to 6:00 p.m. (ET), or via e-mail at eBusiness_Service@bcbst.com.

7. Corrected Bills

Corrected Electronic Claims (Required Method)

If a claim is denied on a remittance advice, it requires correction and resubmission electronically. Corrected Bills for Institutional and Professional claims can be filed electronically in the ANSI-837, version 5010 format. The following guidelines are based on National Implementation Guides found at http://www.wpc-edi.com and BlueCare Tennessee /BCBST Companion Documents found at: http://www.bcbst.com/providers/ecomm/technical-information.shtml

ANSI-837P – (Professional) and ANSI-837I – (Institutional)

In most instances, claims correction should be submitted in an electronic format.

1. **In the 2300 Loop, the CLM segment (claim information), CLM05-3 (claim frequency type code) must indicate the third digit of the Type of Bill being sent. The third digit of the Type of Bill is the frequency and can indicate if the bill is an Adjustment, a Replacement or a Voided claim as follows:**
   - "7" – REPLACEMENT (Replacement of Prior Claim)
   - "8" – VOID (Void/Cancel of Prior Claim)

2. **In the 2300 Loop, the REF segment (claim information), must include the original claim number issued to the claim being corrected. The original claim number can be found on the electronic remittance advice.**
   - REF01 must contain 'F8'
   - REF02 must contain the original BCBST claim number

     Example: REF*F8*1234567890~
3. **In the 2300 Loop, the NTE segment (free-form 'Claim Note'), must include the explanation for the Corrected/Replacement Claim.**
   - NTE01 must contain 'ADD'
   - NTE02 must contain the free-form note indicating the reason for the corrected/replacement

     Example: NTE*ADD*CORRECTED PROCDURE CODE ON LINE 3

For Technical Support assistance, contact eBusiness Technical Support at 423-535-5717 (Option 2) or via e-mail at Ecomm_TechSupport@bcbst.com. Technical support is available Monday through Thursday, 8 a.m. to 5:15 p.m. (ET), and Friday, 9 a.m. to 5:15 p.m. (ET).

Corrected Paper Claims - ***Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated.***

Submit a new claim form with the correct data as follows:

- **CMS-1500 Claim Form**
  - Submit a Frequency Code **"7" (Replacement of prior claim)** or **"8" (Void/Cancel of prior claim)** in the **"Resubmission Code"** field of Block 22.
  - The claim number originally used by BlueCare Plus to process the claim should be included in the **"Original Ref. No."** field of Block 22.
  - Failure to include the appropriate **"Resubmission Code"** and **"Original Ref. No."** in Block 22 may result in a claim rejection or denial.
- **CMS-1450 Claim Form**
  - Submit a Frequency Code **"7"** (**Replacement of prior claim**) or **"8"** (**Void/Cancel of prior claim**) as the fourth digit in the "**Type of Bill**" field (FL 4).
  - The claim number originally used by BlueCare Plus to process the claim should be include in the "**Document Control Number**" **(DCN)** field (FL 64).
  - Failure to include the appropriate "**Frequency Code**" in FL 4 and "**Document Control Number (DCN)**" in FL 64 may result in a claim rejection or denial.

8. Timely Filing Guidelines

Contracted and non-contracted providers must submit all claims for medical services within one (1) year of the date of service or from the date of discharge.

The provider has two (2) years from the end of the year in which the claim was originally submitted to file a corrected claim.

BlueCare Plus will not be obligated to pay such claims filed after expiration of the applicable time period, and such claims shall not be billed to the BlueCare Plus member. BlueCare Plus will process in the normal course of its business all claims submitted by the Physician/Supplier.

BlueCare Plus generates the 277 Health Care Information Status Notification report as proof of timely filing for electronically submitted BlueCare Plus claims. The electronic claims 277CA Health Care Information Status Notification supplies providers with one comprehensive report of all claims received electronically. This report should be maintained by the provider/supplier for proof of timely filing. Providers submitting claims electronically either directly or through a billing service/clearinghouse will automatically receive claims receipt reports in their electronic mailbox. To learn more about retrieving your electronic reports, call eBusiness Service at 423-535-5717, Option 2, Monday through Thursday, 8:00 a.m. to 6:00 p.m. (ET), Friday 9:00 a.m. to 6:00 p.m. (ET), or email at eBusiness_Service@bcbst.com.

Note: Submission dates of claims filed electronically that are not accepted due to transmission errors are not accepted as proof of timely filing.

9. Code Edits

CMS developed the National Correct Coding Initiatives (NCCI) to promote national correct coding methodologies and to control improper coding that leads to inappropriate payment in Medicare Part B claims. The coding policies are based on coding conventions defined in the American Medical Association (AMA) Current Procedural Terminology (CPT) Manual, Healthcare Common Procedure Coding System (HCPCS) Manual, national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice. Updated NCCI edits are published on The CMS website on a quarterly basis.

Code bundling edits are performed during the initial claim processing phase, **when possible**, and are based on nationally recognized code bundling guidelines including:

- National Correct Coding Initiative (NCCI)
- American Medical Association (AMA) coding guidelines
- Centers for Medicare and Medicaid (CMS) guidelines
- Guidelines published by medical societies/associations such as the American Academy of Orthopedic Surgeons (AAOS) and American College of Obstetricians and Gynecologists (ACOG)
- Clinical rationale/expertise
- BlueCare Plus code bundling rules are also based on reimbursement policies such as, but not limited to, the following:
    - Bundled Services regardless of the Location of Service
    - Bundled Services when the Location of Service is the practitioner's Office
    - Durable Medical Equipment (Purchase and Rentals)
    - Home Pulse Oximetry
    - Screening Test for Visual Acuity
    - Visual Function Screening
    - Quarterly Reimbursement Changes

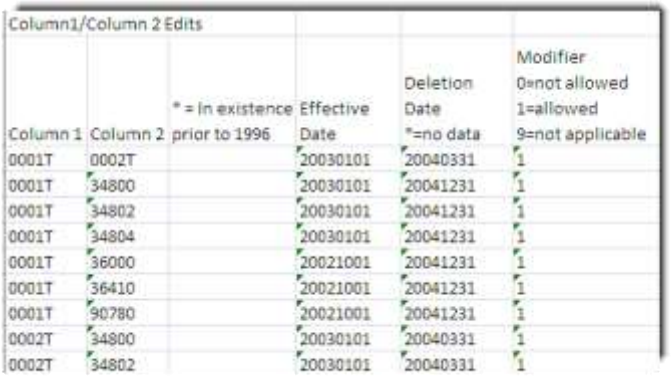
- Medically Unlikely Edits (MUEs)
  An MUE for a HCPCS/CPT code is the maximum units of service that a provider would report under most circumstances for a single member on a single date of service. All HCPCS/CPT® codes do not have an MUE. BCBST reserves the right to request supplemental information (e.g., anesthesia record, operative report, specific medical records) to determine appropriate application of its code editing rules.

- Maximum Units of Service
  Edits are also applied for maximum units of service derived from several sources: CMS, AMA CPT® (American Medical Association Current Procedural Terminology), knowledge of anatomy, the standards of medical practice, FDA (U.S. Food and Drug Administration) and other nationally recognized drug references and outlier claims data from provider billing patterns.

- Comprehensive and Component Code Pairs

Edits may be applied when all associated claims are processed in some situations. In those cases, the edit will be applied during the retrospective audit process when all associated claims are available for review. The Column One/Column Two Correct Coding Edits table includes code pairs that should not be reported together for a number of reasons. Code bundling rules reflect edits where a comprehensive and component code pair exists.

The column 1/column 2 correct coding edit table contains two types of code pair edits. In the "Comprehensive Code" edits table, the column 1 code generally represents the more significant procedure or service when reported with the column 2 code. When reported with the column 2 code, "column 1" generally represents the code with the greater work RVU of the two codes. The "Mutually Exclusive" edit table contains code pairs that Medicare believes should not be reported together where one code is assigned as the column 1 code and the other code is assigned as the column 2 code. If a provider submits two codes of a code pair edit for the same Medicare beneficiary for the same date of service without an appropriate modifier, the column 1 code is paid. If clinical circumstances justify appending a NCCI/CCI-associated modifier to the column 2 code of a code pair edit, payment of both codes may be allowed. Below is an example of the coding edit table



Column1/Column 2 Edits					
Column 1	Column 2	* = In existence prior to 1996	Effective Date	Deletion Date *=no data	Modifier 0=not allowed 1=allowed 9=not applicable
0001T	0002T		20030101	20040331	1
0001T	34800		20030101	20041231	1
0001T	34802		20030101	20041231	1
0001T	34804		20030101	20041231	1
0001T	36000		20021001	20041231	1
0001T	36410		20021001	20041231	1
0001T	90780		20021001	20041231	1
0002T	34800		20030101	20040331	1
0002T	34802		20030101	20040331	1

Note: The example above is an excerpt from the CMS CCI code table located at www.cms.gov

Although the Column 2 code is often a component of a more comprehensive Column 1 code, this relationship is not true for many edits. In the latter type of edit the code pair edit simply represents two codes that should not be reported together, unless an appropriate modifier is used.

Comprehensive (Column 1) code generally represents the major procedure or service when reported with another code.

Component (Column 2) code generally represents the lesser procedure or service. Reimbursement for a component code is considered included in the reimbursement for the comprehensive code when the service is billed by the same provider, for the same patient on the same date of service and is not made separately from the comprehensive code.

Code bundling can occur on multiple levels depending on the combination of codes reported. For example, when multiple codes are billed for one date of service, two codes could bundle into one code. That one code could then bundle into another code. Providers can access the most current code bundling rules for code pairs via http://www.cms.gov

B. Health Insurance Form CMS-1500

1. Overview

The Form CMS-1500 version 02/12 is used by health care professionals and suppliers, and in some cases, for ambulance services. More instruction is available at the NUCC website for the www.nucc.org

All professional services should be filed on the CMS-1500 claim form or its electronic equivalent. These include:

- Professional Outpatient Services;
- Emergency Room Physician Fees must be filed with Location Code 23 (Emergency Room, Hospital)
- Clinic Visits (professional fees)

A claim is a request for payment of HMO D-SNP Plus benefits for services furnished by a health care professional or supplier. Claims must be submitted within one year from the date of service and BlueCare Plus members cannot be charged for completing or filing a claim. Offenders may be subject to penalty for violations.

The 1500 Health Insurance Claim Form Reference Instruction Manual for 02/12 Version can be found on the National Uniform Claim Committee (NUCC) Web site, www.nucc.org. A sample copy of the CMS1500 (02/12) claim form and block descriptions are as follows:

2. General Instructions

A summary of suggestions and requirements needed to complete the CMS-1500 claim form follows:

- Only one line item of service per claim line (Block #24) can be reported. If more than 6 lines per claim are needed, additional claim forms will be required.
- "Super bills," statements, computer printout pages, or other sheets listing dates, service, and/or charges cannot be attached to the CMS-1500 claim form.

- The form is aligned to a standard typing format of 10 pitch (PICA) or standard computer-generated print of 10 characters per inch. Vertical spacing is 6 lines per inch.
- The form is designated for double spacing with the exception of Blocks #31, 32 and 33, which may be single-spaced.
- Use standard fonts: do not intermix font styles on the same claim form.
- Do not use italics and script on the form.
- In completing all claim information COLOR OF INK should be as follows:
    1. Computer generated color of black
    2. Manual typewriter standard of Sinclair and Valentine J6983
- Use upper case (CAPITAL) letters for all alpha characters.
- Do not use dollar signs ($), decimals (.), or commas (,) in any dollar amount blocks.
- Enter information on the same horizontal plane.
- Enter all information within the boundaries of the designated block.
- Extraneous data (handwritten or stamped) may not be printed on the form.
- Pin feed edges should be evenly removed prior to submission.

Form Alignment
The CMS-1500 is designed for printing or typing 6 lines per inch vertically and 10 characters per inch horizontally. On the title line of the form above Block #1 and Block #1A are 6 boxes labeled “PICA”. These boxes should be considered Line 1, Columns 1, 2 and 3, and Line 1, Columns 77, 78 and 79. Form alignment can be verified by printing “X’s” in these boxes.

Entering All Dates
In Blocks 3, 9B, and 11A please include a space between each digit. The blank space should fall on the vertical lines provided on the form.

Unless otherwise indicated, all date information should be shown in the following format:

For Blocks 3, 9B, and 11A

MMblankDDblankCCYY
MM=month (01-12)
1 blank space
DD=day (01-31)
1 blank space
CC=century (20, 21)
YY=year (00-99)

The blank space should fall on the vertical lines provided on the form. Do NOT exclude leading zeros in the date fields.
(Correct: January 1, 1924 = 01 01 24; Incorrect: 1124).

Note: *New requirement for Block 24A. Omit spaces in Field 24A (date of service). By entering a continuous number, the date(s) will penetrate the dotted vertical lines used to separate month, day, and year. This is acceptable. Ignore the dotted vertical lines without changing font size.*

For Block 24A
MMDDCCYY
MM=month (01-12)
DD=day (01-31)
CC=century (20, 21)
YY=year (00-99)

Physical Claim Form Specifications

While CMS-1500 claim forms can be ordered from the Government Printing Office, some providers may elect to deal with independent form vendors. All CMS-1500 claim forms must conform to the following print specifications:

- **PAPER**
  - OCR bon -JCP25
  - 20 pound
  - 217 mm x 281mm (+ or -2mm)
  - Cut square, corners 90 degrees (+ or -.025)

- **INK**
  - Standard is Sinclair and Valentine J6983
  - Same ink front and back of form
  - Multi-part forms must have same ink on all copies

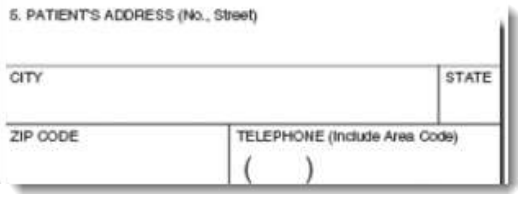
- **MARGIN**
  - Top to typewriter alignment bar is 34mm
  - Right to left margin is 9mm

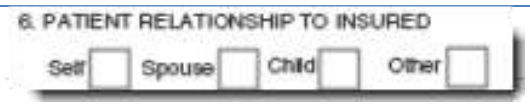
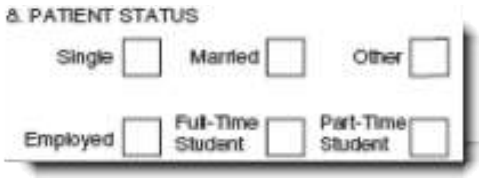
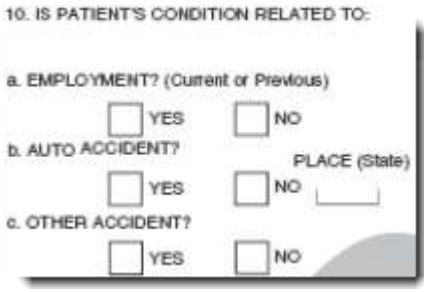
- **ASKEWITY**
  - No greater than .15mm in 100mm

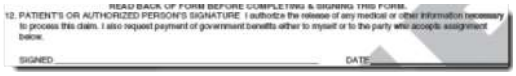
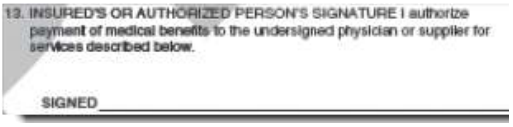
  X and Y OFFSET for MARGINS must not vary by more than + or -0.010 inches from page to page (x= horizontal distance form left margin to print, y= vertical distance from top to print). NO MODIFICATIONS may be made to the CMS-1500 without the prior approval of the Centers for Medicare and Medicaid Services.

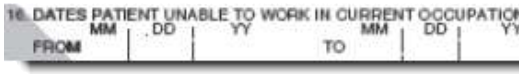
3. CMS 1500 Quick Reference Guide

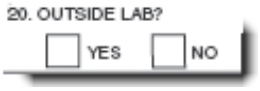
Below is a description of each block on the form for completing each area.

