BlueCross BlueShield of Texas

Blue Cross Medicare Advantage (HMO℠) Supplement to the Blue Essentials℠, Blue Premier℠, Blue Advantage HMO℠ and MyBlue Health℠ Provider Manual

Updated 6/24/2026

Important Note: Throughout this provider manual there will be instances when there are references unique to Blue Essentials℠, Blue Advantage HMO℠, Blue Premier℠ and MyBlue Health℠. These specific requirements will be noted with the plan/network name. If a plan/network name is not specifically listed or the "Plan" is referenced, the information will apply to all products.

All references to “members” are referring to members enrolled in **Blue Cross Medicare Advantage(HMO).**

All references to “participating providers” are referring to providers who have signed an agreement with Blue Cross Medicare Advantage(HMO

Capitated Medical Groups - Health care providers who are contracted/affiliated with a capitated Medical Group must contact the Medical Group for instructions regarding referral and prior authorization processes, contracting and claims-related questions. Additionally, health care providers who are not part of a capitated Medical Group but who provide services to a member whose PCP is contracted/affiliated with a capitated Medical Group must also contact the applicable Medical Group for instructions. Health care providers who are contracted/affiliated with a capitated Medical Group are subject to that entity’s procedures and requirements for the Plan's provider complaint resolution

Blue Cross and Blue Shield of Texas, a Division of Health Care Service Corporation,
a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

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1 Introduction

Blue Cross and Blue Shield of Texas is pleased to welcome you as a **Blue Cross Medicare Advantage (HMO)** participating health care provider. The **Blue Essentials℠**, **Blue Advantage HMO℠, Blue Premier℠ and MyBlue Health℠** Provider Manual plus this Supplement explain the policies and procedures of the **Blue Cross Medicare Advantage (HMO)** network.

We hope it provides you and your office staff with helpful information as you serve **Blue Cross Medicare Advantage (HMO)** members. The information is intended to provide guidance in most situations your office will encounter while participating in **Blue Cross Medicare Advantage (HMO)**. This Supplement to the Blue Choice Health Care Provider Manual is applicable only to the operation of **Blue Cross Medicare Advantage (HMO).**

2 The Blue Cross Medicare Advantage (HMO) Network

Blue Cross Medicare Advantage HMO is a Medicare Advantage Plan. **Blue Cross Medicare Advantage HMO** maintains and monitors a network of participating health care providers through which members obtain Covered Services. Participating health care providers are encouraged to coordinate care on behalf of their patients.

Blue Cross Medicare Advantage HMO SNP is a coordinated care special needs plan specifically designed to provide targeted care and limited enrollment to special needs individuals who are eligible for both Medicare *and* Medicaid. The plan is an integrated care model used to improve the health of our most vulnerable members. Additionally, the model of care is considered a vital quality improvement tool and integral component for ensuring that the unique needs of each beneficiary enrolled in a Special Needs Plan are identified and addressed. The Center for Medicare and Medicaid Services requires all contracted and out-of-network providers seen by members on a routine basis to receive training on the SNP MOC.

DSNP Training for Providers and Staff

- All DSNP State Plans will need to provide ongoing staff training and provider training on the DSNP Model of Care. This can occur through live in-person training sessions as well as Webex or Computer-based Training Modules.
- Training must occur at least annually for providers and internal staff and will be ongoing for staff as needed.
- A provider can submit an attestation indicating that they have completed the DSNP Model of Care Training.

SNP MOC Goals

- Improve beneficiary outcomes
- Integrate and coordinate care
- Ensure use of preventive health services
- Improve management of chronic disease through goal setting
- Improve access to affordable care

Cost Sharing Protections for Dual Eligible Members

CMS Notification Network Providers (effective 2022):

- Must not hold a Dual Eligible Member liable for the Cost Sharing Obligations; and
- Must accept as payment in full the Medicare plan and/or provider may submit claim to Medicaid plan for cost sharing. Provider cannot bill the member.

Medicare Advantage DSNP Trainings

Blue Cross Medicare Advantage Dual Care (HMO SNP) Model of Care Training

Blue Cross Medicare Advantage HMO and HMO SNP will market its Medicare Advantage Plans to eligible individuals for Medicare Parts A and B that live in the following approved Service Area in the state of Texas:

Blue Cross Medicare Advantage (HMO) Service Area

Anderson, Andrews, Aransas, Archer, Armstrong, Atascosa, Austin, Bailey, Bandera, Bastrop, Baylor, Bee, Bell, Bexar, Blanco, Borden, Bosque, Bowie, Brazoria, Brazos, Brewster, Briscoe, Brooks, Burleson, Burnet, Caldwell, Calhoun, Cameron, Camp, Carson, Cass, Castro, Chambers, Cherokee, Childress, Clay, Cochran, Coke, Coleman, Collin, Colorado, Comal, Concho, Cooke, Coryell, Crane, Crosby, Culberson, Dallam, Dallas, Dawson, Deaf Smith, Delta, Denton, Dewitt, Dickens, Dimmit, Donley, Duval, El Paso, Ellis, Erath, Falls, Fannin, Fayette, Fisher, Floyd, Foard, Fort Bend, Franklin, Freestone, Frio, Gaines, Galveston, Garza, Gillespie, Glasscock, Goliad, Gonzales, Grayson, Gregg, Grimes, Guadalupe, Hale, Hall, Hamilton, Hansford, Hardeman, Hardin, Harris, Harrison, Hartley, Haskell, Hays, Henderson, Hidalgo, Hill, Hockley, Hood, Hopkins, Houston, Howard, Hudspeth, Hutchinson, Irion, Jack, Jackson, Jeff Davis, Jefferson, Jim Hogg, Jim Wells, Johnson, Karnes, Kaufman, Kendall, Kenedy, Kent, Kimble, King, Kinney, Kleberg, Knox, La Salle, Lamar, Lamb, Lampasas, Lavaca, Lee, Leon, Liberty, Limestone, Live Oak, Llano, Loving, Lubbock, Lynn,

Madison, Marion, Martin, Mason, Matagorda, McCulloch, McLennan, McMullen, Medina, Menard, Midland, Milam, Mills, Mitchell, Montague, Montgomery, Moore, Morris, Motley, Nacogdoches, Navarro, Nueces, Oldham, Orange, Palo Pinto, Panola, Parker, Pecos, Polk, Potter, Presidio, Rains, Randall, Reagan, Real, Red River, Reeves, Refugio, Roberts, Robertson, Rockwall, Runnels, Rusk, San Augustine, San Jacinto, San Patricio, San Saba, Schleicher, Shackelford, Shelby, Sherman, Smith, Somervell, Stephens, Sterling, Stonewall, Sutton, Swisher, Tarrant, Terry, Throckmorton, Titus, Tom Green, Travis, Trinity, Tyler, Upshur, Upton, Van Zandt, Victoria, Walker, Waller, Washington, Webb, Wharton, Willacy, Williamson, Wilson, Winkler, Wise, Wood, Yoakum, Young, Zapata, Zavala.

Blue Cross Medicare Advantage (HMO) will furnish members with a Member Handbook and Evidence of Coverage that will include a summary of the terms and conditions of its plan.

3 General Information

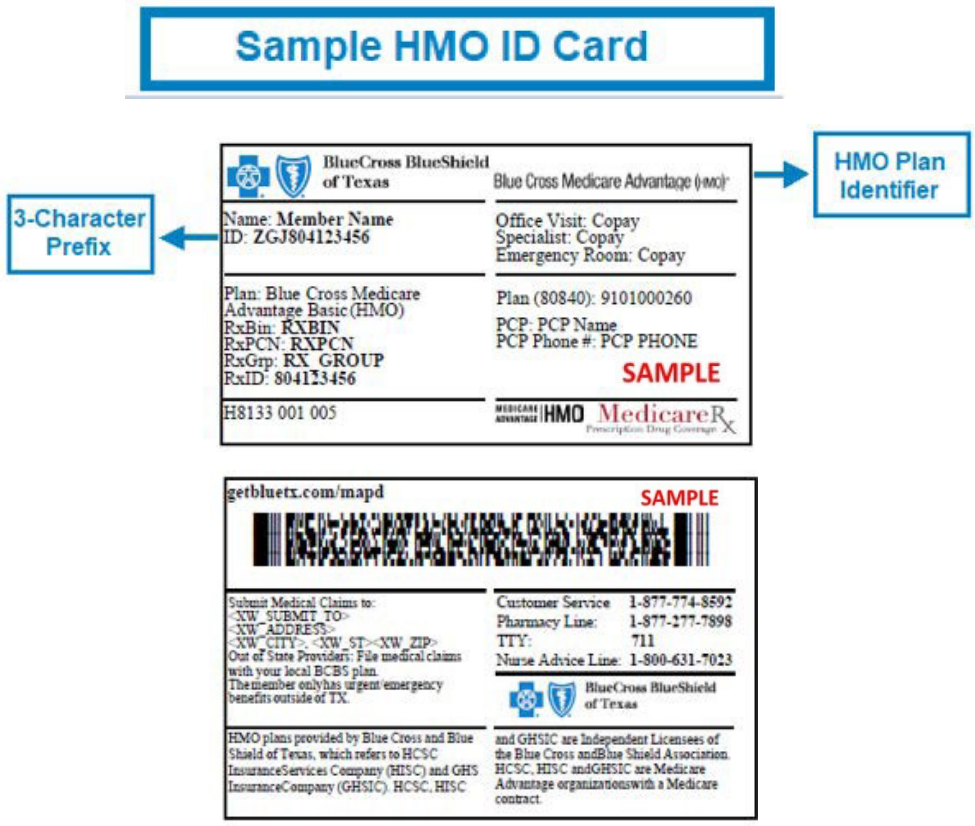
ID Cards & Checking Eligibility and Benefits

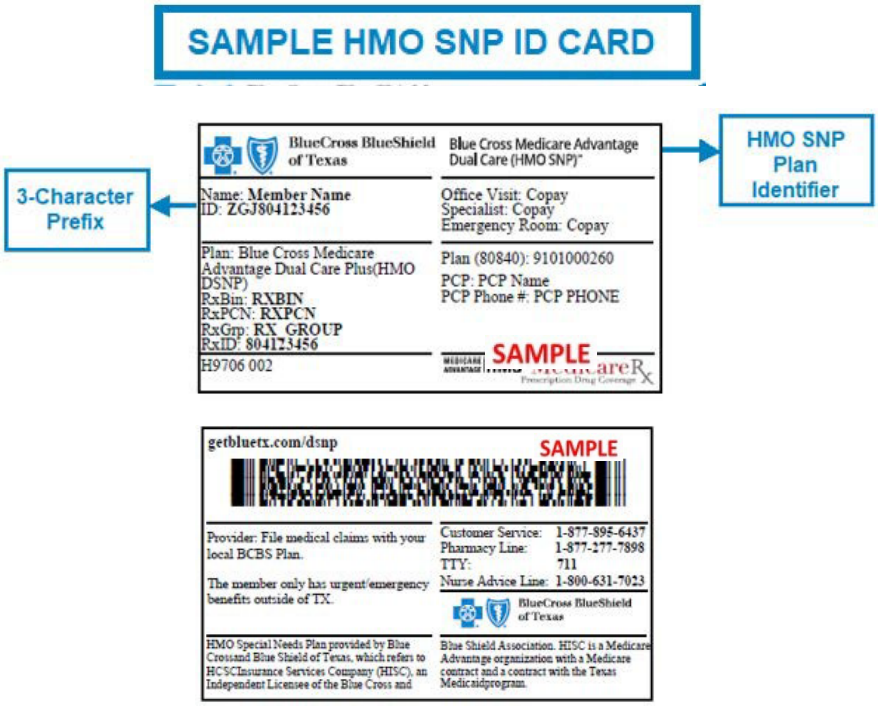
Each **Blue Cross Medicare Advantage (HMO)** member will receive a **Blue Cross Medicare Advantage (HMO)** identification card containing the member's name, member ID number and information about their benefits.

At each office visit, your office staff should:

- Ask for the member's ID card
- Copy both sides of the member's ID card and keep the 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 check eligibility in the **Blue Cross Medicare Advantage HMO or HMO SNP** deductibles, coinsurance amounts, copayments, and other benefit information
- Check eligibility and for other relevant information
- Member ID Cards will show designated Primary Care Providers name on the front of the card.

