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Section 1: Welcome to Blue Cross and Blue Shield of Illinois

Blue Cross and Blue Shield of Illinois (BCBSIL) Medicare Advantage (MA) plans are health plans (Plans) provided by Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), an Independent Licensee of Blue Cross and Blue Shield Association. HCSC is a Medicare Advantage Organization (MAO) with a Medicare contract (H8634) with the Centers for Medicare and Medicaid Services (CMS). Enrollment in HCSC's plans depends on contract renewal.

This Provider Manual applies to Participating IPAs and its Providers who have agreed to participate in the BCBSIL MA Preferred Provider Organization (PPO) network. The relationship of Participating IPA to BCBSIL is that of independent contractor. This BCBSIL Provider Manual is applicable only to the operation of the BCBSIL MA PPO network. Participating IPAs agree to comply and will require its Providers to comply through a written agreement, with all terms and conditions of this Provider Manual.

Providers that are contracted with one of the Participating IPAs are eligible to participate in the MA PPO network.

The Provider Manual explains the policies and procedures of BCBSIL. It provides you and your office staff with helpful information as you serve BCBSIL MA PPO Members. The information is intended to provide guidance for some of the situations your office will encounter while participating in the BCBSIL MA PPO network.

Please refer to the Glossary of Terms for certain definitions of capitalized terms used in this Provider Manual.

This MA PPO Plan maintains and monitors a network of Participating IPAs and its Providers, including medical groups, Physicians, Hospitals, skilled nursing facilities, ancillary and other health care Providers through which Members obtain Covered Services. The BCBSIL MA PPO Plan is described as: PPO H8634: MA PPO Plan for Medicare beneficiaries who are not eligible for a Dual Care Special Needs plan.

Members who select our MA PPO Plan are not required to designate a Primary Care Physician (PCP), although we recommend that they do select a PCP to help coordinate their care. Members of our MA PPO Plan may self-refer to specialty care Participating Providers.
Section 2: General Information

2 Eligibility and Benefits

Eligibility and benefits for Members should be verified prior to every scheduled appointment. Eligibility and benefit quotes include membership verification, coverage status and other important information, such as applicable copayment, coinsurance and deductible amounts. Every Member will be supplied with an appropriate identification card and the Participating IPA shall be responsible for verifying the identity of the Member (e.g., government issued photo identification or other proof of identity). The identity of the Member must be verified each time services are provided. When services may not be covered, Members must be notified and consent in writing that they may be billed directly if non-covered benefit and elective service is rendered. If denied for medical necessity, member is not liable.

2.1 Verification of Coverage

At each office visit, your office staff should:

- Ask for the Member’s identification (ID) card;
- Copy both sides of the ID card and keep a copy with the patient’s file;
- Determine if the Member is covered by another health plan to record information for coordination of benefits purposes;
- Refer to the Member’s ID card for the appropriate telephone number to verify eligibility, deductible, coinsurance, copayments and other benefit information or use your preferred vendor to check these items online;
- Inform Members that as a Participating IPA, your Providers will recommend that Members be admitted to Participating Providers, including facility and ancillary services, unless an emergency exists that precludes safe access to a Participating Provider;
- Inform the Member that he or she will receive in-network benefits only when services are performed at a Participating Provider;
- Provider office should use best efforts to ensure the provider they are referring a member to are in the BCBS IL network of MA PPO providers and instruct member to check provider participation prior to services being rendered;
- Members do have out of network (OON) benefits; refer to the current Evidence of Coverage (EOC) posted on the BCBS IL website for specific details.

Note: To obtain benefits and eligibility information and/or claims processing status for MA PPO Plans call 877-774-8592 or use your preferred vendor to check these items online.
2.1.2 ID Cards

Each MA PPO Plan Member will receive an ID card containing the Member’s name, ID number, Group Number and information about his or her benefits. The 3-digit prefix numbers for the MA PPO Plan is: XOD = BCBSIL MA PPO Plan. For information on vision, dental, hearing, transportation, and fitness providers, Participating IPAs and its Providers should advise Members to contact the customer service telephone number on the back of their ID cards.

See BCBSIL MA PPO ID card Samples below:
Section 3: Claims

3.1 Claim Requirements

Participating IPAs and its Providers must submit claims to BCBSIL within 180 days of the date of service, electronically or using the standard CMS-1500 or UB-04 claim form as discussed below. Services billed beyond 180 days from the date of service are not eligible for reimbursement, and therefore no payments may be sought by Participating IPA or its Providers from the Member for claims submitted after the 180-day filing deadline.

To expedite claim processing, at a minimum, the following items must be submitted on all claims:

- Member’s name;
- Member’s date of birth and gender;
- Member’s ID number (as shown on the Member’s ID card, including the 3-digit alpha prefix XOJ);
- Member’s group number;
- Indication of: 1) job-related injury or illness, or 2) accident-related illness or injury, including pertinent details;
- ICD-9 diagnosis codes (or ICD-10 codes when mandated);
- CPT® procedure codes;
- Rendering;
- Date(s) of service(s);
- Charge for each service;
- Provider’s Tax Identification Number (TIN);
- Provider NPI Number;
- Name and address of Provider;
- Signature of Provider providing services; and,
- Place of service code.

BCBSIL will process electronic claims consistent with the requirements for standard transactions set forth in 45 C.F.R. Part 162 (Code of Federal Regulations). Any electronic claims submitted to BCBSIL must comply with those requirements.

3.2 Submitting Claims

Claims should be submitted electronically through the Availity™ Health Information Network or your preferred vendor portal for processing. For information on electronic filing of claims, contact Availity at 800-282-4548. Registered users will have a dropdown menu on the Availity website for Medicare Advantage selection.

The BCBSIL MA Electronic Payer ID # for Participating IPAs and its Providers is (66006). The EFT trace number for electronic payment will start with a s source code of “M” instead of “C”.

835 Electronic Remittance Advice (ERA) files will be distributed to the address/Receiver ID associated with the billing provider’s Tax ID, rather than being distributed to multiple locations/receivers. Paper PCSs will be sent by mail for all government programs claims to ERA and non-ERA receivers.

Paper claims must be submitted on the standard CMS-1500 (physician/professional provider) or UB-04 (facility) claim form to:

Blue Cross Medicare Advantage c/o Provider Services
PO Box 3686
Scranton, PA 18505
Claims containing required information and submitted in accordance with these guidelines will be paid within 30 days. In the event BCBSIL requires additional information to process the claim, BCBSIL will notify Participating IPA or its Provider, as appropriate. Duplicate claims may not be submitted prior to the applicable 30-day claim payment period. Any corrected claims should be submitted with proper identified coding.

3.3 Coordination of Benefits

If a Member has coverage with another plan that is primary to Medicare, that claim should first be submitted for processing to the primary plan. The amount payable by the MA PPO Plan will be governed by the amount paid by the primary plan and Medicare secondary payer laws, rules, policies, and regulations.

3.4 Claim Review and Overpayment Recoveries

Participating IPAs and its Providers may dispute an organizational determination by requesting a claim review, utilizing the BCBSIL claim review. A claim review is not a provider appeal; contracted Providers under MA PPO do not have post claim appeal rights. Providers may only dispute claim decisions. If you have questions regarding claim reviews, please contact the BCBSIL MA Provider Customer Service Department at the number listed on the Key Contacts page or your assigned Provider Network Consultant found on the BCBSIL website under Provider Network Consultant Assignments.

Participating IPA agrees to provide BCBSIL notice of any overpayments identified by Participating IPA promptly after identifying such overpayment and shall refund BCBSIL any amounts due to BCBSIL immediately after identifying such overpayments. BCBSIL has the right to recover any amounts owed by Participating IPA, for any reason, by way of offset or recoupments from current or future amounts due from BCBSIL to Participating IPA. Providers that have overpayments identified will be sent a refund letter in the mail. Providers may submit the requested refund amount and voluntary refunds to the following lockbox address:

Blue Cross and Blue Shield of Illinois
Claims Overpayments
Dept. CH 14212
Palatine, IL 60055-4212

3.5 Balance Billing

An important protection for Members when they obtain Covered Services in a MA Plan is that they do not pay more than MA PPO Plan allowed cost sharing.

You may not bill a Member for a non-Covered Service unless:

a) You have informed the Member in advance that the service(s) are not covered by his or her Certificate of Coverage, and,

b) The Member has agreed in writing to pay for the services if they are not covered by his or her Certificate of Coverage.

c) If CMS has an allowed amount on the standard fee for service schedule posted for your locality you may not bill for monies above and beyond 100% of CMS for the locality where services are rendered.
3.6 Coding Related Updates

Provider acknowledges and agrees that BCBSIL may apply claim editing rules or processes, in accordance with correct coding guidelines and other industry-standard methodologies, including, but not limited to, CMS, CPT, McKesson and Cotiviti coding process edits and rules.
Section 4: Benefits and Member Rights

4.1 Non-Discrimination

The MA PPO Plan, Participating IPAs and its Providers, may not establish rules for eligibility of any individual for enrollment under the terms of the MA PPO Plan, or condition coverage, or the provision of health care services, based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, or source of payment, or based on any of the following health status-related factors (42 C.F.R.§ 422.10) in relation to the individual or a dependent of the individual:

a) health status;

b) medical condition (including both physical and mental illnesses);

c) claims experience;

d) receipt of health care;

e) medical history;

f) genetic information;

g) evidence of insurability (including conditions arising out of acts of domestic violence);

h) disability; and,

i) any other health status-related factor determined appropriate by the Secretary of the Department of Health and Human Services.