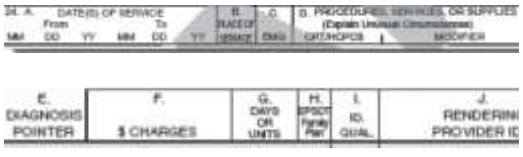
Block	Description	CMS 1500 Form Examples
1	Identify the applicable health insurance coverage (not required)	
1a	Enter the BlueCare Plus member identification number (required) Example: Y12345678	
2	Enter the member's last name, first name and middle initial as appears on the BlueCare Plus card (required)	
3	Enter the patient's birth date in the following format; MMDDCCYY and sex (required)	
4	Enter primary insurance either through the patient's or spouse's employment or any other source. If the insured and patient are the same enter the word SAME (situational)	
5	Enter the BlueCare Plus patient's mailing address, city, zip and telephone number (required)	

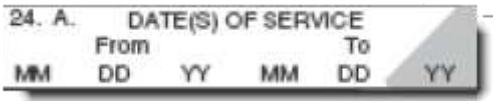
Block	Description	CMS 1500 Form Examples
6	When item 4 is completed check appropriate box (conditional)	
7	Enter insured's address and telephone if the same as patient enter SAME (conditional)	
8	Check appropriate box for marital status, employed or student (not required)	
9	This field may be used in the future for supplemental insurance plans	
9a-d	Participating physicians and suppliers must enter information required in item 9 and its subdivisions if requested by the beneficiary for a Medigap policy	(conditional)
10a-c	Check "YES" or "NO" to indicate whether employment, auto liability, or other accident involvement applies to one or more of the services (required if applicable)	
10d	**Claim Codes (Designated by NUCC)** Not required dual eligible BlueCare Plus member utilize one ID number	

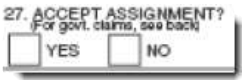
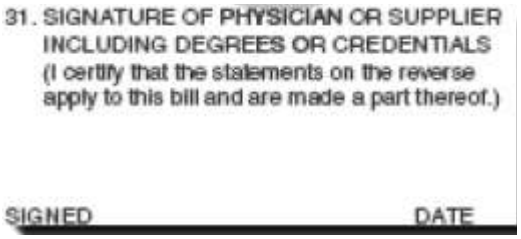
Block	Description	CMS 1500 Form Examples
11	Provider/Supplier made good faith effort to determine who is the primary payer (required) (See the MSP section of this manual)	
11a-c	Additional information only if there is other insurance	
11d	Enter if the patient is or may be entitled to benefits under any other healthcare coverage program other than the	
12	Patient or authorized representative signature with MMDDYY date, unless signature is on file. If no signature is on file, leave blank or enter “No Signature on File”	
13	The patient’s signature or the statement “signature on file” in this item authorizes payment of medical benefits to the physician or supplier. IF there is no signature on file, leave blank or enter “No Signature on File”	
14	Date of current illness, injury or pregnancy (MMDDCCYY or MMDDYY). Chiropractic initiation of course of treatment (required)	

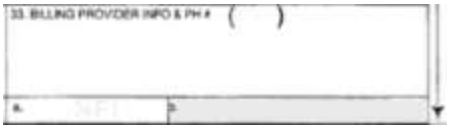
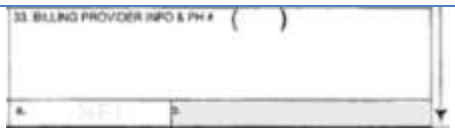
Block	Description	CMS 1500 Form Examples
15	Leave blank. Not required.	
16	Date when patient is unable to work, if employed (situational)	
17	Enter the name of the referring/supervising or ordering physician if the service or item was ordered or referred by a physician (preferred but not required) along with the appropriate qualifier: • DN Referring Provider • DK Ordering Provider • DQ Supervising Provider	
17a	Leave blank	
17b	Enter NPI of referring/ordering/supervising physician from item 17 when item 17 is completed (required)	
18	Enter date when a medical service is furnished as a result of, or subsequent to, a related hospitalization (MMDDYY or MMDDCCYY) (situational)	

Block	Description	CMS 1500 Form Examples
19	Enter date patient was last seen and the NPI of his/her attending physician when a physician providing routine foot care submits claims	
20	Complete when billing for diagnostic tests subject to anti-markup payment limitation (situational)	
21	Enter patient's diagnosis/condition. Code to the highest level of specificity for date of service (DOS) in priority order, version 02/12 accommodates ICD-10-CM (required)	
22	Resubmission Code This block is to be used when submitting a corrected claim "Resubmission" means the code and original reference (claim) number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter. • A Resubmission Code should be filed in the first portion of Block 22. The valid values for this field are "7" Replacement of prior claim and "8" Void/Cancel of prior	

Block	Description	CMS 1500 Form Examples
	claim. These codes should be left-justified in the box so that they will be processed correctly. • The original claim number issued to the claim being corrected should be filed in the Original Ref. No. portion of Block 22. • This block is not intended for use for original claim submissions. • Failure to include the proper "Resubmission Code" and "Original Ref. No." may result in a claim rejection or denial.	
23	Enter Quality Improvement Organization (QIO) prior authorization number for procedures requiring QIO prior approval (situational) NOTE: Air Ambulance services, pick up location zip code should be entered in this block	
24	Six service lines in section 24 have been divided horizontally to accommodate submission of supplemental information to support the	

Block	Description	CMS 1500 Form Examples
	billed service (following will describe each item)	
24a	Date for each procedure, service, or supply MMDDCCYY format (required)	
24b	Enter appropriate place of service code(s) for each item used or service performed (required)	
24c	Not required	
24d	Enter procedures, services or supplies using HCPCS code(s). Modifiers if applicable (required)	
24e	Enter diagnosis code reference number to relate the date of service and procedures performed to the primary diagnosis (required)	
24f	Enter the charge for each listed service (required)	
24g	Enter the number of days or units (required)	
24h	Leave blank (not required)	
24i	Enter the ID qualifier 1c (required)	

Block	Description	CMS 1500 Form Examples
24j	Rendering provider's NPI number (required)	
25	Enter Federal Tax ID (Employer Identification Number or Social Security Number) (required)	
26	Enter patient's account number assigned by provider of service (required)	
27	Check block to indicate if supplier accepts assignment of Medicare benefits (required)	
28	Enter total charges for services (required)	
29	Enter total amount patient paid on covered services only if applicable	
30	Leave blank (not required)	
31	Enter signature of provider of service and date the form was signed (MMDDYY or MMDDCCYY) (required)	
32	Enter the name and address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other	

Block	Description	CMS 1500 Form Examples
	than the patient's home or physician's office (required)	
33	Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number (required)	
33A	Enter the Billing provider's NPI	
33B	**Enter the two-digit qualifier identifying the non-NPI number followed by the ID number**	

C. CMS 1450 Facility Claim Form

1. Overview

Note: Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated.

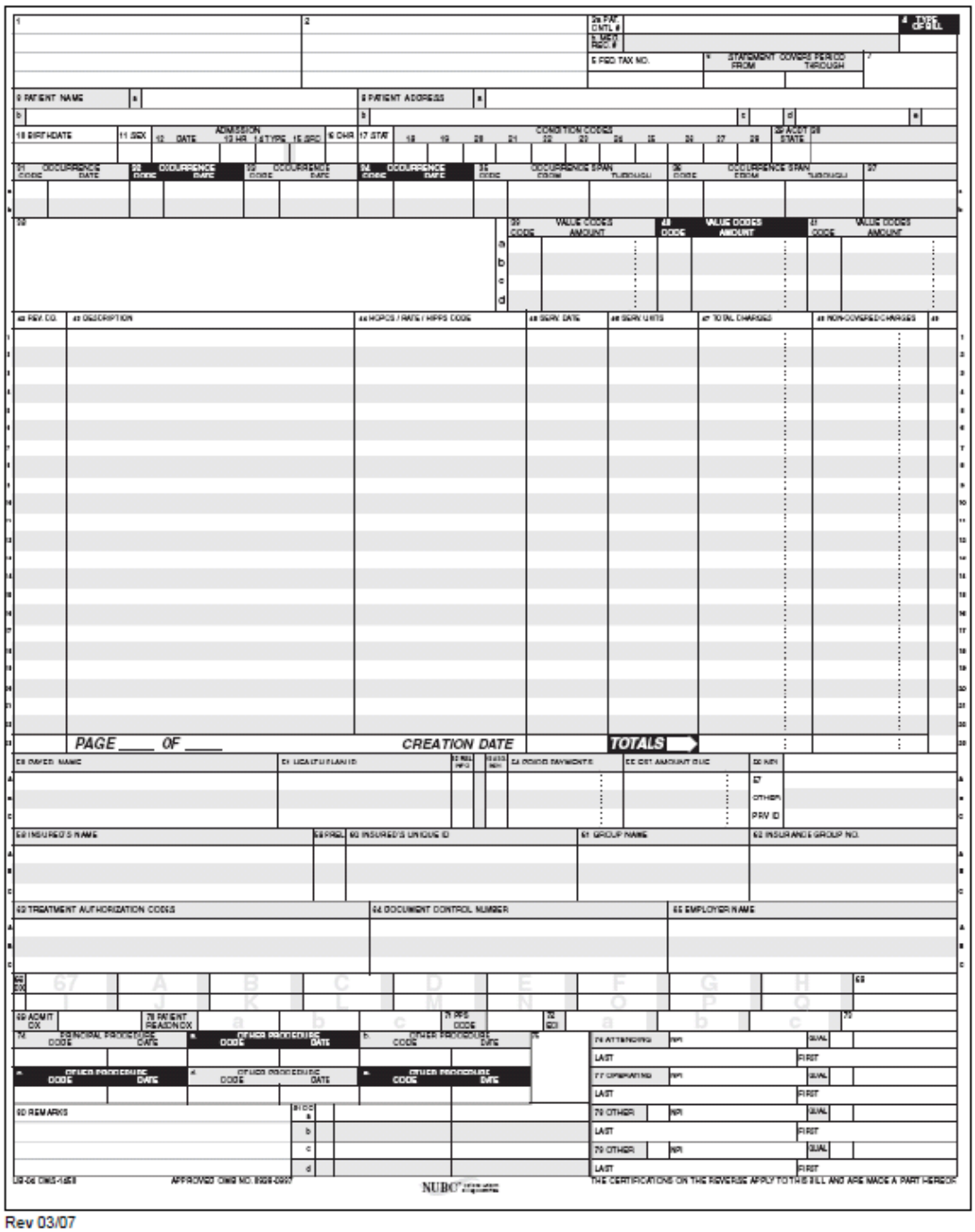
Facility claims submitted to BlueCare Plus must be filed on the CMS-1450 (UB-04) paper claim form or its electronic equivalent.

BlueCross BlueShield of Tennessee follows the Centers for Medicare & Medicaid Services (CMS) Guidelines for filing the National Provider Identifier (NPI) number.

The UB-04 contains a number of improvements and enhancements over the UB-92 paper claim form that include better alignment with the electronic HIPAA ASC X 12N 837-Institutional Transaction Standard. The UB-04 paper billing form is able to accommodate the reporting of the National Provider Identifier (NPI) Number. The NPI is a single provider identifier, replacing the different provider identifiers health care systems used for each health plan with which they do business. The NPI Identifier, which implements a requirement of Health Insurance Portability and Accountability Act of 1996 (HIPAA), must be used by all HIPAA covered entities, which are health plans, healthcare clearinghouses, and healthcare providers.

A sample copy and field descriptions of the CMS-1450 claim form follow:

CMS 1450-UB04



Rev 03/07

2. General Instructions

The UB-04 claim form is a hard-copy facility/institutional claim used by providers/suppliers to submit charges for services. The description below includes specifications for each form locator (field) of the UB-04 claim form. Additional instruction and information can be reviewed at the National Uniform Billing Committee Website.

D. Hospital Inpatient Acute Care

The following guidelines are used in administering DRG reimbursement:

1. DRG Assignment

The DRG assignment will be based on the principal diagnosis, up to twenty-four (24) other secondary
diagnoses, additional associated present on admission codes, as well age, sex, and discharge status
of patient. If CMS changes the DRG assignment criteria, BlueCare Plus will remain on current grouper
assignment until a time and in a manner mutually agreed upon by the parties to ensure revenue neutrality to both parties. Until such time that the parties mutually agree, the contracted DRGs will be
utilized. In the event the parties cannot reach an agreement, the dispute shall be resolved by the Provider Dispute Resolution Procedure as described in this Manual. The base rate and relative weights in effect at the admission date are used to calculate the payment level.

2. Inpatient Short Stay Payments

Inpatient stays for Observation will be subject to retroactive audit. Medical records that support the claim will be reviewed to determine if the payment is for services rendered. Where BlueCare Plus has paid for services beyond those actually provided, a recovery will be processed in accordance to audit recovery procedures. The claims will be adjusted in agreement with the allowed amount for Observation Services provided in an outpatient setting. To facilitate a more accurate accounting of the service, Institutions are encouraged to authorize Observation Services and bill these stays appropriately in an outpatient setting when applicable.

Under all circumstances, BlueCare Plus shall be the ultimate determiner of the DRG assignment. Hospitals that disagree with the DRG assignment, a request for review may be submitted.

3. Expired Patient Payments

If a member expires after admission, full DRG will be allowed. The patient discharge status must be accurately reflected on the CMS-1450 claim form, or its electronic equivalent.

4. Transfer Payments

If a member is transferred to another facility for the same or similar condition, a discharge as defined under the DRG payment system has not occurred. Cases that have been transferred are considered

normal admissions for the receiving Institution and payment to there will be made in accordance with Provider Agreement. The facility transferring the member is paid based upon outlier per diems not to exceed the appropriate inlier payment. These claims are identified by the Discharge Status Codes filed on the claim as follows: 02, 05, 66, 70, or 82-85.The facility from which the member is ultimately discharged receives the full DRG payment rate. When billing for a transfer payment, the appropriate discharge status must be indicated on the CMS-1450 claim in Form Locator 17, or its electronic claims equivalent. BlueCare Plus will authorize payment only if:

- The receiving facility initiated and followed the transfer review procedures of BlueCare Plus; and the services were medically necessary

5. Readmissions

Readmission Reimbursement

Submitting a corrected bill or combining the services from a readmission with those of the initial (index) admission will result in all services on the claim being disallowed. Also, billing with a “leave of absence” revenue code (018X) for the interval period and combining all the dates of service in a single claim will lead to a disallowed claim. Similarly, submitting a corrected bill or other alternate outpatient resubmission for these services is not appropriate without a Condition Code 44 appended, and services will be disallowed.

6. Readmission Quality Program

(i) 31-Day Same or Similar-Cause Readmission Quality Program

The Centers for Medicare & Medicaid Services (CMS) recognizes the growing challenge of readmissions for the Medicare population. Medicare Advantage plans are held to an All-Cause Readmissions measure that differs from the Original Medicare Hospital Readmissions Reduction Program. Because of this, BlueCross has developed a same or similar diagnosis readmissions program to more closely align with how CMS evaluates our Plan.

BlueCross will reimburse for a readmission within thirty-one (31) days from an index admission as follows:

- For purposes of this program, the date of discharge from the original acute inpatient admission (called the **Index Admission**) is the start of the 31-day window.
- This readmission program is limited to same or similar diagnoses between the Index Admission and the Readmission as determined by a Plan Medical Director, even though BlueCross is held to an all-cause readmission standard.
- Only readmissions that occur as an acute inpatient admission to the same or similar facility, or facility operating under the same contract are included in this program.
- Readmissions in the 31-day window should also have a **modifiable cause** leading to the readmission. Because

readmissions are a multi-stakeholder concern, the modifiable cause does not have to be related only to direct illness related complications, but also issues that arose from the discharge plan, such as but not limited to, the Member not receiving new prescriptions, home health not showing up timely at the Member's residence or lack of transportation to make outpatient appointments after discharge, etc.

- All readmissions in this program are reviewed by a Plan Medical Director as part of a medical necessity review. This is not an automated claims based adjudication. Thus the Provider has their normal medical necessity based denial appeal rights.
- The facility reimbursement under this Same or Similar-Cause Readmission Quality Program provides for reimbursement for both hospital stays, but does so as a single bundled payment as follows. The higher weighted DRG between the index admission and the readmission will be paid, and all the diagnoses, procedures and approved days from the opposite admission will be put into the Medicare approved pricing system as part of the paid DRG to allow those services to be accounted for in the allowed pricing for the bundled payment.
- Readmissions that occur in an observational (outpatient) setting are exempt from this program and are reimbursed as per the facility agreement.
- *Readmissions for Members undergoing active chemotherapeutic treatment or in the immediate post-transplant period (30 days) are also excluded from this program.*
- If there is a second or more readmission(s) that occur within the original thirty-one (31) day window from the original index admission discharge, then this will likewise bundle into the original admission, if the above parameters are met. A new index readmission is not set until a full thirty- one (31) days has elapsed.

Note: *The Member cannot be held liable for payment of services received when not authorized.*

(ii) 48 Hour Same or Similar-Cause Readmission Quality Program

The Centers for Medicare & Medicaid Services (CMS) recognizes the growing challenge of readmissions for the Medicare population. Medicare Advantage plans are held to an All-Cause Readmissions measure that differs from the Original Medicare Hospital Readmissions Reduction Program. Additionally, Medicare specifically identifies short term readmissions as a likely deviation in quality of care in the original discharge plan or discharges occurring before the Member was stable for transition of care. Because of this, BlueCross has developed a same or similar diagnosis readmissions program to more closely align with how CMS evaluates our Plan.

BlueCross will reimburse for a readmission within forty-either (48) hours from an index admission as follows:

- For purposes of this program, the date of discharge from the original acute inpatient admission (called the **Index Admission**) is the start of the 48-hour window.

- This readmission program is limited to same or similar diagnoses between the Index Admission and the Readmission as determined by a Plan Medical Director, even though BlueCross is held to an all-cause readmission standard.
- Only readmissions that occur as an acute inpatient admission to the same or similar facility, or facility operating under the same contract, are included in this program.
- Because of the close proximity to the index discharge, there is no modifiable cause component of this program.
- Also, because this readmission program has a denial of the readmission, the Medical Necessity of the readmission is not evaluated.
- All readmissions in this program are reviewed by a Plan Medical Director as part of a same or similar diagnosis review. This is not an automated claims based adjudication. Thus the Provider has their normal medical necessity based denial appeal rights.
- In this readmission scenario, the facility will not be reimbursed for the readmission regardless of the readmission length of stay. This penalty is due to the fact that CMS considers a short-term readmission for the same or similar diagnosis to generally be due to a process failure in discharge planning or due to the Member not being clinically stable for discharge at the time of the original discharge.
- Readmissions that occur in an observational (outpatient) setting are exempt from this program and are reimbursed as per the facility agreement.
- Readmissions for Members undergoing active chemotherapeutic treatment or in the immediate post-transplant period (30 days) are also excluded from this program.