Sample ID Cards





ID Card Copayment Information

The office visit copayment (in-network) or coinsurance (out-of-network) is determined by how a health care provider is contracted for **Blue Cross Medicare Advantage (HMO)**.

- If the health care provider is contracted for **Blue Cross Medicare Advantage (HMO)** as a Primary Care Physician/Provider, provider should collect the in-network copayment indicated on the member ID card for the PCP.
- If the health care provider is contracted with **Blue Cross Medicare Advantage (HMO)** as an in-network Specialty Care Provider, the provider should collect the in-network copayment indicated on the member ID card for Specialists.
- If the health care provider is contracted as an in-network PCP **and** a Specialty Care Provider, then the provider should collect the PCP in-network copayment indicated on the member ID card.
- If the healthcare provider is out of network, contact the Customer Service number listed on the member's ID card to determine the member's patient share.

NOTE: BCBSTX strongly encourages providers to check patient eligibility and benefit information prior to every scheduled appointment. Refer to the member's ID card for the Customer Service phone number or check benefits through Availity® or your preferred web vendor.

Verification of How a Particular Service Will be Paid

Under the Prompt Pay Legislation, providers of service have the right to request verification that a particular service will be paid by the insurance carrier. Verification as defined by the Texas Department of Insurance is a guarantee of payment for health care or medical care service if the services are rendered within the required timeframe to the patient for whom the services are proposed.

Refer to section B of the "Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual" which can be found on bcbstx.com/.

Lab Provider

Quest Diagnostics, Inc. is the ***preferred*** outpatient clinical reference laboratory provider for **Blue Cross**

Medicare Advantage HMO members.

***Note**: This arrangement excludes lab services provided during emergency room visits, inpatient admissions and outpatient day surgeries (hospital and free standing ambulatory surgery centers).*

Quest Diagnostics Offers:

- On-line scheduling for Quest Diagnostics' Patient Service Center locations. To schedule a PSC appointment, log onto www.QuestDiagnostics.com/patient or call **1-888-277-8772.**
- Convenient patient access to over 150 PSCs.
- 24/7 access to electronic lab orders, results, and other office solutions through *Care360®Labs and Meds*.

For more information about Quest Diagnostics lab testing solutions or to setup an account, contact your Quest Diagnostics' Physician Representative or call **1-866-MY-QUEST**.

Reminder of CLIA Requirements

This is a reminder that **Blue Cross Medicare Advantage HMO** follows the same billing and coverage guidelines as original Medicare. This includes the requirement to report the Clinical Laboratory Improvements Amendments of 1988 number on claims submitted by all laboratories, including physician office laboratories. The CLIA number must be included on each Form CMS-1500 claim for laboratory services by any laboratory performing tests covered by CLIA. The CLIA number is required in field 23 of the paper Form CMS-1500. Modifier QW must be reported on claims for CLIA waived laboratory tests. The CLIA number is not required on the Form CMS-1450 (UB04).

Addresses for Claims Filing & Customer Service Phone Numbers

The member's ID card provides claims filing and customer service information. If in doubt, please call **Blue Cross Medicare Advantage HMO** Provider Customer Service at the number listed below. Although the submission of claims electronically is the preferred method, when a paper claim is submitted for a member with a PCP not affiliated with a capitated Independent Practice Association or Medical Group, use the appropriate address indicated below.

Provider Customer Service	Claims and Refund Filing Address
877-774-8592	Blue Cross Medicare Advantage HMO c/o Provider Services PO Box 3586 Scranton, PA 18505-9998

Traveler Benefits

When the member is continuously absent from the service area for more than six months, they may be disenrolled from the plan. We offer as a supplemental benefit a visitor/traveler program in the U.S., which will allow the member to remain enrolled in our plan when the member is outside of our service area for up to 6 months. This program is available to all Blue Cross Medicare Advantage members who are temporarily in the visitor/traveler area. Under our visitor/ traveler program you may receive all plan Medicare-covered services at in- network cost sharing when the member notifies the plan in advance of their travel. Members are encouraged to contact the plan for assistance in locating a provider when using the visitor/traveler benefit.

Medical Records

Network providers are required to provide medical records requested by **Blue Cross Medicare Advantage (HMO)**. The medical records are used for CMS audits of risk adjustment data which are used to determine health status adjustments to CMS capitation payments to the **Blue Cross Medicare Advantage HMO** organization.

Medical records are also used for the following:

- Advance determination of coverage
- Plan coverage

- Medical necessity
- Proper billing
- Quality reporting
- Fraud and abuse investigations
- Plan initiated internal risk adjustment validation

24-Hour Coverage

Participating health care providers are required to provide coverage for **Blue Cross Medicare Advantage (HMO)** members 24 hours a day, 7days a week. When a participating health care provider is unavailable to provide services, the participating health care provider must ensure that he or she has arranged for coverage from another participating health care provider. The member must have the ability to leave a message and receive a return call within 30 minutes, or the provider must have an answering service to relay urgent calls to providers attention after hours. Hospital emergency rooms or urgent care centers are not substitution for covering participating health care providers. Participating health care providers can consult their **Blue Cross Medicare Advantage HMO** Provider Directory to identify health care providers participating in the **Blue Cross Medicare Advantage HMO** network. You may also contact the **Blue Cross Medicare Advantage HMO** Provider Customer Service Department at the number listed on the back of the member's ID card with questions regarding which health care providers participate in the **Blue Cross Medicare Advantage HMO** network.

Emergency Services Definition

Covered inpatient or outpatient services that are:

- furnished by a provider qualified to provide Emergency Services; and
- needed to evaluate or stabilize an Emergency Medical Condition.

Emergency Medical Conditions

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

Emergency Care

Emergency Care 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

Emergency Care services necessary to evaluate and stabilize an Emergency Medical Condition are covered by **Blue Cross Medicare Advantage (HMO)**. Members with an Emergency Medical Condition should be instructed to go to the nearest Emergency Provider. Evaluation and stabilization of an Emergency Medical Condition in a hospital or comparable facility does not require prior authorization. Providers need to notify the UM department of inpatient admissions for post stabilization care services within one (1) business day of the admission following treatment of an emergency medical condition for Medicare Advantage HMO members. Failure to timely notify BCBSTX and obtain pre-approval for further post-stabilization care services may result in denial of the claim(s) for such post- stabilization care services, which cannot be billed to the member pursuant to your provider agreement with BCBSTX. Emergency Care services will be covered at the in-network benefit level.

Emergency Services are inpatient or outpatient services that are:

- furnished by a provider qualified to provide Emergency Services; and
- needed to evaluate or stabilize an Emergency Medical Condition.
- when the member, or any other prudent layperson with an average knowledge of health and medicine, believes that the member has medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.

Emergency medical condition is a medical condition immediate 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

eviCore®

BCBSTX has contracted with eviCore healthcare (eviCore)* to provide certain utilization management prior authorization services. Services requiring prior authorization as well as information on how to prior authorize services with eviCore are outlined on the Utilization Management page under Claims and Eligibility on our provider website. Refer to the eviCore page on our website for additional information.

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

Out-of-Area Renal Dialysis Services

A member may obtain medically necessary dialysis services from any qualified health care provider the member selects when the member is temporarily absent from the **Blue Cross Medicare Advantage (HMO)** Service Area and cannot reasonably access **Blue Cross Medicare Advantage (HMO)** dialysis providers**.** Prior authorization is not required.

Note: Pre-notification from the member is recommended for the member's case manager to follow-up with the member. Also, a member may voluntarily advise **Blue Cross Medicare Advantage (HMO)** when they will temporarily be out of the Service Area. **Blue Cross Medicare Advantage (HMO)** may assist the member in locating a qualified dialysis health care provider.

Preventive Services

Members may access the following services directly from any applicable participating health care provider. Some examples are:

- Screening mammograms
- Annual routine vision exams
- Glaucoma screening
- Hearing screening
- Influenza or pneumococcal vaccinations *(Members are not charged a copayment for influenza or pneumococcal vaccinations)*
- Routine and preventive women's health services (such as pap smears and pelvic exams)
- Bone Mass Measurements
- Colorectal Screening Exams
- Prostate Cancer Screening Exams
- Cardiovascular Disease Screening
- Diabetes Screening

- Diabetes Self-Management Training
- Medical Nutritional Therapy
- Smoking Cessation
- Annual Physical Exam
- Abdominal Aortic Aneurysm Screening for high-risk individuals

Access CMS Medicare Learning Network® Medicare Preventive Services for detailed information on Medicare Preventive Services.

Inpatient Hospital Admissions

All inpatient hospital admissions require prior authorization from the **Blue Cross Medicare Advantage (HMO)** Utilization Management Department. The prior authorization process for admissions is carried out by the admitting health care provider or hospital personnel.

In addition, providers need to notify the UM department of inpatient admissions for post stabilization care services within one (1 business day of the admission following treatment of an emergency medical condition for Medicare Advantage HMO members. **Failure to timely notify BCBSTX and obtain prior approval for further post-stabilization care services may result in denial of the claim(s for such post-stabilization care services, which cannot be billed to the member pursuant to your provider agreement with BCBSTX.**

Additionally, when a **Blue Cross Medicare Advantage (HMO)** member arrives at the facility for an elective admission, providers should notify the BCBSTX UM department to assist in patient care coordination.

Admitting health care providers are responsible for contacting the UM Department to request prior authorization for additional days if an extension of the approved length of stay is required. The admitting health care providers will provide appropriate referrals for extended care. **Blue Cross Medicare Advantage (HMO)** UM personnel will assist with coordinating all services identified as necessary in the discharge planning process.

Behavioral Health Services

Blue Cross Medicare Advantage (HMO) members requiring Behavioral Health Services (Mental Health and Chemical Dependency) can call Behavioral Health Customer Service at **877-774- 8592**. Telephonic access is available 24 hours a day, 7 days a week.

The Blue Cross Care Managers will provide:

- Prior authorization for hospital admissions and outpatient care
- Referral services if required
- Case Management
- Assistance in the selection of a participating health care provider
- Crisis intervention

The following referral procedures apply to behavioral health services and require authorizations:

Inpatient Levels of Care

- Inpatient mental health
- Inpatient Substance Use Disorder
- Partial Hospital Program

Outpatient Levels of Care/Services:

- Intensive Outpatient Program
- Outpatient Program Substance Use Disorder
- Electro-Convulsive Therapy
- Psychological Testing

***Note**: Services must be Medically Necessary before a prior authorization number is issued. **Claims received that do not have a** prior authorization **number for a hospital admission or outpatient care will be denied. Blue Cross Medicare Advantage HMO** behavioral health professionals or physicians may not seek payment from the member when a claim is denied for lack of a prior authorization number.*

The call to prior authorize can be made by the member, the behavioral health professional, physician or

authorized caretaker.

Behavioral health professionals and physicians are encouraged to admit patients to a participating facility unless an emergency situation exists that precludes safe access to a participating facility or if the admission is approved for a non-participating facility.

The member will only receive in-network benefits when services are performed at a **participating Blue Cross Medicare Advantage HMO** facility unless the admission is approved for a non-participating facility.

Behavioral Health Claims Filing Address	**Claims and Refund Filing Address**
Blue Cross Medicare Advantage HMO Claims Payment Request PO Box 4195 Scranton, PA 18505	837P - Professional: **66006** 837I - Institutional: **66006**

4 Roles and Responsibilities

Role of Primary Care Provider

The member must contact his/her Primary Care health care provider (family practice physician, general practice physician, internal medicine physician, advanced nurse practitioner, physician assistant, obstetrics& gynecology physician)* for all of their health care needs. The member's chosen PCP will be indicated on the front of the member's ID card.

*Please Note: An obstetrics & gynecology physician can choose to be a Primary Care Physician or a Specialty Care Physician. If the obstetrics & gynecology physician chooses to be a PCP and the **Blue Cross Medicare Advantage HMO** member chooses the obstetrics & gynecology physician as their PCP then the obstetrics & gynecology physician must assume and meet all of the **PCP** roles and requirements indicated on Section B "Provider Roles and Responsibilities" in the below Plan manual:

Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health – Provider Manual.