Additionally, the MA PPO Plan, Participating IPAs and its Providers, must comply with Section 1557 of the Patient Protection and Affordable Care Act, Title VI of the Civil Rights Act of 1964, The Age Discrimination Act of 1975, Section 508 of the Rehabilitation Act of 1973, Title II of the Americans with Disabilities Act, Titles VI and XVI of the Public Health Service Act and the Genetic Information Nondiscrimination Act of 2008.

4.1.1 Third-Party Premium Payments

Premium payments for individual plans are a personal expense to be paid for directly by individual and family plan subscribers. In compliance with Federal guidance, Blue Cross and Blue Shield of Illinois will accept third-party payment for premium directly from the following entities:

(1) the Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act; (2) Indian tribes, tribal organizations or urban Indian organizations; and (3) state and federal Government programs.

BCBSIL may choose, in its sole discretion, to allow payments from not-for-profit foundations, provided those foundations meet nondiscrimination requirements and pay premiums for the full policy year for each of the Covered Persons at issue. Except as otherwise provided above, third-party entities, including hospitals and other health care providers, shall not pay BCBSIL directly for any or all an enrollee’s premium.
4.2 Confidentiality

Participating IPAs, their Providers, employees, subcontractors and delegates, must comply with all state and federal laws concerning confidentiality of Members’ protected health information (PHI) and personally identifiable information (PII). MA PPO Plan Members have the right to privacy and confidentiality of their PHI and PII.

Medical records should be maintained in a manner designed to protect the confidentiality of PHI and PII and in accordance with applicable state and federal laws, rules and regulations. All consultations or discussions involving the Member or his or her treatment should be conducted discreetly and professionally in accordance with all applicable state and federal laws, including the privacy and security rules and regulations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). All Participating IPAs, Providers, practice personnel, employees, subcontractors and delegates must be trained on HIPAA Privacy and Security regulations.

Participating IPAs must ensure there is a policy, procedure, or process in place for maintaining confidentiality of Members’ medical records and other PHI as defined under HIPAA; and that the practice and its Providers is following those procedures and/or obtaining appropriate authorization from Members to release information or records where required by applicable state and federal law. Procedures should include protection against unauthorized/inadvertent disclosure of all confidential medical information, including PHI. Every Participating IPA is required to provide Members with information regarding their privacy practices and to the extent required by law, with their Notice of Privacy Practices (NPP). Employees, subcontractors and delegates who have access to Member records, PHI, PII and other confidential information are required to sign a Confidentiality Statement. Examples of confidential information include, but are not limited to, the following:

a) Medical records;
b) Communications between a Member and a Provider regarding the Member’s medical care and treatment;
c) All PII and PHI as defined under the federal HIPAA privacy regulations, and/or other state or federal laws;
d) Any communication with other clinical persons involved in the Member’s health, medical and mental care (i.e., diagnosis, treatment and any identifying information such as name, address, Social Security Number (SSN), etc.);
e) Member transfer to a facility for treatment of drug abuse, alcoholism, mental or psychiatric problem; and
f) Any communicable disease, such as AIDS or HIV testing that is protected under federal or state law.

The NPP informs the patient or Member of their Member rights under HIPAA and how the Participating IPA, its Providers and/or BCBSIL may use or disclose the Members’ PHI. HIPAA regulations require each covered entity, as defined by HIPAA, including Participating IPAs, to provide a NPP to each new patient or Member. Participating IPAs and its Providers also agree to create and maintain all Member records and information in an accurate and timely manner, and to ensure timely access by Members to records and information that pertain to them. In the event of an unauthorized disclosure by Participating IPA or its Providers, Participating IPA agrees to immediately notify BCBSIL of such disclosure verbally and in writing at the following address:

Blue Cross and Blue Shield of Illinois
Legal Division, 28th Floor
300 E. Randolph Street
Chicago, IL 60601

4.3 Plan Benefits

The BCBSIL MA PPO Plan provides benefits for Parts A and B (“Original Medicare”) covered items and services that are medically necessary. MA PPO Plan benefits are offered uniformly to all Members residing in the plan Service Area and are offered at a uniform premium, with uniform benefits and cost-sharing.
4.3.1 Exceptions

The following circumstances are exceptions to the rule that BCBSIL MA PPO Plans must cover the costs of benefits, which are also covered under Original Medicare:

a) Hospice – Original Medicare, and not BCBSIL, will pay hospice services received by a BCBSIL MA PPO Plan Member.

b) Inpatient Stay During which a Member’s Enrollment Ends - BCBSIL is required to continue to cover inpatient services of the non-plan enrollee if the individual was a BCBSIL MA PPO Plan Member at the beginning of an inpatient stay. Note that incurred non-inpatient services are paid by Original Medicare or the new MA Plan that the enrollee joined as of the effective date of the new coverage. Member cost-sharing for the inpatient Hospital stay is based on the cost-sharing amounts as of the date of admission into the Hospital.

c) Skilled Nursing Facility (SNF) Cases Involving Enrollment and Disenrollment – If a Member enrolls or disenrolls from a BCBSIL MA PPO Plan during the dates of service for a SNF stay, the facility will submit a split claim to BCBSIL and to Original Medicare. If the Member is in a SNF during December in a plan that does not require a prior qualifying three (3) day Hospital stay and then joined Original Medicare on January 1, the stay continues to be considered a covered stay (if medically necessary).

d) Clinical Trials – Original Medicare, and not BCBSIL, pays for the costs of routine services provided to a MA PPO Plan Member who joins a qualifying clinical trial. BCBSIL pays the Member the difference between the Original Medicare cost-sharing incurred for qualifying clinical trial items and services and BCBSIL’s in-network cost sharing for the same category of items and services. The Clinical Trial National Coverage Determination (NCD) defines what routine costs mean and clarifies when items and services are reasonable and necessary. All other Medicare rules apply. Go to the Medicare Clinical Trial Policies page on the CMS website for more information.

4.4 Access and Availability

4.4.1 24-Hour Coverage

Participating IPAs and its Providers are expected to provide coverage for MA PPO Plan Members 24 hours a day, 7 days a week. When a Participating IPA is unable to provide services, the Participating IPA must ensure that he or she has arranged for coverage from another Participating Provider. Hospital emergency rooms or urgentcare centers are not substitutes for covering Participating Providers.

Refer to the BCBSIL Blue Cross Medicare Advantage (PPO) Provider Finder to locate Participating Providers. You may also contact the Provider Customer Service Department at the number listed on the back of the Member's ID card with questions regarding which Participating Providers are available in the network.
4.4.2 Provider Access and Availability Guidelines

The following appointment availability and access guidelines should be followed by Participating IPA and its Providers to ensure timely access to medical care and behavioral health care:

a) Appointment for preventative care – within four weeks of request.
b) Appointment for routine care - within 10 business days or two weeks of request, whichever is sooner
c) Appointment for urgent care - within 24 hours of request
d) Emergency care – 24 hours a day, 7 days per week
e) Response by Participating IPA Provider - within 30 minutes of an emergency call
f) Behavioral health care Providers must provide access to care for non-life-threatening emergencies within six hours.

Adherence to Member access guidelines will be monitored through BCBSIL office site visits and the tracking of complaints and grievances related to access and availability, which are reviewed by the BCBSIL Quality Improvement Committee.

4.4.3 Hours of Operation

Hours of operation must not discriminate against MA Members relative to other members. All Participating IPAs and its Providers will treat all BCBSIL MA PPO Plan Members with equal dignity and consideration as their non-BCBSIL MA patients.

Participating IPAs standard hours of operation shall allow for appointment availability during:

a) Early Morning Hours or Evening Hours three or more times per week; and,
b) Weekend office hours two or more times per month.

For purposes of this section, Early Morning Hours means the hours beginning at 7 a.m. and ending at 9 a.m. Evening Hours means the hours beginning at 6 p.m. and ending at 9 p.m.

All Members should normally be seen within 30 minutes of a scheduled appointment or be informed of the reason for delay (e.g., emergency cases) and be provided with an alternative appointment.

After-hours access shall be provided to assure a response to after-hours phone calls. Individuals who believe they have an Emergency Medical Condition should be directed to immediately seek Emergency Services.

4.5 Member Rights

BCBSIL MA PPO Plan Members have specific rights and responsibilities when it comes to their care. The Member rights and responsibilities are provided to Members in the Member’s Evidence of Coverage and are outlined below.

Members have the right to:

- Be treated with fairness, respect, and dignity;
- Have information provided in a way that works for them including information that is available in alternate languages and formats;
- See BCBSIL Participating IPAs and its Providers, receive Covered Services, and have their prescriptions filled in a timely manner;
- Privacy and to have their private health information protected;
- Information about BCBSIL, its network of Participating Providers, their Covered Services, and their rights and responsibilities;
- Know their treatment choices and participate in decisions about their health care;
- Use advance directives (such as a living will or a durable health care power of attorney);
• Make complaints about BCBSIL or the care provided and feel confident it will not affect the way they are treated;
• Appeal medical or administrative decisions BCBSIL has made by using the grievance or appeal process;
• Make recommendations about BCBSIL’s Member rights and responsibilities policies;
• Talk openly about care needed for their health, regardless of cost or benefit coverage, as well as the choices and risks involved; and,
• Receive all information in a way Members understand and without additional cost.

