BlueCross BlueShield of Oklahoma

WELCOME PROVIDERS

This provider manual explains the policies and procedures of the:

Blue Cross Medicare Advantage (HMO)[SM]

Blue Cross Medicare Advantage Dual Care Plus (HMO SNP)[SM]

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How to Navigate This Manual

We developed this manual to make it easy for you as a participating provider to find information that will help you understand our Medicare Advantage plans and to help you serve our members.

A few tips in navigating the manual:

- You can click on the header on any section to move directly to that section.
- You can also click on highlighted links throughout the manual. Those links will take you to other sections of the manual that relate to the topic you're reading about or will take you to relevant online information from Blue Cross and Blue Shield of Oklahoma, Medicare or other sources.

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Section 1:
Overview

INTRODUCTION

Blue Cross Medicare Advantage (HMO) and Blue Cross Medicare Advantage Dual Care Plus (HMO SNP) are pleased to welcome you as a participating health care provider. This provider manual explains the policies and procedures of the Blue Cross Medicare Advantage[SM] plans. It will provide you and your office staff with helpful information as you give care to our members. This manual applies only to the operations of the Blue Cross Medicare Advantage (HMO) and the Blue Cross Medicare Advantage Dual Care Plus (HMO SNP).

BLUE CROSS MEDICARE ADVANTAGE (HMO) - THE NETWORK

Blue Cross Medicare Advantage (HMO) is a Medicare Advantage plan. HMO stands for health maintenance organization. The plan maintains and monitors a network of participating health care providers. Providers include primary care physicians, specialists, nurse practitioners, physician assistants and other health professionals.

Blue Cross Medicare Advantage Dual Care Plus (HMO SNP) is a coordinated care special needs plan (SNP) designed to provide targeted care to special needs individuals who are eligible for both Medicare and Medicaid. The plan is an integrated care model that works to improve the health of our most vulnerable members.

SNP Model of Care

The SNP's Model of Care is a quality improvement tool that ensures that participating providers identify and address the unique needs of each person enrolled in the plan.

The SNP Model of Care goals are to:

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

SNP Model of Care Training for Providers

The Centers for Medicare and Medicaid Services requires all contracted and out-of-network providers serving members on a routine basis to receive training on the SNP Model of Care.

DSNP Training for Providers and Staff

Plans for people who are eligible for both Medicare and Medicaid — like the Blue Cross Medicare Advantage Dual Care Plus (HMO SNP) — are called Dual Eligible Special Needs Plans. They have specific training requirements for providers:

- All DSNP plans must 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 computer-based training modules.
- Training must occur at least annually for providers and internal staff and will be ongoing for staff as needed.

Providers can access online Model of Care training here.

Cost Sharing Protections for Dual Eligible Members

People who are eligible for both Medicare and Medicaid do not have to pay any deductible amounts, copayments or coinsurance payments.

That means providers must accept the Medicare Advantage SNP's payment for a covered service for a dual eligible member as payment in full. The provider must not seek additional payment from the member, or from the Oklahoma Health Care Authority.

BLUE CROSS MEDICARE ADVANTAGE (HMO) - THE SERVICE AREAS

We market our Blue Cross Medicare Advantage (HMO) and Blue Cross Medicare Advantage Dual Care Plus (HMO SNP) plans to people eligible for Medicare Parts A and B who live in the following approved service areas and counties in the state of Oklahoma:

Blaine, Bryan, Canadian, Cherokee, Cleveland, Comanche, Creek, Custer, Garfield, Garvin, Grady, Hughes, Johnston, Kay, Kingfisher, Lincoln, Logan, Love, Marshall, Mayes, McClain, McIntosh, Okfuskee, Oklahoma, Okmulgee, Osage, Pawnee, Pittsburg, Pontotoc, Pottawatomie, Seminole, Tulsa and Washington counties.

A continuation of enrollment option is not offered to enrollees when they no longer reside in the service area of their MA plan.