Each Primary Care health care provider is responsible for making his/ her own arrangements for patient coverage when unavailable.

A health care provider who has contracted with **Blue Cross Medicare Advantage HMO** as a PCP will agree to render services to the **Blue Cross Medicare Advantage HMO** member primary, preventive, acute and chronic health care management and:
Provide the same level of care to **Blue Cross Medicare Advantage HMO** patients as provided to all other patients.

- Provide urgent care and emergency care or coverage for care 24 hours a day, seven days a week.
- PCPs should have a verifiable mechanism in place for immediate response for directing patients to alternative after hours care based on the urgency of the patient's needs. Acceptable mechanisms may include: an answering service that offers to call or page the physician; a recorded message that directs the patient to call the answering service with the provided phone number.
- Be available at all times to hospital emergency room personnel for emergency care treatment and post-stabilization treatment to members. Such requests must be responded to within one hour.
- Meet required Patient Appointment Access Standards *(for more detail refer to Section G – Quality Improvement Program):*
    - Emergency Care - perform immediate triage during office hours and have a method for directing patients to alternative care after hours.
    - Urgent Care - Immediately.
    - Symptomatic Non-Urgent Care (Routine) - within 5 business days.
    - Annual Physical Exam - within 30 business days.
    - Initial New Patient Visit - within 30 business days.
    - In-office Wait Time - within 30 minutes.
    - After Hours Access – immediate
- Keep a central record of the member's health and health care that is complete and accurate
- Refer the **Blue Cross Medicare Advantage HMO** member to specialty care health care providers within the same Provider Network.
  For Dental – Dental Networks of America - call **1-800-972-7565**.
- PCPs will assist with referrals to vision care providers for members with medical conditions.
  For **Routine Vision** – EyeMed Vision Care - call **1-844-684-2255**
- Complete referral authorizations, outpatient prior authorizations and inpatient admissions by calling the Utilization Management Department number on the back of the member's card when applicable.
- Refer to the detailed information and instructions in Sections C & E of the Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual for more information on the Availity Authorizations & Referrals tool for referrals and prior authorizations.
- Provide copies of X-ray, laboratory results, and other health records to specialty care health care providers to enhance continuity of care and to prevent duplication of diagnostic procedures.
- Provide copies of medical records when requested by **Blue Cross Medicare Advantage**

HMO.

- Enter into the **Blue Cross Medicare Advantage HMO** member's health record all reports received from SCPs.
- Assume the responsibility for obtaining prior authorization for hospital admissions in which the provider is the admitting health care physician or delegate this responsibility to the admitting specialty care health care providers.
- Assume responsibility for care management as soon as possible after receiving information that a **Blue Cross Medicare Advantage HMO** member on his/her PCP list has been hospitalized in the local area on an emergency basis.
- Follow HIPPA guidelines when sharing any member PHI.

Panel Closure

Each **Blue Cross Medicare Advantage HMO** member shall select a PCP in accordance with the procedures set forth in the Membership Agreement. PCP's or Medical Group agree to accept **Blue Cross Medicare Advantage HMO** members who have selected or who have been assigned to the PCP. PCP or Medical Group must **Blue Cross Medicare Advantage HMO** that their practice is closed to new patients of **Blue Cross Medicare Advantage HMO**, as well as new patients of all other health plans. PCPs or Medical Group must give **Blue Cross Medicare Advantage HMO** at least ninety (90) days prior written notice of closing their practice to **new Blue Cross Medicare Advantage HMO** members.

Individual PCP or Medical Group agrees that **Blue Cross Medicare Advantage HMO** shall have no obligation to guarantee any minimum number of **Blue Cross Medicare Advantage HMO** members to Individual PCP or Medical Group and that Individual PCP or Medical Group shall accept all patients enrolling as **Blue Cross Medicare Advantage HMO** members.

Key Points:

- PCP may close practice with at least 90 days' prior written notice.
- PCP may only close his/her practice to **Blue Cross Medicare Advantage HMO** members if they have at least 300 or more **Blue Cross Medicare Advantage HMO** members.

Back Up PCPs

The PCP designates backup (covering) PCP during the network application process.

Referrals to Specialty Care Providers Not Required

Referrals to SCPs are not required if **Blue Cross Medicare Advantage HMO** members receive medical care from a **Blue Cross Medicare Advantage HMO** participating physicians and professional providers.

A PCP may not refer to himself as a specialty care health care provider when treating a member who is already on his/her PCP list.

For more information on referrals and submitting via the Availity Authorizations & Referrals tool, refer to Sections C & D of the Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual and Provider Tools on the provider website.

If the SCP determines that a **Blue Cross Medicare Advantage HMO** member needs to be seen by another SCP, the **Blue Cross Medicare Advantage HMO** member must be referred back to the member's PCP.

Note: The SCP cannot refer to other SCP.

Exception: PCP or SCP have the ability to directly manage and coordinate a woman's care for obstetrical and gynecological conditions, including obtaining referrals through the Availity tool for obstetrical/gynecological related specialty care and testing to other **Blue Cross Medicare Advantage HMO** participating health care providers that participate in the same Provider Network as the member's PCP, as applicable

Role of Specialty Health Care Providers

A **Blue Cross Medicare Advantage HMO** participating health care provider who provides services as a specialty care health care provider is expected to:

- Provide the same level of care to **Blue Cross Medicare Advantage HMO** patients as provided to all other patients.
- Provide urgent care and emergency care or coverage of care 24 hours a day, seven days a week. SCPs have a verifiable mechanism in place, for immediate response directing patients to alternative after hours care based on the urgency of the patient's need. Acceptable mechanisms may include: an answering service that offers to call or page the physician; a recorded message that directs the patient to call the answering service with the provided phone number, or a recorded message that directs the patient to call or page the physician with the provided phone number.
- Make his/her own arrangements for patient coverage when out of town or unavailable.
- Meet required Patient Appointment Access *Standards (for more details refer to Section G – Quality Improvement Program in the Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health Provider Manual).*
    - Emergency Care – perform immediate triage during office hours and have a method for directing patients to alternative care after hours
    - Urgent Care – immediately
    - Symptomatic Non-Urgent Care (Routine) – within 7 business days
    - Initial New Patient Visit – within 30 business days
    - In-Office Wait Time – within 30 minutes
    - After Hours Access – immediate
- Keep a central record of the member's health and health care that is complete and accurate.
- Accept referrals for Blue Cross Medicare Advantage HMO members in accordance with the services and the number of visits requested by the PCP in the same Provider Network, if applicable.
- Report back to the PCP upon completion of the consultation/treatment.
- Provide copies of x-ray and laboratory results and other health record information to the member's PCP, as appropriate.
- Coordinate inpatient care with the PCP so that unnecessary visits by other physicians or professional providers are avoided.
- The Medical Care Management IQMP staff will send notification of the approval, to include the effective date [first (1st) day of the month following the approved decision] to the member within 30 calendar days of receiving the request for special consideration.
- If the request for special consideration is denied by **Blue Cross Medicare Advantage HMO**, the medical director will send a denial letter within 30 days of receiving the request explaining the denial and the member's right to appeal the decision through the **Blue Cross Medicare Advantage HMO** Complaint Process.
- The effective date of the new designation of the non-primary care specialist will not be retroactive and may reduce the amount of compensation owed to the original PCP for services provided before the date of the new designation. For further details, contact Provider Customer Service for **Blue Cross Medicare Advantage HMO,** call **1-877- 774-8592.**
- Cooperate with BCBSTX for proper coordination of benefits involving covered services and in the collection of third-party payments including workers' compensation, party liens and other third-party liability. BCBSTX contracted physicians agree to file claims and encounter information to BCBSTX even if the physician or professional provider believes or knows there is not any third-party liability.
- Only bill **Blue Cross Medicare Advantage HMO** members for copayments, cost share (coinsurance) and deductibles, where applicable. Specialty care physicians or professional providers will not offer to waive or accept lower copayments or cost share or otherwise provide financial incentives to members, including lower rates in lieu of the member's insurance coverage.
- Use his/her best efforts to participate with BCBSTX Plan's Electronic Funds Transfer and Electronic Remittance Advice under the terms and conditions set forth in the EFT Agreement and as described on the ERA enrollment form.
- For services requiring authorization, if additional services and/or visits are needed, beyond

authorized by the PCP, a new authorization must be obtained from the PCP.

- If authorized by the PCP, arrange for the hospital admission of the **Blue Cross Medicare Advantage HMO** member into a participating Facility through the Utilization Management Department, and assume responsibility for completion of steps required by **Blue Cross Medicare Advantage HMO** to prior authorize the admission.

Specialist as a Primary Care Provider

Any Specialist providing medical services to a **Blue Cross Medicare Advantage HMO** member with a chronic, disabling or life- threatening illness may apply to the **Blue Cross Medicare Advantage HMO** Medical Director to be a specialty care health care provider as a PCP, provided that:

- The request for the specialty care health care providers includes certification of medical need, along with the applicable supporting documentation, and is signed by the **Blue Cross Medicare Advantage HMO** member or the specialty care health care provider interested in serving as the PCP.
- The specialty care health care provider must meet **Blue Cross Medicare Advantage HMO** requirements for PCP participation. Refer to Section B "Provider Roles and Responsibilities" in the Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health –Provider Manual.
- The specialty care health care provider is willing to coordinate all of the member's health care needs and accept **Blue Cross Medicare Advantage HMO** reimbursement.

5 Claim Information

Claim Process

Participating health care providers must submit claims to **Blue Cross Medicare Advantage (HMO)** within **180** days of the date of service, using the standard claim form or electronically as discussed below unless specified otherwise in your contract. Services billed beyond **180** days from date of service are not eligible for reimbursement. **Blue Cross Medicare Advantage (HMO)** participating health care providers may not seek payment from the member for claims submitted after the **180-**day filing deadline.

To expedite claims payment the following items must be submitted on your claims:

- Member's name, date of birth, and sex
- Member's **Blue Cross Medicare Advantage (HMO)** ID number
- Individual member's policy number
- Indication of: 1) job-related injury or illness, or 2) accident-related illness or injury, including pertinent details
- ICD10 diagnosis codes and procedure codes
- Date(s) of service(s)
- Charge for each service
- Provider's Tax Identification Number
- Name/address of participating provider
- Signature of participating provider who is providing services
- Place of Service Code
- National Provider Identifier Number

Blue Cross Medicare Advantage (HMO) will process electronic claims consistent with the requirements for standard transactions set forth in 45 CFR Part 162. Any electronic claims submitted to **Blue Cross Medicare Advantage (HMO)** should comply with those requirements.

Claims will be paid at the lesser of (1) billed charges for services and (2) the amount due on the claim per the provider's contract terms. In no event will claims be paid greater than provider's billed charges.

Claim Submission Information

Blue Cross Medicare Advantage (HMO) claims should be submitted electronically as follows:

- Submit through Availity® Essentials.
- Use Electronic Payor ID # **66006 for Blue Cross Medicare Advantage (HMO)**

For information on electronic filing of **Blue Cross Medicare Advantage (HMO)** claims, contact Availity at **1-800-282- 4548**.

B**lue Cross Medicare Advantage (HMO)** claims must be submitted within 180 days of the date of service. Claims not submitted within 180 days from the date of service are not eligible for reimbursement. **Blue Cross Medicare Advantage (HMO)** health care providers may not seek payment from the Member for claims submitted after the 180-day filing deadline.

Blue Cross Medicare Advantage (HMO) claims may be submitted -

- electronically in the CMS National Standard Format (NSF) or the current version of the ANSI 837 format or
- on a completed version of the applicable CMS-1500 claim form and mailed to:

  Blue Medicare Advantage (HMO)
  Medical Claims Payment Request
  PO Box 4195
  Scranton, PA 18505

Blue Cross Medicare Advantage (HMO) claims (electronic & paper) must be filed with the member's complete ID number exactly as shown on the member's ID card, including the 3-character prefix – **ZGJ.**

Blue Cross Medicare Advantage (HMO) claims containing adequate information and submitted in accordance with these guidelines will be paid within 45 days for paper claims and 30 days for electronic claims.