Members also have certain responsibilities. These include the responsibility to:

• Become familiar with their coverage and the rules they must follow to get care as a Member;
• Tell BCBSIL and Participating IPAs, its Providers and other Participating Providers, if they have any additional health insurance coverage or prescription drug coverage;
• Tell their PCP and other health care Providers that they are enrolled with BCBSIL;
• Give their PCP and other Providers complete and accurate information to care for them, and to follow the treatment plans and instructions that they and their providers agree upon;
• Understand their health problems and help set treatment goals that they and their Provider agree to;
• Ask their PCP and other Providers questions about treatment if they do not understand;
• Make sure their doctors know all the drugs they are taking, including over-the-counter drugs, vitamins, and supplements;
• Act in a way that supports the care given to other patients and helps the smooth running of their doctor’s office, Hospitals, and other offices;
• Pay their plan premiums and any co-payments or coinsurance they owe for the Covered Services they get;
• Meet their other financial responsibilities as described in the Evidence of Coverage;
• Inform BCBSIL if they move; and
• Inform BCBSIL of any questions, concerns, problems or suggestions by calling our Customer Service Department listed in their Evidence of Coverage.

BCBSIL is committed to ensuring that enrolled Members are treated in a manner that respects their rights as individuals entitled to receive specific BCBSIL MA PPO health care benefits. BCBSIL MA PPO Members are entitled to participate in decision-making regarding their treatment, to be confident that their PHI and PII is kept confidential, to be treated with dignity, courtesy and respect, as well as to be free from inappropriate interference with the Provider-patient relationship. BCBSIL Members are also advised of their rights and responsibilities within the Evidence of Coverage.

4.6 Member Satisfaction

BCBSIL conducts a Member satisfaction survey annually. Satisfaction with services, quality and access is evaluated by BCBSIL through the annual survey, as well as through the aggregation, trending and analysis of Member complaint and Appeal data, which includes evaluation of quality of care, access, attitude and service, billing and financial issues and the quality of the Participating IPAs’ and Providers’ office site(s). BCBSIL uses the information obtained in the survey to address areas requiring improvement. If certain Provider areas of responsibility require improvement, BCBSIL will notify Participating IPA of those areas and the action plan for improvement for Participating IPA and its Providers. Participating IPA agrees to comply with the BCBSIL action plan, and to require its Providers to comply with such plan.

The Centers for Medicare and Medicaid Services (CMS) collects information about Medicare beneficiaries’ experiences with, and ratings of, Medicare Advantage (MA-only) plans, Medicare Advantage Prescription Drug (MA-PD) plans, and stand-alone Medicare Prescription Drug Plans (PDP) via surveys of beneficiaries who have been enrolled in their plans for six months or longer. The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey is administered annually to a sample of MA & PDP beneficiaries by mailings and telephone follow-up of non-respondents to the mailed questionnaire. Questions ask about ease of getting needed care and seeing specialists, getting appointments and care quickly, doctors who communicate well, coordination of members’ health care services, health and/or drug plan provides information or help when members need it, ease of getting prescriptions filled, rating of health and/or drug plan, rating of health care quality, annual flu vaccine, and pneumonia vaccine. CAHPS ratings account for a fifth of the overall CMS Star Ratings.
4.7 Cultural Competency

The MA PPO Plan, Participating IPAs and its Providers, are obligated to ensure that services are provided in a culturally competent manner (42 C.F.R. § 422.112 (a)(8)) to all Members, including those with limited English proficiency or reading skills or who are from diverse cultural and ethnic backgrounds.

The MA PPO Plan Customer Service Department (phone number appears on the back of Member’s ID card) has the following services available for MA PPO Plan Members: a) teletypewriter (TTY) services; and b) translation services.

Participating IPAs and its Providers, and their employees, subcontractors and delegees, must have an awareness and recognition of customs, values, and beliefs of Members and the ability to incorporate those attributes into the assessment, treatment and interaction with any individual. Since culture is an integrated pattern of human behavior that includes thought, communication, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group, Participating IPAs and its Providers must be sensitive to culturally preferred ways of meeting Member needs which may be influenced by factors such as geographic location, lifestyle and age. If a Member has limited English proficiency and therefore cannot, or is unable to speak, read, write or otherwise understand the English language at a level that permits the individual to interact effectively with Participating IPA or its Providers, translation assistance must be provided to the Member. In addition, to comply with the requirements of 42 C.F.R. § 422.112 (a)(8), Participating IPAs and its Providers are strongly encouraged to:

a) Recognize cultural, racial, ethnic, geographic, social, spiritual and economic diversity and individuality within and across all Members and their families and caretakers;

b) Implement practices and policies that support the needs of Members and families, including medical, developmental, educational, emotional, cultural, environmental and financial needs;

c) Provide training on cultural competence to employees, subcontractors and delegees;

d) Acknowledge that families are essential to Members’ health and well-being and are crucial allies for quality within the service delivery system; and

e) Appreciate and recognize the unique nature of each Member and his or her family.

4.8 Preventive Services

Members may access certain preventive services from any Participating IPA and its Providers in accordance with the Member’s Evidence of Coverage. BCBSIL does not require Member cost-sharing for those covered preventive services provided in-network for which there is no cost sharing required under Original Medicare. If, during the provision of a preventive service, additional non-preventive services are furnished, cost-sharing under the Member’s Evidence of Coverage will apply.

Members may directly access (through self-referral to any Participating Provider) in-network screening mammography and influenza vaccine. For additional information, refer to the preventive services section on the CMS website.

4.9 Advance Directives

Participating IPAs and its Providers must document in a prominent part of the Member’s current medical record whether the Member has executed an advance directive. Advance directives are written instructions, such as living wills or durable powers of attorney for health care, recognized under the law of the State of Illinois and signed by a Member, that explain the Member’s wishes concerning the provision of health care if the Member becomes incapacitated or for any other reason is unable to make those wishes known. Participating IPAs and its Providers are not required to provide care that conflicts with an advance directive. In addition, Participating IPAs and its Providers shall, as a condition of treatment, require a Member to execute or waive an advance directive.
As a courtesy, Participating IPAs and its Providers may inform Members that the Department of Public Health is required to make available a uniform advance directive for a do-not-resuscitate order that may be used in all settings, the statutory Living Will Declaration form, the Illinois Statutory Short Form Power of Attorney for Health Care, the statutory Declaration of Mental Health Treatment Form, and the summary of advance directives law in Illinois. (Section 2310-600 of the Department of Public Health Powers and Duties Law of the Civil Administrative Code of Illinois, 20 ILCS 2310-600). Participating IPAs and its Providers should inform individuals that any complaints concerning noncompliance with advance directive requirements maybe filed with the Illinois Department of Public Health (42 C.F.R. § 422.128(b)(3)).

4.10 Additional Benefits

Some BCBSIL MA PPO Plans offer additional benefits above and beyond those traditionally covered by Original Medicare such as vision, hearing, dental, travel benefit services and health/fitness programs. Members are advised to review their Evidence of Coverage and to contact Customer Service for information regarding these services.
Section 5: Compliance Standards

5.1 Provider Standards

In accordance with generally accepted professional standards, Participating IPAs and its Providers must:

- Meet the requirements of all applicable state and federal laws, rules and regulations, including applicable CMS managed care guidance in the form of manuals, transmittals or otherwise;
- Agree to cooperate with BCBSIL to monitor compliance with its MA Plan contract(s) and/or MA rules and regulations, and assist BCBSIL in compliance with corrective action plans necessary to comply with such laws, rules and regulations;
- Retain all agreements, documents, papers and medical records related to the provision of services to BCBSIL Members as required by state and federal laws;
- Provide Covered Services in a manner consistent with professionally recognized standards of health care [42 C.F.R. § 422.504(a)(3)(iii)];
- Use Physician Assistants (PA) and Advanced Registered Nurse Practitioners (ARNPs) appropriately. PAs and ARNPs should provide direct Member care within the scope of practice established by the rules and regulations of the state and applicable BCBSIL policies, procedures or guidelines; Assume full responsibility to the extent of the law when supervising PAs and ARNPs, whose scope of practice should not extend beyond statutory limitations;
- Clearly identify their title (e.g. M.D., D.O., ARNP, PA) to Members and to other Providers;
- Honor any Member request to be seen by a Physician rather than a PA or ARNP;
- Administer treatment for any Member in need of healthcare services they provide;
- Respond within the identified timeframe to BCBSIL’s requests for medical records for compliance with regulatory requirements;
- Maintain accurate medical records and adhere to all BCBSIL policies and procedures governing the content and confidentiality of medical records;
- Allow BCBSIL to use Participating IPA’s and its Providers’ performance data;
- Ensure that all Providers, employed Physicians and other health care practitioners comply with the terms and conditions of the Participating IPA’s medical service agreement with BCBSIL and this Provider Manual;
- Ensure that to the extent a Participating IPA employed Physician maintains written agreements with contracted Physicians or other health care practitioners and providers, that the agreements mirror required and applicable provisions in the IPA’s medical service agreement with BCBSIL and this Provider Manual;
- Maintain an environmentally safe office with equipment in proper working order to comply with city, state and federal regulations concerning accessibility, safety and public hygiene;
- Communicate timely clinical information between Providers, which will be analyzed by BCBSIL during medical record review;
- Upon request, provide timely transfer of clinical information to BCBSIL, the Member or the requesting party at no charge, unless otherwise agreed;
- Preserve Member dignity and observe the rights of Members to know and understand the diagnosis, prognosis and expected outcome of recommended medical, surgical and medication treatment;
- Not discriminate in any manner between BCBSIL MA PPO Members and non-MA PPO Members or non- BCBSIL members;
- Ensure that the hours of operation offered to BCBSIL MA PPO Members is no less than those offered to commercial Members;
• Not deny, limit or condition treatment to any BCBSIL MA PPO Member on the basis of any of the following factors:
  a) health status;
  b) medical condition (including both physical and mental illnesses);
  c) claims experience;
  d) receipt of health care;
  e) medical history;
  f) genetic information;
  g) evidence of insurability (including conditions arising out of acts of domestic violence);
  h) disability; and,
  i) any other health status-related factor determined appropriate by the Secretary of the Department of Health and Human Services.