Note: *The Member cannot be held liable for payment of services received when not authorized.*

7. Left against Medical Advice

In the event that a member discharges himself or herself from the facility, against the advice of their doctor, payment will be made based upon outlier per diems not to exceed the appropriate inlier payment. Patient discharge status must be accurately reflected on the CMS-1450 claim form, or its electronic equivalent.

8. Unbundling of Services

The BlueCare Plus rates are calculated with the assumption that professional and/or technical components of hospital-based practitioners and Certified Registered Nurse Anesthetists (CRNAs) will be separately billed on a CMS-1500 claim form. Bills for hospital-based practitioners and CRNA services must be submitted on a CMS-1500.

9. Outpatient Services Treated as Inpatient Services

Pre-admission Diagnostic Services performed on an outpatient basis by the admitting hospital, or by an entity wholly owned or operated by the facility (or by another entity under arrangements with the facility), within three days of an inpatient admission will be covered under the inlier portion of the DRG payment. No separate payment will be made for pre-admission diagnostic services within the three-day period. Other Pre-admission Non-Diagnostic Services that are related to the member's facility admission and performed by the admitting facility, or by an entity wholly owned or operated by the facility (or by another entity under arrangements with the facility) during the three days immediately preceding the date of admission will be covered under the inlier portion of the DRG payment for approved admissions. No separate payment will be made for these services. All testing performed on the day of discharge or within one day following the discharge will also be covered under the inlier portion of the DRG payment. No separate payments will be made for outpatient testing within the one-day period. The term "day" refers to the calendar day(s) immediately preceding the date of admission or day following discharge. For example, if a member is admitted on Wednesday, services provided on Sunday, Monday and/or Tuesday are included in the inlier portion of the DRG payment, as opposed to 72 hours from the admission hour.

Exclusions: Ambulance Services, Chronic Maintenance Renal Dialysis Treatments, Home Health Services, Inpatient Services.

10. Policy for Present on Admission (POA) Indicators

This policy applies to claims billed on a CMS-1450/UB-04/ANSI-837I. Inpatient admissions to general acute care hospitals, requires the Present on Admission (POA) code on diagnoses (Form Locator 67) for discharges on or after Dec. 31, 2007, by using National Coding Standard guidelines.
This may impact reimbursement. POA indicators are needed when Acute Inpatient Prospective Payment System (IPPS) Hospital providers bill for selected Hospital Acquired Conditions (HACs), including some conditions on the National Quality Forum's (NQF) list of Serious Reportable Events (commonly referred to as "Never Events"), these certain conditions have been selected according to the criteria in section 5001(c) of the Deficit Reduction Act (DRA) of 2005 and are reportable by The Centers for Medicare & Medicaid Services (CMS) POA Indicator Options:

Present on Admission (POA) Indicator Options:

- Y = Diagnosis was present at time of inpatient admission.
- N = Diagnosis was not present at time of inpatient admission.
- U = Documentation insufficient to determine if the condition was present at the time of inpatient admission.
- W = Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.
- 1 = Unreported/Not used. Exempt from POA reporting on paper claims. A blank space is only valid when submitting this data via the ANSI 837 5010 version.

The Present on Admission Indicator Reporting requirement applies **only** to Acute Inpatient Prospective Payment System (IPPS) hospitals. Facilities (as indicated by CMS) that are exempted from the POA Indicator requirements will **not** be required to submit the POA Indicator Option "1".

When filing electronic ANSI 837 inpatient facility claims, providers should no longer enter Indicator Option "1" in the POA field when exempt from POA reporting. The POA field should be left blank for EDI format 5010 claims.

When filing paper CMS-1450 (UB04) inpatient facility claims, providers should enter a "1" in the POA field when exempt from POA reporting.

When any other POA Indicator Options apply, they should be reported in the POA field on **both** electronic and paper claims.

Claims will reject if:

- POA "1" is submitted on an electronic ANSI 837 inpatient claim; or
- POA is left blank on a paper CMS-1450 (UB04) inpatient claim; or
- POA is required, but not submitted.

The guidelines for reporting POA Indicators can be found on the Centers for Medicare & Medicaid (CMS) website at http://www.cms.gov/HospitalAcqCond/.

11. Emergency/Non-emergency

Emergency Room Services:
Emergency Room services (revenue code 0450) do not require an authorization. Reimbursement will be based upon the current fee schedule. Ancillary charges should be filed with the appropriate CPT® or HCPCS code.

Emergency Room Services filed with Observation:
Observation room (revenue code 0762) is considered part of the emergency room charge and is not reimbursed separately.

Emergency Room Services filed with Outpatient Surgery:
Emergency Room services (revenue code 0450) filed with Outpatient Surgery will be reimbursed in addition to the outpatient surgical reimbursement. Ancillary services are considered all-inclusive in the Outpatient Surgical Fee (OSF) reimbursement.

Emergency Room Services filed with Observation and Outpatient Surgery:
Emergency Room services (revenue code 0450) and Observation services filed with Outpatient Surgery services are considered all-inclusive in the Outpatient Surgery reimbursement and are not reimbursed separately. Ancillary services are considered all-inclusive in the OSF reimbursement.

Emergency Room Services filed on an Inpatient CMS-1450 claim form (Inpatient setting):
Emergency Room services filed on a CMS-1450 claim are considered all-inclusive to the facility inpatient reimbursement and are not reimbursed separately.

Observation filed with Outpatient Surgery:
Observation charges may not be billed until six (6) hours after surgery. Recovery times up to six (6) hours are included in the outpatient surgery all-inclusive rates.

Observation filed on an Inpatient claim (inpatient setting):
Observation services filed on a CMS-1450 claim form are considered all-inclusive to the facility inpatient reimbursement and **are not reimbursed separately**.

*Incidental services include but are not limited to those services billed under Revenue Codes:

0250 – 0259 (Pharmacy)
0270 – 0279 (Surgical Supplies)
0290 – 0299 (DME)
0370 – 0379 (Anesthesia)

12. Therapy and Rehab Services

Comprehensive Outpatient Rehabilitation Facility (CORF) and Outpatient Rehabilitation Facility (ORF)

Type of Bill	Description
074X	Outpatient Rehabilitation Facility
075X	Comprehensive Outpatient Rehabilitation Facility

Revenue Code	Modifiers	Description
0420	GP	Physical Therapy
0430	GO	Occupational Therapy
0440	GN	Speech Therapy

Facilities are required to report line item dates of service per revenue code line for outpatient rehabilitation services. CORFS are required to report their full range of CORF services by line item date of service. This means each service (revenue code) provided must be repeated on a separate line item along with the specific date the service was provided for every occurrence.

Freestanding Inpatient/Outpatient Rehabilitation Facilities and Skilled Nursing Facilities

Outpatient Rehabilitation services should be billed with an appropriate Type of Bill in Form Locator 4 according to Type of Facility as indicated below:

Type of Bill	Description
013X	Freestanding Inpatient Rehab Facilities-Outpatient Therapy Services
022X 023X	Skilled Nursing Facilities-Outpatient Therapy Services
074X	Outpatient Rehabilitation Facility
075X	Comprehensive Outpatient Rehabilitation Facility

The appropriate revenue codes are required to identify specific accommodation and/or ancillary charges. The numeric revenue code must be entered on the adjacent line in FL 42 to explain each charge in FL 47.

For additional information visit The Centers for Medicare & Medicaid Services (CMS) Website at www.cms.gov/Medicare/Billing/TherapyServices/index.html.

13. National Drug Code (NDC) Billing

BlueCare Tennessee Provider Administration Manual National Drug Code (NDC) Claim Filing (Previously Provider-Administered Drug Claims)

Beginning January 1, 2007, the Deficit Reduction Act (DRA) of 2005 required states to collect rebates on Provider-administered drugs. Effective with dates of service June 1, 2007, and forward, providers must include the National Drug Code (NDC) of the drug(s) administered, along with the correct quantity and unit, for all provider-administered drugs for medical claims filed on a CMS-1500 Health Insurance Claim form or submitted electronically in the ANSI-837 version 5010 format with some exceptions indicated below. Home Infusion Therapy Providers should continue submitting claims using the same codes in place today. All other Providers should submit claims with the NDC information for "J" codes only.

Exceptions to NDC Requirement for Provider-Administered Medical and Facility Drug Claims:

- Inpatient administered drugs
- Vaccines

Note: Effective with date of service 4/01/08 and after, NDC requirements must also be fulfilled by facilities filing Outpatient UB claims on a CMS-1450 claim form or submitted electronically in the ANSI-837 Institutional version format with the same exceptions listed above. NDC information is not required on Inpatient UB claims. When an NDC code is required, all of the following data elements are required, in addition to the HCPCS/ CPT® code. Any missing element may result in the claim being returned unprocessed.

National Drug Code (NDC) Electronic Billing Requirements

When an NDC code is required, all of the following data elements are required, in addition to the HCPCS/CPT® code. Any missing element will result in the claim being returned unprocessed.

In Loop 2410:

- **LIN02** must equal “N4” and **LIN03** must contain an 11 digit NDC number.
  Example: LINN4*01234567891~**
- **CTP04** must contain a numeric value, which quantifies the number of units, grams or milliliters administered. Decimal points are allowed in the event they are needed.

- **CTP05-1** must contain one of the NDC Quantity Qualifiers **(F2-International Unit, GR-Gram, ME-Milligram, ML-Milliliter, UN-Unit)**
  Example: CTP*2*UN~**

Not Otherwise Classified (NOC) Drug Code Billing

When billing NOC J-codes in the ANSI 837 format you are required to provide a description of the drug in the 2400 Loop, SV101-7 (Professional), SV202-7 (Institutional).

Example: SV1/2*HC:J3490::::FOLIC ACID 5MG*5.62*UN*1*3~**

In order for BlueCare Tennessee to correctly reimburse NOC J-codes, providers must indicate the following in the electronic narrative: the name of the drug, total dosage (plus strength of dosage, if appropriate) and method of administration.

ANSI 837 Loop	Field Description	837P Segment	837I Segment
2400	Drug Name description information	SV101-7	SV202-7
2400	Drug Ingredient Billed Amount	SV102	SV203
2400	HCPCS Unit of Measure	SV103	SV204
2400	HCPCS Quantity	SV104	SV205
2410	NDC Qualifier of N4	LIN02	LIN02
2410	NDC code **(11 digits)**	LIN03	LIN03
2410	NDC Quantity	CTP04	CTP04
2410	NDC Unit of Measure **(F2, GR, ME, ML, UN)**	CTP05-1	CTP05-1

Paper Claim Submission -Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated.

In the shaded portion of Block 24 on the CMS-1500 (02/12) claim form:

- The first two positions must be “N4” and the next eleven positions must be the NDC code comprised of eleven numeric digits.
- The next position must be a space.
- The next two positions must be one of the NDC Quantity Qualifiers identified in the element table above.
- The next few positions must be a numeric value, which quantifies the number of units, grams, milligrams or milliliters administered. No specific number of digits is required; however, the number submitted may not exceed 15 digits. If entering a whole number, do not use a decimal. Decimal points are allowed in the event they are needed. Do not use commas.

  For example, when specifying 2 micrograms, use the “ME” qualifier and add “0.002” as the quantity.

When entering supplemental information for NDC, add in the following order qualifier, NDC code, one space, unit/basis of measurement qualifier, quantity.

- The next three positions must be spaces.
- The next two positions must be “ZZ” and the next few positions must be drug name.

Example: N450242006101 ME1.25 ZZAvastin

E. Reimbursement General Provisions

Eligible services not priced by the Centers for Medicare & Medicaid Services (CMS) will be based on a reasonable allowable fee as determined by BlueCare Plus HMO DSNP.

BlueCare Plus HMO DSNP reserves the right to request documents submitted to or issued by the Medicare Fiscal Intermediary or Carrier that are necessary to determine the appropriate fee under Medicare-based reimbursement methodology.

Should payments to managed care organizations participating in federal health care programs, such as BlueCare Plus HMO DSNP be adjusted other than through the payment methodology for the applicable federal health care program, BlueCare Plus HMO DSNP may implement the same or a similar adjustment to payment rates and/or payments for Covered Services.

XIII. Remittance Advice

BlueCare Plus issues notices called Remittance Advices (RA) to communicate claims processing decisions such as payments and adjustments. The RA provides justification for the payment, as well as input to your accounting system/accounts receivable and general ledger applications. The codes on the RA identify any additional action you may need to take; for example, an RA code may indicate you may need to resubmit the claim with corrected information.

The RA provides detailed payment information about a health care claim(s) and describes the payment; it also features valid codes and specific values that make up the claim payment.

Once you receive the RA you may:

- Post the decision and payment information automatically when a compatible provider accounts receivable software application is being used
- Identify reasons for any adjustments, denials or payment reductions
- Note when the Electronic Funds Transfer (EFT) payment issued with the RA is scheduled for deposit

The Remittance Advice displays the following columns.

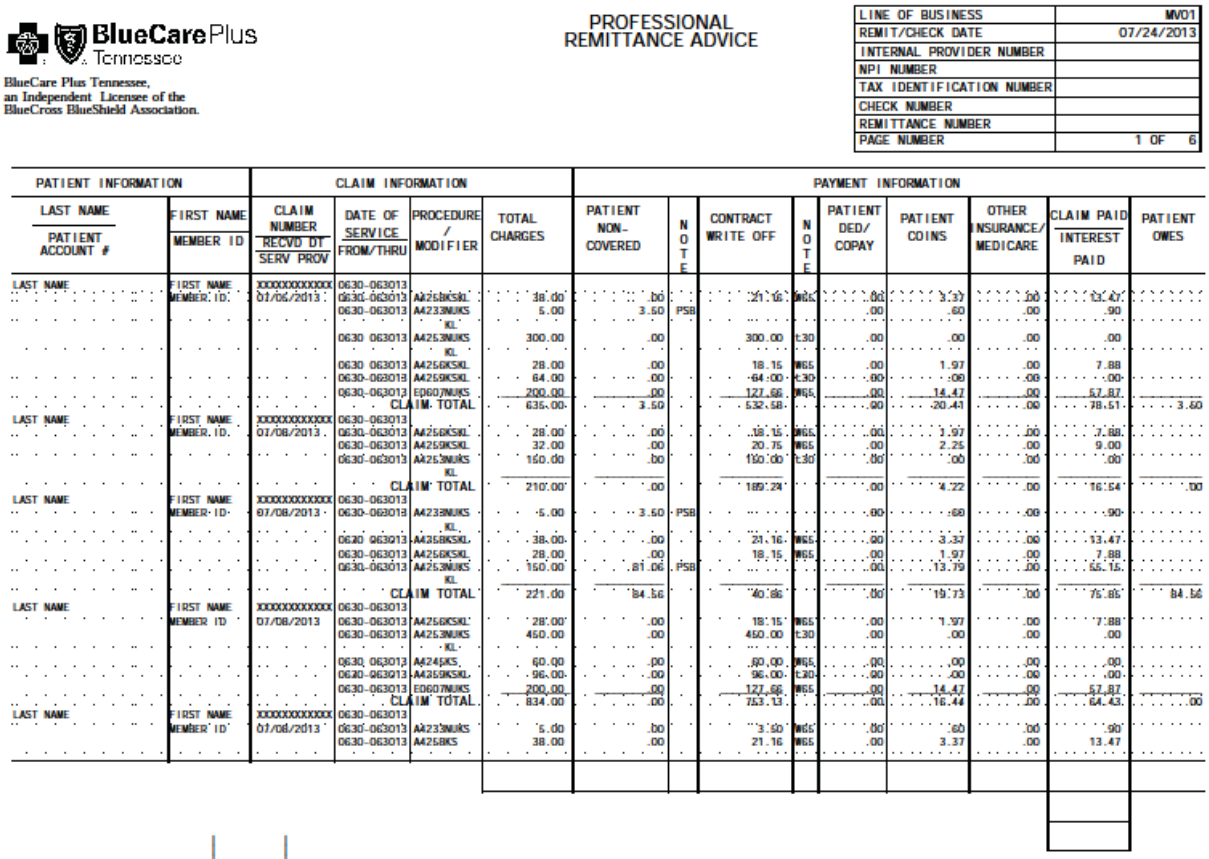
Patient Information	
Last Name	This field displays the last name of the member.
First Name	This field displays the first name of the member.
Patient Account	This field displays the Medical Record Number (MRN) or Patient Account that was submitted on the claim.
Member ID	BlueCare Plus assigned member identification.

Claim Information	
Claim Number	This field display the Claim Number assigned to the claim at the time it is received by BlueCare Plus.
Recv'd DT	This field indicates the date BlueCare Plus received the claim for processing.
Serv Prov	
Date of Service From/Thru	This field indicates the start date of services and the last date of services on the processed claim.
Procedure/Modifier	This field indicates the HCPC or CPT code filed with the claim including any modifier appended by the provider of service(s).
Total Charges	This field indicates the total charges submitted by the provider.