Duplicate Claims

Providers submitting electronic claims for **Blue Cross Medicare Advantage HMO** members may experience duplicate claim rejections if claims are resubmitted within 180 days of a previously processed claim, that includes the exact data for the same patient and date(s) of service. However, duplicate claim rejections should not occur if the following elements are different on the resubmitted claim:

- Patient Control Number (Loop 2300 – CLM01 Data Element)
- Clearinghouse Trace Number (Loop 2300 – REF02 where REF01=D9)
- Line-Item Control Number (Loop 2400 – REF02 where REF01=6R)

Duplicate paper claims should not be submitted prior to the applicable 45- day claims payment period.

Note: Claims with lab services will be denied if the CLIA number is not on the CMS-1500 form in field 23.

Coordination of Benefits

If a **Blue Cross Medicare Advantage (HMO)** member has coverage with another plan that is primary to Medicare, please submit a claim for payment to that plan first. The amount payable by **Blue Cross Medicare Advantage (HMO)** will be governed by the amount paid by the primary plan and Medicare secondary payer law and policies.

30-Day Readmission Facility Review

BCBSTX performs clinical reviews of acute care facility readmissions that occur within 30 days of discharge of our **Blue Cross Medicare Advantage (HMO)** members, or consistent with your provider contract. If we determine that the acute stays were clinically related, we may deny payment to the facility for related admissions.

These reviews support quality improvement, consistent with Centers for Medicare & Medicaid Services guidelines

When we request medical records for a 30-day facility readmission review to a facility:

- The facility must forward related medical records and any documents involving the admissions.
- If it is determined that the acute stays were clinically related, BCBSTX may deny payment to the facility for the readmission.
- Providers may dispute determinations through existing processes.

Refer to CMS resources:

- Medicare Claims Processing Manual, Chapter 3, Section 40.2.5 (Repeat Admissions)
- Medicare Quality Improvement Organization Manual, Chapter 4, Section 4240 (Readmission Review)

Claim Disputes

You may dispute a claims payment decision by requesting a claim review. Providers have one year from the time of the initial claim determination to dispute a claim. If you have questions regarding claims appeals, please contact the **Blue Cross Medicare Advantage (HMO)** Provider Customer Service Department at **877-774-8592** or by mail:

Blue Cross Medicare Advantage (HMO)

Attn: Claim Disputes
PO Box 4555
Scranton, PA 18505

Process Used to Recover Overpayments on Claims

If an overpayment occurs on a **Blue Cross Medicare Advantage (HMO)** health care provider's claim, automatic recoupment will be used to recover the overpayment. Should you have any questions, please contact **Blue Cross Medicare Advantage (HMO)** Provider Customer Service at **877-774-8592**. Providers who would like to refund the payment for an overpaid claim, can submit the funds and any accompanying paperwork to the Blue Cross Medicare Advantage HMO Claims and Refunds Address.

Remittance address for claim overpayment returns:
Blue Cross Blue Shield of Texas Claims Overpayments
Dept. CH 14212
Palatine, IL 60055-4212

Courier address for claim overpayment returns:
Blue Cross Blue Shield of Texas - Claims Overpayments
Box 14212
5505 North Cumberland Ave., Ste. 307
Chicago, IL 60656-1471

Note: Electronic Refund Management is not available for **Blue Cross Medicare Advantage HMO**

Balance Billing

You may not bill a **Blue Cross Medicare Advantage (HMO)** member for a non-covered service unless

- You have informed the **Blue Cross Medicare Advantage (HMO)** member in advance that the service is not covered, and,
- The **Blue Cross Medicare Advantage (HMO)** member has agreed **in writing** to pay for the services if they are not covered.

6 Benefits-Beneficiary Rights

Non-Discrimination

A **Blue Cross Medicare Advantage HMO** plan may not deny, limit, or condition enrollment to individuals eligible to enroll in a **Blue Cross Medicare Advantage HMO** plan offered by the organization on the basis of any factor that is related to health status, including, but not limited to the following: claims experience; receipt of health care; medical history and medical conditions arising out of acts of domestic violence; evidence of insurability, including conditions arising out of acts of domestic violence and disability.

Additionally, a **Blue Cross Medicare Advantage HMO** plan must comply with the provisions of the Civil Rights Act, Age Discrimination Act, Rehabilitation Act of 1973, Americans with Disabilities Act, and the Genetic Information Nondiscrimination Act of 2008.

Confirm that its **Blue Cross Medicare Advantage HMO** plans have procedures in place to ensure that members are not discriminated against in the delivery of health care services, consistent with the benefits covered in their policy, based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information or source of payment.

Confidentiality

The **Blue Cross Medicare Advantage HMO** plan must safeguard the privacy of any information that identifies a particular enrollee and have procedures that specify purposes for which the information will be used within the organization, and to whom and for what purpose it will disclose information outside the organization.

Basic Rule

A **Blue Cross Medicare Advantage HMO** organization offering a Medicare Advantage plan must provide the following to plan enrollees:

- All Part A and Part B, original Medicare services, if the enrollee is entitled to benefits under both parts
- Part B services if the enrollee is a grandfathered "Part B only" enrollee.

The **Blue Cross Medicare Advantage HMO** organization fulfills its obligation of providing original Medicare benefits by furnishing the benefits directly through arrangements, or by paying for the benefits on behalf of enrollees. The following requirements apply with respect to the rule that the **Blue Cross Medicare Advantage HMO** organization must cover the costs of original Medicare benefits:

- **Benefits** – **Blue Cross Medicare Advantage HMO** plans must provide or pay for medically necessary Part A (for those entitled) and Part B covered items and services
- **Access** – **Blue Cross Medicare Advantage HMO** enrollees must have access to all medically necessary Parts A and B services. However, **Blue Cross Medicare Advantage HMO** plans are not required to provide **Blue Cross Medicare Advantage HMO** enrollees with the same access to providers that is provided under original Medicare.
- **Cost-Sharing** – **Blue Cross Medicare Advantage HMO** plans may impose cost-sharing for a particular item or service that is above or below original Medicare cost-sharing for that service, provided the overall cost-sharing under the plan is actuarially equivalent to that under Original Medicare and the plan cost-sharing structure does not discriminate against sicker beneficiaries.

The following circumstances are exceptions to the rule that **Blue Cross Medicare Advantage HMO** organizations must cover the costs of original Medicare benefits:

- **Hospice** – Original Medicare (rather than the **Blue Cross Medicare Advantage HMO** organization) will pay the hospice for the services received by an enrollee who has elected hospice while enrolled in the plan.
- **Inpatient stay during which enrollment ends** – **Blue Cross Medicare Advantage HMO** organizations must continue to cover inpatient services of a non-plan enrollee if the individual was an enrollee at the beginning of an inpatient stay.
- **Clinical Trials** – Original Medicare pays for the costs of routine services provided to a **Blue Cross Medicare Advantage HMO** enrollee who joins a qualifying clinical trial. **Blue Cross Medicare Advantage HMO** plans pay the enrollee the difference between original Medicare cost-sharing incurred for qualifying clinical trial items and services, and the Medicare Advantage plan's in-

network cost-sharing for the same category of items and services.

In addition to providing original Medicare benefits, to the extent applicable, the **Blue Cross Medicare Advantage HMO** organization also furnishes, arranges, or pays for supplemental benefits and prescription drug benefits to the extent they are covered under the plan.

Uniform Benefits

All plan benefits must be offered uniformly to all enrollees residing in the service area of the plan and must be offered at uniform premium, with uniform benefits and cost-sharing throughout the plan's service area.

Benefits During Disasters and Catastrophic Events

In the event of a Presidential emergency declaration, a Presidential (major) disaster declaration, a declaration of emergency or disaster by a Governor, or an announcement of a public health emergency by the Secretary of Health and Human Services, but absent a 1135 waiver by the Secretary, Medicare Advantage plans are expected to:

- Allow Part A/B and supplemental Part C plan benefits to be furnished at specified non-contracted facilities.
- Waive in full, requirements for gatekeeper referrals where applicable.
- Temporarily reduce plan-approved out-of-network cost- sharing to in-network cost-sharing amounts; and
- Waive the 30-day notification requirement to enrollees as long as all the changes (such as reduction of cost-sharing and waiving authorization) benefit the enrollee.

Access and Availability Rules

A **Blue Cross Medicare Advantage HMO** organization may specify the providers through whom enrollees may obtain services if it ensures that all original Medicare covered services and supplemental benefits contracted for, by, or on behalf of Medicare enrollees are available and accessible under the coordinated care requirements. To accomplish this, the organization must meet the following requirements:

- Maintain and monitor a network of appropriate providers, supported by , that is sufficient to provide adequate access to covered services to meet the needs of the population served. This involves ensuring that services are geographically accessible and consistent with local community patterns of care.
- Establish and maintain provider network standards that define the types of providers to be used when more than one type of provider can furnish a particular item or service; identify the types of mental health and substance abuse providers in their network; and specify the types of providers who may serve as a member's PCP.
- Employ written standards for timeliness of access to care and member services that meet or exceed such standards as may be established by CMS. These standards must ensure that the hours of operation of the **Blue Cross Medicare Advantage HMO** organization's providers are convenient to, and do not discriminate against, members. The Medicare Advantage organization must also ensure that, when medically necessary, services are available 24 hours a day, seven days a week. This includes requiring PCPs to have appropriate backup for absences. The standards should consider the member's need and common waiting times for comparable services in the community. Examples of reasonable standards for primary care services are:
  - urgently needed services or emergency -immediately;
  - services that are not emergency or urgently needed, but in need of medical attention - within 7 business days; and
  - routine and preventive care - within 30 days
- Establish, maintain, monitor and validate credentials for a panel of primary care providers from which the member may select a personal primary care provider.
- Provide or arrange for necessary specialist care, and in particular give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services. The **Blue Cross Medicare Advantage HMO** organization must arrange for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet a member's medical needs.

- Ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all members, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds.
- **Blue Cross Medicare Advantage (HMO)** Member Customer Service *(phone number is listed on back of the member's ID card)* has available the following services for **Blue Cross Medicare Advantage (HMO)** members:
    - Teletypewriter services
    - Language services, and
    - Spanish speaking customer service representatives
- Establish and maintain written standards, including coverage rules, practice guidelines, payment policies and utilization management protocols that allow for individual medical necessity determinations. These standards must be available to both enrollees and providers.
- Provide coverage for ambulance services, emergency and urgently needed services, and post-stabilization care services. Ambulance services include services dispatched through 911 or its local equivalent when either an emergency exists, or other means of transportation would endanger the beneficiary's health.

Cost Sharing for Network Preventive Services

Medicare Advantage organizations are required to cover in-network Medicare covered preventive services for which there is no cost-sharing under original Medicare.

Medicare Advantage organizations may not charge for facility fees, professional services, or physician office visits if the only services provided during the visit is a preventive service that is covered at zero cost-sharing under original Medicare. However, if during provision of the preventive service, additional non-preventive services are furnished, then the plan's cost- sharing standards apply.

Enrollees of a Medicare Advantage organization may directly access (through self-referral) to any plan participating provider in-network screening mammography and influenza vaccine. The Medicare Coverage web page is at: http://www.cms.gov/center/coverage.asp.

Drugs Coverage

The following broad categories of drugs will be covered under the medical benefit and not covered under the original Medicare Part B for all **Blue Cross Medicare Advantage HMO members who have a Medicare Advantage Pharmacy Drug program (MAPD plan.**

Note: the following broad categories of drugs may be covered for individuals who are covered under Medicare Part B, subject to coverage requirements and regulatory and statutory limitations:

- Injectable drugs that have been determined by Medicare Contract Administrative Contractors to be "not usually self-administered" and are administered incidentally to physician services
- Durable Medical Equipment Supply Drugs. These are drugs that require administration by the use of a piece of covered DME (e.g., a nebulizer, external or implantable pump - albuterol sulfate, ipratropium bromide, some chemotherapeutic agents, etc.
- Certain vaccines including pneumococcal, hepatitis B (high or intermediate risk), influenza, and vaccines directly related to the treatment of an injury or direct exposure to a disease or condition
- Certain oral anti-cancer drugs and anti-nausea drugs
- Hemophilia clotting factors
- Drugs used in immunosuppressive therapy (such as cyclosporine) for a beneficiary who has received a Medicare covered organ transplant
- Some antigens
- Intravenous immune globulin administered in the home for the treatment of primary immune deficiency
- Injectable drugs used for the treatment of osteoporosis in limited situations
- Certain drugs, including erythropoietin, administered during treatment of end stage renal disease
- Some drugs are covered under either Part B or Part D depending on the circumstances.