• Communicate with and advise Members regarding the Member’s condition, including, but not limited to diagnosis and available treatments;
• Advocate on the Member’s behalf for the Member’s health status, medical care and available treatment or non-treatment options including any alternative treatments, regardless of whether any treatments are Covered Services;
• Identify Members who need services related to domestic violence, smoking cessation or substance abuse. If indicated, Participating IPA and its Providers agree to refer Members to available BCBSIL-sponsored or community-based programs;
• Document referrals to available BCBSIL-sponsored or community-based programs in the Member’s medical record and provide appropriate follow-up to ensure and document that the Member actually accessed the services; and,
• Adhere to all BCBSIL policies and procedures, including, but not limited to, preauthorization requirements and timeframes, medical policies, credentialing requirements, care management and disease management program referrals, appropriate release of inpatient and outpatient utilization and outcomes information and providing treatment to Members at appropriate levels of care.

Participating IPAs and its Providers acting within the lawful scope of practice are encouraged to advise patients who are Members of a BCBSIL MA PPO Plan about:

  a) The patient’s health status, medical care or treatment options (including any alternative treatments that maybe self-administered), including the provision of sufficient information to provide an opportunity for the patient to make an informed treatment decision from all relevant treatment options;
  b) The risks, benefits and consequences of treatment or non-treatment; and
  c) The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

These Member advisements set forth above are considered supportive of MA PPO Plan Members.

MA plan marketing is regulated by CMS. Participating IPA and its Providers should familiarize themselves with CMS regulations at 42 CFR Part 422, Subpart V, and the CMS Managed Care Manual, Chapter 3, Medicare Marketing Guidelines for MA Plans, MA-PDs, PDPs and 1876 Cost Plans (Marketing Guidelines), including, without limitation, materials governing “Provider Based Activities” in Section 70.8.3.

Participating IPA and its Providers must adhere to all applicable laws, regulations and CMS guidelines regarding MA plan marketing, including without limitation 42 CFR Part 422, Subpart V and the Marketing Guidelines. CMS holds MA Organizations such as BCBSIL responsible for any comparative/descriptive material developed and distributed on their behalf by their Participating IPAs or its Providers. Participating IPAs and its Providers are not authorized to engage in any marketing activity on behalf of BCBSIL without the prior express written consent of an authorized BCBSIL representative, and then, only in strict accordance with such consent.
5.2 Sanctions

Participating IPAs must disclose to BCBSIL whether the Participating IPA, its Providers, or any of their employees, independent contractors, subcontractors or delegees, have any prior violation, fine, suspension, termination or other administrative action taken under Medicare or Medicaid laws, the rules or regulations of the State of Illinois, the state or federal government, or any public insurer.

No Participating IPA or its Providers, or its employees, independent contractors, subcontractors or delegees, shall have been convicted of any criminal offense related to involvement with Medicaid, Medicare or other state or federal health care programs. Participating IPA agrees to immediately notify BCBSIL of any charge of criminal wrongdoing, or any similar charge, allegation or penalty, state or federal sanction connected to its, or its Providers, employees, independent contractors, subcontractors or its delegees, involvement in Medicaid, Medicare or other state or federal health care programs.

Accordingly, and as specifically described and set forth in the MSA, Participating IPAs shall immediately notify BCBSIL within five (5) business days of any of the following occurrences related to any Provider:

a) loss, suspension or limitation of license or certification;
b) any lapse or material change in the liability insurance coverage required under the MSA;
c) any judgment or finding against any Provider which might materially impair his/her ability to perform under the MSA;
d) any indictment or conviction of a felony or any criminal charge related to the practice of any Provider;
e) loss, suspension or limitation of medical staff or admitting privileges at any BCBSIL credentialed Hospital;
f) a professional review action based on the professional competence or professional conduct that reduces, restricts, suspends, revokes, denies, fails to renew or otherwise adversely affects clinical privileges of a Provider for a period of more than thirty (30) days;
g) failure to renew, or acceptance of the surrender, restriction, suspension, revocation or denial of or other adverse action affecting clinical privileges of a Provider while under investigation or in return for not conducting an investigation by a health care entity relating to possible professional incompetence or improper professional conduct;
h) entry of a civil judgment by a federal or state court relating to the delivery of a health care item or service, except as may relate to claims of malpractice;

i) Federal or state criminal conviction relating to the delivery of a health care item or service, except as may relate to claims of malpractice;
j) action by a federal or state agency responsible for licensing or certification resulting (i) in reprimand, censure or probation, (ii) in revocation, suspension or loss of license, or loss of right to apply for or to renew license, whether by operation of law, voluntary surrender, non-renewal or otherwise, or (iii) in other publicly available negative action or finding; or

k) exclusion from participation in any federal or state health care program.

BCBSIL reserves the right to take appropriate action, including termination of Participating IPA for failure to make any required disclosure under this Section, or for any violation related to Participating IPAs’, its Providers’, employees’, independent contractors’, subcontractors’ or its delegees’, involvement in Medicaid, Medicare or other state or federal health care programs.
5.3 Reporting Obligations

5.3.1 Cooperation and Meeting CMS Service Requirements

BCBSIL must provide CMS with information that is necessary for CMS to administer and evaluate the BCBSIL MA PPO program and to establish and facilitate a process for current and prospective Members to exercise choice in obtaining services. The information includes MA PPO Plan quality and performance indicators such as disenrollment rates, information on Member satisfaction and information on health outcomes. Participating IPAs must cooperate with BCBSIL in its data reporting obligations by providing to BCBSIL any information, including Participating IPA or Provider information that BCBSIL requires to meet its obligations.

5.3.2 Certification of Diagnostic Data

BCBSIL is specifically required to submit to CMS data necessary to characterize the context and purposes of each encounter between a Member and a Provider, supplier or other practitioner (encounter data). As set forth in the Medical Service Agreement, Participating IPAs and its Providers that furnish diagnostic data to assist BCBSIL in meeting BCBSIL’s reporting obligations to CMS must attest by sworn statement, based upon the Participating IPA and/or Provider’s knowledge, information and belief, that the data provided is accurate, complete and truthful.

5.4 Compliance, Fraud, Waste and Abuse Program and Reporting

IPA are required to implement and maintain a compliance program that, at a minimum, meets the standards for an effective compliance program set forth in Laws, including, without limitation, the Federal Sentencing Guidelines, and that addresses the scope of services of services under the Medicare Advantage Plan. The IPA compliance program shall require cooperation with BCBSIL’s compliance plan and policies and shall include, without limitation, the following:

1. A code of conduct particular to Provider that reflects a commitment to preventing, detecting and correcting fraud, waste, and abuse in the administration or delivery of Covered Services to Members.

2. Compliance training for all employees, Subcontractors, any affiliated party or any Downstream Entity involved in the administration or delivery of Covered Services to Members or involved in the provision of Delegated Activities.

   a) IPA shall provide general compliance training to employees, Subcontractors, any affiliated party or any Downstream Entity involved in the administration or delivery of Covered Services to Members or involved in the provision of Delegated Activities at the time of initial hiring (or contracting) and annually thereafter. The general compliance training shall address matters related to Provider’s compliance responsibilities, including, without limitation, a) Provider’s code of conduct, applicable compliance policies and procedures, disciplinary and legal penalties for non-compliance, and procedures for addressing compliance questions and issues; (b) Provider’s obligations to comply with Laws; (c) common issues of non-compliance in connection with the provision of health care services to Members; and (d) common fraud, waste and abuse schemes and techniques in connection with the provision of health care services to Members.
b) IPA also must provide specialized compliance training to personnel whose job function directly relates to the administration or delivery of Covered Services to Members on issues particular to such personnel’s job function. The specialized training shall be provided (i) upon each individual’s initial hire (or contracting); (ii) annually; (iii) upon any change in the individual’s job function or job requirements; and (iv) upon IPA’s determination that additional training is required because of issues of non-compliance.

c) IPA shall maintain records of the date, time, attendance, topics, training materials, and results of all training and related testing. IPA shall, upon request, provide to BCBSIL annually and upon request a written attestation certifying that IPA has provided compliance training in accordance with this section. The training shall be subject to BCBSIL review/prior approval and shall incorporate those provisions that BCBSIL determines to be important.

3. Policies and procedures that promote communication and disclosure of potential incidents of non-compliance or other questions or comments relating to compliance with Laws and IPA’s compliance and anti-fraud, anti-waste, and anti-abuse initiatives. The program must include implementation and publication to IPA’s directors, officers, employees, agents and contractors of a compliance hotline, which provides for anonymous reporting of issues of non-compliance with Laws or other questions or comments relating to compliance with Laws and IPA’s anti-fraud, anti-waste, and anti-abuse initiatives;

4. Annual compliance risk assessments, performed at IPA’s sole expense. IPA will, upon request, share the results of such assessments with BCBSIL to the extent any part of the assessment directly or indirectly relates to BCBSIL.

5. Routine monitoring and auditing of IPA’s responsibilities and activities with respect to the administration or delivery of Covered Services to Members. IPA hereby represents and warrants to BCBSIL that IPA has an adequate work plan in place to perform such monitoring and audit activities. IPA will take corrective action to remedy any deficiencies found as appropriate.