Section 2:
Reference Guide/Helpful Links

QUICK REFERENCE GUIDE AND CONTACT INFO:

GENERAL INFO FOR PROVIDERS

Providers can visit bcbsok.com/provider for a range of helpful information. That webpage gives you access to:

- Details on prior authorization and other requirements to make sure our members get the right care, at the right time, in the right setting
- A link to a Quick References webpage that gives providers their most-needed information in one place
- A link to provider news and updates
- Other helpful info

Providers also can call Provider Customer Service at **1-877-774-8592** 24 hours per day, seven days per week. Providers can reach a live representative from 8 a.m. to 8 p.m. CT, seven days per week. Outside of those hours, you can reach an interactive voice response system that can help you check the status of claims and authorizations.

PROVIDER PORTALS

The Medicare Advantage plans encourage participating providers to use two provider portals to help with prior authorizations, referrals and other processes: Availity® Essentials and eviCore®.

Availity

The Availity portal helps providers and the Medicare Advantage plans to securely share information easily and efficiently. As a registered Availity user, you may quickly check our members' eligibility and benefits, submit prior authorization requests, check claim status and obtain provider claim summaries. You can do all this online, without having to call the Medicare Advantage plans.

How to access and use the Availity tool:

1. Go to the Availity website and create an account.
2. Log in.
3. Select the Patient Registration menu option, then choose Authorizations and Referrals.
4. Select either Authorizations or Referrals.
5. Select Payer BCBSOK, then choose your organization.
6. Select a Request Type and start request.
7. Review and submit your request.

Providers can learn more about Availity and get free webinar training on the Availity tool.

You can also call Availity for help and more information, at **1-800-282-4548.**

eviCore

The eviCore tool also helps providers with prior authorizations in specific circumstances and to upload clinical documents. The tool manages prior authorization requests for the following specialized clinical services:

- Radiology
- Medical oncology
- Molecular genetics
- Musculoskeletal
- Joint surgery
- Spine surgery
- Interventional pain
- Radiology therapy
- Sleep
- Specialty drug

You can learn more on our website. (Scroll down on that page and click on "eviCore Prior Authorization Program.") Providers can also call eviCore for more information at **1-855-252-1117** from 6 a.m. to 6 p.m. CT Monday through Friday and from 9 a.m. to noon Saturday, Sunday and legal holidays.

PRIOR AUTHORIZATIONS

Providers should use the Availity and eviCore portals to understand requirements for prior authorization and submit them when needed.

Providers can learn more about prior authorization requirements on our utilization management webpage and read prior authorization lists and other information on our network participation webpage. (Scroll down to "Prior Authorizations Lists" about one-third down the page.)

Peer to Peer or Provider to Provider Consultation for Outpatient Specialty Authorizations – 1-855-252-1117 (toll free)

- Urgent requests only
- Standard requests – http://www.evicore.com/

Prior Authorization Help by Phone – **1-877-774-8592**

- Live representative business hours: Monday – Friday 8 a.m. to 8 p.m. CT

Prior Authorization Forms

You can access a Prior Authorization form at https://www.bcbsok.com/pdf/forms/bma_prior_auth_form.pdf.

For specialized clinical services, check eviCore Clinical Worksheets for more details about specific service areas and clinical solutions: http://www.evicore.com/provider/online-forms

You can learn more about prior authorizations in Section 6: Utilization Management and Quality Improvement.

CLAIMS

Claims Filing Information

Submit electronic claims (837 transactions):

- Via Availity or your preferred vendor portal
- Use the Medicare Advantage plans' Electronic Payer ID – 66006
- For out-of-state Medicare Advantage plans, please submit claims to the local Blue plan.

Mail paper claims to:

Blue Cross Medicare Advantage
C/O Claims Department
PO Box 3686
Scranton, PA 18505

Claim Info by Phone

To get more information about claims by phone, call Provider Customer Service at **1-877-774-8592.**

Fax: **1-855-674-9192**

Check Claim Status Online

At Availity.com, the Availity Claim Research Tool provides the equivalent of an Explanation of Benefits, including line-item breakdowns.

Claims Disputes

You may dispute a claims payment decision by requesting a claim review.

You can submit a claim review form by mail to:

Blue Cross Medicare Advantage
C/O Claim Disputes
PO Box 4555
Scranton, PA 18505

If you have questions regarding claims or claims appeals, please contact Provider Customer Service at **1-877-774-8592**.

APPEALS

Preservice Appeals Process

The Medicare Advantage plans administer a preservice appeals process for denied or partially denied benefit prior authorization requests. When submitting a preservice appeal, always follow the directions included within the denial letter.