Medical Supplies Associated with the Delivery of Insulin

Medical supplies directly associated with delivering insulin to the body, including syringes, needles, alcohol swabs, gauze, and insulin injection delivery devices not otherwise covered under Medicare Part B, such as insulin pens, pen supplies, and needle- free syringes, can satisfy the definition of a Part D drug. However, test strips, lancets and needle disposal systems are not considered medical supplies directly associated with the delivery of insulin for purposes of coverage under Part D.

Clinical Trials

For clinical trials covered under the Clinical Trials National Coverage Determination, Medicare covers the routine costs of qualifying clinical trials for all Medicare enrollees, including those enrolled in Medicare Advantage plans, as well as reasonable and necessary items and services used to diagnose and treat complications arising from participating in all qualifying clinical trials.

The Clinical Trial National Coverage Determination defines what routine costs means and also clarifies when items and services are reasonable and necessary. All other Medicare rules apply. Refer to the Medicare Clinical Trial Policies page for more information. Medicare Advantage plans pay the enrollee the difference between original Medicare.

Advance Directives

The Medicare Advantage organization must provide to its adult enrollees, at the time of initial enrollment, written information on their rights under the law of the state in which the Medicare Advantage organization furnishes services to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives.

7 Performance and Compliance Standards – Utilization Management

Medical Necessity

Blue Cross Medicare Advantage (HMO) determinations must be based on:

- The medical necessity of plan-covered services – (including emergency, urgent care and post-stabilization) based on internal policies (including coverage criteria no more restrictive than original Medicare's national and local coverage policies) reviewed and approved by the medical director.
- Where appropriate, involvement of the **Blue Cross Medicare Advantage (HMO)** medical director; and
- The member's medical history (e.g., diagnoses, conditions, functional status), physician recommendations, and clinical notes. Furthermore, if the plan approved the furnishing of a service through an advance determination of coverage, it may not deny coverage late on the base of a lack of medical necessity.

If the Medicare Advantage organization expects to issue partially or fully adverse medical necessity decision based on the initial review of the request, the organization's determination must be reviewed by a physician or other appropriate health care professional with sufficient medical or other expertise, including knowledge of Medicare coverage criteria, before the Medicare Advantage organization issues the decision. The health care provider must have a current and unrestricted license to practice within the scope of his or her profession in a State, Territory, Commonwealth of the United States (that is, Puerto Rico), or the District of Columbia.

Medical Policy

Health Care providers participating in the **Blue Cross Medicare Advantage (HMO)** network should refer directly to Medicare coverage policies when making coverage decisions. There are two types of Medicare coverage policies: **National Coverage Determinations** and **Local Coverage Determination**. As a Medicare Advantage plan, **Blue Cross Medicare Advantage (HMO)** must cover all services and benefits covered by Medicare. Coverage information concerning original Medicare also applies to **Blue Cross Medicare Advantage (HMO).**

National Coverage Determinations

The CMS explains NCDs through program manuals, which are found at http://cms.hhs.gov/manuals/. Key manuals for coverage includes:

- Medicare National Coverage Determination
- Manual Medicare Program Integrity Manual
- Medicare Benefit Policy Manual

CMS updates program manuals through program transmittals and also sends updated information via articles through the Medicare Learning Network. These articles can be found at www.cms.hhs.gov/MLNMattersArticles/.

Local Coverage Determinations

CMS contractors (e.g., carriers and fiscal intermediaries develop and assist local coverage determination to provide guidance to the public and provider community within a specific geographic area. LCDs supplement an NCD or explain when an item or service will be considered covered if there is no NCD and LCD cannot contradict an NCD.

Provider may access our region's LCF s at the following website addresses:

- Go to: www.cms.gov
- Durable Medical Equipment: www.cgsmedicare.com
- Regional Home Health Intermediary: www.palmettogba.com

Medicare Coverage Database
CMS launched the Medicare Coverage Database in 2002. The Medicare Coverage Database can be accessed at www.cms.hhs.gov/Coverage Geninfo/.

The following areas may be searched:

- National Coverage Determinations
- National Coverage Analyses – These documents support the NCD process.

Local Coverage Determinations – This section of the Medicare Coverage Database is updated monthly. Therefore, the most current information should be accessed through the local websites listed in the area above.

In coverage situations where there is an NCD, LCD, or guidance on coverage in original Medicare manuals, a Medicare Advantage organization may adopt the coverage of other Medicare Advantage organizations in its service area. The Medicare Advantage organization may also make its own coverage determination and provide a rationale using an objective evidence-based process.

Prior Authorization Requirements List

Links to the Blue Cros Medicare Advantage (HMO prior authorization requirements lists are located on then Medicare Advantage HMO page on the bcbstx.com/provider website. BCBSTX has contracted with eviCore to provide certain utilization management prior authorization services. Services requiring prior authorization as well as information on how to prior authorize services with eviCore are outlined on the Utilization Management page. Refer to the eviCore page on our website for additional information. Services performed without prior authorization or that do not meet medical necessity criteria may be denied for payment and the rendering provider may not seek reimbursement from the member.

Inpatient Prior Authorization

The admitting health care providers or hospital or other inpatient facility should notify the **Blue Cross Medicare Advantage (HMO)** Utilization Management Department if they are admitting a **Blue Cross Medicare Advantage (HMO)** member to a hospital or other inpatient facility.

The **Blue Cross Medicare Advantage** UM Department will review the initial hospitalization request to confirm that the hospitalization and/or procedures are Medically Necessary. If the **Blue Cross Medicare Advantage** UM Department concludes that certain services are not Medically Necessary, the **Blue Cross Medicare Advantage** physician reviewer will attempt to contact the **Blue Cross Medicare Advantage** admitting health care provider to discuss the treatment plan and treatment options prior to issuing the denial determination.

Availity Authorizations & Referrals

The admitting health care providers or hospital/facility should utilize Availity's Authorizations & Referrals tool (HIPAA -standard 278 transaction). This tool allows for the electronic submission of inpatient admissions, select outpatient services and referral requests handled by BCBSTX.

Additionally, providers can also check status on previously submitted requests and/or update applicable existing requests. Benefits of using this online functionality:

- No separate user enrollment needed
- Direct access within Availity portal
- Simplified 5-step process

How to access and use Availity Authorizations & Referrals:

- Log in to Availity
- Select Patient Registration menu option, choose Authorizations & Referrals, then Authorizations*
- Select Payer BCBSTX, then choose your organization
- Select a Request Type and start request
- Review and submit your request

*Choose Referrals instead of Authorizations if you are submitting a referral request.

If you are not yet registered with Availity, sign up at no charge. If you need registration assistance, contact Availity Client Services at **800-282-4548.**

The UM Department will review the initial hospitalization request to confirm that the hospitalization and/or procedures are Medically Necessary. If the UM Department concludes that certain services are not Medically Necessary, the physician reviewer will attempt to contact the admitting health care provider to discuss the treatment plan and treatment options prior to issuing the denial determination.

Concurrent Hospital Review

If an extension of the initially approved length of stay is required, the **Blue Cross Medicare Advantage (HMO)** admitting health care providers or **Blue Cross Medicare Advantage (HMO)** Hospital/Facility should contact the UM Department to request the extension.

Discharge Planning

The **Blue Cross Medicare Advantage (HMO)** UM Department clinical staff will assist **Blue Cross Medicare Advantage (HMO)** participating health care providers and facilities/hospitals in the inpatient discharge planning process. At the time of admission and during the hospitalization, the UM Department clinical staff will discuss discharge planning with the participating health care providers, member and member's family.

8 Performance and Compliance Standards – Case Management

Care Coordination

The **Blue Cross Medicare Advantage (HMO)** organization must ensure continuity of services through arrangements that include, but are not limited to, the following:

- Offering to provide each enrollee with an ongoing source of primary care and providing a primary care source to each enrollee who accepts the offer.
- Establishing coordination of plan services that integrate services through arrangements with community and social service programs.
- Utilizing procedures to ensure that enrollees are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health.
- Employing systems to identify and address barriers to enrollee compliance with prescribed treatments or regimens.

To support the above requirements, **Blue Cross Medicare Advantage (HMO)** has a robust case management program. Our suite of programs includes care transition support, condition management, longitudinal care and complex case management programs. Case managers identify members with complex needs so that timely interventions can be provided to increase positive health outcomes, lower costs, and decrease utilization. Case managers, who are telephonically based, coordinate, monitor and evaluate the options and services required to meet the member's needs, by ensuring care is provided in the right place and the right time.

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. The original Medicare initial preventive visit (i.e. "Welcome to Medicare" preventive visit), an Annual Wellness Visit, or a recent previous physical examination in a commercial plan (to which the Medicare Advantage organization has access) would fulfill this obligation.

Annual Health Risk Assessment

The **Blue Cross Medicare Advantage (HMO)** Annual Health Assessment serves as a platform to identify essential clinical and care management needs and meets the requirements of the Medicare initial preventive and annual visits. The components of the AHA include the member's past medical history, social history, family history, review of systems, physical exam (including BMI), preventive screenings, and chronic disease monitoring. The AHA provides the opportunity to document all diagnoses for MA Covered Persons, any conditions diagnosed during the visit, and active treatment as documented in the medical record. The AHA should capture all relevant conditions documented to the highest specificity to ensure accurate coding. These assessments can occur in the provider's office or member's home to remove barriers to completion.

Annual Wellness Visit Resources

We have two new resources to help you care for our Medicare Advantage members during their annual wellness visits: an Annual Wellness Visit Guide and Annual Wellness Visit form. These resources can help you document our members' visits to more easily meet Medicare requirements. The guide and form are for your use only and do not need to be returned to us. The Annual Wellness Visit Guide includes a wellness visit checklist and information on:

- Medicare coverage for wellness visits
- Correct coding for wellness visits
- Guidance to help ensure all member conditions are correctly coded each year
- Coding for other evaluation and management services, such as lab tests
- Preventive services and screenings
- Closing care gaps by performing Healthcare Effectiveness Data and Information Set (HEDIS®) measurements
- Coding tips to help minimize requests for medical records and help expedite claims processing

You may use the new Annual Wellness Visit form during wellness visits. It includes sections for members' medical history, risk factors, conditions, treatment options, coordination of care and advance care planning.

9 Performance and Compliance Standards – Quality Improvement

Quality Improvement

Quality improvement is an essential element in the delivery of care and services by **Blue Cross Medicare Advantage (HMO)**. To define and assist in monitoring quality improvement, the **Blue Cross Medicare Advantage (HMO)** Quality Improvement Program focuses on measurement of clinical care and service delivered by health care providers against established goals. Key components of the program described below include the Chronic Care Improvement Program, Quality Improvement Projects and performance monitoring (HEDIS, CAPHS, HOS). Formal evaluation of the program occurs annually to assess the impact and effectiveness of the program.

Chronic Care Improvement Program

A set of interventions designed to improve the health of individuals who live with multiple or sufficiently severe chronic conditions and include patient identification and monitoring. Other programmatic elements may include the use of evidence- based practice guidelines, collaborative practice models involving physicians as well as support-services providers, and patient self- management techniques.

Quality Improvement Project

An organization's initiative that focuses on specified clinical and non-clinical areas.

HEDIS®

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.

Consumer Assessment of Healthcare Providers and Systems

A patient's perspective of care survey, administered annually, in which a sample of members from provider organizations (e.g., MAOs, PDPs, PFFS) 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 return for the public investment.

Health Outcomes Survey

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 Medicare Advantage organization health plan is surveyed. Two years later these same members are surveyed again in order to evaluate changes in health status.

Quality of Care Issues

The Quality Improvement Program includes aggregation and analysis of trends for quality-of-care issues. A quality -of-care complaint may be filed through the Medicare health plan's grievance process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by a Medicare health plan meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

The QIO is comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare enrollees. QIOs review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, 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.