6. Upon request, provision of a report to BCBSIL of the activities of IPA’s compliance program required by BCBSIL, including, without limitation, reports and investigations, if any, of alleged failures to comply with laws, regulations, the terms and conditions of the CMS Contract, or the BCBSIL Medical Service Agreement (MSA) so that BCBSIL can fulfill its reporting obligations under Laws and the CMS Contract. Upon request, IPA will provide to BCBSIL the results of any audits related to the administration or delivery of Covered Services to Members. IPA will make appropriate personnel available for interviews related to any audit or monitoring activity.

5.4.1 Incidents of Suspected Non-Compliance, Fraud, Waste or Abuse

IPA shall promptly investigate any potential and/or suspected incidents of non-compliance with Laws, fraud, waste, or abuse in connection with the BCBSIL MSA and/or the administration or delivery of Covered Services to Members (“Incident”) and report any such Incident to BCBSIL as soon as reasonably possible, but in no instance later than thirty (30) calendar days after IPA becomes aware of such Incident. Notice to BCBSIL will include a statement regarding IPA’s efforts to conduct a timely, reasonable inquiry into the Incident, proposed or implemented corrective actions in response to the Incident, and any other information that may be relevant to BCBSIL in making its decision regarding self-reporting of such Incident.
IPA must cooperate with any investigation by BCBSIL, CMS, HHS or their authorized designees relating to such Incident, and IPA acknowledges that its failure to cooperate with any such investigation may result in a referral to law enforcement and/or other implementation of corrective actions permitted under Laws.

IPA must cause its Downstream Entities to promptly report to IPA, who must report to BCBSIL, any Incidents in accordance with this section.

5.4.2 Compliance Reviews

IPA must provide BCBSIL with access to IPA’s and IPA’s Providers’ records, physical premises and facilities, equipment and personnel in order for BCBSIL, in its sole discretion and at its sole cost and expense, to conduct compliance reviews in connection with the terms of the BCBSIL MSA.

5.5 Conflicts of Interest

IPA must require any manager, officer, director or employee associated with the administration or delivery of Covered Services to Members to sign a conflict of interest statement, attestation or certification at the time of hire and annually thereafter certifying that such individual is free from any conflict of interest in administering or delivering Covered Services to Members. IPA must supply the form of such statement, attestation or certification to BCBSIL upon request.

5.5.1 Exclusion of Certain Individuals

IPA must certify that neither IPA nor its employees, any Subcontractor, including but not limited to IPA Providers, any affiliated party or any Downstream Entity involved in the provision of a Delegated Activity under the BCBSIL MSA has been: (i) charged with a criminal offense in connection with obtaining, attempting to obtain, or performing of a public (Federal, state or local) contract or subcontract, (ii) listed by a federal governmental agency as debarred, (iii) proposed for debarment or suspension or otherwise excluded from federal program participation, (iv) been convicted of or had a civil judgment rendered against them regarding dishonesty or breach of trust, including but not limited to, the commission of a fraud including mail fraud or false representations, violation of a fiduciary relationship, violation of Federal or state antitrust statutes, securities offenses, embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, tax evasion, or receiving stolen property; or (v) within a three (3) year period preceding the date of this Agreement, had one or more public transactions (federal, state or local) terminated for cause or default.

IPA shall check appropriate databases at least annually to determine whether any of IPA’s employees, Subcontractors or affiliated parties or Downstream Entities involved in the provision of a Delegated Activity under the BCBSIL MSA have been suspended or excluded from participation in the Medicare Program, any other Federal health care program, state contracts or state medical assistance programs. Databases include, without limitation, the HHS Office of Inspector General List of Excluded Individuals-Entities, the Healthcare Integrity and Protection Data Bank, and the General Service Administration List of Parties Excluded from Federal Procurement and Non-procurement Programs.

IPA acknowledges and agrees that it has a continuing obligation to notify BCBSIL in writing within seven (7) business days if any of the above-referenced representations change. IPA further acknowledges and agrees that any misrepresentation of its status or any change in its status at any time during the term of the BCBSIL MSA may be grounds for immediate termination of the BCBSIL MSA, at the sole discretion of BCBSIL.
5.5.2 Lobbying Prohibitions

The IPA certifies to the best of his knowledge and belief, that:

No federal appropriated funds have been paid or will be paid by or on behalf of the IPA, to any Person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any federal contract, the making of any federal loan or grant, the entering into of any cooperative agreement, or the extension, continuation, renewal, amendment, or modification of any federal contract, grant, loan, or cooperative agreement.

If any funds other than Federally appropriated funds have been paid or will be paid to any Person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the IPA shall complete and submit a Federal Standard Form LLL, “Disclosure Form to Report Lobbying,” in accordance with its instructions. Such Disclosure Form may be obtained by request from the Illinois Department of Healthcare and Family Services, Bureau of Fiscal Operations.
Section 6: Organization Determinations

6.1 Overview

BCBSIL can receive organization determination requests by mail, phone or fax. BCBSIL requires prior authorization or precertification for:

- All non-emergent and non-urgent inpatient admissions except for normal newborn deliveries;
- All non-emergent or non-urgent out-of-network services (except out-of-area renal dialysis);
- Service requests identified in the Medicare authorization guidelines;
- All other services requiring pre-authorization or pre-certification as further described in the Prior Authorization Requirements section of this manual or on the Prior Authorization Required List in the Standards and Requirements/BCBSIL Provider Manual section of our Provider website.

For initial and continuation of services, BCBSIL has appropriate processes to ensure consistent application of review criteria for authorization reviews and organization determinations, which include, but are not limited to:

- Medical necessity - approved medical review criteria will be referenced and applied;
- Where appropriate, involvement of a BCBSIL medical director;
- The Member's medical history (e.g. diagnoses, conditions, functional status), treating Physician recommendations and clinical notes;
- Inter-rater reliability – a process that evaluates the consistency of decisions made by licensed staff when making authorization determinations and ensures consistent application of medical review criteria; and
- Consultation with the requesting Provider when appropriate.

If BCBSIL expects to issue a partial or full adverse medical necessity (or any substantively equivalent term used to describe the concept of medical necessity) decision based on the initial review of the request, the organization determination must be reviewed by a Physician or other appropriate health care professional with sufficient medical and other expertise, including knowledge of Medicare coverage criteria, before BCBSIL issues the organization determination decision. The Physician or other health care professional must have a current and unrestricted license to practice within the scope of his or her profession in a State.

BCBSIL’s organization determination process provides authorization numbers, effective dates for the authorization and specifies the services being authorized. The requesting Provider will be notified verbally via telephone, fax, or online, of the authorization.

In the event of an adverse determination, BCBSIL will notify the Member and the Member’s Representative or Provider, as appropriate. Participating IPA or its Providers may request copies of the criteria used for any specific determination of medical necessity by contacting BCBSIL’s Utilization Management Department. The Member may receive copies of the criteria by contacting BCBSIL’s Customer Service Department.

6.2 Standard Organization Determinations

Standard organization determinations are made as expeditiously as the Member’s health condition requires, but no later than 14 calendar days after BCBSIL receives the request for service. An extension may be granted for 14 additional calendar days if the Member requests an extension, or if BCBSIL justifies the need for additional information and documents that the delay is in the interest of the Member.
6.3 Expedited Organization Determinations

Expedited organization determinations are requests to BCBSIL for expediting an organization determination when the Member or his or her Provider believes that waiting for a decision under the standard timeframe could place the Member’s life, health or ability to regain maximum function in serious jeopardy. The request will be made as expeditiously as the Member’s health condition requires, but no later than 72 hours after receiving the Member’s or Provider’s request. The 72-hour period begins when the request is received by the appropriate office or department designated by BCBSIL. An extension maybe granted for 14 additional calendar days if the Member requests an extension, or if BCBSIL justifies a need for additional information and documents how the delay is in the interest of the Member. Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that the Member has already received.
Section 7: Utilization Management

7.1 Overview

Participating IPAs and its Providers should refer directly to Medicare coverage policies for information on Medicare coverage policies and determinations. There are two types of Medicare coverage policies: 1) National Coverage Determinations (NCDs) and, 2) Local Coverage Determinations (LCDs). As an MA plan, BCBSIL must cover all services and benefits covered by Original Medicare.

7.2 National Coverage Determinations (NCDs)

The Centers for Medicare and Medicaid Services (CMS) explains NCDs through program manuals, which are located on the CMS website under Regulations & Guidance/Guidance/Manuals. Key manuals for coverage include the: a) Medicare National Coverage Determinations Manual; b) Medicare Program Integrity Manual; and, c) Medicare Benefit Policy Manual.

CMS updates program manuals through program transmittals and sends updated information via articles through the Medicare Learning Network located in the Outreach & Education section of the CMS website.

7.3 Local Coverage Determinations (LCDs)

CMS contractors (e.g., Medicare Administrative Contractors or MACs) develop and issue LCDs to provide guidance to the public and provider community within a specific geographical area. LCDs supplement an NCD or explain when an item or service will be considered covered if there is no NCD. An LCD cannot contradict an NCD. Participating IPAs and its Providers may access LCDs online with the appropriate local contractor website for the region at issue.

7.4 Medicare Coverage Database

CMS launched the Medicare Coverage Database in 2002. To access, go to CMS/Medicare/Medicare Coverage – General Information and select the Medicare Coverage Database. The following areas may be searched:

- National Coverage Determinations (NCDs)
- National Coverage Analyses (NCAs) – These documents support the NCD process.
- Local Coverage Determinations (LCDs) – This section of the Medicare Coverage Database is updated monthly. Therefore, the most current information should be accessed through the local contractor websites listed in the preceding box.