Payment Information	
Patient Non-Covered	This field indicates the number of non-covered days or visits that are submitted by the provider when it is know that the days or

	visits are not covered by Medicare. Providers do not anticipate payment on non-covered days or visits.
Note	
Contract Write Off	
Note	
Patient DED/COPAY	This field indicates the deductible and co-pay for covered services the deductible/co-pay **should not be billed** to the member. This amount will automatically crossover to TennCare for processing of member cost sharing.
Patient COINS	This field shows the total dollar amount of coinsurance for which the beneficiary is responsible. This amount will automatically crossover to TennCare for processing of member cost sharing.
Other Insurance	This field indicates if other insurance or coverage applicable.
Claim Paid	This field indicates the amount paid by BlueCare Plus.
Interest Paid	This field indicates if any interest has been applied to the amount paid.
Patient Owes	This $0 cost sharing program unless for a non-covered service.

Included is an example of the BlueCare Plus Remittance Advice



BlueCare Plus Tennessee
an Independent Licensee of the
BlueCross BlueShield Association.

PROFESSIONAL
REMITTANCE ADVICE

LINE OF BUSINESS	MVO1
REMIT/CHECK DATE	07/24/2013
INTERNAL PROVIDER NUMBER	
NPI NUMBER	
TAX IDENTIFICATION NUMBER	
CHECK NUMBER	
REMITTANCE NUMBER	
PAGE NUMBER	1 OF 6

PATIENT INFORMATION		CLAIM INFORMATION				PAYMENT INFORMATION								
LAST NAME / PATIENT ACCOUNT #	FIRST NAME / MEMBER ID	CLAIM NUMBER / RECVD DT / SERV PROV	DATE OF SERVICE FROM/THRU	PROCEDURE / MODIFIER	TOTAL CHARGES	PATIENT NON-COVERED	NOTE	CONTRACT WRITE OFF	NOTE	PATIENT DED/ COPAY	PATIENT COINS	OTHER INSURANCE/ MEDICARE	CLAIM PAID / INTEREST PAID	PATIENT OWES
LAST NAME	FIRST NAME	XXXXXXXXXXXX	0630-063013											
	MEMBER ID	07/06/2013	0630-063013	A4256KSKL	38.00	.00		21.16	M65	.00	3.37	.00	13.47	
			0630-063013	A4233NUKS KL	5.00	3.50	PSB			.00	.60	.00	.90	
			0630 063013	A4253NUKS KL	300.00	.00		300.00	L30	.00	.00	.00	.00	
			0630 063013	A4256KSKL	28.00	.00		18.15	M65	.00	1.97	.00	7.88	
			0630-063013	A4259KSKL	64.00	.00		64.00	L30	.00	.00	.00	.00	
			0630-063013	E0607NUKS	200.00	.00		127.66	M65	.00	14.47	.00	57.87	
				CLAIM TOTAL	635.00	3.50		532.58		.00	20.41	.00	78.51	3.60
LAST NAME	FIRST NAME	XXXXXXXXXXXX	0630-063013											
	MEMBER ID	01/08/2013	0630-063013	A4256KSKL	28.00	.00		18.15	M65	.00	1.97	.00	7.88	
			0630-063013	A4259KSKL	32.00	.00		20.75	M65	.00	2.25	.00	9.00	
			0630-063013	A4253NUKS KL	150.00	.00		150.00	L30	.00	.00	.00	.00	
				CLAIM TOTAL	210.00	.00		189.24		.00	4.22	.00	16.54	.00
LAST NAME	FIRST NAME	XXXXXXXXXXXX	0630-063013											
	MEMBER ID	07/08/2013	0630-063013	A4233NUKS KL	5.00	3.50	PSB			.00	.60	.00	.90	
			0620 063013	A4256KSKL	38.00	.00		21.16	M65	.00	3.37	.00	13.47	
			0630-063013	A4256KSKL	28.00	.00		18.15	M65	.00	1.97	.00	7.88	
			0630-063013	A4253NUKS KL	150.00	81.06	PSB			.00	13.79	.00	55.15	
				CLAIM TOTAL	221.00	84.56		40.86		.00	19.73	.00	75.85	84.56
LAST NAME	FIRST NAME	XXXXXXXXXXXX	0630-063013											
	MEMBER ID	07/08/2013	0630-063013	A4256KSKL	28.00	.00		18.15	M65	.00	1.97	.00	7.88	
			0630-063013	A4253NUKS KL	450.00	.00		450.00	L30	.00	.00	.00	.00	
			0630 063013	A4245KS	60.00	.00		60.00	M65	.00	.00	.00	.00	
			0620-063013	A4259KSKL	96.00	.00		96.00	L30	.00	.00	.00	.00	
			0630-063013	E0607NUKS	200.00	.00		127.66	M65	.00	14.47	.00	57.87	
				CLAIM TOTAL	834.00	.00		753.13		.00	16.44	.00	64.43	.00
LAST NAME	FIRST NAME	XXXXXXXXXXXX	0630-063013											
	MEMBER ID	07/08/2013	0630-063013	A4233NUKS	5.00	.00		3.00	M65	.00	.60	.00	.90	
			0630-063013	A4256KS	38.00	.00		21.16	M65	.00	3.37	.00	13.47	

PLEASE RETAIN FOR YOUR RECORDS

The Patient Deductible Copay of Coinsurance amounts should not be billed to the member. BlueCare Plus will forward these claims to the Bureau of TennCare for the processing of member cost sharing.

The patient deductible, copay and coinsurance amounts should not be billed to the member. BlueCare Plus forwards these claims to the Division of Tenncare for processing of member cost sharing.

BlueCare Plus currently receives electronic claims, which include; initial claims submission and corrected bills.

To discuss issues specific to your organization, please contact eBusiness Technical Support at (423) 535-5717, or (800) 924-7141, Monday – Thursday 8 a.m. to 5:15 p.m. (ET) or Friday 9 a.m. to 5:15 p.m. (ET). More information is also available at the following link: http://www.bcbst.com/providers/ecomm/, or you can contact us via email at eBusiness_Service@bcbst.com.

All providers enrolling in the Medicare Program for the first time, changing existing enrollment data or revalidating enrollment, must use Electronic Funds Transfer (EFT) to receive payments. For EFT enrollment, information is available on the CAQH Solutions website at https://solutions.caqh.org.

A. Risk Adjustment

Risk Adjustment is the process by which the Centers for Medicare & Medicaid Services (CMS) reimburses Medicare Advantage (MA) plans, such as BlueCare Plus, for the health status and demographic characteristics of their enrollees.

CMS utilizes the Hierarchical Condition Category (HCC) payment model (supported by ICD-10-CM codes and successor codes) and encounter data submitted by MA plans to establish risk scores. The primary source of encounter data or ICD-10 codes and successor codes routinely submitted to CMS is extracted from claims with additional conditions being identified during retrospective chart review.

CMS looks to providers to code identified conditions accurately using ICD-10-CM coding guidelines and successor codes with supporting documentation in their medical record. The physician's role in risk adjustment includes:

- Accurately reporting ICD-10-CM diagnosis codes and successor codes to the **highest level of specificity** (critical as this determines disease severity).
- Documentation should be complete, clear, concise, consistent and legible.
- Documentation of all conditions treated or monitored at the time of the face-to-face visit in support of the reported diagnoses codes.
- Use of standard abbreviations.
- Notifying the Medicare Advantage plan of any erroneous data submitted and following the appropriate procedures to correct erroneous data (see Section VI. Billing and Reimbursement in this Manual for instructions on submitting a Corrected Bill).
- Submitting claims data in a timely manner, generally within thirty (30) days of the date of service (or discharge for hospital inpatient admissions).

Physician data is critical for accurate risk adjustment. Physicians are the largest source of ambulatory data for the risk adjustment model. CMS-HCC model relies on ICD-10-CM and successor codes coding specificity.

1. Risk Adjustment Data Validation (RADV) Audits conducted by CMS

Annually, CMS selects (both random and targeted) Medicare Advantage (MA) Organizations for a data validation audit. CMS utilizes medical records to validate the accuracy of risk adjustment diagnoses submitted by MA or Medicare Advantage organizations. The medical record review process includes confirming that appropriate diagnosis codes and level of specificity were used, verifying the date of service is within the data collection period, and ensuring the provider's signature and credentials are present. If CMS identifies discrepancies and/or confirms there is not adequate

documentation to support a reported diagnosis in the medical record during the data validation process, financial adjustments will be imposed.

2. Risk Adjustment Impact for Physicians and Members

It is important to keep in mind that the risk adjustment process also benefits the provider and the patient. Increased coding accuracy helps BlueCross BlueShield of Tennessee identify patients who may benefit from disease and medical management programs. More accurate health status information assists in matching health care needs with the appropriate level of care. Risk adjustment helps meet the provider's CMS responsibilities regarding reporting ICD-10-CM codes and successor codes, including:

- Secondary diagnoses, to the highest level of specificity
- Maintaining accurate and complete medical records (ICD-10-CM codes and successor codes must be submitted with proper documentation)
- Reporting claims and encounter data in a timely manner

With provider assistance in providing accurate and timely coding for risk adjustment, Unnecessary and costly administrative revisions can be avoided, and provide patients and BCBST's members with superior customer service.

3. Medical Record Documentation Tips for meeting CMS requirements for submission of encounter data and RADV audits:

Federal regulations require Medicare and its agents (BCBST) to review and validate medical records in order to avoid underpayments or overpayments. It is important for the physician's office to code each encounter in its entirety; the claim should report the ICD-10-CM code and successor codes of every diagnosis that was addressed and should only report codes of diagnoses that were actively addressed.

Contributory (co-morbid) conditions should be reported if they impact the care and are therefore addressed at the visit, but not if the condition is inactive or immaterial. It should be obvious from the medical record entry associated with the claim that all reported diagnoses were addressed and that all diagnoses are reported.

Medical Record Documentation

- Documentation should be clear, concise, consistent, complete and legible.
- Documentation of coexisting conditions at least annually.
- Use standard abbreviations.
- Utilize problem lists (ensuring they are comprehensive, show evaluation and treatment for each condition relating to an ICD-10-CM code and successor codes on the date of service, and are signed and dated by the physician or physician extender).
- Identify patient and date on each page of the record.
- Authenticate the record with signature and credentials.

Progress Note Requirements:

- Progress notes must contain patient name and DOS on each page.
- If the progress note is more than one page or two-sided, the pages must be numbered, (i.e., 1 of 2). If pages are not numbered, then the provider must sign each page of the progress note.
- Progress notes should follow the standard S.O.A.P. format.

Provider Signature Requirements on Progress Note:

- All progress notes must be signed by the provider rendering services.
- Provider credentials must either be pre-printed on the progress notes as a stationary or the provider must sign all progress notes with his/her credentials as part of the signature.
- Dictated notes and consults must be signed by the provider.
- Provider signature must be legible, i.e., "John Smith Doe, M.D." or "JSD, MD". If a Provider's signature is illegible, a signature log must be completed.
- Stamped signatures are no longer acceptable for provider documents as of April 28, 2008, as stated by CMS (Medicare Program Integrity Manual, Transmittal 248, Change Request 5971.5550). For risk adjustment purposes (Part C), signature stamps will no longer be acceptable on medical records with dates of service on or after January 1, 2009.
- Electronic Medical Record (EMR) progress notes must have the following wording as part of the signature line: "Electronically signed", "Authenticated by", "Signed by", "Validated by", Approved by", or "Sealed by". The signed EMR record must be closed to all changes.
- Sign off on medical records should be completed timely.

Diagnosis Documentation Requirements on Progress Note:

- Documentation should include evaluation of each diagnosis on the progress note, not just the listing of chronic conditions, i.e., DM w/Neuropathy – meds adjusted, CHF-compensated COPD – test ordered, HTN – uncontrolled, Hyperlipidemia – stable on meds. CMS considers diagnoses listed on the progress note without an evaluation or assessment as a "problem list", which is not acceptable for risk adjustment submission.
- Use the words "history of" cancer, stroke, etc., to indicate the condition is no longer a current health concern. Avoid using "history of" for conditions the member still has or for which they are being treated. For example, indicating a history of diabetes is not correct. While the member has diabetes in his history, it is still a current condition. Likewise, a patient may have CHF exacerbation in his past but CHF stable is the current condition. The coding for CHF is the same for both instances – 428.0.
- Each progress note must be able to "**stand alone**". Do not refer to diagnoses from a preceding progress note, problem list, etc.
- Avoid documentation of diagnosis as probable, suspected, questionable, rule out, or working, rather, document or code to the highest degree certainty known for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

4. Releasing Medical Records

BlueCare Plus has the right to request medical records without charge to ensure appropriate coding and/or identify additional diagnosis for risk adjustment data submission to CMS. Providers may

receive requests from the Risk adjustment Department for medical records with specific dates of service for review. Medical records can be mailed, faxed or collected on site from the provider's office.

Mail to:

ATTN: **BlueCare Plus HMO DSNP - Risk Adjustment**
BlueCare Plus
1 Cameron Hill Circle, Ste 0037
Chattanooga, TN 37402-9923

Fax to: 1-800-495-1944
(423) 535-3609

5. Confidentiality and General Consent

Confidentiality of patient information is important to BlueCross BlueShield of Tennessee. Any information disclosed by you in response to medical record requests for risk adjustment will be treated in accordance with applicable privacy laws. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 C.F.R. § 164.502, you are permitted to disclose the requested data for purpose of treatment, payment and health care operations after you have obtained the "general consent" of the patient. A general consent form should be an integral part of your patient's medical records file.

6. Risk Adjustment Data

Providers are encouraged to code all members' diagnoses to the highest level of specificity. All encounters for dually eligible members must be submitted to BlueCare Plus.

A sample copy of the Risk Adjustment Medical Record Request letter follows:

Date

Provider Name/Credentials
Address Member Name:
City, State Zip DOB:

Member ID Number:
Member Name:
DOB:
Reference #
Provider #
Doc Class: MedRec
Cost Center # 7570

Dear Provider:

To ensure integrity of risk adjustment data submitted to the Centers for Medicare & Medicaid Services (CMS), and, as part of our ongoing Risk Adjustment Program, we have reviewed claims history for the above-referenced member and determined that additional information is needed. Our request for medical records is conducted in accordance with CMS guidelines and is based upon the terms and conditions of your Medicare Advantage Provider Agreement (Section C.7) and/or the Model Terms and Conditions of Payment (Section 6). *Please submit a copy of this letter along with all pertinent medical records for dates of service _____, including any narrative history and physical results, all notes written or dictated, and a copy of the Subjective Objective Assessment Plan (SOAP).* CMS requires that medical record documentation contain the dates of service, patient's name and a legible physician's signature with credentials. Please mail or fax the requested medical records within **21 business days** to:

ATTN: Risk Adjustment Department
BlueCross BlueShield of Tennessee
BlueCare Plus Operations
1 Cameron Hill Circle, Ste 0037
Chattanooga, TN 37402-9923
Fax: 1-800-495-1944
(423) 535-3609

Confidentiality of "individually identifiable patient information" is important to BlueCross BlueShield of Tennessee, Inc. and is required by law. Any information disclosed by you in response to this request will be treated in accordance with applicable privacy laws. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 C.F.R. § 164.502, you are permitted to disclose the requested data for purpose of treatment, payment and health care operations after you have obtained the "general consent" of the patient. A general consent form should be an integral part of your patient's medical records file. Thank you in advance for your cooperation. If you should have any questions, please contact us at 1-800-515-2121, ext. 3589.

Sincerely,

Name
Medicare Advantage Risk Adjustment Department
BlueCross BlueShield of Tennessee

For additional information regarding risk adjustment, visit:

Provider Quick Reference Guide – Risk Adjustment:
http://www.bcbst.com/providers/medicare-advantage/quick_reference_guide.pdf

XIV. Appeals and Grievances

A. Member or Representative Appeals and Grievances

BlueCare Plus has incorporated formal mechanisms to address member concerns and complaints or grievances. Concerns raised by members and providers will be utilized to continuously improve product lines, processes and services. All employees are alert for and responsive to inquiries, complaints and concerns and address such issues promptly and professionally. All other written concerns or complaints are considered grievances and will be processed through BlueCare Plus's HMO D-SNP usual grievance procedure described in the section below. Member concerns, complaints, and resolutions, if applicable, are documented and maintained by BlueCare Plus in accordance with its corporate policies. If a member has an inquiry, concern or complaint regarding any aspect of services received, the member may contact the designated Customer Service Representative of BlueCare Plus to discuss the matter. If a member feels that the Customer Service Representative has not resolved a problem, it is his/her right to submit a written grievance or suggestion for improvement to the Grievance Committee.

A member or representative may appeal an adverse initial decision made by BlueCare Plus concerning payment or medical necessity for a healthcare service. Appeals may include entitlement to services, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the member), or on any amounts the member must pay for a service(s).

For additional information, review The Centers for Medicare & Medicaid Services (CMS) Internet Only Manuals (IOMs) Publication 100-16, Chapter 13.

