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Appeal
Any of the procedures that deal with the review of adverse determinations on the health care services a member is entitled to receive or any amounts that the member must pay for a covered service. The procedures may include reconsiderations by Blue Cross Medicare Advantage HMO, an independent review entity (IRE), hearings before an Administrative Law Judge (ALJ), review by the Medicare Appeals Council and federal judicial review.

Annual Health Assessment
The Blue Cross Medicare Advantage HMO/POS Annual Health Assessment (AHA) serves as a platform to identify essential clinical and care management needs and meets the requirements of the Medicare initial preventive and annual visits. The components of the AHA include the member's past medical history, social history, family history, physical exam (including BMI), preventive screenings and chronic disease monitoring. These assessments can occur in the provider's office or member's home to remove barriers to completion. The Annual Health Assessments are part of the Quality Program. The Annual Health Assessment Form is available on the provider portal.

Basic Benefits
All health care services covered under the Medicare Part A and Part B Programs, except hospice services and additional benefits. All members of Blue Cross Medicare Advantage HMO are eligible to receive all covered basic benefits.

Center for Health Dispute Resolution (CHDR)
An independent Centers for Medicare & Medicaid Services (CMS) contractor that reviews appeals by members of Medicare managed care plans, including Blue Cross Medicare Advantage HMO.

Centers for Medicare & Medicaid Services (CMS)
CMS is the federal agency responsible for administering Medicare.

Covered Services
Those benefits, services or supplies that are:

- Covered under the HMO Medicare Plan and approved for a member by an IPA Primary Care Physician
- Emergency services and urgently needed services that may be provided by non-contracted providers
- Renal dialysis services provided while the member is temporarily outside the service area.
- Basic and supplemental benefits

Detailed Explanation of Non-Coverage (DENC)
The CMS and HMO approved form to be completed and issued upon notice from the Quality Improvement Organization QIO that a member has appealed termination of services for skilled nursing, home health or comprehensive outpatient rehabilitation.

Effectuation
Compliance with a reversal of the Blue Cross Medicare Advantage HMO's original adverse organization determination. Compliance may entail payment of a claim, authorization for a service, or provision of services.

Emergency Medical Condition
Medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to receive immediate medical care could result in:

- Serious jeopardy of the patient's health;
- Serious impairment of bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement; or
- Serious jeopardy to the health of the fetus, in the case of a pregnant patient.

Emergency Services
Covered inpatient or outpatient services that are:

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

Explanation of Payment (EOP)
The statement provided to the provider when payment is made that informs the provider which procedures are being paid.

Experimental Procedures and Items
Items and/or procedures determined by not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, Blue Cross Medicare Advantage HMO will consider CMS guidance if applicable, and/or determinations already made by Medicare.

Facility
Hospital and ancillary providers, which include, but are not limited to: Durable Medical Equipment (DME) suppliers and Skilled Nursing Facilities (SNFs).

Fee-for-Service Medicare
A payment system by which doctors, hospitals and other providers are paid for each service performed (also known as traditional and/or original Medicare).

Grievance
Any complaint or dispute other than one involving an organization determination. Examples of issues that involve a complaint that will be resolved through the grievance rather than the appeal process may include: waiting times in physician offices; and rudeness or unresponsiveness of customer service staff.

Hospital - Acquired Conditions
Conditions that are generally considered by CMS: (a) high cost or high volume or both, (b) result in the assignment of a case to a diagnosis related groups (DRG) that has a higher payment when present as a secondary diagnosis and (c) could reasonably have been prevented through the application of evidence-based guidelines. These criteria are subject to change by CMS.

Home Health Agency (HHA)
A Medicare-certified agency which provides intermittent skilled nursing care and other therapeutic services in the member's home when medically necessary, when members are confined to their home and when authorized by their participating physician/professional provider.

Hospice
An organization or agency, certified by Medicare, which is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Hospital
A Medicare-certified institution licensed in the State of Illinois, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term “hospital” does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily custodial care, including training in routines of daily living.

Independent Physicians Association (IPA)
IPA means an Individual Practice Association, Independent Physician Association, organized Medical Group, Physician Hospital Organization or other legal entity organized to arrange for the provision of professional medical services.

Integrated Denial Letter (IDN)
The CMS and HMO approved letter to be completed and issued when the Medical Group denies a request for payment of a service already received or when the Medical Group terminates benefit coverage of a member.

Maximum Out-of-Pocket (MOOP)
The maximum amount that a member is subject to pay out-of-pocket during the calendar year for in network covered services.

Medicare
The federal government health insurance program established by Title XVIII of the Social Security Act.

Medicare Part A
Hospital insurance benefits including inpatient hospital care, SNF care, home health agency care and hospice care offered through Medicare.

Medicare Part A Premium
That portion of the premium required under Medicare to pay for Medicare Part A.

Medicare Part B
Medical insurance offered under Medicare that is optional and requires a monthly premium. Part B covers physician services (in both hospital and non-hospital settings) and services furnished by certain non-physician practitioners. Other Part B services include lab testing, DME, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services and blood not covered under Part A.

Medicare Part B Premium
A monthly premium paid to Medicare to cover Medicare Part B services. Members must pay this premium to Medicare to receive covered services whether members are covered by a Medicare Advantage Plan or by Original Medicare.

Medicare Advantage (MA) Plan
A policy or benefit package offered by a Medicare Advantage Organization under which a specific set of health benefits offered at a uniform premium and uniform level of cost sharing to all Medicare beneficiaries residing in the service area covered by the Medicare Advantage Organization. A Medicare Advantage Organization may offer more than one benefit plan in the same service area. Blue Cross and Blue Shield of Illinois (BCBSIL) is a Medicare Advantage Organization and Blue Cross Medicare Advantage HMO is a Medicare Advantage Plan.