In coverage situations where there is no NCD, LCD or guidance on coverage in original Medicare manuals, BCBSIL may adopt the coverage policies of other MA Organizations in its Service Area. BCBSIL may also make its own coverage determination(s) and provide a rationale using an objective evidence-based process.
7.5 Prior Authorization Requirements

Prior authorization is intended to facilitate the most appropriate level of care, in the most appropriate setting, at the right time. Prior authorization may be obtained by the Member’s PCP, treating specialist or facility. BCBSIL helps with the prior authorization process, including medical necessity and benefit determinations, prior to services being rendered. Prior authorization requirements apply to pre-service coverage determinations.

BCBSIL has contracted with eviCore healthcare (eviCore) to manage benefit preauthorization requests for certain specialized clinical services for MA PPO members. For additional information, refer to the MA PPO Prior Authorization Required List. This document is available under the eviCore Preauthorization Program - Government Programs header in the Claims and Eligibility/Prior Authorization section of our website at bcbsil.com/provider.

Services performed without preauthorization or that do not meet medical necessity criteria may be denied for payment, and the rendering provider may not seek reimbursement from the member.

eviCore healthcare (eviCore) is an independent specialty medical benefits management company that provides utilization management services for BCBSIL.

Please note that the fact that a service has been preauthorized/pre-certified is not a guarantee of payment. Benefits will be determined once a claim is received and will be based upon, among other things, the member’s eligibility and the terms of the member’s evidence of coverage applicable on the date services were rendered.

Providers may submit requests for prior authorization by calling 877-774-8592 or by utilizing the prior authorization form available in the Standards and Requirements/BCBSIL Provider Manual section of our Provider website. In the event there is a need to request an expedited review for an urgent service after hours (to include weekends and holidays) BCBSIL recommends that Providers call 877-774-8592. When requesting prior authorization for coverage, please include the following items:

- Member name and identification number;
- Services being requested;
- Pertinent medical information related to the request, including current plan of treatment, progress notes describing medical necessity, effectiveness of the treatment and goal of treatment;
- Applicable medical history;
- Diagnosis code(s) and place of service;
- Physician’s Current Procedural Terminology; and
- Requesting Provider’s TIN and demographics

Additional information for Providers pertaining to requests for prior authorization, including service category codes, may be in the Prior Authorization Required List available in the Standards and Requirements/BCBSIL Provider Manual section of our Provider website. Preauthorization for benefits is not required for Emergency Medical Conditions.

The attending Physician must obtain preauthorization for the services on the Prior Authorization List except in an emergency. This list is subject to change and is provided at the CPT code level. Service category codes may be in the Prior Authorization Required List available in the Standards and Requirements/BCBSIL Provider Manual section of our Provider website.

All inpatient admissions require prior authorization from the BCBSIL’s Utilization Management (UM) Department. The prior authorization process for admissions is carried out by the admitting Provider or Hospital personnel.

Notification of admission and extension requests for an inpatient level of care must be received within 1 business day of admission.
Admitting Providers are responsible for contacting the BCBSIL UM department at 877-774-8592 to request authorization for additional days of coverage if an extension of the approved length of stay is required. The admitting Provider will provide appropriate referrals for extended care. BCBSIL UM personnel will assist in coordinating all necessary services identified by the facility during the discharge planning process.

7.6 Emergency Care

Emergency services are health care services provided in a Hospital or comparable facility to evaluate and stabilize 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 to 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 are Covered Services (inpatient or outpatient) that are needed to evaluate or stabilize an Emergency Medical Condition, and which are furnished by a Provider qualified to furnish services to individuals experiencing an Emergency Medical Condition.

Participating IPA, and its Providers, may not furnish any materials to Members, including, but not limited to, wallet card instructions, which state that the Member must seek prior authorization for Emergency Services. Participating IPA and its Providers, and BCBSIL, may always instruct a Member to seek Emergency Services, for any appropriate reason, within or outside of the Member’s BCBSIL MA PPO Plan coverage. BCBSIL is not responsible to provide benefits for care provided for an unrelated non-emergency problem or issue during treatment for an emergency condition, unless such services are considered Covered Services under the Member’s Evidence of Coverage. Evaluation and stabilization of an Emergency Medical Condition does not require preauthorization from BCBSIL.
Section 8: Case Management

8.1 Care Coordination

BCBSIL assists Providers with continuity of services through arrangements that include, but are not limited to, the following:

- Offering each BCBSIL MA PPO Plan Member access to an ongoing source of primary care and providing access to a primary care source to each Member who accepts the offer;
- Establishing coordination of plan services that integrate arrangements with community and social service programs;
- Informing Members of specific health care needs that may require follow-up and receive, as appropriate, training from Providers in self-care and other measures they may take to promote their own health; and
- Employing systems to identify and address barriers to Member compliance with a Provider’s prescribed treatments or regimens.

To support the above requirements, BCBSIL has a comprehensive case management program. Our suite of programs includes care transition support, condition management, longitudinal care and complex case management programs. Where appropriate and possible, case managers identify Members with complex needs so that interventions may be suggested by Providers to increase positive health outcomes and facilitate appropriate utilization and level of care. Case managers, who are telephonically based, coordinate and evaluate the options and services available to meet the Member’s needs.

8.2 Initial Health Risk Assessment

CMS requires that a good faith effort is made to conduct an initial health assessment of all new members within 90 days of the effective date of enrollment and follows up on unsuccessful attempts to contact an enrollee.

8.3 Annual Health Risk Assessment

The Blue Cross Medicare Advantage 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 and family history, physical exam (including BMI), vital signs, functional ability and level of safety review, psychosocial and behavioral risks, medication review, preventive screenings, chronic disease monitoring and assessment of current conditions (management and/or treatment plan). These assessments can occur in the provider’s office or member’s home to remove barriers to completion. The Annual Health Assessments is a part of the Quality Program.
8.3.1 Process for Submitting AHA – Paper Submission Procedure

1. The provider conducts a face-to-face annual visit with the member and completes the Annual Health Assessment form according to the instructions provided.

2. The provider completes the encounter claim documenting the appropriate diagnosis codes and submits via normal claims submission to the IPA.
   a) The IPA provider shall document on the encounter claim the appropriate HCPCS codes for well visits for medical billing purposes:
      i. **G0402 – Initial Preventive Physical Examination**
         Code is limited to new beneficiary during the first 12 months of Medicare Enrollment.
      ii. **G0438 – Annual Wellness Visit (AWV), Initial**
          The initial AWV, G0438, is performed on patients who have been enrolled with Medicare for more than one year, including new or established patients.
      iii. **G0439 – Annual Wellness Visit (AWV), Subsequent**
          The subsequent AWV occurs one year after the patient’s initial visit.

The provider ensures all required fields are completed on the AHA form. Upon completion, the original AHA should be retained by the members medical record. The completed AHA should be made available to BCBSIL upon request. Please send any questions in reference to this form to RiskAdjustment@bcbsil.com.

The codes G0402, G0438, and G0439 are preventive services and members receiving an Annual Wellness Visit are not responsible for a copayment or deductible. If rendering a significant, separately identifiable, medically necessary Evaluation and Management (E/M) service (e.g., 99213) in addition to the AHA, the Current Procedural Terminology (CPT) code with modifier -25 can be reported.

Both the evaluation and management (E/M) code and the HCPC “G” code should be submitted to Blue Cross Medicare Advantage as part of the normal MA PPO claim process on standardized billing format and preferred submission via EDI or if necessary paper claims.
Section 9: Member Appeals and Grievances

9.1 Overview

Members have the right to make a complaint in the form of an appeal or grievance if they have concerns or problems related to their coverage or care. All Participating IPAs and its Providers must cooperate in the BCBSIL MA appeals and grievances process for Members.

- An appeal is the type of request when the Member wants BCBSIL to reconsider a decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs the Member has already received.
- A grievance is the type of complaint regarding any other type of problem with BCBSIL or a Provider. For example, complaints concerning quality of care, waiting times in the waiting room or the cleanliness of the facilities are grievances. The Participating IPA, on behalf of its Providers, agrees to address any Member grievance concerns with its BCBSIL Provider Network Representative.

Standard grievances and/or appeal requests regarding authorization of benefits, or termination of benefits, for a health care service should be mailed or faxed to:

Blue Cross Medicare Advantage  
Attn: Appeals/Grievances  
PO Box 4288  
Scranton, PA 18505  
Fax: 855-674-9185

Expedited appeals requests regarding authorization of benefits, or termination of benefits, for a health care service should be mailed, faxed or directed to the BCBSIL MA Provider Customer Service line:

Blue Cross Medicare Advantage  
Attn: Appeals/Grievances  
PO Box 4288  
Scranton, PA 18505  
Phone: 877-774-8592

Note: For claims submission errors contact BCBSIL MA Provider Customer Service at 877-774-8592.

9.2 Resolving Grievances

If a Member has a grievance about BCBSIL, a Participating IPA, its Provider or any other issue, Participating IPAs should instruct the Member to contact the Customer Service Department at the number listed on the back of the Member’s ID card.

9.3 Resolving Appeals

A Member or the Member’s authorized Representative as denoted by an appropriately executed authorization form called the AOR or its equivalent, may appeal an adverse initial decision by BCBSIL concerning benefits for a health care service. A Member’s appeal of the denial for authorization of benefits or termination of benefits must generally be resolved by BCBSIL within 30 days, or sooner, if the Member’s health condition requires. An appeal concerning payment must generally be resolved within 60 days.
If the normal time-period for an Appeal could jeopardize the life or health of the Member or the Member’s ability to regain maximum function, the Member can request an expedited Appeal. Such Appeals are generally resolved within 72 hours unless it is in the Member’s interest to extend this time-period. When a Member requests an expedited Appeal, BCBSIL will automatically expedite the Appeal.