Submit your request and supporting documentation by mail or fax.

Mailing Address:

Blue Cross Medicare Advantage
C/O Appeals and Grievances
PO Box 4288
Scranton, PA 18505

Fax: 1-855-674-9185

For expedited appeals, call:

- Individual plans: **1-877-774-8592**
- Employer plans: **1-877-299-1008**
- TTY: 711

PRESCRIPTION DRUGS

Customer Service for Blue Cross MedicareRx℠

Call **1-888-285-2249** (TTY 711)

Representatives are available 8:00 a.m. to 8:00 p.m., local time, seven days per week. If you're calling from April 1 through September 30, alternate technologies (for example, voicemail) will be used on weekends and holidays.

SUPPORT

Provider Network Representatives: These representatives serve as the liaison between the Medicare Advantage plans and our provider community. The Provider Network Representative webpage includes all lines of business that Blue Cross and Blue Shield of Oklahoma offers; there are specific components outlined for the Medicare Advantage plans.

Email: OKNetworkManagement@bcbsok.com

Training and Reference Information

You can visit Blue Cross Medicare Advantage Plans to access Medicare Advantage forms, tips, and tools.

Blue Review℠

You can visit https://www.bcbsok.com/provider/education/education-reference/news-updates/blue-review to enroll to receive our monthly newsletter by email.

MEDICARE INFO

The Medicare coverage webpage is at: http://www.cms.gov/center/coverage.asp.

You can learn more about National Coverage Determinations through program manuals at http://cms.hhs.gov/manuals/.

You can also visit the CMS Medicare Learning Network® to learn more about Medicare Preventive Services.

OTHER INFO

Dental and Vision Referrals

PCPs can also assist with referrals to dental and vision care.

For **dental care** – Dental Networks of America — call **1-877-774-8592**.

For **routine vision care** – EyeMed Vision Care — call **1-844-684-2255.**

Refunding Overpaid Claims

For refunds of overpaid claims, submit the information to:

Claims Overpayments for BCBSOK
Dept. CH 14212
Palatine, IL 60055-4212

Courier Address:

Claims Overpayments for BCBSOK
PO Box 14212
5505 North Cumberland Ave, Ste 307
Chicago, IL 60656-1471

MEMBER ID CARDS

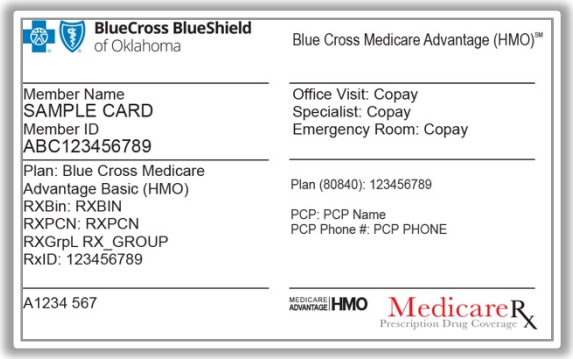
Each member of either Medicare Advantage plan receives an identification card containing the member's name, member ID number, and information about their benefits.

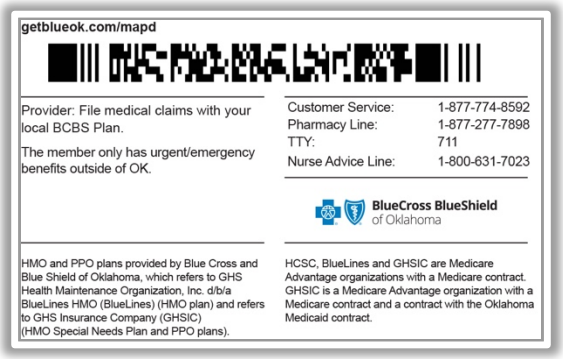
At each office visit, your staff should:

- Ask for the member's ID card.
- Copy both sides of the ID card and keep the copy with the patient's file.
- Check member's eligibility.
- Determine if the member is covered by another health plan to record information for coordination of benefits.
- Refer to the ID card for the appropriate telephone number to verify deductibles, coinsurance amounts, copayments, and other benefit information.