CMS Star Ratings

The CMS posts quality ratings of Medicare Advantage plans to provide Medicare beneficiaries with additional information about the various Medicare Advantage plans offered in their area. CMS rates Medicare Advantage plans on a scale of one to five star 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
1	Star	Poor performance

The quality scores for Medicare Advantage plans are based on performance measures that are derived from four sources:

- HEDIS
- Consumer Assessment of Healthcare Providers and Systems
- Health Outcomes Survey
- CMS administrative data, including information about member satisfaction, plans' appeals processes, audit results, and customer service.

The CMS groups the quality measures 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
- Health plan customer service

All rated plans receive both summary scores and overall scores. The summary score 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 differs from the summary score because it combines a plan's summary score with its Part D plan rating.

Cooperation

Participating health care providers must comply and cooperate with all **Blue Cross Medicare Advantage (HMO)** Medical Management policies and procedures and in the **Blue Cross Medicare Advantage (HMO)** Quality Assurance and Performance Improvement Programs. In addition, participating health care providers must cooperate with the independent quality review and improvement organization [Quality Improvement Organization] approved by CMS in its review of quality of care and investigation of quality complaints on behalf of the Medicare program. Texas Medical Foundation is the QIO for **Blue Cross Medicare Advantage (HMO)**.

Utilization Management Program

The Utilization Management program does not prohibit health care providers from advocating on behalf of members within the utilization management process.

Specialty Care Health Care Providers

A member may not self-refer to any **Blue Cross Medicare Advantage (HMO)** participating specialty care health care provider. A referral is not required to access a participating specialty care health care provider. If it is necessary to utilize a non-participating specialty care health care provider due to network inadequacy or continuity of care concerns, the health care provider must obtain prior authorization from the UM Department for claims to pay at the in-network benefit level. If prior authorization is not obtained, claims will be paid at the out-of- network benefit level.

Members self-referring and participating health care providers making referrals to other participating health care providers can check the **Blue Cross Medicare Advantage (HMO)** Provider Directory to identify the specialty health care providers that are participating in the **Blue Cross Medicare Advantage (HMO)** network.

The referring health care providers should provide the specialty care health care providers with the following clinical information:

- Member's name
- Reason for the consultation
- History of the present illness

- Diagnostic procedures and results
- Pertinent past medical history
- Current medications and treatments
- Problem list and diagnosis
- Specific request of the Specialty Care health care provider

Specialty Care Health Care Providers Responsibilities

Following an evaluation of a **Blue Cross Medicare Advantage (HMO)** Member, the specialty health care providers should:

- Contact the referring health care provider to discuss the **Blue Cross Medicare Advantage HMO** member's condition and any recommendation for treatment or follow up care, and
- Send the referring **Blue Cross Medicare Advantage HMO** health care provider the consultation report including medical findings, test results, assessment, recommendations, treatment plan and any other pertinent information.

30-Day Readmissions

Inpatient readmission rate is a quality-of-care metric that incentivizes facilities to improve quality of care to ensure member safety and promote the health of the member. Consistent with CMS payment methodology and to help improve quality for our members, BCBSTX will review readmissions to an acute care facility that occur within 30 days of discharge from the same facility. For participating providers, BCBSTX performs a clinical validation of acute care facility claims to determine if such readmissions to the same facility within 30 days of discharge are related and may deny payment to the facility for related readmissions.

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

Exclusions: Readmissions, including but not limited to 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.
- Skilled Nursing Facility 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.

10 Care Management

Blue Cross Medicare Advantage (HMO) will assist in managing the care of members with acute or chronic conditions that can benefit from care coordination and assistance. **Blue Cross Medicare Advantage (HMO)** participating health care providers shall assist and cooperate with the **Blue Cross Medicare Advantage (HMO)** Care Management Programs. Under its Care Management Program, and in coordination with health care providers, **Blue Cross Medicare Advantage (HMO)** shall:

- Implement procedures to ensure that members are informed of specific health care needs that require follow-up and receive, as appropriate, training in self- care and other measures they may take to promote their own health.
- Make best efforts to conduct a health assessment of all new members within 90 days of the effective date of enrollment;
- Identify individuals with complex or serious medical conditions;
- Establish and implement care management plans that:
    - Are appropriate;
    - Facilitate direct access visits to specialty care health care providers;
    - Are time specific and updated periodically;
    - Facilitate coordination among health care providers; and
    - Consider the member's input.

The participating health care providers will diagnose, assess, treat and monitor those conditions on an ongoing basis.

The Care Management Program includes, but is not limited to:

- Identification and monitoring of quality and performance indicators;
- Implementation of measures that contribute to improving quality of care and cost-effective management of targeted conditions;
- Promotion of preventive care strategies to keep **Blue Cross Medicare Advantage HMO** members healthy;
- Promotion of **Blue Cross Medicare Advantage HMO** member education and behavioral modification that improve outcomes;
- Evaluation of outcomes and program effectiveness.

Blue Cross Medicare Advantage HMO members are informed of available programs through the enrollment process, marketing materials, and discussions with health care providers. **Blue Cross Medicare Advantage (HMO)** will proactively identify members who could benefit from Care Management and encourage enrollment in the Care Management Program including the Disease Management Programs for certain chronic care conditions.

Second Medical or Surgical Opinion

A **Blue Cross Medicare Advantage HMO** member may request a second opinion if:

- the member disputes the reasonableness of the treatment recommendation.
- the member disputes necessity of the recommended procedure;
- or the member does not respond medical treatment after a
- reasonable amount of time.

Clinical Review Criteria

The **Blue Cross Medicare Advantage HMO** Clinical Quality Improvement Committee will review and approve the utilization management processes, and clinical review criteria used to determine whether services are Medically Necessary. **Blue Cross Medicare Advantage (HMO)** currently uses Milliman Care Guidelines®' which promotes consistent decisions based on nationally accepted, physician-created clinical criteria for Inpatient Certification and concurrent review requests. For more information or to receive a copy of these guidelines, please contact the Utilization Management Department at **877-774-8592**.

Blue Cross Medicare Advantage (HMO) may develop recommendations or clinical guidelines for the treatment of specific diagnoses, or for the utilization of specific drugs. These guidelines will be communicated to health care providers through the monthly Blue Review newsletter. Clinical Practice Guidelines are published in the **Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Health - Provider Manual** and is also located online at www.bcbstx.com/provider,under the Standards and Requirements area, then click on Manuals.

Health Risk Assessment

A health risk assessment questionnaire will be sent to **Blue Cross Medicare Advantage (HMO)** members as a component of the enrollment materials. Medical Care Management staff will evaluate results and:

- Identify healthcare needs;
- Assist with access to healthcare services;
- Assist with coordination of care;
- Provide telephonic educational or written materials via mail as needed;
- Refer **Blue Cross Medicare Advantage(HMO)** members to appropriate case and disease management programs as needed.

Disease Management Programs

The Disease Management Programs include**:**

Medical:

- Diabetes
- Chronic Obstructive Pulmonary Disease
- Coronary Artery Disease
- Congestive Heart Failure

Behavioral Health:

- Depression
- Substance Abuse
- Schizophrenia/Psychotic disorders
- Bipolar
- Anxiety/Panic disorders
- Alzheimer/Dementia

Blue Cross Medicare Advantage(HMO) member participation is voluntary. Members receive both telephonic and hardcopy educational information to enhance self- management of their condition. The treating health care providers is an integral part of the disease management program.

For additional information on **Blue Cross Medicare Advantage(HMO)** Disease Management Programs, call the Disease Management Programs phone number listed on the Blue Cross Medicare Advantage Provider Quick Reference Guide on the Blue Cross Medicare Advantage (HMO) page.

11 Health Care Providers Performance Standards and Compliance Obligations

Evaluating Performance of Health Care Providers

When evaluating the performance of a health care provider, **Blue Cross Medicare Advantage (HMO)** will review at a minimum the following areas:

- **Quality of Care** measured by clinical data related to the appropriateness of a member's care and member outcomes.
- **Efficiency of Care** measured by clinical and financial data related to a member's health care costs.
- **Member Satisfaction** measured by the members' reports regarding accessibility, quality of health care, member - health care providers, and the comfort of the practice setting.
- **Administrative Requirements** measured by the participating
- health care provider's methods and systems for keeping records and transmitting information, hours of operation, appointment waiting time, and appointment availability.
- **Participation in Clinical Standards** measured by the participating health care provider's involvement with panels used to monitor quality of care standards.

Health Care Providers Compliance to Standards of Care

Blue Cross Medicare Advantage (HMO) health care providers must comply with all applicable laws and licensing requirements. In addition, participating health care providers must furnish covered services in a manner consistent with standards related to medical and surgical practices that are generally accepted in the medical and professional community at the time of treatment. Participating health care providers must also comply with the **Blue Cross Medicare Advantage (HMO)** standards, which include but are not limited to:

- Guidelines established by the Federal Center for Disease Control (or any successor entity); and
- All federal, state and local laws regarding the conduct of their profession.

Health care providers must also comply with **Blue Cross Medicare Advantage (HMO)** policies and procedures regarding the following:

- Participation on committees and clinical task forces to improve the quality and cost of care;
- Prior Authorization requirements and time-frames; Participating health care providers credentialing requirements.
- Care Management & Disease Management Program referrals.
- Appropriate release of inpatient and outpatient utilization and outcomes information.
- Accessibility of member medical record information to fulfill the business and clinical needs of **Blue Cross Medicare Advantage (HMO)**;
- Providing treatment to Members at the appropriate level of care; and
- Providing equal access and treatment to all **Blue Cross Medicare Advantage (HMO)** members.

Health care providers acting within the lawful scope of practice are encouraged to advise patients who are members of **Blue Cross Medicare Advantage (HMO)** about:

- The patient's health status, medical care, or treatment options (including any alternative treatments that may be 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.
- The risks, benefits, and consequences of treatment or non- treatment; and
- The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Such actions shall not be considered non-supportive of **Blue Cross Medicare Advantage (HMO).**

Laws Regarding Federal Funds

Payments that participating health care providers receive for furnishing services to **Blue Cross Medicare Advantage HMO** members are, in whole or part, from Federal funds. Therefore, participating health care providers and any of their subcontractors must comply with certain laws that are applicable to individuals and entities receiving Federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975

as implemented by 45 CFR part 91; the Rehabilitation Act of 1973; and the Americans With Disabilities Act.

Marketing

Participating health care providers may not develop and use any materials that market **Blue Cross Medicare Advantage (HMO)** without the prior approval of **Blue Cross Medicare Advantage (HMO)** in compliance with Medicare Advantage requirements. Under Medicare Advantage law, generally, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Medicare Advantage plan unless the materials are approved prior to use by CMS or are submitted to CMS and not disapproved within 45 days.

Sanctions under Federal Programs and State Law

Participating health care providers must ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare or other Federal Health Care Programs are employed or subcontracted by the participating health care providers.

Participating health care providers must disclose to **Blue Cross Medicare Advantage (HMO)** whether the participating health care providers or any staff member or subcontractor has been the subject of any prior violation, fine, suspension, termination or other administrative action taken under Medicare or Medicaid laws; the rules or regulations of the state of Texas; the federal government; or any public insurer.

Participating Health care providers must notify **Blue Cross Medicare Advantage (HMO)** immediately if any such sanction is imposed on a participating health care provider, a staff member or a subcontractor.

12 Selection and Retention of Health Care Providers

Participation Requirements for Health Care Providers

To participate in **Blue Cross Medicare Advantage (HMO)**, the health care providers:

- must have privileges at one of the **Blue Cross Medicare Advantage (HMO)** participating hospitals *(unless inpatient admissions are uncommon or not required for the health care provider's specialty)*
- must have a valid National Provider Identifier Number
- must sign a **Blue Cross Medicare Advantage (HMO)** amendment to his/her Blue Choice agreement, and
- cannot have opted out of Medicare or have any sanctions or reprimands by any licensing authority or review organizations. **Blue Cross Medicare Advantage (HMO)** health care providers cannot be named on the Office of the Inspector General or Government Services Administration lists which identify health care providers found guilty of fraudulent billing, misrepresentation of credentials, etc. **Blue Cross Medicare Advantage (HMO)** participating health care providers cannot be sanctioned by the Office of Personnel Management or be prohibited from participation in the Federal Employees Health Benefit Program.