BCBSIL will comply with all CMS-required appeal timeframes for MA plans. Members should be directed by Participating IPA and Providers to refer to their Evidence of Coverage for specific Appeal information.

9.4 Further Appeal Rights

If BCBSIL denies the Member’s Appeal in whole or part, BCBSIL will forward the Appeal to an independent review entity (IRE) that has a contract with the federal government and is not part of BCBSIL. BCBSIL must forward the Member’s case file to the IRE within applicable regulatory timeframes.

The IRE will review the Appeal and, if the Appeal involves authorization for benefits, decide as expeditiously as the Member’s health condition requires, but no later than within 30 days of receipt of the Member’s case file. If the Appeal involves payment determination, the IRE will generally make the decision within 60 days of receipt of the Member’s case file. If the Appeal involves an expedited Reconsideration decision, the IRE will make the decision as expeditiously as the Member’s health condition requires, but no later than within 72 hours of receipt of the Member’s case file.

If the IRE issues an adverse decision and the amount at issue meets a specified dollar threshold, the Member may Appeal to an Administrative Law Judge (ALJ). If the Member is not satisfied with the ALJ’s decision, the Member may request review by the Medicare Appeals Council (MAC). If the MAC refuses to hear the case or issues an adverse decision, the Member may be able to request Judicial Review.

BCBSIL will comply with all CMS-required Appeal timeframes for MA plans. Members should be directed by Participating IPA and Providers to refer to their Evidence of Coverage for specific Appeal information.

9.5 Detailed Notice of Discharge

Hospitals are required to deliver the Important Message from Medicare (IM), CMS-R-193, to all MA PPO Plan Members who are Hospital inpatients. The IM informs Hospitalized inpatient beneficiaries of their Hospital discharge Appeal rights. Members who choose to Appeal a discharge decision must receive the Detailed Notice of Discharge (DND) from the Hospital or their MA Plan, if applicable. These requirements were published in a final rule, CMS-4105-F: Notification of Hospital Discharge Appeal Rights, which became effective on July 2, 2007.

9.6 SNF, HHA, and CORF Discharge Notification Requirements

All health care Providers providing services to BCBSIL MA PPO Plan Members, must give an advance, completed copy of the Notice of Medicare Non-Coverage (NOMNC) to Members receiving skilled nursing (SNF), home health agency (including psychiatric home health) (HHA), or comprehensive outpatient rehabilitation facility services (CORF), no later than two days before the termination of services, and a copy must be provided to:

Fax: 855-874-4711  
Mail: BCBSIL  
PO Box 4288  
Scranton, PA 18505
If the Member’s services are expected to be fewer than 2 days in duration, the Provider should notify the Member at the time of admission. If, in a non-institutional setting, the span of time between services exceeds two days, the notice should be given no later than the next to last time that services are furnished. This notice fulfills the requirement at 42 C.F.R. 422.624(b)(1) and (2). Providers are expected to comply with all applicable provisions of 42 C.F.R. 422.624.

The notice must be validly delivered. Valid delivery means that the Member must be able to understand the purpose and contents of the notice to sign for receipt of it. The Member must be able to understand that he or she may Appeal the termination decision. If the Member is not able to comprehend the contents of the notice, it must be delivered to and signed by a Representative.

Valid delivery does not preclude the use of assistive devices, witnesses or interpreters for notice delivery. Thus, if a Member is not able to physically sign the notice to indicate receipt, then delivery may be proven valid by other means.

Do not use the NOMNC if coverage is being terminated for any of the following reasons:

- Because the MA benefit is exhausted;
- For denial of MA admission;
- For denial of non-MA Covered Services; or
- Due to a reduction or termination of an MA service, that does not end the skilled MA stay.

In these cases, BCBSIL will issue the CMS form 10003 - Notice of Denial of Medical Coverage (NDMC).

The NOMNC is a standardized notice. Therefore, MA Plans, Participating IPAs and Providers may not re-write, re-interpret or insert non-OMB-approved language into the body of the notice except where indicated.

The Member must be able to understand that he or she may Appeal the termination decision. If the Member thinks his or her coverage is ending too soon, the Member can Appeal directly and immediately to the Quality Improvement Organization (QIO). The Member must request an Appeal to the QIO no later than noon of the day before the date services are to end. If the Member misses the deadline for Appealing to the QIO, the Member can request an expedited Appeal from BCBSIL.

### 9.7 Detailed Explanation of Non-Coverage

BCBSIL will provide a completed copy of the Detailed Explanation of Non-Coverage (DENC) to Members receiving SNF, HHA or CORF services upon notice from the QIO that the Member has appealed the termination of services in these settings. This notice fulfills the requirement at 42 CFR 422.626(e)(1) and will be provided to the Member no later than close of business of the day of the QIO’s notification. The DENC is a standardized notice. BCBSIL may not deviate from the wording or content of the form except where authorized to do so. BCBSIL will also send a copy of the DENC to the QIO. The DENC will include the following:

- A specific and detailed explanation why services are either no longer reasonable and necessary or otherwise no longer covered;
- A description of any applicable Medicare coverage rule, instruction or other Medicare policy, including citations to the applicable Medicare policy rules or information about how the Member may obtain a copy of the Medicare policy from BCBSIL;
- Any applicable BCBSIL MA plan policy, contract provision, or rationale upon which the termination decision was based; and
- Facts specific to the Member and relevant to the termination decision that is sufficient to advise the Member of the applicability of the coverage rule or policy to the Member’s case.
Section 10: Quality Improvement

10.1 Overview

Quality improvement is an essential element in the delivery of benefits by BCBSIL. To define and assist in monitoring quality improvement, the BCBSIL Quality Improvement Program (QIP) focuses on measurement of clinical care and service against established goals. Some of the programs included in the QIP are described below.

10.2 Quality Improvement Project

The Quality Improvement Project is BCBSIL’s initiative that focuses on specified clinical and non-clinical areas. The QIP provider specific details are defined on an annual basis and defined in the Medical Service Agreement.

10.3 Healthcare Effective Data and Information Set (HEDIS®)

HEDIS is a widely used set of health plan performance measures utilized by both private and public health care purchasers to promote accountability and assess the quality of care provided by managed care organizations.

10.4 Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

CAHPS is a patient’s perspective of care survey, administered annually, in which a sample of Members from provider organizations (e.g., MA organizations, prescription drug plans, private fee-for-service) are asked for their perspectives of care that:

- allow meaningful and objective comparisons between Providers on domains that are important to consumers;
- create incentives for providers to improve their quality of care through public reporting of survey results; and,
- enhance public accountability in health care by increasing the transparency of the quality of the care provided in connection with the public investment.

10.5 Health Outcomes Survey (HOS)

This survey is the first outcomes measure used in the Medicare program. It is a longitudinal, self-administered survey that uses a health status measure, the VR-12, to assess both physical and mental functioning. A sample of Members from each MA organization health plan is surveyed. Two years later, these same Members are surveyed again to evaluate changes in health status.
10.6 Quality of Care Issues

The QIP may include aggregation and analysis of trends for quality of care issues. A quality of care complaint may be filed through BCBSIL’s grievance process and/or the QIO. The QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by a Provider meets professionally recognized standards of health care, including whether appropriate health care settings were provided and whether services were provided in appropriate settings.

The QIO is comprised of practicing doctors and other health care experts under contract with the federal government to monitor and improve the care given to BCBSIL MA PPO Members. QIOs review complaints raised by Members about the quality of care provided by Physicians, Hospitals, skilled nursing facilities, home health agencies, Medicare health plans and ambulatory surgical centers. The QIOs also review continued stay denials for Members receiving care in acute inpatient Hospital facilities as well as coverage terminations in SNFs, HHAs and CORFs.

10.7 CMS Star Ratings

The Centers for Medicare & Medicaid Services (CMS) posts quality ratings of MA plans to provide Medicare beneficiaries with additional information about the various MA plans offered in their area. CMS rates MA plans on a scale of one to five stars and defines the star ratings in the following manner:

- 5 Stars = Excellent performance;
- 4 Stars = Above average performance;
- 3 Stars = Average performance;
- 2 Stars = Below average performance; and,
- 1 Star = Poor performance.

The quality scores for MA plans are based upon performance measures that are derived from four sources:

- Healthcare Effective Data and Information Set (HEDIS®);
- Consumer Assessment of Healthcare Providers and Systems (CAHPS®);
- Health Outcomes Survey (HOS); and,
- CMS administrative data, including information about Member satisfaction, plans’ Appeals processes, audit results and customer service.

CMS groups the quality measure into five domains:

- Staying healthy: screenings, tests, and vaccines;
- Managing chronic (long-term) conditions;
- Ratings of health plan responsiveness and care;
- Member complaints, problems getting services and choosing to leave the plan; and,
- Health plan customer service.

All rated plans receive both summary scores and overall scores. The summary score for MA plans is used to provide quality-based payments and an overall measure of a plan’s quality based on indicators specific to quality and access to care. The overall score for MA plans differs from the summary score because it combines a plan’s summary score with its Part D plan rating. For more information on summary scores and overall scores, please refer to www.cms.gov.
10.8 30 Day Readmissions

Consistent with CMS payment methodology and to help improve quality for our members, BCBS will review readmissions to an acute care facility that occur within 30 days of discharge from the same facility. For participating providers, BCBS performs a clinical validation of acute care hospital claims to determine if such readmissions to the same facility within 30 days of discharge are related and may deny payment to the hospital for related readmissions.