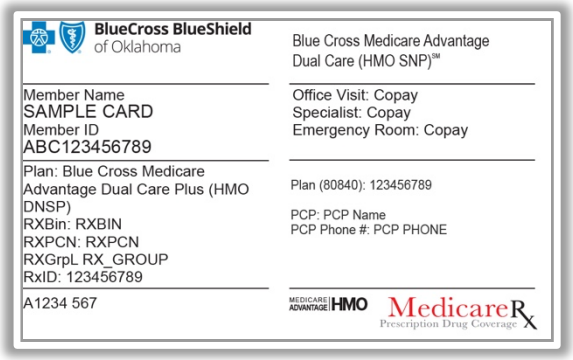
Here is a front and back view of a sample ID card:

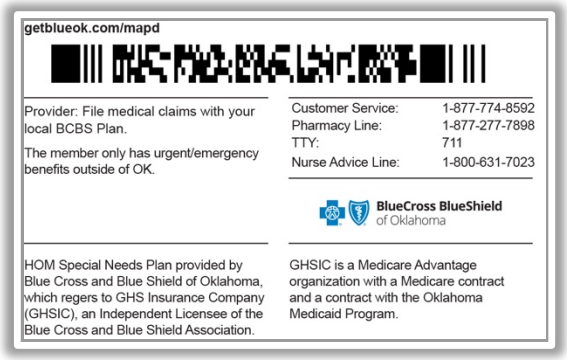
Blue Cross Medicare Advantage (HMO)





Blue Cross Medicare Advantage Dual Care Plus (HMO SNP)





ID Card Copayment Information

The office visit copayment (in-network) or coinsurance (out-of-network) is determined by how a provider is contracted with the Medicare Advantage plans.

- If the provider is contracted with the Medicare Advantage plans as a Primary Care Provider, the provider should collect the in-network copayment indicated on the ID card for Office Visit.
- If the provider is contracted with the Medicare Advantage plans as an in-network Specialty Care Provider, the provider should collect the in-network copayment indicated on the ID card for Specialists.
- If the provider is contracted with the Medicare Advantage plans as a PCP and a SCP, then the provider should collect the PCP in-network copayment indicated on the ID card for Office Visit.
- If the provider is out of network, contact the Customer Service number listed on the ID card to determine the member's patient share.

The Medicare Advantage plans strongly encourage providers to check patient eligibility and benefit information prior to each scheduled appointment. You can call the Provider Customer Service number on the back of the member ID card or check benefits through Availity or through your preferred web vendor.

FREQUENTLY ASKED QUESTIONS

How can I verify a patient's eligibility and benefits under the health plan?

You can verify a patient's eligibility and benefits through the Availity tool. You can also call Provider Customer Service at **1-877-774-8592**.

What is the process for submitting a claim and receiving reimbursement?

You can submit a claim electronically, through the Availity tool. You can also file a paper claim through the mail. See the Claims subsection in the Quick Reference Guide above for more info.

How do I obtain or verify prior authorization?

You can use the Availity and eviCore portals to submit a prior authorization request. You can also call Provider Customer Service, at **1-877-774-8592**, and choose the option for "prior authorization" or the "Utilization Management" department. Staff there can help you with prior authorizations or questions.

How do I check on the status of a claim?

You can check on Availity or contact Provider Customer Service, at **1-877-774-8592**, for claim status.

How can I understand why a claim was denied?

You can check on the Availity portal, which helps providers with claims, prior authorizations and other processes. You can also contact Provider Customer Service, at **1-877-774-8592**, for claim denial information.

How do I fix the issues with a denied claim?

You can submit a corrected claim by mail at the Claims address in the Reference Guide section or through fax at 1-855-674-9192. If you need more help, contact your Provider Network Representative at **1-800-722-3730** (option 2), or via email at OKNetworkManagement@bcbsok.com.

How do I monitor the status of a dispute?

You can contact Provider Customer Service, at **1-877-774-8592**, to check on the status of an appeal.

Are there specific requirements for referrals to specialists within the network?

Yes, members are required to have their PCP refer them to an SCP or other provider, even if the other provider is in-network. If a member wants to see a specialist outside of the network, members must get a PCP referral and their PCP must also get a prior authorization from the plans. You can read more details in Section 3.

How can I find in-network providers?

You can find in-network providers here.