Credentialing & Recredentialing of Participating Health Care Providers

Blue Cross Medicare Advantage (HMO) continuously reviews and evaluates participating health care providers information, and recredentials participating health care providers every three years. The credentialing guidelines are subject to change based on industry requirements and **Blue Cross Medicare Advantage (HMO)** standards.

Credentialing & Recredentialing of Participating Institutional Providers

Blue Cross Medicare Advantage (HMO) continuously reviews and evaluates Institutional Provider information and recertifies Institutional Providers every three years. The credentialing guidelines are subject to change based on industry requirements and **Blue Cross Medicare Advantage (HMO)** standards.

Appeal Process for Health Care Providers Participation Decisions

If **Blue Cross Medicare Advantage (HMO)** decides to suspend, terminate or non-renew a health care providers participation status, **Blue Cross Medicare Advantage (HMO)** will give the affected health care providers written notice of the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the health care providers and the numbers and mix of health care providers needed by **Blue Cross Medicare Advantage (HMO)**. **Blue Cross Medicare Advantage (HMO)** will allow the health care providers to appeal the action to a hearing panel and give the health care providers written notice of his/her right to an appeal hearing and the process and timing for requesting a hearing. **Blue Cross Medicare Advantage (HMO)** will ensure that the majority of the hearing panel members are peers of the affected health care providers. A recommendation by the hearing panel is advisory and is not binding on **Blue Cross Medicare Advantage (HMO)**.

If a reduction, suspension or termination of a participating health care provider's participation is final and is the result of quality-of-care deficiencies, **Blue Cross Medicare Advantage (HMO)** will notify the National Practitioner Data Bank and any other applicable licensing or disciplinary body to the extent required by law.

Subcontracted health care providers groups must ensure that these procedures apply equally to health care providers within those subcontracted groups.

Notification to Members of Health Care Provider Terminations

Blue Cross Medicare Advantage (HMO) will make a good faith effort to provide written notice of a termination of a participating health care provider to all members who are patients seen on a regular basis by that health care provider at least 30 calendar days before the termination effective date regardless of the reason for the termination.

13 Medical Records Review

A **Blue Cross Medicare Advantage (HMO)** representative may visit the health care providers office to review the medical records of **Blue Cross Medicare Advantage (HMO)** members as described in the Physician Office Review Program section of the **Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Provider Manual**.

Standards for Medical Records

Blue Cross Medicare Advantage (HMO) participating health care providers must have a system in place for maintaining medical records that conforms to regulatory standards. Each medical encounter whether direct or indirect must be comprehensively documented in the members' medical record. Each medical record chart must include all of the elements specified in the **Blue Essentials, Blue Advantage HMO, Blue Premier and MyBlue Provider Manual**. In addition, each medical record must also include the following:

- All health care providers participating in the member's care and information on services furnished by these providers.
- Prescribed medications, including dosages and dates of initial or refill prescriptions.
- Advance Directives - the health care providers must document whether or not the member has executed an Advance Directive.
- Physical examinations, necessary treatments, possible risk factors for particular treatments, and evidence of member input into the proposed treatment plan.

Advance Directives

Blue Cross Medicare Advantage (HMO) participating health care providers must document in a prominent part of the member's current medical record whether or not 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 Texas and signed by a patient, that explain the patient's wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known.

Confidentiality of Member Information

Blue Cross Medicare Advantage HMO participating health care providers must comply with all state and Federal laws concerning confidentiality of health and other information about members. **Blue Cross Medicare Advantage HMO** participating health care providers must have policies and procedures regarding use and disclosure of health information that comply with applicable laws.

14 Reporting Obligations

Cooperation in Meeting CMS Requirements

Blue Cross Medicare Advantage (HMO) must provide to CMS information that is necessary for CMS to administer and evaluate the Medicare Advantage program and to establish and facilitate a process for current and prospective members to exercise choice in obtaining Medicare services. Such information includes plan quality and performance indicators such as disenrollment rates, information on member satisfaction, and information on health outcomes.

Participating health care providers must cooperate with **Blue Cross Medicare Advantage (HMO)** in its data reporting obligations by providing to **Blue Cross Medicare Advantage (HMO)** any information that it needs to meet its obligations.

Certification of Diagnostic Data

Blue Cross Medicare Advantage (HMO) is specifically required to submit to CMS data necessary to characterize the context and purposes of each encounter between a member and a health care provider (encounter data). Participating health care providers that furnish diagnostic data to assist **Blue Cross Medicare Advantage (HMO)** in meeting its reporting obligations to CMS must certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data.

15 Initial Decisions, Appeals and Grievances

Initial Decisions

The "initial decision" is the first decision **Blue Cross Medicare Advantage (HMO)** makes regarding coverage or payment for care. In some instances, a participating health care provider, acting on behalf of the member, may make a request for an initial inquiry regarding whether a service will be covered.

- If a member asks **Blue Cross Medicare Advantage (HMO)** to pay for medical care the member has already received, this is a request for an "initial decision" about payment for care.
- If a member, or participating health care provider acting on behalf of a member, asks for prior authorization for treatment, this is a request for an "initial decision" about whether the treatment is covered by **Blue Cross Medicare Advantage (HMO)**.
- If a member asks for a specific type of medical treatment from a participating health care provider this is a request for an initial decision" about whether the treatment the member wants is covered by **Blue Cross Medicare Advantage (HMO)**.

Blue Cross Medicare Advantage (HMO) will generally make decisions regarding payment for care that members have already received within 30 calendar days.

A decision about whether **Blue Cross Medicare Advantage (HMO)** will cover medical care can be a "standard decision" that is made within the standard time frame (typically within 14 calendar days) or an expedited decision that is made more quickly (typically within 72 hours).

A member can ask for an expedited decision **only** if the member or any health care provider believes that waiting for a standard decision could jeopardize the life or health of the member or the member's ability to regain maximum function. The member or a health care provider can request an expedited decision. If an expedited decision is requested by the member or health care provider, **Blue Cross Medicare Advantage (HMO)** will automatically provide an expedited decision.

If **Blue Cross Medicare Advantage (HMO)** does not make a decision within the required timeframe and does not notify the member regarding why the timeframe must be extended, the member can treat the failure to respond as a denial and may appeal, as set forth below.

Appeals and Grievances

Members have the right to make a complaint if they have concerns or problems related to their coverage or care. "Appeals" and "grievances" are the two different types of complaints. All participating health care providers must cooperate in the **Blue Cross Medicare Advantage (HMO)** Appeals and Grievances process.

- An "appeal" is a complaint a member makes when the member wants **Blue Cross Medicare Advantage (HMO)** to reconsider and change an initial decision made by **Blue Cross Medicare Advantage (HMO)** or a participating health care provider about what services are necessary or covered or what **Blue Cross Medicare Advantage (HMO)** will pay for a service.
- A "grievance" is a complaint a member makes regarding any other type of problem with **Blue Cross Medicare Advantage (HMO)** or a participating health care provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room, and the cleanliness of the participating health care providers facilities are grievances.

Utilization Management Appeals Contacts

Appeals regarding Outpatient or Inpatient Prior Authorization/Referral Authorization for, or termination of coverage of a health care service should be sent to:

Mail: Blue Cross Medicare Advantage (HMO) - Attn: Appeals
PO Box 663099
Dallas, TX 75266
Fax: 800-419-2009

For an Expedited Appeal Only, call: **877-774-8592**

For Claim Inquiries:
Call: Provider Customer Service **877-774-8592**

Mail: Blue Cross Medicare Advantage (HMO)
Attn: Claim Disputes
PO Box 4555
Scranton, PA 18505

Resolving Grievances and Complaints

If a **Blue Cross Medicare Advantage (HMO)** member has a Grievance about **Blue Cross Medicare Advantage (HMO)**, a health care provider or any other issue, participating health care providers should instruct the member to contact the **Blue Cross Medicare Advantage (HMO)** Member Customer Service Department at the number listed on the back of the Member's ID card.

Resolving Appeals

A member may appeal an adverse initial decision by **Blue Cross Medicare Advantage (HMO)** or a participating health care provider concerning a prior authorization or termination of coverage of a health care service. A member may also appeal an adverse initial decision by **Blue Cross Medicare Advantage (HMO)** concerning payment for a health care service. A member's appeal of an initial decision about authorizing health care or terminating coverage of a service must be resolved by **Blue Cross Medicare Advantage (HMO)** within 30 calendar days, or sooner if the member's health condition requires it. An appeal concerning payment must be resolved within 60 calendar 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 or the member's physician or provider can request an expedited appeal. Such an appeal is generally resolved within 72 hours unless it is in the member's interest to extend this time period. When a member, physician, or provider requests an expedited appeal, **Blue Cross Medicare Advantage (HMO)** will automatically expedite the appeal.

A special type of appeal applies only to hospital discharges. Hospitals affected by these instructions include any facility providing care at the inpatient hospital level. Inpatient hospital care would include short term, long term, acute or non-acute, paid through a prospective payment system or other reimbursement basis, limited to specialty care, or providing a broader spectrum of services, and acute and non-acute access hospitals. Under this heading, hospitals would also include Indian Health Service hospitals, Medicare dependent hospitals, rehabilitation hospitals, long-term care hospitals, psychiatric hospitals, critical access hospitals, children's hospitals, and cancer hospitals. Swing beds in hospitals are excluded because they are considered a lower level of care. Hospitals must notify Medicare members who are hospital inpatients about their hospital discharge appeal rights. Hospitals will use the CMS form entitled Important Message from Medicare (IM) to explain the member's rights as a hospital patient, including discharge appeal rights. Hospitals must issue the IM within 2 calendar days of admission, must obtain the signature of the beneficiary or his/her representative and provide a copy at that time. Hospitals should deliver this notice as far in advance as possible but no less than 2 days before discharge. If the member requests an appeal a Detailed Notice of Discharge must be issued to the member. Copies of the IM and Detailed Notice of Discharge have been included with these instructions. Refer to page S19-21 for the IM and Detailed Notice of Discharge.

The IM and Detailed Notice of Discharge forms and further guidance can be found at the following internet address: https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ ffs-ma-im.

Another special type of appeal applies only to a member dispute regarding when coverage will end for skilled nursing facility, home health agency or comprehensive outpatient rehabilitation facility services. The DENC is a standardized written notice that provides specific, and detailed information to Medicare enrollees concerning why their SNF, HHA, or CORF services are ending (see Appendix). The Medicare health plan (or the provider by delegation) must issue the DENC to the enrollee (with a copy provided to the QIO) whenever an enrollee appeals a termination decision about their SNF, HHA or CORF services. The DENC must 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 enrollee may obtain a copy of the Medicare policy from the Medicare health plan.
- Any applicable Medicare health plan policy, contract provision, or rationale upon which the termination decision was based.

- Facts specific to the enrollee and relevant to the *termination decision* that are sufficient to advise the enrollee of the applicability of the coverage rule or policy to the enrollee's case.

Further Appeal Rights

If **Blue Cross Medicare Advantage (HMO)** denies the member's appeal in whole or in part, **Blue Cross Medicare Advantage (HMO)** will forward the appeal to an independent review entity that has a contract with the federal government and is not part of **Blue Cross Medicare Advantage (HMO)**. This organization will review the appeal and, if the appeal involves a precertification/ prior authorization for health care it will make a decision within 30 days. If the appeal involves payment for care, the IRE will make the decision within 60 days. If the appeal involves an expedited reconsideration decision, the IRE will make the decision within 72 hours.

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. If the member is not satisfied with the ALJ's decision, the member may request review by the Medicare Appeals Council. If the MAC refuses to hear the case or issues an adverse decision, the Member may be able to request Federal Judicial Review.

Participating Health Care Provider Obligations – Organization Determinations

At each patient encounter with a **Blue Cross Medicare Advantage (HMO)** member, the health care providers must notify the member of his or her right to receive, upon request, a detailed written notice from **Blue Cross Medicare Advantage (HMO)** regarding the member's services. The participating health care provider's notification must provide the member with the information necessary to contact **Blue Cross Medicare Advantage (HMO)** and must comply with any other requirements specified by CMS. If a member requests **Blue Cross Medicare Advantage (HMO)** to provide a detailed notice of a participating health care provider's decision to deny a service in whole or part, **Blue Cross Medicare Advantage (HMO)** must give the member a written notice of the determination.