Member
The Medicare beneficiary, entitled to receive covered services, who has voluntarily elected to enroll in the Blue Cross Medicare Advantage HMO and whose enrollment has been confirmed by CMS.

Non-Contracting Medical Physician/Professional Provider or Facility
Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the State of Illinois or Medicare to deliver or furnish health care services, and also being neither employed, owned, operated by, nor under contract with Blue Cross Medicare Advantage HMO or IPA to deliver covered services to Blue Cross Medicare Advantage HMO members.

Notice of Medicare Non Coverage (NOMC)
The CMS and HMO approved letter to be completed and issued when the Medical Group terminates benefits for skilled nursing, home health, or comprehensive outpatient rehabilitation.

Organization Determination
Any determination made by Blue Cross Medicare Advantage HMO with respect to any treatment of services that may be covered by Blue Cross Medicare Advantage HMO including, but not limited to:

- Payment for temporarily out-of-area renal dialysis services, emergency services, post-stabilization care or urgently needed services;
- Payment for any other health services furnished by a provider that the member believes are covered under Medicare, or, if not covered under Medicare, should have been furnished, arranged for, or reimbursed by Blue Cross Medicare Advantage HMO;
- Blue Cross Medicare Advantage HMO's refusal to provide or pay for services, in whole or in part, including the type or level of services, that the member believes should be furnished or arranged for by Blue Cross Medicare Advantage HMO;
- Reduction, or early discontinuation of a previously authorized ongoing course of treatment; and/or
- Failure of Blue Cross Medicare Advantage HMO to approve, furnish, arrange for, or provide payment for health care services in a timely manner, or to provide the member with timely notice of an adverse determination, such that a delay would adversely affect the health of the member.

Out-of-Network Provider or Out-of-Network Facility
A provider or facility that is not part of IPA's roster or normal referral pattern.

Participating Hospital
An independently contracted hospital that has a contract to provide services and/or supplies to Blue Cross Medicare Advantage HMO members.

Participating Pharmacy
An independently contracted pharmacy that has an agreement to provide Blue Cross Medicare Advantage HMO members with medication(s) prescribed by member's provider in accordance with Blue Cross Medicare Advantage HMO.

Contracted Provider
Any independently contracted professional person, organization, health facility, hospital or other person or institution licensed and/or certified by the State of Illinois and Medicare to deliver or furnish health care services and has a written agreement to provide services directly or indirectly to Blue Cross Medicare Advantage HMO members pursuant to the terms of the Agreement.

Point of Service (POS)
A benefit option that offers Blue Cross Medicare Advantage HMO enrollees a supplemental benefit. The POS benefit option allows members the option of receiving specified services outside of the MG provider network. Members will have a higher cost-sharing level when selecting an out-of network provider for these specified services.

Post-stabilization Care Services
Post-stabilization care services defined under the Blue Cross Medicare Advantage HMO plan that generally 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.

Preferred Pharmacy Network
A network pharmacy that offers covered drugs to members at a lower cost-sharing level than other Participating Pharmacies.

Primary Care Physician (PCP)
Any independently contracted IPA physician who has been selected by the member to be primarily responsible for treating and coordinating the member's health care needs. A PCP may be a physician who is Board Certified or Board Eligible in Internal Medicine, Family Practice, General Practice or Geriatric Medicine.

Quality Improvement Organization (QIO)
Organizations comprising practicing doctors and other health care experts under contract to the federal government to monitor and improve the care given to Medicare enrollees. QIOs review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, Skilled Nursing Facilities (SNF), Home Health Agencies (HHA), 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 Comprehensive Outpatient Rehabilitation Facility (CORFs).

Quality of Care Issue
A quality of care complaint may be filed through Blue Cross Medicare Advantage HMO's grievance process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided 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 Blue Cross Medicare Advantage HMO member's first step in the appeal process after an adverse organization determination. Blue Cross Medicare Advantage HMO 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 Blue Cross Medicare Advantage HMO member or other party, or authorized under state or other applicable law, to act on behalf of the member or other party involved in an appeal or grievance. Unless otherwise stated, the representative will have all of the rights and responsibilities of the member or party in obtaining an organization determination, filing a grievance or in dealing with any of the levels of the appeal process, subject to the applicable rules described at 42 CFR Part 405.

Serious Reportable Adverse Events (SRAEs)
CMS will not cover a particular surgical or other invasive procedure to treat a particular medical condition when the practitioner erroneously performs: 1) a different procedure altogether; 2) the correct procedure but on the wrong body part; or 3) the correct procedure but on the wrong patient. The Blue Cross Medicare Advantage HMO plan, consistent with Medicare, will also not cover hospitalizations and other services related to these non-covered procedures as defined in the Medicare Benefit Policy Manual (BPM), chapter 1, sections 10 and 180 and chapter 16, section 120.

Service Area (HMO)
A geographic area approved by CMS within which an eligible individual may enroll in a Medicare Advantage Plan. The geographic area for the Blue Cross Medicare Advantage HMO includes Cook, DuPage, Kane, Kendall, Lake, McHenry and Will Counties of Illinois.

Service Area (POS)
A geographic area that is out of the HMO CMS approved counties and/or not within the MG Provider network.

Urgently Needed Services
Covered services provided that are not emergency services as defined above but that are medically necessary and immediately required as a result of an unforeseen illness, injury or condition.

Reviewed December 2020