Section 3:
Provider Roles and Responsibilities

PARTICIPATION IN THE MEDICARE ADVANTAGE PLANS

Participation Requirements

To participate in the Blue Cross Medicare Advantage (HMO) or Blue Cross Medicare Advantage Dual Care Plus (HMO SNP) (the Medicare Advantage plans), the health care provider:

- Must be a BlueLincs[SM] participating health care provider
- Must have privileges at a participating hospital with the plans. The exception: This is not required if inpatient admissions are uncommon or not required by the Medicare Advantage plans for the participating health care provider's specialty.
- Must have a valid National Provider Identifier Number
- Must sign a Medicare Advantage plans agreement/amendment
- Cannot have opted out of Medicare or have any sanctions or reprimands by any licensing authority or review organizations. That means:
    - Participating providers cannot be named on the federal Office of the Inspector General General List of Excluded Individuals-Entities, the National Practitioner Databank, or the Government Services Administration List of Parties Excluded from Federal Procurement and Non-Procurement Programs. These lists identify health care providers found guilty of fraudulent billing, misrepresentation of credentials, patient abuse or neglect, financial misconduct, or similar offenses.
    - Participating providers cannot be sanctioned by the federal Office of Personnel Management or be prohibited from participation in the Federal Employees Health Benefit Program.

Credentialing and Recredentialing of Participating Health Care Providers

The Medicare Advantage plans continuously review and evaluate information about participating providers, recredentialing them every three years. The credentialing guidelines are subject to change, based on industry requirements and the Medicare Advantage plans' standards.

Credentialing and Recredentialing of Participating Institutional Providers

The Medicare Advantage plans continuously review and evaluate information about participating Institutional Providers and recertify them every three years. The certification guidelines for credentialing and recredentialing institutions are subject to change, based on industry requirements and the Medicare Advantage plans' standards.

Appeals Process for Health Care Provider Participation Decisions

If the Medicare Advantage plans decide to suspend, terminate or non-renew a provider's participation status, we will give the affected provider written notice of the reasons for that action. Those reasons may include the standards and profiling data used to evaluate the provider. Reasons may also include the number of members a provider serves and the specialty mix of providers the Medicare Advantage plans need.

The Medicare Advantage plans will give the participating provider written notice of their right to appeal the action to a hearing panel. We will also detail the process and timing for requesting a hearing. A majority of the hearing panel members will be providers in the same medical discipline as the affected provider. A recommendation by the hearing panel is advisory and is not binding on the Medicare Advantage plans.

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

Notification to Members of Health Care Provider Termination

The Medicare Advantage plans will make a good faith effort to provide written notice of a participating provider's termination to all members seen regularly by that provider within 30 days of when it becomes effective. That notice will come regardless of the reason for the termination.

PROVIDER ROLES

Definitions of Provider Types

- Primary Care Provider: Each member chooses a PCP to coordinate their health care. A PCP is a patient's first point of contact when a patient has a health concern. A PCP can be a family practice physician, general practice physician, internal medicine physician, pediatric physician, advanced nurse practitioner, physician assistant or, in some cases, an obstetrics and gynecology physician*
- Specialty Care Provider: An SCP is a health care provider who has a specialty outside of internal medicine, family practice medicine, pediatrics, geriatrics and obstetrics and gynecology.

* Please Note: An obstetrics and gynecology physician can choose to be a PCP or an SCP. If the obstetrics and gynecology physician chooses to be a PCP and the member chooses the obstetrics and gynecology physician as their PCP, then the obstetrics and gynecology physician must assume and meet all of the PCP roles and requirements.

Role of PCP

A participating provider who has contracted with the Medicare Advantage plans as a PCP will agree to render to the member primary, preventive, acute and chronic health care management. The provider will also:

- Provide the same level of care to Blue Cross Medicare Advantage (HMO) and Blue Cross Medicare Advantage (HMO SNP) patients as provided to all other patients.
- Provide urgent care and emergency care, or coverage for such care, 24 hours per day and seven days per week. A PCP will use a verifiable mechanism that can immediately direct patients to alternative after-hours care, if needed. Acceptable mechanisms may include:
    - An answering service that offers to call or page the provider or on-call provider.
    - A recorded message that directs the patient to call an answering service, with the phone number provided.
    - A recorded message that directs the patient to call or page the provider or on-call provider, with the phone number provided.
- 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
- Make arrangements for patient coverage when the provider is unavailable. (See Backup PCPs section.)
- Provide copies of X-rays and laboratory results and other health records to SCPs to enhance continuity of care and to prevent duplication of diagnostic procedures
- Keep a central record of the member's health and health care that is complete and accurate. (See Medical Records section.)
- Follow Health Insurance Portability and Accountability Act (HIPAA) guidelines when sharing any Protected Health Information of a member. (See Medical Records section.)
- Provide copies of medical records when requested by the Medicare Advantage plans
- Enter into the member's health record all reports received from SCPs
- Arrange and get prior authorization for hospital admissions in which the provider is the admitting health care provider. The provider can also delegate this responsibility to the admitting SCP
- Be responsible for care management as soon as possible after receiving information that a member who the provider serves as PCP has been hospitalized in the local area on an emergency basis
- Refer the member to SCPs within the Provider Network
- Work with the Medicare Advantage plans to coordinate covered services for members and in the collection of third-party payments. Those payments might include workers' compensation and other third-party liability. Participating providers agree to file claims information to the Medicare Advantage plans even if the provider believes there is third-party liability for the claim.

IMPORTANT INFORMATION ABOUT PROVIDER REFERRALS:

In-network Referrals

Members are required to have their PCP refer them to an SCP or other provider, even if the other provider is in-network. The Medicare Advantage plans do not require the PCP to obtain prior authorization from the plans to refer to an in-network SCP or other provider.

Members and PCPs coordinating care can check our webpage that offers tips on finding a new provider. That page can help you identify SCPs or other providers that are in-network in the Medicare Advantage plans.

Out-of-network Referrals Required

A member may need to use a non-participating specialty provider because they can't find an appropriate provider in-network or because of continuity-of-care concerns. If that's the case, the member must get a referral from the member's PCP to see a specialist outside of the Medicare Advantage plans' networks. In addition to that referral, members must also have their PCP get a prior authorization from the plans to see an out-of-network specialist. Without that prior authorization, claims will be denied.

Other Referral Guidance

A PCP may not make a referral to themselves, as an SCP, when treating a member who is already on their PCP list of patients.

There is one exception to this rule: Both a PCP and an SCP can directly manage and coordinate a woman's care for obstetrical and gynecological conditions. They can also use the Availity tool to provide referrals for OB-GYN-related specialty care and testing to other providers participating in the same network as the PCP.

If a PCP does help a member with a referral to an SPC or other specialist, the PCP should provide the SCP with the following information:

- Member's name
- Reason for consultation
- History of present illness
- Diagnostic procedures and results
- Pertinent medical history
- Current medications and treatments
- Problem list and diagnosis
- Specific information requested by SPC

After an SPC evaluates a member referred to them, the SPC should:

- Contact the referring PCP to discuss the member's condition and any recommendation for treatment or follow up care
- Send the referring PCP a consultation report that includes medical findings, test results, assessment, recommendations, treatment plan and any other pertinent information
- Consult with the PCP if the SCP believes the member should be seen by another SCP. The SCP should not directly refer the member to another SPC.

If a member or provider has questions about referrals, they can contact Customer Service at **1-877-774-8592.**

Providers can also use the Availity and eviCore tools for referrals and referral information. (More information on those tools is in Section 2 of the manual.)

PCPs can also assist with referrals to dental and vision care.

For **dental care** – Dental Networks of America — call **1-877- 774-8592**

For **routine vision care** – EyeMed Vision Care — call **1-844-684-2255**

Role of SCP

A participating provider who performs services as an SCP is expected to perform many of the same duties and satisfy the same requirements as a PCP.