1. Definition of Terms

Appeal: An appeal includes any of the procedures that deal with the review of adverse determinations on the health care services. A member believes he or she is entitled to services, including delay in providing, arranging for, or approving the health care services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service as defined in 42 CFR 422.566(b). These procedures include reconsideration by BlueCare Plus and if necessary, an independent review entity, hearings before Administrative Law Judges (ALJs), reviews by the Medicare Appeals Council (MAC), and judicial review.

Assignee: A non-contracted physician or other non-contracted provider who has furnished a service to the enrollee and formally agrees to waive any right to payment from the enrollee for that service.

Complaint: Any expression of dissatisfaction to BlueCare Plus, provider, facility or Quality Improvement Organization (QIO) by a member made orally or in writing. This can include concerns about the operations of providers or Medicare health plans such as: waiting times, the demeanor of health care personnel, the adequacy of facilities, the respect paid to enrollees, quality of care and the claims regarding the right of the member to receive services or receive payment for services

previously rendered. It also includes a plan's refusal to provide services to which the member believes he or she is entitled. A complaint could be either a grievance or an appeal, or a single complaint could include elements of both. Every complaint must be handled under the appropriate grievance and/or appeal process.

Cost Sharing Obligations: Medicare deductibles, premiums, co-payments and coinsurance that TennCare is obligated to pay for certain Medicare beneficiaries (QMBs, SLMB-Plus's, and Other Medicare/Medicaid Dual Eligibles). For SLMB-Plus's and Other Medicare/Medicaid Dual Eligibles, TennCare is not required to pay Medicare coinsurance on those Medicare services that are not covered by TennCare unless the enrollee is a child under 21 or an SSI beneficiary. No Plan can impose cost sharing obligations on its members which would be greater than those that would be imposed on the member if they were not a member of the Plan.

Dual Eligible: As used in Tennessee, a Medicare enrollee who is also eligible for TennCare and for whom TennCare has a responsibility for payment of Medicare Cost Sharing Obligations under the State Plan. For purposes of this Contract, Dual Eligibles are limited to the following categories of recipients: QMB Only, QMB Plus, SLMB Plus, and Other Full Benefit Dual Eligible ("FBDE").

Dual Eligible Member: An enrollee who is Dual-Eligible and is enrolled in a Plan.

Effectuation: Compliance with a reversal of the BlueCare Plus original adverse organization determination. Compliance may entail payment of a claim, authorization for a service, or provision of services.

Encounter: A Medicare Part C covered service or group of covered services, as defined by the MA-SNP Agreement, delivered by a health care service provider to a Dual Eligible Member during a visit between the Dual Eligible Member and health care service provider.

Encounter Data: In the context of the MA Agreement, data elements from an Encounter service event for a fee-for-service claim or capitated services proxy claim.

Full Benefit Dual Eligible (FBDE): An individual who is eligible both for Medicare Part A and/or Part B benefits and for TennCare benefits [services], including those who are categorically eligible and those who qualify as medically needy under the State Plan.

Grievance: Any complaint or dispute, other than an organization determination, expressing dissatisfaction with the manner in BlueCare Plus or delegated entity provides health care services, regardless of whether any remedial action can be taken. A member or their representative may make the complaint or dispute, either orally or in writing, to a BlueCare Plus, provider, or facility. An expedited grievance may also include a complaint that BlueCare Plus refused to expedite an organization determination or reconsideration, or invoked an extension to an organization determination or reconsideration period.

In addition, grievances may include complaints regarding the timeliness, appropriateness, access to, and/or setting of a provided health service, procedure, or item. Grievance issues may also include

complaints that a covered health service procedure or item during a course of treatment did not meet accepted standards for delivery of health care.

Independent Review Entity (IRE): An independent entity contracted by CMS to review BlueCare Plus and other D-SNPs adverse reconsiderations of organization determinations.

Individually Identifiable Health Information: Information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) identifies the individual; or (ii) with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Inquiry: Any oral or written request to BlueCare Plus, provider, or facility, without an expression of dissatisfaction, e.g., a request for information or action by a member. Inquiries are routine questions about benefits (i.e., inquiries are not complaints) and do not automatically invoke the grievance or organization determination process.

MA Agreement: The Medicare Advantage Agreement between the BlueCare and CMS to provide Medicare Part C and other health plan services to the BlueCare members.

Marketing: Shall have the meaning established under 45 CFR § 164.501 and includes the act or process of promoting, selling, leasing or licensing any TennCare information or data for profit without the express written permission of TennCare.

Medicare Advantage Plan: A plan as defined at 42 CFR. 422.2 and described at 422.4.

Medicare Health Plan: For purposes of this chapter, a collective reference to Medicare Advantage Plans, Cost Plans, and Health Care Prepayment Plans (HCPPs).

Organization Determination: Any determination made by BlueCare Plus with respect to any of the following:

- Payment for temporarily out of the area renal dialysis services, emergency services, post-stabilization care, or urgently needed services;

- Payment for any other health services furnished by a provider other than the BlueCare Plus that the member believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by BlueCare Plus;

- The Medicare health plan's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the enrollee believes should be furnished or arranged for by the Medicare health plan;

- Reduction, or premature discontinuation of a previously authorized ongoing course of treatment;

- Failure of BlueCare Plus to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the enrollee with timely notice of an adverse determination, such that a delay would adversely affect the health of the member.

Personally Identifiable Information (PHI): Any information about an individual maintained by an agency, including, but not limited to, education, financial transactions, medical history, and criminal or employment history and information which can be used to distinguish or trace an individual's identity, such as their name, Social Security Number, date and place of birth, mother's maiden name, biometric records, including any other personal information which can be linked to an individual.

Protected Health Information/Personally Identifiable Information (PHI/PII): (45 C.F.R. § 160.103; OMB Circular M-06-19 located at http://www.whitehouse.gov/sites/default/files/omb/memoranda/fy2006/m06-19.pdf) – Protected health information means individually identifiable health information that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.

Qualified Medicare Beneficiary (QMB): An individual who is entitled to Medicare Part A, who has income that does not exceed one hundred percent (100%) of the Federal Poverty Level (FPL), and whose resources do not exceed twice the Supplemental Security Income (SSI) limit. A QMB is eligible for Medicaid Payment of Medicare Premiums, Deductibles, Coinsurance, and Co-payments (except for Medicare Part D). Collectively, these benefits [services] are called "QMB Medicaid Benefits [Services]." Categories of QMBs covered by this Contract are as follows:

QMB Only – QMBs who are not otherwise eligible for full Medicaid.

QMB Plus – QMBs who also meet the criteria for full Medicaid coverage and are entitled to all benefits [services] under the State Plan for fully eligible Medicaid recipients.

Quality Improvement Organization (QIO): Organizations comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare members. QIOs review complaints raised by members about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and CORFs.

Quality of Care Issue: A quality of care complaint may be filed through the BlueCare Plus HMO D-SNP grievance process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided for BlueCare Plus meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

Reconsideration: A member's first step in the appeal process after an adverse organization determination; BlueCare Plus or an independent review entity may re-evaluate an adverse organization determination, the findings upon which it was based, and any other evidence submitted or obtained.

Representative: An individual appointed by a member or other party, or authorized under State or other applicable law, to act on behalf of an enrollee or other party involved in an appeal or grievance. Unless otherwise stated, the representative will have all of the rights and responsibilities of a member or party in obtaining an organization determination, filing a grievance, or in dealing with any of the levels of the appeals process, subject to the applicable rules described at 42 CFR Part 405.

Specified Low-Income Medicare Beneficiary (SLMB) PLUS: An individual entitled to Medicare Part A who has income that exceeds 100% FPL but less than 120% FPL, and whose resources do not exceed twice the SSI limit, and who also meets the criteria for full Medicaid coverage. Such individuals are entitled to payment of the Medicare Part B premium, as well as full State Medicaid benefits.

Special Needs Plan (SNP) or Plan: A type of Medicare Advantage plan that also incorporates services designed for a certain class of members. In the case of the TennCare Program the special class of members are persons who are both Medicare and Medicaid Dual eligible. These plans must be approved by CMS. A SNP plan may also provide Medicare Part D drug coverage.

SSA-supplied Data: Information, such as an individual's social security number, supplied by the Social Security Administration to the State to determine entitlement or eligibility for federally-funded programs (Computer Matching and Privacy Protection Agreement, "CMPPA" between SSA and F&A; Individual Entity Agreement, "IEA" between SSA and the State).

State Plan: The program administered by TennCare pursuant to Title XIX of the Social Security Act and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs.

TennCare: The medical assistance program administered by Tennessee Department of Finance and Administration, Division of TennCare pursuant to Title XIX of the Social Security Act, the Tennessee State Plan, and the Section 1115 research and demonstration waiver granted to the State of Tennessee and any successor programs.

TennCare MCO: A Managed Care Organization (MCO) under contract with the State to provide TennCare benefits.

F. Appeals

- BlueCare Plus members or their representatives;
    - Have the right to request an expedited reconsideration
    - The right to request and receive appeal data from BlueCare Plus
    - The right to receive notice when an appeal is forwarded to an Independent Review Entity (IRE)

- The right to automatic reconsideration by an IRE contracted by CMS, when BlueCare Plus upholds it original adverse determination in whole or in part.
- The right to an Administrative Law Judge (ALJ) hearing if the independent review entity upholds the original adverse determination in whole or in part and the remaining amount in controversy meets the appropriate threshold requirement;
- The right to request Medicare Appeals Council (MAC) review if the ALJ hearing decision is unfavorable to the member in whole or in part;
- The right to judicial review of the hearing decision if the ALJ hearing and/or MAC review if unfavorable to the member, in whole or in part, and the amount in controversy meets the appropriate threshold requirement;

i. The right to request a QIO review of termination of coverage of inpatient hospital care. If the member receives immediate QIO review of a determination on non-coverage of inpatient hospital care, the above rights are limited. In this case, the member is not entitled to the additional review of the issue by BlueCare Plus. The QIO review decision is subject to an ALJ hearing if the amount in controversy meets the appropriate threshold, and review of an ALJ hearing decision or dismissal by the MAC. Member may submit request for QIO review of determination of non-coverage of inpatient hospital care;

ii. The right to request a QIO review of a termination of services in skilled nursing facilities (SNF), home health agencies (HHA) and comprehensive outpatient rehabilitation facilities (CORF). If the member receives a QIO review of the above service termination, the member is not entitled to the additional review of the issue by BlueCare Plus.

iii. The right to request and be given timely access to the member's case file and a copy of that case subject to federal and state law regarding confidentiality of patient information.

G. The right to challenge local and national coverage determinations. Under §1869(f)(5) of the Act, as added by §522 of the Benefits Improvement and Protection Act (BIPA), certain individuals ("aggrieved parties") may file a complaint to initiate a review of National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). Challenges concerning NCDs are to be reviewed by the Departmental Appeals Board (DAB) of the Department of Health and Human Services. Challenges concerning LCDs are to be reviewed by ALJs. The appeal process is available to both members with original Medicare and those enrolled in BlueCare Plus

Below is a quick reference guide for the processes;

2. Appeal Levels

Level 1 Appeal

BlueCare Plus

Dissatisfied with determination by BlueCare Plus

- Member or representative may request an appeal
- Send request for reconsideration to:
  BlueCare Plus Member Appeals
  1 Cameron Hill Circle Suite 0042
  Chattanooga, TN 37402-0042
  Fax: 1.888.416.3026
- Request for reconsideration must be within 60 days of initial decision
- Member or representative will be notified:
  - 30 days if the decision involves a request for service
  - 60 days if the decision involves a request for payment
- Expedited Review in Special Circumstances
- A member or physician may request an **expedited reconsideration** by BlueCare Plus in situations where the standard reconsideration time frame might jeopardize the member's health, life, or ability to regain maximum function. Expedited appeal request may be submitted verbally.
- If a member disagrees with BlueCare Plus decision to discharge or discontinue services while the member is receiving inpatient hospital care, skilled nursing facility care, home health care or comprehensive rehabilitation facility care, the member may request an immediate review by a Quality Improvement Organization.
- Automatic Forward to Level 2 Appeal.
  - The member's appeal to and independent outside entity for a Level 2 review. If BlueCare Plus does not meet the response deadline it will forward the appeal to an independent outside entity for a Level 2 review.
  - If during the Level 1 appeal BlueCare Plus does not decide in the member or representative's favor, it is required for BlueCare Plus to forward

Level 2 Appeal

Independent Review Entity

Dissatisfied with Reconsideration (Level 1) file Level 2 Appeal

- Independent Review Entity (IRE) (CMS contracted reviewer) conducts the Level 2 appeal (reconsidered determination)
- Level 1 automatically forwarded to Level 2 IRE of the appeals process if:
  - BlueCare Plus does not meet the response deadline
  - Unfavorable redetermination
- After the IRE has reviewed the case it will send a notice of its decision in the mail.
  - The IRE notice will include detailed information about the right to appeal to OMHA (Level 3). You may appeal to Level 3 if:
  - Dissatisfied with IRE decision
  - Amount in controversy is $140 (2013) or more (this amount may change annually)
  - Less than 60 days have passed from reconsideration determination

Level 3 Appeal

Office of Medicare Hearings and Appeals (OMHA)

- If you disagree with outcome of Reconsidered Determination Level 2 appeal

- Member or representative can request hearing before the Administrative Law Judge (ALJ)
- This must be filed within 60 days
- ALJ may decide a case on-the-record if a party waives its rights to an oral hearing or in some cases when the documentary evidence supports a finding fully favorable to the appellant.

Level 4 Appeal

Medicare Appeals Council

If the member or representative is not satisfied with the Level 3 decision/dismissal, a review by the Medicare Appeals Council (MAC) may be filed.

- The MAC is part of the Departmental Appeals Board of the Department of Health and Human Services (HHS) and is independent of OMHA and ALJs
- A member may request a Medicare Appeals Council (MAC) with the following information within 60 days:
  - Beneficiary's name;
  - Name of the health services provider;
  - Date and type of service;
  - Medicare contractor or managed care organization that issued the initial determination in a member's case; Health Insurance Claim Number (HICN);
  - OMHA appeal number;
  - Date of the Administrative Law Judge (ALJ) decision or dismissal;
  - An appointment of representative, such as CMS Form 1696 (PDF, 66.4 KB) (if applicable);
  - Any additional evidence, clearly marked as new or duplicate; and
  - Proof that a member provided copies of the request to all other parties.
  - Submit the request to:

    Department of Health and Human Services
    Departmental Appeals Board, MS 6127
    Medicare Appeals Council
    330 Independence Avenue, SW, Room G-644
    Washington DC 20201
    Fax the request to (202) 565-0227