Upon request, the hospital must forward any medical records and related documents involving the admissions. These documents will be clinically reviewed to determine if readmissions within 30 days was clinically related. If it is determined that the stays were clinically related, BCBS will not pay for the second DRG.

Exclusions: Readmissions, including but not limited to, under the following circumstances are excluded from 30-day readmission review:

- Obstetrical readmissions
- Transfers of patients to receive care that was unable to be provided at the initial facility
- SNF and rehabilitation facility admissions
- Planned readmissions for repetitive health care treatments, including but not limited to: chemotherapy, staged surgical procedures, procedures involving malignancies, burns procedures, cystic fibrosis procedures, and other treatments
- Patient non-compliance, ONLY if this is adequately documented in medical records
### Section 11: BCBSIL MA PPO Plan Contact Information

<table>
<thead>
<tr>
<th>Contact</th>
<th>Phone/Fax/Internet</th>
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<tbody>
<tr>
<td><strong>Member/Provider Customer Service</strong>&lt;br&gt;(To obtain benefits, eligibility or claims status)</td>
<td>(877)-774-8592&lt;br&gt;Hours of operation: 8 a.m. - 8 p.m., MST, 7 days a week. From February 15 through September 30 alternate technologies (for example, voicemail) will be used on the weekends and holidays.</td>
</tr>
<tr>
<td><strong>Network Services Representative:</strong>&lt;br&gt;April Johnson, PNC&lt;br&gt;Tracye Vann, PNC&lt;br&gt;Matt Peglow, PNC&lt;br&gt;Ekata Patel, Manager&lt;br&gt;Liz Signorella, Director</td>
<td>(630) 328-4342&lt;br&gt;(630) 328-4315&lt;br&gt;(630) 328-5747&lt;br&gt;(630) 328-1058&lt;br&gt;(630) 328-4195</td>
</tr>
<tr>
<td><strong>Utilization Management (UM)</strong>&lt;br&gt;(For Medical and Behavioral Health)</td>
<td>(877)-774-8592 (P)&lt;br&gt;(855)-874-4711 (F)&lt;br&gt;eviCore Website <a href="https://www.evicore.com/healthplan/bcbsil">https://www.evicore.com/healthplan/bcbsil</a>&lt;br&gt;For a detailed listing of CPT codes that require authorization, please see the document titled “Prior Authorization Procedure Code List” under the Blue Cross Medicare Advantage PPO Manual/Resources section on the <a href="http://www.bcbsil.com">www.bcbsil.com</a> website.</td>
</tr>
<tr>
<td><strong>Care Management Programs</strong>&lt;br&gt;(Medical &amp; Behavioral Health)</td>
<td>(855)-390-6567</td>
</tr>
<tr>
<td><strong>The Availity Health Information Network</strong>&lt;br&gt;(For electronic claim questions)</td>
<td>(800)-282-4548&lt;br&gt;<a href="http://www.availity.com">www.availity.com</a></td>
</tr>
<tr>
<td><strong>Claims Address</strong>&lt;br&gt;(For submission of paper claims)</td>
<td>Blue Cross Medicare Advantage&lt;br&gt;c/o Provider Services&lt;br&gt;P.O. Box 3686&lt;br&gt;Scranton, PA 18505</td>
</tr>
<tr>
<td><strong>EDI Claim Submission- PAYER ID</strong></td>
<td>66006</td>
</tr>
</tbody>
</table>
| Provider Pre-Service Appeal | Blue Cross Medicare Advantage  
|                           | Attn: Appeals  
|                           | P.O. Box 4288  
|                           | Scranton, PA 18505  
|                            |
| Fax – 855-674-9185  
| For expedited appeals only – Call 877-774-8592 |
| Provider Claim Dispute  
| *(Post Service - Claim Only)*  
| Blue Cross Medicare Advantage  
| c/o Provider Services  
| P.O. Box 4288  
| Scranton, PA 18505  
| Dispute Fax: (855)-674-9185  
| Phone: (877)-774-8592 |
| Appeals and Grievances (Members)  
| Blue Cross Medicare Advantage  
| c/o Provider Services  
| P.O. Box 4288  
| Scranton, PA 18505  
| Customer Service Phone: (877)-774-8592  
| Appeals Fax: (855)-674-9185  
| Grievances Fax: (855)-674-9189 |
| Blue Medicare Rx  
| *MAPD Pharmacy Help Desk*  
| (800)-693-6704 |
| CMS Website Address  
| www.cms.gov |
## Section 12: Glossary of Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td>Appeal</td>
<td>Any of the actions or procedures that involve a request for review of adverse organization determinations pertaining to healthcare services received, or any amounts that the Member must pay for a covered service (including prescription drugs).</td>
</tr>
<tr>
<td>Evidence of Coverage</td>
<td>The document(s) which describe the health benefits coverage available to Members enrolled in a BCBSIL MA PPO Plan.</td>
</tr>
<tr>
<td>Covered Services</td>
<td>Those health care benefits which are available to the Member enrolled in the BCBSIL MA PPO Plan and described in the Member’s Evidence of Coverage.</td>
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</table>
| 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 injuries 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.                                                                 |
<p>| Emergency Services          | These are Covered Services that are needed to evaluate or stabilize an Emergency Medical Condition, and which are furnished by a Provider qualified to furnish services to individuals experiencing an Emergency Medical Condition. |
| Hospital                    | A Medicare-certified institution licensed in a State, 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. |
| Annual Health Assessment    | An Annual Health Assessment (AHA) may be completed with a health professional who may be a physician, physician assistant, nurse practitioner or clinical nurse specialist.                                          |</p>
<table>
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<tr>
<th><strong>Laws</strong></th>
<th>Means all applicable laws, rules, regulations, statutes, orders, and standards of the United States of America, the states or any department or agency thereof with jurisdiction over any or all the Parties, as such laws, rules, regulations, statutes, orders and standards are adopted, amended or issued from time to time. Laws include, without limitation, the Health Insurance Portability and Accountability Act of 1996 (&quot;HIPAA&quot;) and its implementing regulations, including the HIPAA Privacy Rule and HIPAA Security Rule; Parts C and D of Title XVIII of the Social Security Act and its implementing regulations, including Parts 422 and 423 of Title 42 of the Code of Federal Regulations; all CMS guidance and instructions relating to the Medicare Advantage and Medicare Prescription Drug Programs; Title VI of the Civil Rights Act of 1964; the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; the Americans with Disabilities Act; the requirements applicable to individuals and entities receiving federal funds; the federal False Claims Act; any applicable state false claims statute, the federal anti-kickback statute; and the federal regulations prohibiting the offering of beneficiary inducements.</th>
</tr>
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<tr>
<td><strong>Medicare</strong></td>
<td>The Federal Government health insurance program established by Title XVIII of the Social Security Act.</td>
</tr>
<tr>
<td><strong>Medicare Part A</strong></td>
<td>Part A includes benefits for Hospital insurance benefits including inpatient Hospital care, skilled nursing facility care, home health agency care and hospice care offered through Medicare.</td>
</tr>
<tr>
<td><strong>Medicare Part B</strong></td>
<td>Part B includes benefits for Physician services (in both Hospital and non-Hospital settings) and services furnished by certain non-Physician practitioners. Other Part B services include lab testing, durable medical equipment, 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.</td>
</tr>
<tr>
<td><strong>Medicare Advantage (MA) Plan</strong></td>
<td>A policy or benefit package offered by an MA 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 MA organization. An MA organization may offer more than one benefit plan in the same Service Area. In many cases, MA Plans also offer Medicare Part D (prescription coverage). These plans are called MA Plans with Prescription Drug Coverage (MAPD).</td>
</tr>
<tr>
<td><strong>Member</strong></td>
<td>A Medicare beneficiary entitled to receive Covered Services who has voluntarily elected to enroll in a BCBSIL MA PPO Plan and whose enrollment has been confirmed by CMS.</td>
</tr>
<tr>
<td><strong>Participating IPA</strong></td>
<td>Any duly organized Individual Practice Association (IPA), Independent Physician Association, organized Medical Group, Physician Hospital Organization or other legal entity organized to arrange for the provision of professional medical service which has in force a contract or agreement with BCBSIL to provide professional and ancillary services to Members enrolled in BCBSIL as outlined in BCBSIL Provider Manual and according to the Member’s plan of benefits outlined in his or her Evidence of Coverage.</td>
</tr>
</tbody>
</table>
Participating Provider | A Hospital facility, health care facility, laboratory, Physician, person or other Provider of medical services which has a written agreement with BCBSIL at the time Covered Services are provided to Members and that is duly licensed by the appropriate State and local authority to provide such services.

Physician | Any person currently licensed to practice medicine or osteopathy in the state in which the person maintains their office.

Primary Care Physician (PCP) | Any 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.

Provider | Any Physician or health care practitioner, to include, but not limited to, a Physician, physical therapist, psychologist, hospital facility, health care facility, laboratory and any other provider of medical services, licensed in accordance with all applicable Laws.

Provider Manual | This booklet which describes the requirements and responsibilities of Participating IPAs and their Providers who have agreed to participate in the BCBSIL MA PPO network.

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 MA members and Medicare enrollees. QIOs review complaints raised by MA 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. KEPRO in Area 4 located at 5201 W. Kennedy Blvd., Suite 900, Tampa, FL 33609 is the QIO for BCBSIL.

Toll-free Phone Number: 855-408-8557
Fax: 844-834-7130
Local Phone Number: 813-280-8256

Reconsideration | A BCBSIL MA Member’s first step in the Appeal process after an adverse organization determination. BCBSIL 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 BCBSIL MA PPO Plan 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 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 Appeals process, subject to the applicable rules described at 42 CFR Part 405.