Participating Health Care Provider Obligations - Appeals

Participating health care providers must also cooperate with **Blue Cross Medicare Advantage (HMO)** and members in providing necessary information to resolve the appeals within the required time frames. Participating health care providers must provide the pertinent medical records and any other relevant information. In some instances, participating health care providers must provide the records and information quickly to allow **Blue Cross Medicare Advantage (HMO)**, the IRE or QIO to make an expedited decision.

16 Member Rights and Responsibilities

Rights

Blue Cross Medicare Advantage (HMO) members have the right to timely, high-quality care, and treatment with dignity and respect. Participating Health Care Providers must respect the rights of all **Blue Cross Medicare Advantage (HMO)** members.

Blue Cross Medicare Advantage (HMO) members have been informed that they have the following rights:

- Choice of a qualified participating health care providers and contracting hospital.
- Candid discussion of appropriate or Medically Necessary treatment options for their condition, regardless of cost or benefit coverage.
- Timely access to their participating health care providers and recommendations to specialty care health care providers when Medically Necessary.
- To receive Emergency Services when the member, as a prudent layperson, acting reasonably would believe that an Emergency Medical Condition exists.
- To actively participate in decisions regarding their health and treatment options.
- To receive Urgently Needed Services when traveling outside of the **Blue Cross Medicare Advantage (HMO)** Service Area or in the **Blue Cross Medicare Advantage (HMO)** Service Area when unusual or extenuating circumstances prevent the member from obtaining care from a participating health care provider.
- To request the aggregate number of grievances and appeals and dispositions.
- To request information regarding health care providers' compensation.
- To request information regarding the financial condition of **Blue Cross Medicare Advantage (HMO)**.
- To be treated with dignity and respect and to have their right to privacy recognized.
- To exercise these rights regardless of the member's race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for care.
- To confidential treatment of all communications and records pertaining to the member's care.
- To access, copy and/or request amendment to the
- member's medical records consistent with the terms of HIPAA.
- To extend their rights to any person who may have legal responsibility to make decisions on the member's behalf regarding the member's medical care.
- To refuse treatment or leave a medical facility, even against the advice of health care providers (providing the member accepts the responsibility and consequences of the decision).
- To complete an Advance Directive, living will or other directive to the member's health care providers.

Responsibilities

Blue Cross Medicare Advantage (HMO) members have been informed that they have the following responsibilities:

- To get familiar with their coverage and the rules they must follow to get care as a member.
- To give their health care providers the information they need to care for them, and to follow the treatment plans and instructions that they and their health care providers agree upon. To be sure to ask their health care providers if they have any questions.
- To act in a way that supports the care given to other patients and to help the smooth running of their health care provider's office, hospitals, and other offices.
- To pay their plan premiums and any copayments they may owe for the covered service they receive. They must also meet their financial responsibilities.
- To let **Blue Cross Medicare Advantage (HMO)** know if they have any questions, concerns, problems, or suggestions.

Member Satisfaction

Blue Cross Medicare Advantage HMO periodically surveys **Blue Cross Medicare Advantage HMO** members to measure overall customer satisfaction as well as satisfaction with the care received from **Blue Cross Medicare Advantage HMO** participating physicians and professional providers. Survey information is reviewed by **Blue Cross Medicare Advantage HMO** and results are shared

with the **Blue Cross Medicare Advantage HMO** participating physicians and professional providers.

Services Provided in Culturally Competent Manner

Blue Cross Medicare Advantage HMO is obligated to ensure that services are provided in a culturally competent manner to all **Blue Cross Medicare Advantage HMO** members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. **Blue Cross Medicare Advantage HMO** participating physicians and professional providers must cooperate with **Blue Cross Medicare Advantage HMO** in meeting this obligation.

Blue Cross Medicare Advantage HMO Member Customer Service *(phone number is listed on the back of the Member's ID card)* has available the following services for **Blue Cross Medicare Advantage HMO** members:

- Teletypewriter services
- Language services, and
- Spanish speaking customer service representatives

Advance Directive

Blue Cross Medicare Advantage HMO members have the right to complete an "Advance Directive" statement. This statement indicates, in advance, the **Blue Cross Medicare Advantage HMO** member's choices for treatment to be followed in the event the **Blue Cross Medicare Advantage HMO** member becomes incapacitated or otherwise unable to make medical treatment decisions. **Blue Cross Medicare Advantage HMO** suggests that **Blue Cross Medicare Advantage HMO** participating physicians and professional providers have Advance Directive forms in their office and available to members.

Member Complaints and Grievances

Blue Cross Medicare Advantage HMO tracks all complaints and grievances to identify areas of improvement for **Blue Cross Medicare Advantage HMO.** This information is reviewed by the Quality Improvement Committee.

17 Obligation to Provide Access to Care

Member Access to Health Care Guidelines

The following appointment availability access guidelines should be used to ensure timely access to medical care and behavioral health care:

Provider Type	Appointment:	Access/Availability Standard:
Medical, Mental Health, Substance Abuse	Initial new patient visit	within 30 business days
Medical	Annual Physical Exam	within 30 business days.
Medical	Preventive care	within 30 business days
Medical, Mental Health, Substance Abuse	Symptomatic non-urgent care	within 5 business days
Medical	Services that are not emergency or urgently needed, but the enrollee requires medical attention	within 7 business days
Medical, Mental Health, Substance Abuse	Urgent care visit	within 24 hours
Medical, Mental Health, Substance Abuse	Emergency Care/After-hours access	immediately or directed to emergency room
Medical, Mental Health, Substance Abuse	In-office wait time	within 30 minutes

Adherence to **Blue Cross Medicare Advantage HMO** member access guidelines will be monitored through the office site visits and the tracking of complaints/grievances related to access and availability which are reviewed by the Clinical Quality Improvement Committee.

All participating **Blue Cross Medicare Advantage HMO** health care providers and hospitals/facilities will treat all **Blue Cross Medicare Advantage HMO** members with equal dignity and consideration as their non-**Blue Cross Medicare Advantage HMO** patients.

Health Care Provider Availability

Blue Cross Medicare Advantage HMO participating health care providers shall provide coverage 24 hours a day, 7 days a week. When a **Blue Cross Medicare Advantage HMO** participating health care provider is unavailable to provide services, he or she must ensure that another **Blue Cross Medicare Advantage HMO** participating health care provider is available. Hours of operation must not discriminate against **Blue Cross Medicare Advantage HMO** members relative to other members.

The **Blue Cross Medicare Advantage HMO** member 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 hour phone calls. Individuals who believe they have an Emergency Medical Condition should be directed to immediately seek emergency services.

Health Care Provider Office Confidentiality Statement

Blue Cross Medicare Advantage HMO members have the right to privacy and confidentiality regarding their health care records and information. **Blue Cross Medicare Advantage HMO** participating health care providers and each staff member will sign an Employee Confidentiality Statement to be placed in the staff member's personnel file.

Prohibition Against Discrimination

Neither **Blue Cross Medicare Advantage HMO** or **Blue Cross Medicare Advantage HMO** participating health care providers may deny, limit, or condition the coverage or furnishing of services to Members based on

any factor that is related to health status, including, but not limited to the following:

- Medical condition, including mental as well as physical illness
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability
- Race, ethnicity, national origin
- Religion
- Sex, sexual orientation
- Age
- Mental or physical disability
- Source of payment

Blue Cross Medicare Advantage HMO participating health care providers must have practice policies demonstrating that they accept for treatment any **Blue Cross Medicare Advantage HMO** member in need of health care services they provide.

18 Glossary of Terms

Appeal
Any of the procedures that deal with the review of adverse organization determinations on the health care services a **Blue Cross Medicare Advantage HMO** member is entitled to receive or any amounts that the **Blue Cross Medicare Advantage HMO** member must pay for a covered service. These procedures include reconsiderations by **Blue Cross Medicare Advantage HMO**, an independent review entity, hearings before Administrative Law Judge, review by the Medicare Appeals Council and Federal Judicial Review.

Basic Benefits
All health care services that are covered under the Medicare Part A and Part B programs except Hospice services and additional benefits. All Members of **Blue Cross Medicare Advantage HMO** receive all Basic CMS Benefits.

Centers for Medicare & Medicaid Services
The Centers for Medicare & Medicaid Services, the Federal Agency responsible for administering Medicare.

Covered Services
Those benefits, services or supplies which are:

- Provided or furnished at the in-network benefit level by participating **Blue Cross Medicare Advantage HMO** physicians and professional providers or authorized by Blue Cross Medicare Advantage HMO or its participating physicians and professional providers.
- Provided or furnished by non-participating physicians and professional providers at the in-network benefit level when authorized by **Blue Cross Medicare Advantage HMO** due to network inadequacy or continuity of care concerns.
- Provided or furnished by non-participating physicians and professional providers at the out-of-network benefit level.
- Emergency Services that are provided or furnished at the in- network benefit level, and may be provided by non- participating physicians and professional providers.
- Renal dialysis services provided at the in-network benefit level while the member is temporarily outside the Service Area.
- Basic and Supplemental Benefits.

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

- Serious jeopardy of the patient's health;
- Serious impairment 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 ofa pregnant patient.

Experimental Procedures and Items
Items and procedures determined by **Blue Cross Medicare Advantage HMO** and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, **Blue Cross Medicare Advantage HMO** will follow CMS guidance (via the Medicare Carriers Manual and Coverage Issues Manual) if applicable or rely upon determinations already made by Medicare.

Grievance
Any **complaint** or **dispute** other than one involving an Organization Determination. Examples of issues that involve a complaint that will be resolved through the Grievance rather than the Appeal

process are: waiting times in health care provider offices; and rudeness or unresponsiveness of Customer Service Staff.

Home Health Agency

A Medicare-certified agency which provides intermittent Skilled Nursing Care and other therapeutic services in the member's home when Medically Necessary, when members are confined to their home and when authorized by their participating health care provider.

Hospice

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

Hospital

A Medicare-certified institution licensed in the state of Texas, 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.

Medically Necessary

Services or supplies that: are proper and needed for the diagnosis or treatment of a medical condition; are used for the diagnosis, direct care, and treatment of a medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of a Member or a member's health care provider.

Medicare

The Federal Government health insurance program established by Title XVIII of the Social Security Act.

Medicare Part A

Hospital Insurance benefits including inpatient Hospital care, Skilled Nursing Facility care, Home Health Agency care and Hospice care offered through Medicare.

Medicare Part B

Supplemental medical insurance that is optional and requires a monthly premium. Part B covers physician services (in both Hospital and non- hospital settings) and services furnished by certain non-physician practitioners. Other Part B services include lab testing, 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.

Medicare Advantage Plan

A policy or benefit package offered by a Medicare Advantage Organization under which a specific set of health benefits are offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area covered by the Medicare Advantage Organization. A Medicare Advantage Organization may offer more than one benefit Plan in the same Service Area. HISC is a Medicare Advantage Organization and Medicare Advantage HMO is a Medicare Advantage Plan.

Member

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

Non Contracting Medical Health Care Provider or Facility

Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the state of Texas or Medicare to deliver or furnish health care services; and who is neither employed, owned, operated by, nor under contract with **Blue Cross Medicare Advantage HMO** to deliver Covered Services to **Blue Cross Medicare Advantage HMO** members.

Participating Health Care Provider

The **Blue Cross Medicare Advantage HMO** participating health care provider who a member chooses to coordinate their health care is responsible for providing covered services for **Blue Cross**

Medicare Advantage HMO members and coordinating specialty care.
Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the state of Texas and Medicare to deliver or furnish health care services. This individual or institution has a written agreement with **Blue Cross Medicare Advantage HMO** to provide services directly or indirectly to **Blue Cross Medicare Advantage HMO** members pursuant to the terms of the agreement.

Quality Improvement Organization

The independent quality review and improvement organization approved by CMS. Texas Medical Foundation is the QIO for **Blue Cross Medicare Advantage HMO.**

Service Area

A geographic area approved by CMS within which an eligible individual may enroll in a Medicare Advantage Plan. Refer to service area above for the approved Texas Service area.

19 Provider Quick Reference Guide

Key Contacts

Refer to the **Provider Quick Reference Guide** on the Blue Cross Medicare Advantage (HMO) page.

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