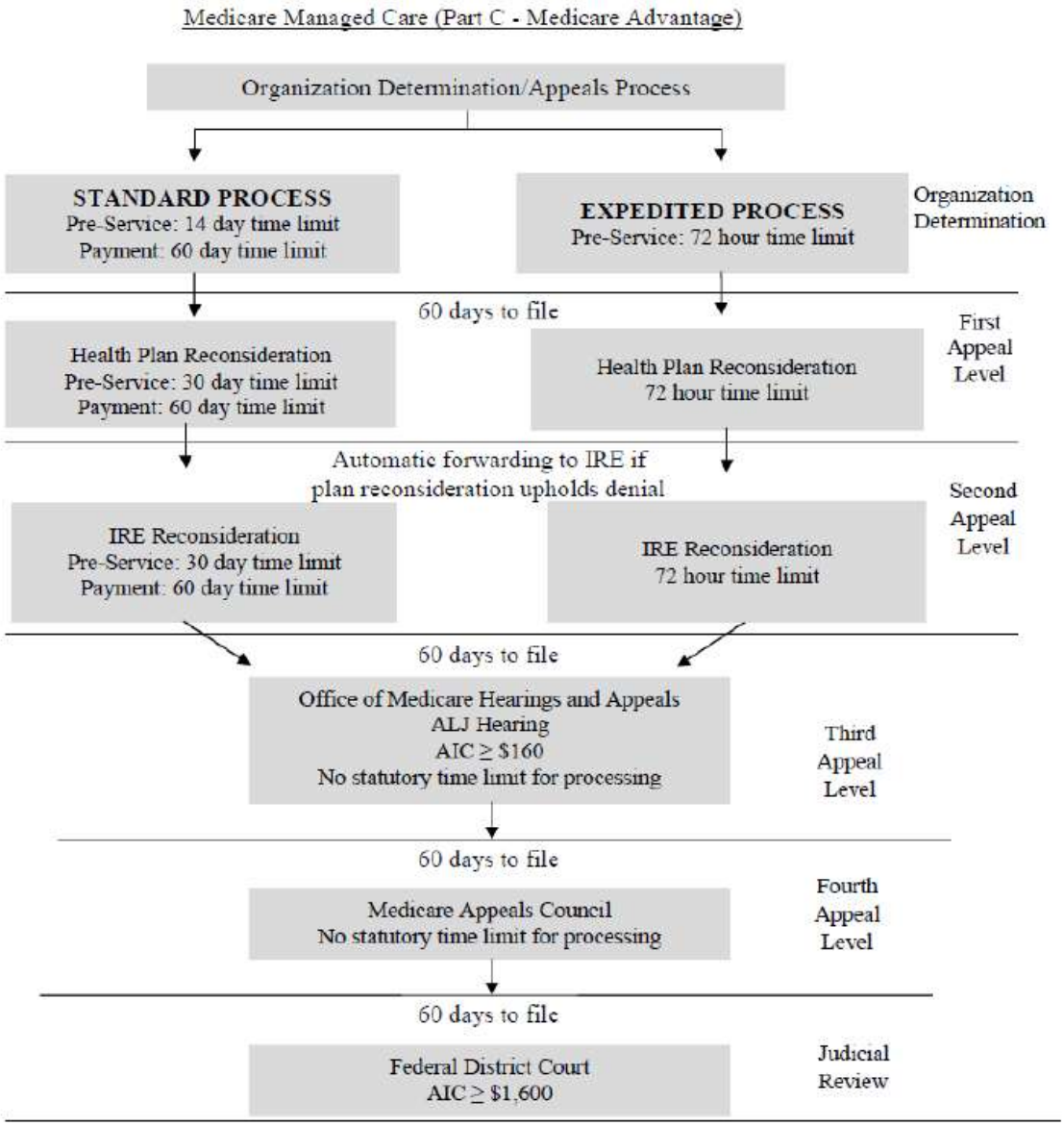
Level 5 Appeal

Federal District Court

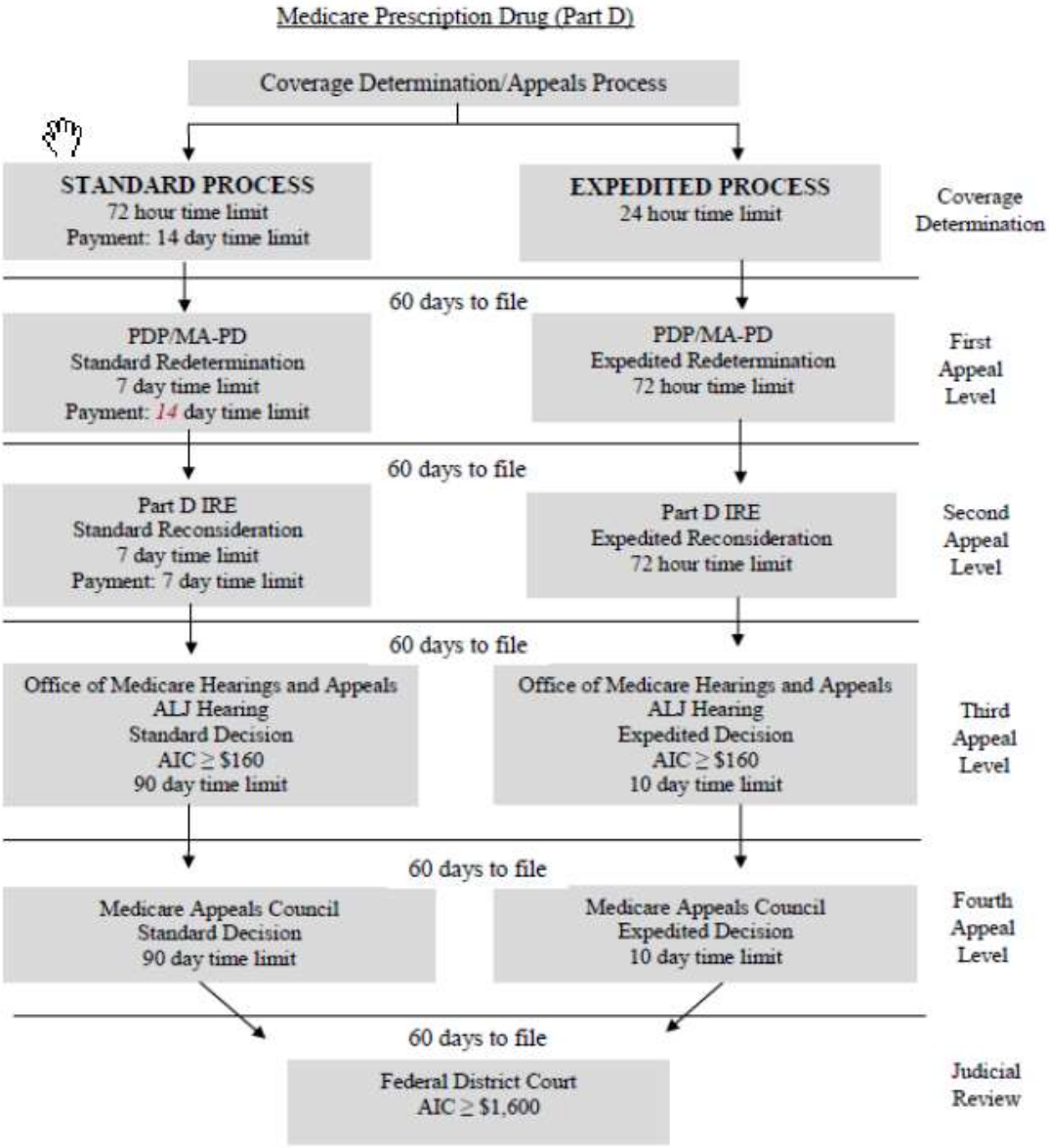
If the member disagrees with the Level 4 decision and the amount in controversy is $1,400 ((2013) the amount may change annually)

- The member or representative may file with the Federal District Court
  - The request must be filed within 60 days of the MAC decision.
- The notice of decision from the MAC will give the member or representative about filing a civil action
  - Last level of appeals

Appendix 1 – Medicare Managed Care (Part C) Appeals Process Overview



Appendix 2 – Medicare Prescription Drug (Part D) Appeals Process Overview



3. Representatives Filing on Behalf of Members

Individuals who represent members may either be appointed or authorized (for purposes of this chapter [and the definition under 42 CFR Part 422, Subpart M], they are both referred to as

"representatives") to act on behalf of the member in filing a grievance, requesting an organization determination, or in dealing with any of the levels of the appeals process. A member may appoint any individual (such as a relative, friend, advocate, an attorney, or any physician) to act as his or her representative. Alternatively, a representative (surrogate) may be authorized by the court or act in accordance with State law to act on behalf of a member. A surrogate could include, but is not limited to, a court appointed guardian, an individual who has Durable Power of Attorney (POA), or a health care proxy, or a person designated under a health care consent statute. Due in part to the incapacitated or legally incompetent status of a member, a surrogate is not required to produce a representative form. Instead, he or she must produce other appropriate legal papers supporting his or her status as the enrollee's authorized representative.

To be appointed by a member, both the member making the appointment and the representative accepting the appointment (including attorneys) must sign, date, and complete a representative form (for purposes of this section, "representative form" means a Form CMS-1696 Appointment of Representative or other equivalent written notice). An "equivalent written notice" is one that:

- Includes the name, address, and telephone number of enrollee;
- Includes the enrollee's HICN [or Medicare Identifier (ID) Number];
- Includes the name, address, and telephone number of the individual being appointed;
- Contains a statement that the enrollee is authorizing the representative to act on his or her behalf for the claim(s) at issue, and a statement authorizing disclosure of individually identifying information to the representative;
- Is signed and dated by the enrollee making the appointment; and
- Is signed and dated by the individual being appointed as representative, and is accompanied by a statement that the individual accepts the appointment.

Either the signed representative form for a representative appointed by a member, or other appropriate legal papers supporting an authorized representative's status, must be included with each request for a grievance, an organization determination, or an appeal. Regarding a representative appointed by a member, unless revoked, an appointment is considered valid for one year from the date that the appointment is signed by both the member and the representative. Also, the representation is valid for the duration of a grievance, a request for organization determination, or an appeal. A photocopy of the signed representative form must be submitted with future grievances, requests for organization determinations, or appeals on behalf of the enrollee in order to continue representation. However, the photocopied form is only good for one year after the date of the enrollee's signature. Any grievance, request for organization determination, or appeal received with a photocopied representative form that is more than one year old is invalid to appoint that person as a representative and a new representative form must be executed by a member.

Please note that the OMB-approved Form CMS-1696, Appointment of Representative (AOR) contains the necessary elements and conforms to the Privacy Act requirements, **and is preferred**. For purposes of the Medicare health plan disseminating the AOR form, the most current edition must be used and prior versions of Form CMS-1696 are obsolete. **Please note that only sections I, II, and III of the form apply to the Medicare Advantage program.** Medicare health plans may not require appointment standards beyond those included in the CMS form.

Note: The CMS-1696 form, as written, applies to all Title XVIII Medicare benefits. However, a valid appointment of representative form submitted with a request that specifically limits the appointment to Part D prescription drug benefits is not valid for requests that involve Medicare Advantage (MA) benefits. In this situation, a member must properly execute a separate representative form if he or she wishes the Part D representative to also serve as his or her MA representative (or vice versa). If a representative (who is representing a member in regards to a Part D claim) files a MA grievance or requests an organization determination or appeal without a newly executed representative form, the Medicare health plan should explain to the representative that a new representative form must be executed, and provide the representative with a reasonable opportunity to submit the new form before dismissing the request.

4. Authority of a Representative

Unless otherwise stated in the 42CFR subpart M of part 422, the representative has all the rights and responsibilities of a member in filing a grievance, obtaining an organization determination, or in dealing with any of the levels of the appeals process. On behalf of the member the representative can;

- Obtain information about the member's claim to the extent consistent with Federal and state law;
- Submit evidence;
- Make statements of fact and law; and
- Make any request or give or receive any notice about the proceedings

All notices intended for the member must be sent to the member's representative instead of the member.

Details for the Form: CMS 1696 can be found at http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207.html.

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved OMB
No. 0938-0950

Appointment of Representative

Name of Party	Medicare or National Provider Identifier Number

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):
I appoint this individual, _____ to act as my representative in connection with my claim or asserted right under title XVIII of the Social Security Act (the "Act") and related provisions of title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

Section 2: Acceptance of Appointment

To be completed by the representative:
I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)
I waive my right to charge and collect a fee for representing _____ before the Secretary of the Department of Health and Human Services.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)
I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

Form CMS-1696 (Rev 06/12)

-CMS 1696 Appointment of Representative
For Spanish version visit The Centers for Medicare and Medicaid Forms page.

5. Complaints

Complaints may include both grievances and appeals. They may be processed as an appeal or as a grievance or both depending on the extent to which the issues wholly or partially contain elements that are organization determinations.

6. Organization Determination

Providers or members may obtain a written advance coverage determination (known as an organization determination) from BlueCare Plus before a service is furnished to confirm whether the service will be covered. To obtain an advance organization determination, call us at 1-866-789-6314 (be sure to have the member's ID number including the 3 character alpha prefix when you call) or fill out the form located at http://bluecareplus.bcbst.com/docs/providers/UM_Advance_Determination_Request_Fax.pdf and fax it to 1-866-325-6698. BlueCare Plus will make a decision and notify you and the member within 14 days of receiving the request, with a possible (up to) 14-day extension either due to the member's request or BlueCare Plus justification that the delay is in the member's best interest. In cases where you believe that waiting for a decision under this time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy, you can request an expedited determination. A physician may request an expedited determination, by calling us at 1-866-789-6314. We will notify you of our decision as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request, unless we invoke a (up to) 14-day extension either due to the member's request or BlueCare Plus justification (for example, the receipt of additional medical evidence may change BlueCare Plus decision to deny) that the delay is in the member's best interest. In the absence of an advance organization determination, BlueCare Plus can retroactively deny payment for a service furnished to a member if we determine that the service was not covered by our plan (e.g., was not medically necessary). Contracted providers have the ability to appeal and follow the outlined dispute resolution processes. Non-contracted providers have the right to dispute our decision by submitting a waiver of liability (promising to hold the member harmless regardless of the outcome), and exercising member appeals rights see the Federal regulations at 42 CFR Part 422, subpart M, Chapter 13 of the Medicare Managed Care Manual).

Advanced Beneficiary Notice (ABN)

An ABN is a document used by Original Medicare to inform members that an item or service is unlikely to be considered for coverage under Medicare rules and regulations. Medicare Advantage plans do not recognize ABNs. When informing a member that a service is not covered or excluded from their health benefit plan, it's considered an organization determination under 42 CFR, 422.566(b), and requires a formal organization determination denying coverage.

An "ABN waiver" isn't sufficient documentation of this notification; therefore, please request a pre-determination on the member's behalf before you provide any non-covered service/supply. This includes network providers referring a patient/member to a non-network provider for services and supplies.

7. Notice Requirements for Non-contract Providers

If BlueCare Plus denies a request for payment from a non-contract provider, BlueCare Plus will notify the provider of the specific reason for the denial and provide a description of the appeals process. A written notification will be provided.

Non-contract Provider Appeals

A non-contract provider, on his or her own behalf, is permitted to file a standard appeal for a denied claim only if the non-contract provider completes a waiver of liability statement, which provides that the non-contract provider will not bill the enrollee regardless of the outcome of the appeal.

8. Re-openings and Revising Determinations and Decisions

A reopening is a remedial action to change a final determination or decision even though the determination or decision was correct based on the evidence of record. The action may be taken by the following;

BlueCare Plus to revise the organization determination or reconsideration
An IRE to revise the reconsidered determination.

- An ALJ to revise the hearing decision
- The MAC to revise the hearing or review decision

BlueCare Plus processes clerical including minor errors and omissions as reopening rather than reconsiderations. If however a request for reopening is submitted and after review determined that the issue is a clerical error, the reopening request will be dismissed and the member or representative will be advised of any appeal rights, provided the timeframe to request an appeal on the original claim has not expired.

Examples of errors may include mathematical or computational mistakes, inaccurate data entry or denials of claims as duplicates.

According to CMS regulations, BlueCare Plus must process clerical errors, minor errors and omissions as a reopening.

The following are guidelines for submitting a reopening request;

- The request must be made in writing;
- The request for a reopening must be clearly stated;
- The request must include the reason for requesting a reopening; and
- The request should be made within the time frames permitted;

9. Re-opening Timeframes

- Within 1 year from the date of the organization determination or reconsideration for any reason;

- Within 2 years plus the current year from the date of the organization determination or reconsideration for good cause;
- At any time if there exists reliable evidence (i.e., relevant, credible, and material) that the organization determination was procured by fraud or similar fault;
- At any time if the organization determination is unfavorable, in whole or in part, to the party thereto, but only for the purpose of correcting a clerical error on which that determination was based; or
- At any time to effectuate a decision issued under the coverage (National Coverage Determination (NCD)) appeals process.

Resource

Additional information for the appeals process is available at http://cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c13.pdf.

B. Provider Dispute Resolution

Purpose: To address and resolve any and all matters causing participating Providers ("Providers") or BlueCross BlueShield of Tennessee or its affiliated companies ("BCBST") to be dissatisfied with any aspect of their relationship with the other party (a "Dispute"). Providers are encouraged to contact a representative of BlueCross BlueShield of Tennessee's Provider Network Management Division if they have any questions about this procedure statement or concerns related to their network participation.
*Non-contracted, non-participating, and out-of-state Providers may also utilize the PDRP pursuant to the terms hereof and in accordance with BCBST policy.

Introduction.

A. This Procedure describes the exclusive method of resolving any Disputes related to a Provider's participation in BCBST's network(s). It is incorporated by reference into the participation agreement between the parties (the "Participation Agreement") and shall survive the termination of that Agreement.

B. This Procedure shall only be applicable to resolve Disputes that are subject to BCBST's or the Provider's control, such as claims, administrative or certification issues. It shall not be applicable to issues involving third parties that are not within a party's control (e.g. determinations made by a customer purchasing administrative services only ("ASO Customers") from BCBST).

C. This Procedure shall not be applicable to actions that may be reportable pursuant to the Federal Health Care Quality Improvement Act. Matters involving peer review evaluation of an applicant's professional qualifications, conduct or competence must be resolved pursuant to BCBST's "Medical Management Corrective Action Plan" (Section XI.D).

D. The initiation of a Dispute shall not require a party to delay or forgo taking any action that is otherwise permitted by the Participation Agreement.

E. This Procedure statement establishes specific time periods for parties to respond to inquiries and requests for reconsideration. If it is not reasonably possible to provide a final response within those

time periods, the responding party may, in good faith, advise the other party that it needs additional time to respond to that matter. In such cases, the responding party shall advise the other party of the status of that matter at least once every thirty (30) days until it submits a final response to the other party.

F. A party must commence an action to resolve a Dispute pursuant to this Dispute Resolution Procedure within eighteen (18) months of the date of the event causing that Dispute occurred (e.g. the date of the letter informing the Provider of a determination) or, with respect to a Provider request for reimbursement of unpaid or underpaid claims, within eighteen (18) months of the date the Provider received payment or, in the event of unpaid claim, the date the Provider received notice that the claim was denied. This provision shall not extend the period during which a Participating Provider must submit a claim to BCBST pursuant to applicable provisions of the Provider's agreement(s) with BCBST, although the Provider may commence a dispute related to the denial of a claim that was not filed in a timely manner within eighteen (18) months after receiving notice of the denial of that claim. If BCBST discovers a matter creating a Dispute with a Participating Provider during an audit which is in progress at the end of the eighteen (18) month period referenced in this paragraph, it shall have one hundred twenty days (120) from the conclusion of that audit to initiate a Dispute concerning that matter. The failure to initiate a Dispute within that period specified in this subsection shall bar any type of action related to the event causing that Dispute, unless the parties agree to extend the time period for initiating an action to resolve that Dispute pursuant to this procedure statement.

G. ALL DISPUTES WILL BE SUBJECT TO BINDING ARBITRATION IF THEY CAN NOT BE RESOLVED TO THE PARTIES' SATISFACTION PURSUANT TO SECTIONS II (A-B) OF THIS PROCEDURE STATEMENT.

DESCRIPTION OF THE DISPUTE RESOLUTION PROCEDURE.

A. INQUIRY/RECONSIDERATION.

Providers should contact a representative of the BCBST division or department that is directly involved in any matter that may cause a Dispute between the parties. (e.g. the Claims Service Department if there is a question concerning a claims related issue). If Providers do not know whom to contact, they may contact a representative of the Provider Network Management Division for assistance in directing their inquiries to the appropriate BCBST representative. BCBST may initiate an inquiry by contacting the Provider or the person that the Provider designates to respond to such inquiries (e.g. an office manager). If a party cannot respond immediately to the other party's inquiry, it shall make a good faith effort to investigate and respond to that inquiry within thirty (30) days.

B. APPEAL.

If not satisfied, a party may submit a written appeal within sixty (60) days after receiving the other party's response to its inquiry/reconsideration. That request shall state the basis of the Dispute, why the response to its inquiry/reconsideration is not satisfactory, and the proposed method of resolving the Dispute. The receiving party will make a good faith effort to respond, in writing, within sixty (60) days after receiving that appeal.

C. BINDING ARBITRATION.

If the parties do not resolve their Dispute, the next and final step is binding arbitration. If a party is not satisfied with an adverse decision, then it shall make a written demand that the Dispute be submitted to binding arbitration pursuant to the Commercial Arbitration Rules of the American Arbitration Association (current ed.). Either party may make a written demand for binding arbitration within sixty (60) days after it receives a response to its appeal. The venue for the arbitration shall be Chattanooga, TN unless otherwise agreed. The arbitration shall be conducted by a panel of three (3) qualified arbitrators, unless the parties otherwise agree. The arbitrators may sanction a party, including ruling in favor of the other party, if appropriate, if a party fails to comply with applicable procedures or deadlines established by those Arbitration Rules.

Each party shall be responsible for one-half of the arbitration agency's administrative fee, the arbitrators' fees and other expenses directly related to conducting that arbitration. Each party shall otherwise be solely responsible for any other expenses incurred in preparing for or participating in the arbitration process, including that party's attorney's fees. The claimant shall pay the applicable filing fee established by the American Arbitration Association, but the filing fee may be reallocated or reassessed as part of an arbitration award either, in whole or in part, at the discretion of the arbitrator/arbitration panel if the claimant prevails upon the merits. If the claimant withdraws its demand for arbitration, then the claimant forfeits its filing fee and it may not be assessed against BCBST.

The arbitrators: shall consider each claimant's demand individually and shall not certify or consider multiple claimants' demands as part of a class action; shall be required to issue a reasoned written decision explaining the basis of their decision and the manner of calculating any award; shall limit review to whether or not the Plan's action was arbitrary or capricious; may not award punitive, extra-contractual, treble or exemplary damages; may not vary or disregard the terms of the Provider's participation agreement, the certificate of coverage and other agreements, if applicable; and shall be bound by controlling law; when issuing a decision concerning the Dispute. Emergency relief such as injunctive relief may be awarded by an arbitrator/arbitration panel. A party shall make application for any such relief pursuant to the Optional Rules for Emergency Measures of Protection of the American Arbitration Association (most recent edition). The arbitrators' award, order or judgment shall be final and binding upon the parties. That decision may be entered and enforced in any state or federal court of competent jurisdiction. That arbitration award may only be modified, corrected vacated for the reasons set forth in the United States Arbitration Act (9 USC § 1).

D. EFFECTIVE DATE.

This procedure statement was adopted by BCBST on June 1, 1997.

Note: The former Provider Dispute Form has been replaced with the following fillable forms located on BlueCare Plus Tennessee website: Provider Reconsideration Form

Provider Reconsideration Form and the Provider Appeal Form are located at www.bcbst.com/providers/forms/reconsideration-and-appeals.page.

C. BlueCare Plus Choice (FIDE) Reportable Event Management

Reportable Event Management (REM) Requirements

In HCBS programs, there are three (3) categories of Reportable Events: Tier 1, Tier 2, and Additional Reportable Events and Interventions. The type of Reportable Event dictates the reporting requirements and process that must be followed by the provider, BlueCare, and DIDD, as outlined in the REM Operational Protocol. **Providers are to comply with the requirements specified in the REM Protocol and Definitions document.**

XV. Provider Manual Change Document

Provider Manual Update

Update 20221001

Correction	Page	Description
20221001.01	57	Added “organization providers” to intro
20221001.02	58	Added “organization providers”
20221001.03	59	Added Addictionologist (Non-Psych) and Addictionologist (Buprenorphine)
20221001.04	60	Language added, Behavior Analyst section added
20221001.05	61	Language added, removed Genetic Counselor
20221001.06	62	Language added, LCSW and Marriage & Family Therapist added
20221001.07	63	Language added, Nurse Prac. Clinical Nurse Specialist and Psych. Nurse added
20221001.08	65	Professional Counselors and Psychologists or Psychoanalyst added
20221001.09	66 - 72	Language added, several new sections added to list
20221001.10	74	Language added
20221001.11	83	Language added
20221001.12	84-85	Language added/removed
20221001.13	98	Language added/removed
20221001.14	100	Language added
20221001.15	122	Peer-to-Peer language added
20221001.16	123	Tiering Exception removed
20221001.17	164	Link to Health & Drug Plan Quality & Performance Rating updated
20221001.18	165	“2020” changed to “2022”

Update 20220701

Correction	Page	Description
20220701.01	56	EFT process updated
20220701.02	57	Credentialing process for practitioners updated
20220701.03	58	Language added to Anesthesiologist
20220701.04	59	Language added to CRNA; Dentist – Endontist, Periodontist, & Prosthedontist added
20220701.05	60	Language added to Hospital-Based
20220701.06	61	Oral & Maxillofacial surgeon updated; Language added to Pathologist
20220701.07	63	Credentialing process for Behavioral Health providers/practitioners updated; Language added to Radiologist; “Exclusion” changed to “Exception”
20220701.08	78	Nurse Practitioner – Oncology removed from list; Added Nurse Practitioner – Neonatal and Nurse Practitioner – Pediatrics to list
20220701.09	91	Hyperlink changed
20220701.10	125	“Information Systems” changed to “Enterprise Information Technology”
20220701.11	168	Corrected Bills section added
20220701.12	199	Comma added; “of” replaced with “and”

Update 20220401

Correction	Page	Description
20220401.01	9	Language added
20220401.2	10	Language added
20220401.3	11	Link changed
20220401.4	14	Link changed
20220401.5	22	Language added
20220401.6	23-27	Language added/Benefits grid updated
20220401.7	58	Language added
20220401.8	59	Language added

20220401.9	62	Language removed
20220401.10	65	Radiologist title updated
20220401.11	90	Language added
20220401.12	91	Language added
20220401.13	92	Language added
20220401.14	93	Language added
20220401.15	94	Language added
20220401.16	96	Language added
20220401.17	100	Language added
20220401.18	102	Language added
20220401.19	103	Language added
20220401.20	108	Language added
20220401.21	112	Major section addition
20220401.22	115	Language added
20220401.23	116	Language added
20220401.24	117	Language added
20220401.25	118	Language added
20220401.26	119	Language added
20220401.27	124	Language added
20220401.28	126	Language added
20220401.29	127	Language added
20220401.30	128	Language added
20220401.31	129	Language added
20220401.32	130	Language added
20220401.33	131	Language added
20220401.34	132	Language added

20220401.35	133	Language added
20220401.36	134	Language added
20220401.37	135	Language added
20220401.38	136	Language added
20220401.39	137	Language added
20220401.40	139	Language added
20220401.41	140	Language added
20220401.42	141	Language added
20220401.43	142	Language added
20220401.44	142-154	Prior Authorization Review section addition
20220401.45	158	Language added
20220401.46	159-161	Medical Policy addition
20220401.47	166	2022 Measurement Year Scorecard updated
20220401.48	169	Language added
20220401.49	170	Language added
20220401.50	171	Language added
20220401.51	172	Language added
20220401.52	173	Language added
20220401.53	176	Language added
20220401.54	177-185	CMS 1500 Quick Reference Guide Updated
20220401.55	185	Language added
20220401.56	187	Language added
20220401.57	188	Language added
20220401.58	192	Language added
20220401.59	193	Therapy and Rehab Services section added
20220401.60	194	Language added

20220401.61	195	Language added
20220401.62	196	Language added

Update 20220101

Correction	Page	Description
20220101.01	16	Removed “To arrange Behavioral Health Services.”
20220101.02	66	Reworded “Acupuncturist” language
20220101.03	68	Removed Interventional Radiology and related language; Added language
20220101.04	69	Added “Obstetrics & Gynecology” and related language
20220101.05	71	Added Diagnostic Radiology and Interventional Radiology and related language; Removed description in Radiology title
20220101.06	93	Language added to Sleep Labs
20220101.07	118	Language added/removed
20220101.08	132	Removed “tier exception or”
20220101.09	133	Removed “on any tier” and “tier exception or”
20220101.10	134	Removed “tier exception and” language, other language removed

Update 20211001

Correction	Page	Description
20211001.01	64	Note added
20211001.02	100	Note added
20211001.03	114	Changes to Part B Drug Screen section
20211001.04	114	Removed “ ‘s” from BlueCare Plus
20211001.05	117	Changed “Psych” to “Psychiatric” in table
20211001.06	155-156	Language changed in PDRP
20211001.07	234	REM language modified to be high level per TDCI deficiency #1

Update 20210701

Correction	Page	Description
20210701.01	36	Language added
20210701.02	37	Language added
20210701.03	61-99	Credentialing section changed to match the Commercial and BlueCare Credentialing sections
20210701.04	112	Language added
20210701.05	115	Language removed/added
20210701.06	116	Language added
20210701.07	123	Language added
20210701.08	130	Updated formulary hyperlink
20210701.09	164	Language added
20210701.10	192-195	Language removed/added
20210701.11	239	Language added
20210701.12	256	Change of Ownership attachment added

Update 20210401

Correction	Page	Description
20210401.01	8	XIV. Appeals and Grievances TOC – switched “critical incidents” to “reportable event management”
20210401.02	15	Changed contact number
20210401.03	69-76	Language added
20210401.04	97	Added “/Neuropsychological” to table entry “psychological testing” as well as to “psychological testing” near bottom of page
20210401.05	103	9. Behavioral Health Quality Management - Added/Removed language
20210401.06	104	9. Behavioral Health Quality Management - Added/Removed Language
20210401.07	107	N. Over The Counter - $300 changed to $315
20210401.08	111	Changed hyperlink to direct to the formulary
20210401.09	130	D. Prior Authorization - Language added/removed from list

20210401.10	213-223	C. BlueCare Plus Choice (FIDE) Critical Incidents – Changed entirety of section including title to reflect “reportable event management”
20210401.11	221	Added bullet “COVID-19 test results (positive and negative results only)”
20210401.12	Footer	Added version suffix to footer

Update 20210101

20210101.01	**16**	Replaced phone number in 3. Important Contact Info
20210101.02	**93**	Removed language from D. Part B Drugs
20210101.03	**93**	Correction to 1st bullet under Part B. Drugs Include:
20210101.04	**93**	Language added to 5th bullet under Part B. Drugs Include:
20210101.05	**103**	Language added to Behavioral Health Quality Management
20210101.06	**103**	Language added to Behavioral Health Quality Management

Update 20201001

Correction	Page	Description
20201001.01	**15**	Updated to the Important Contact Information Grid
20201001.02	**93**	Updates to language regarding Part D Drugs in Chapter V, Section D.
20201001.03	**102 to 104**	Updates to Chapter V, Section I, Sub-Section 9 for Behavioral Health Quality Management.
20201001.04	**108**	Addition of the Nurse Line number to Chapter V, Section T.
20201001.05	**111**	Removal of Part D language from Chapter VII.
20201001.06	**123 to 125**	Changes Case Management to Care Management in Chapter IX, Section B, E, and H.
20201001.07	**131**	Addition of language regarding HH Aid and PDN Missed Visits in Chapter X, Section F.
20201001.08	**208**	Addition of language regarding Advanced Beneficiary Notice (ABN) in Chapter XIV, Section A, Subsection 6.
20201001.09	**214**	Update to the BlueCare Plus FIDE fax number for written critical incident reports in Chapter XIV, Section C.

Update 20200701

Correction	Page	Description
20200701.01	**12**	Updated link to the Business Code of Conduct.
20200701.02	**25 to 26**	Language added to Chapter III explaining seamless enrollment and adding more information for the Special Enrollment Period.
20200701.03	**35**	Updated the PCP Change Form.
20200701.04	**85 to 86**	Updated screenshots added to reflect updated BlueCare Plus webpages.
20200701.05	**98**	"CSU" added to footnote at bottom of Chapter I, Section 3.
20200701.06	**98**	Updates to Chapter I, Section 4 related authorization requests.
20200701.07	**100**	Updates to Chapter I, Section 8 to clarify requirements are specific to outpatient treatment providers.
20200701.08	**102**	Updates to Chapter I, Section 8 to remove consent requirements related to adolescents.
20200701.09	**104 to 105**	Updates to Chapter I, Section 9 to revise language for complaint investigation, reporting of adverse occurrences, and site visit reviews.
20200701.10	**211 to 213**	Updates to process for Critical Incident reporting in Chapter XIV, Section C.

Update 20200401

Correction	Page	Description
20200401.01	**97 to 98**	Additional of Medication Assisted Treatment as benefit to Chapter V, Section I, subsection 3.
20200401.02	**112**	Updates to guidance for locating the Pharmacy Directory in Chapter VII, Section A.
20200401.03	**114**	Updated link to Coverage Determination form in Chapter VII, Section A.
20200401.04	**122 to 127**	Updates to chapter IX to reflect implementation of FIDE SNP and case management language updates.
20200401.05	**130; 132 to 133**	Updates to Prior Authorization requirements in Chapter X.
20200401.06	**139**	New Section D, Quality Incentive Program, added to Chapter XI.
20200401.07	**192**	Updates to Quick Reference Guide Link in Chapter XII, Section A, subsection 6.

Update 20200101

Correction	Page	Description

20200101.01	**Entire Manual**	Additional changes to reflect implementation of the FIDE SNP product (BlueCare Plus Choice).
20200101.02	**26 to 31**	Updates to benefits for 2020 calendar year in Chapter III, Section B.
20200101.03	**32**	Updated language added related to BlueCare Plus Choice Member ID Card in Chapter III, Section C.
20200101.04	**36**	Updates to Provider Change Form instructions in Chapter IV, Section A.
20200101.05	**37 to 41**	Miscellaneous language clean-up.
20200101.06	**46 to 47**	Language updates to participation standards in Chapter IV, Section A, subsection 6.
20200101.07	**67 to 76**	Language updates to credentialing requirements in Chapter IV, Section B, subsection 3.
20200101.08	**79 to 80**	Additional requirement added related to CMS screening requirements in Chapter IV, Section B, subsection 5.
20200101.09	**89**	Language added to Chapter V introduction regarding BlueCare Plus Choice Medicaid benefits.
20200101.10	**93**	Language revised in Chapter V, Section C to reflect 2020 benefits.
20200101.11	**96 to 98**	Language revised in Chaptber V, Section I related to Behavioral Health services.
20200101.12	**108**	Language revised in Chapter V, Section S & T to reflect 2020 benefits.
20200101.13	**112**	Language revisions in Chapter VII, Section A related to the redetermination process.
20200101.14	**129**	Language added to Chapter X, Section A regarding BlueCare Plus Choice Medicaid benefits.
20200101.15	**129 to 131**	Language revisions to prior authorization requirements in Chapter X, Section D.
20200101.16	**133**	Language revisions to prior authorization timeframes in Chapter X, Section J.
20200101.17	**137 to 139**	Language updates to STARS information in Chapter XI, Section C.
20200101.18	**186**	Updated references to ICD-9 to ICD-10 in Chapter XIII, Section A.
20200101.19	**210 to 212**	New Section C added to Chapter XIV for BlueCare Plus Choice FIDE Critical Incidents

Update 20191001

Correction	Page	Description
20191001.01	**Entire Manual**	Changes to reflect implementation of the FIDE SNP product (BlueCare Plus Choice).

20191001.02	**31 to 32**	Updated image for the BlueCare Plus DSNP ID Card and added image for the BlueCare Plus Choice ID Card.
20191001.03	**34**	Updated fax number for PCP Change Team.
20191001.04	**35**	Updated PCP Change Form.
20191001.05	**95**	Removal of Member Outreach subsection from Chapter V, section I.
20191001.06	**97**	Updated instructions for contacting BlueCare Plus provider network management.
20191001.07	**103**	Language updates to Chapter V, Section J related to Dental Services.
20191001.08	**106**	Language updates to Chapter V, Section S related to Vision Services.
20191001.09	**107 to 108**	Note added to Chapter VI, Section A related to benefits traditionally excluded from BlueCare Plus that may be considered to be covered benefits for BlueCare Plus Choice.
20191001.10	**112**	Updates to Chapter VII, Section B specific to Member ID Cards redirecting the reader to Chapter III, Section C to view Member ID card images.
20191001.11	**113 to 133**	Miscellaneous terminology updates (care coordination to case management) to Chapter VIII, Chapter IX, and Chapter X.
20191001.12	**143 to 166**	Updates to claims filing instructions in Chapter XII, Section B and Section C.

Update 20190701

Correction	Page	Description
20190701.01	**Entire Manual**	Replaced “BlueAccess” with “Availity” including updates for links and access information.
20190701.02	**14**	Behavioral Health Prior Authorization contact phone and contact fax line updated. Corrected Link for Title VI information.
20190701.03	**16**	Changed Tennessee Health Connection to TennCare Connect in Important Contact Information table.
20190701.04	**38 to 41**	Updates to Provider Requirements Chapter IV, Section A, Subsections 3, 4, and 5 including large revisions to provider participation appeal processes.
20190701.05	**92**	Revised language in Chapter V, Section D.
20190701.06	**95 to 96**	Revised Cover Services Chart in Chapter V, Section I, Subsection 4
20190701.07	**105 to 106**	Updates to benefit limits in Chapter V, Section M, N, and R.
20190701.08	**109**	Language revisions to entire Chapter
20190701.09	**127 to 133**	Language revisions in Chapter X, Sections A and M
20190701.10	**179**	New section added to Chapter XII for Reimbursement General Provisions

20190701.11	**198 to 199**	Updated Appeals Process Charts

Update 20190401

Correction	Page	Description
20190401.01	**98**	Minor updates to fix spelling and grammar errors.
20190401.02	**104 to 105**	Updates to treatment record requirements.
20190401.03	**108**	Updated hyperlink to Behavioral Health Adverse Occurrence Reporting Form.
20190401.04	**115 to 118**	Updates to Pharmacy Chapter including contact information and prior authorization.
20190401.05	**133**	Additional language added to UM Chapter related to requirements for BH services.

Update 20190101

Correction	Page	Description
20190101.01	**Entire Manual**	Rearranging the order of some Chapters and section-realignment.
20190101.02	**12**	Removal of content from Chapter I (Introduction), Section C (Provider Manual Requirements); content was moved to Chapter IV (Provider Requirements), Section B (Provider Credentialing).
20190101.03	**14 to 22**	Updates to content and phone numbers in Chapter II (Administrative).
20190101.04	**23 to 36**	Addition of significant language to Chapter III (Member Enrollment) and significant revisions to Section B (Summary of Benefits).
20190101.05	**71 to 73**	Removal of credentialing requirements for non-applicable specialties in Chapter IV (Provider Requirements), Section B (Provider Credentialing)
20190101.06	**81 to 84**	Updated contact hours for eBusiness Solutions in Chapter IV (Provider Requirements), Section C (Electronic Data Interchange EDI).
20190101.07	**93 to 114**	Language revisions and language additions in Chapter V (General Guidelines for Benefits).
20190101.08	**115 to 116**	Minor language revisions to Chapter VI (Non-Covered Benefits).
20190101.09	**128 to 132**	Minor language revisions to Chapter IX (Care Management).
20190101.10	**135**	Updates to Prior Authorization Requirements in Chapter X (Utilization Management), Section D (Prior Authorization).

20190101.11	**140**	Removal of Section M (Member Appeal Process) in Chapter X (Utilization Management).
20190101.12	**146 to 183**	Minor language revisions in Chapter XII (Billing and Reimbursement).
20190101.13	**174 to 176**	New Readmission Policy added in Chapter XII (Billing and Reimbursement).
20190101.14	**195 to 210**	New Chapter XIV (Appeals and Grievances) created to house all appeals and grievance content.

Update 20181001

Correction	Page	Description
20181001.01	**Entire Manual**	Formatting updates to add consistency to text font, text size, and content alignment.
20181001.02	**Entire Manual**	Changing “BlueCare Plus HMO D-SNP” to “BlueCare Plus”
20181001.03	**Entire Manual**	Correcting links for www.bcbst.com and www.bluecareplus.bcbst.com.
20181001.04	**Entire Manual**	Changing “Bureau of TennCare” to “Division of TennCare”
20181001.05	**13**	Updated Provider Manual Requirements Chart
20181001.06	**17**	Updated Contact Information Chart
20181001.07	**20**	Language changes to reflect online fraud reporting process
20181001.08	**22**	Updating link for reporting suspected TennCare recipient fraud and/or abuse
20181001.09	**27 to 53**	Addition of new language to *Chapter II. Section E. Provider Networks* to bring the content into alignment with the other BCBST Provider Manuals.
20181001.10	**53 to 71**	Addition of new language to *Chapter II. Section F. Provider Credentialing* to bring the content into alignment with the other BCBST Provider Manuals.
20181001.11	**103**	Correcting TennCare links for provider information, member information, and LTSS information.
20181001.12	**103**	Updated BlueCare Plus Summary of Benefits Chart
20181001.13	**113 to 127**	Significant revisions to *Chapter IV. General Guidelines for Benefits* impacting every existing section with additions of new sections.
20181001.14	**128 to 129**	Significant revisions to *Chapter V. Non-Covered Benefits* impacting every existing section with removal of sections.
20181001.15	**137 to 143**	Significant revisions to *Chapter VIII. Model of Care (MOC) D-SNP*

20181001.16	**144 to 145**	Revisions to Chapter IX. Section C. Discharge Planning/Transition of Care
20181001.17	**150 to 156**	Significant revisions to *Chapter X. Utilization Management* including new sections as well as removed sections
20181001.18	**182**	Removal of information pertaining to "Readmission Quality Program"
20181001.19	**233 to 237**	Language revisions within Chapter XIV. Quality Improvement Program to provide process clarity

Update 20170609

Correction	Page	Description
20170609.1	**30**	Inserted Network Participation Criteria
20170609.2	**118**	Removed BlueSource Provider Information CD. Information now communicated through BlueAlert newsletter and manual changes.
20170609.3	**58**	Adding Clinical Practice Guidelines
20170609.4	**126**	Addition of coordination of member's care with PCPs and other treating providers
20170609.5	**86**	Updating Vision allowance for supplemental benefit
20170609.6	**86**	Updating Transportation supplemental benefit
20170609.7	**54**	Updating ecomm URL
20170609.8	**55**	Updating ecomm URL
20170609.9	**87**	Updating BluePerks URL

Update 20170412

Correction	Page	Description
20170412.1	**13**	Changing URL for Interpretation Services (Click on Interpretation for change) from http://www.usdoj.gov/crt/cor/coord/titlevi.htm to www.fhwa.dot.gov/civilrights/programs/tvi.cfm
20170412.2	**17**	Changing URL for Fraud and Abuse (Click on Fraud and Abuse) from http://www.bcbst.com/fraud/report.shtml to www.bcbst.com/fraud/index.page?
20170412.3	**165**	Changing Skilled Nursing Fax Form (Click on Form for change) from http://www.bcbst.com/providers/bcbst-medicare/forms.shtml and fax to 1-888-535-5243 to bluecareplus.bcbst.com/docs/providers/UM_Skilled_Nursing_Facility_Request_Fax.pdf
20170412.4	**179**	Changing URL for CAHPS (Click on CAHPS for change) from http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/CAHPS-Reports.html to www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS
20170412.5	**182**	Changing URL for Health Outcomes Survey (HOS) (Click on Health Outcomes for change)from www.hosonline.org/Content/Default.aspx to www.cms.gov/research-statistics-data-and-systems/files-for-order/limiteddatasets/hos.html

20170412.6		Adding URL (click on URL) www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/mc86c04.pdf to MSP section

Update 20170313

Correction	Page	Description
20170313.1	**20**	Adding Education of Employees, Contract and Agents to Table of Contents
20170313.2	**03**	Adding Non-Discrimination to Table of Contents
20170313.3	**20**	Add section for Non-Discrimination
20170313.4	**53**	Changing sentence to read: A physician may request ~~To obtain~~ an expedited determination, by calling us at 1-866-789-6314
20170313.5	**54**	Adding Provider Dispute Procedure
20170313.6	**160**	Adding Re-Admission Reimbursement and Quality Program Information
20170313.7	**02**	Updating page numbers to Table of Contents to reflect additional information

Update 20150624

Correction	Page	Description
20150624.1	166	Removed "CMS1450using"
20150624.2	166	Changed TOB 33X to 32X as BlueCare Plus does not follow the same Medicare reimbursement methodology as Original Medicare. CMS Internet Only Manual, Publication 100-04, Chapter 10, Section 40.2 "HH PPS applies only to Medicare fee-for-service".
20150624.3	96	Removed "T" from PCP
20150624.4	96	Changed "meetings" to "reviews"
20150624.5	96	Changed "packet" to "document"
20150624.6	96	Changed "meetings" to "reviews"
20150624.7	96	Added "d" to "an" for and
20150624.8	96	Added additional paragraph for the BlueCare Plus ICT process
20150624.9	96	Correct from member to member's
20150624.10	96	Corrected spelling from wither to whether

20150624.11	96	Added electronically or by fax to method of distributing ICT document
20150624.12	161	Remove "or" DUPLICATE

Update 20141110

Correction	Page	Description
20141110.1	166	Addition of National Drug Code Billing instructions including billing information regarding the filing a claim with an NDC number
20141110.2	118	Addition of Observation Notifications information. Adding observation notification requirements and procedure.
20141110.3	166	Correcting "provider" to "providing"
20141110.4	**170**	Changing CMS utilizes the Hierarchical Condition Category (HCC) payment model (supported by ICD-9-CM codes) and encounter data submitted by MA plans to establish risk scores to the following; CMS utilizes the Hierarchical Condition Category (HCC) payment model (supported by ICD-9-CM codes and successor codes) and encounter data submitted by MA plans to establish risk scores
20141110.5	**170**	The primary source of encounter data or ICD-9 codes routinely submitted to CMS is extracted from claims with additional conditions being identified during retrospective chart review. The primary source of encounter data or ICD-9 codes and successor codes routinely submitted to CMS is extracted from claims with additional conditions being identified during retrospective chart review.
20141110.6	**170**	CMS looks to providers to code identified conditions accurately using ICD-9-CM coding guidelines and with supporting documentation in their medical record. CMS looks to providers to code identified conditions accurately using ICD-9-CM coding guidelines and successor codes with supporting documentation in their medical record.
20141110.7	**170**	• Accurately reporting ICD-9-CM diagnosis codes to the **highest level of specificity** (critical as this determines disease severity). • Accurately reporting ICD-9-CM diagnosis codes and successor codes to the **highest level of specificity** (critical as this determines disease severity).
20141110.8	**171**	Physician data is critical for accurate risk adjustment. Physicians are the largest source of ambulatory data for the risk adjustment model. CMS-HCC model relies on ICD-9-CM coding specificity. Physician data is critical for accurate risk adjustment. Physicians are the largest source of ambulatory data for the risk adjustment model. CMS-HCC model relies on ICD-9-CM and successor codes coding specificity.
20141110.9	**171**	Risk adjustment helps meet the provider's CMS responsibilities regarding reporting ICD-9-CM codes, including: Risk adjustment helps meet the provider's CMS responsibilities regarding reporting ICD-9-CM codes and successor codes, including:
20141110.10	**171**	Maintaining accurate and complete medical records (ICD-9-CM codes must be submitted with proper documentation Maintaining accurate and complete medical records (ICD-9-CM codes and successor codes must be submitted with proper documentation).

20141110.11	**171**	It is important for the physician's office to code each encounter in its entirety; the claim should report the ICD-9-CM code of every diagnosis that was addressed, and should only report codes of diagnoses that were actively addressed. It is important for the physician's office to code each encounter in its entirety; the claim should report the ICD-9-CM code and successor codes of every diagnosis that was addressed, and should only report codes of diagnoses that were actively addressed.
20141110.12	**172**	Utilize problem lists (ensuring they are comprehensive, show evaluation and treatment for each condition relating to an ICD-9-CM code on the date of service, and are signed and dated by the physician or physician extender). Utilize problem lists (ensuring they are comprehensive, show evaluation and treatment for each condition relating to an ICD-9-CM code and successor codes on the date of service, and are signed and dated by the physician or physician extender).
20141110.13	**158**	The hospital must include this information on the UB 04 using classifications and terminology consistent with the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM). The hospital must include this information on the UB 04 using classifications and terminology consistent with the International Classification of Diseases, Ninth Edition, Clinical Modification (ICD-9-CM and successor codes).
20141110.14	**177**	1st Paragraph - Corrected spelling error from "Prinvate" to private in the first paragraph.
20141110.15	**177**	2nd Paragraph – Changed "chhosing" to "choosing"
20141110.16	**75**	Removing - BlueCare Plus partners with ValueOptions® of Tennessee to administer behavioral health care services for its BlueCare Plus members. ValueOptions® is responsible for coordinating the provision of covered behavioral health services, establishing and managing a provider network, credentialing and contracting with providers. Providers interested in contracting with ValueOptions® can call 1-800-397-1630. Minimum network criteria required for participation in a ValueOptions® provider network can be found online at http://www.valueoptions.com/providers/Forms/Administrative/Provider_Credentialing_Criteria_Checklist.pdf.
20141110.17	**75**	Replacing the name ValueOptions with BlueCare Plus and adding http://www.bcbst.com/providers/contracting-credentialing.page? - BlueCare Plus utilizes ValueOptions® for credentialing and contracting of Behavioral Health Practitioners. All providers who participate in a ValueOptions® network must be credentialed/recredentialed according to ValueOptions® requirements. For a detailed listing of credentialing requirements for practitioners and facilities, visit www.valueoptions.com provider site and select "Forms" or call the National Provider line at 1-800-397-1630.
20141110.18	**82**	Removing - **Cosmetic Surgery** from Non-Covered Benefits; Section C Custodial Care to new section Created Section E for **Cosmetic Surgery** Cosmetic surgery and expenses incurred in connection with the cosmetic surgery are not covered from under Non-Covered Benefits
20141110.19	**8**	Addition of the BlueCare Plus Manual Change Document
20141110.20	**76**	Replacing "ValueOptions" with BlueCare Plus
20141110.21	**76**	Replacing "ValueOptions" with BlueCare Plus
20141110.22	**76**	Replacing "ValueOptions" with BlueCare Plus
20141110.23	**77**	Replacing "ValueOptions" with BlueCare Plus

2014110.24	**76**	Removing "valueoptions.com"
20141110.25	**77**	Removing the word "and"

Attachment I - Change of Ownership (CHOW) Policy

The change of ownership requirements in this Policy only apply to facility and professional group provider types. It is the responsibility of the entity or person acquiring a provider to provide BCBST at least 60 calendar days advance notice of any change of ownership (CHOW) which is defined as a (a) direct or indirect sale or other disposition of all or a majority of the assets of provider; (b) any transaction resulting in a change in the beneficial owner, directly or indirectly, of more than 25% of the then-outstanding number of units, interests, or shares of the provider's voting stock (or membership interests or other equity); (c) the lease of all or part of Provider's facility or (d) any other transaction that results in a change to the NPI or Tax ID of Provider. When such advance notice is not furnished, payment to the provider may be impacted. The requirements under this policy are in addition to, and do not replace or supersede, any notice or approval requirements triggered by a CHOW, "Change of Control," or assignment that are set forth in the provider's agreement with BCBST.

The person or entity acquiring a provider is required to submit a CHOW notification using the Provider Change of Ownership Notification Form on BCBST's website. The buyer must also furnish a copy of the executed bill of sale or purchase document (minus the purchase price) within five (5) business days of closing. Failure to provide this documentation within this timeframe, will result in the suspension of payments to the provider following the CHOW.

Network Managers will assist the person or entity that is acquiring provider in completing any applicable credentialing and contracting processes prior to the effective date of the CHOW.

The buyer may be given the option to assume the seller's provider agreement, enter into a new agreement, or a single case agreement at BCBST's discretion. If BCBST determines a new agreement is required, the rates of the seller are not guaranteed to transfer to the buyer.

Claims with dates of service prior to the effective date of the CHOW should be submitted using the provider's NPI and Tax Id prior to the CHOW. Once the CHOW transaction closes, all claims for dates of service after the effective date of the CHOW should be submitted using the provider's NPI and Tax ID after the CHOW reflecting any change resulting from the CHOW.

Providers that fail notify BCBST of a CHOW at least 60 calendar days prior to the CHOW effective date may experience a gap in network participation and claims payment. If the buyer notifies BCBST at least 60 days prior to the effective date of the CHOW and BCBST agrees to maintain the seller's provider agreement or enter into a new provider agreement, the following will apply:

- The network effective date will be the CHOW effective date.
- Claims after the CHOW effective date will be reimbursed at 100% of the in-network rate subject to all applicable payment terms under the agreement.

Buyers that do not notify BCBST timely of a CHOW will be handled as follows:

- BCBST may terminate the provider's agreement.
- If credentialing or a new agreement is required, then the network effective date will be the later of the date credentialed or agreement execution, as applicable.
- If BCBST does not choose to terminate the provider's agreement, there nonetheless could be a gap in network participation for the facility or group.
- If BCBST does not choose to terminate the provider's agreement, claims for dates of service after the CHOW closing date will be reimbursed at 100% as of the network effective date instead of the CHOW effective date subject to all applicable payment terms under the agreement.