Similar duties and requirements include:

- Providing the same level of care for all patients
- Providing urgent care and emergency care, with a mechanism to respond to patients after hours
- Making arrangements for patient coverage when the provider is unavailable
- Keeping patient records
- Working with the Medicare Advantage plans in the collection of any third-party payments

SCPs also have other duties and responsibilities under the Medicare Advantage plans:

- Accept referrals for members in accordance with the services and the number of visits requested by the PCP in the same Provider Network
- Report to the PCP upon completion of the consultation/treatment
- Provide copies of X-rays and laboratory results and other health record information to the member's PCP, as appropriate
- Coordinate inpatient care with the PCP to avoid unnecessary visits by other doctors or providers
- Bill members only for copayments, cost share payments and deductibles, where applicable. SCPs cannot offer to waive or accept lower copayments or cost share or otherwise provide financial incentives to members. That includes not offering lower rates in lieu of the member's insurance coverage
- Use their best efforts to participate with the Medicare Advantage plans' Electronic Funds Transfer and Electronic Remittance Advice systems. Providers agree to use the systems under the terms and conditions set forth in the EFT Agreement and as described on the ERA enrollment form.
- Obtain a new authorization for services from the PCP if additional services or visits are needed beyond those first authorized by the PCP
- If authorized by the PCP, arrange for the hospital admission of the member into a participating facility. That should happen through the Medicare Advantage plans' utilization management department. SCPs must complete the steps required by the Medicare Advantage plans to authorize the admission.

SCP as a PCP

Any SCP who provides medical services to a member with a chronic, disabling or life-threatening illness may apply to the Medicare Advantage plans' medical director to be a PCP. Requirements for the application include:

- The request from the SCP must include certification of medical need, along with supporting documentation, and is signed by the member and the SCP interested in serving as the PCP.
- The SCP must meet the Medicare Advantage plans' requirements for PCP participation.
- The SCP must be willing to coordinate all health care needs of the member and accept reimbursement from the Medicare Advantage plans.

PROVIDER RESPONSIBILITIES

Backup PCPs

During the network application process, the PCP should designate a backup provider who can see patients on behalf of the PCP when the PCP is unavailable. The covering health care provider is responsible for filing a claim for any member seen on behalf of the PCP. The PCP's staff must report any upcoming changes in covering PCPs to their Network Management office.

24-Hour Coverage

The Medicare Advantage plans require participating PCPs and SCPs to provide coverage for members 24 hours per day, seven days per week. When a health care provider is unavailable to provide services, the provider must ensure they have arranged for coverage from a backup PCP or SCP. Hospital emergency rooms or urgent care centers are not considered substitutes for providing round-the-clock member coverage.

Participating providers can consult the provider directory for the Medicare Advantage plans to identify providers participating in the network who might be to help with 24-hour coverage. Providers can also contact the Medicare Advantage plans' Customer Service Department at the number on the back of a member's card for more information.

Sub-contractors Meet All Requirements

Participating providers must ensure any entity they contract with to deliver services to members meet all requirements of their contract with the Medicare Advantage plans.

Panel Closure

Any individual PCP or medical group agrees to accept members who have selected or have been assigned to the PCP or medical group unless:

- The PCP or medical group notifies the Medicare Advantage plans the entire practice of the PCP or medical group is closed to new patients of all health plans
- The practice of the PCP or medical group includes 300 or more Blue Cross Medicare Advantage (HMO) or Blue Cross Medicare Advantage (HMO SNP) members

The PCP or medical group must give the Medicare Advantage plans at least 90 days prior written notice of closing their practice to new members.

MEDICAL RECORDS INFORMATION

Providing Requested Medical Records

The Medicare Advantage plans require providers to furnish medical records that we may request. Medical records are used for risk adjustment data that are part of CMS audits. That information is used to determine health status adjustments to CMS capitation payments.

We also use medical records for:

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

Medical Records Review

A Medicare Advantage plan's representative may visit the participating provider's office to review the medical records of members.

Standards for Medical Records

Participating providers must have a system in place for keeping medical records that complies with regulatory standards. Providers must comprehensively document each medical encounter in each member's medical record. Each medical record chart must include the following:

- Names of all health care providers participating in the member's care, along with information on services furnished by these providers
- Prescribed medications, including dosages and dates of initial or refill prescriptions
- Physical examinations, needed treatments and possible risk factors for treatments
- Any evidence of member input into the proposed treatment plan
- Documentation on whether the member has executed an Advance Directive (see details immediately below)

Advance Directives

Participating providers must document in a prominent part of the member's medical record whether the member has executed an advance directive. Advance directives are written instructions, such as living wills or durable powers of attorney for health care, signed by the patient and recognized by Oklahoma state law. An advance directive explains 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

Participating health care providers must have policies and procedures that comply with all state and federal laws concerning confidentiality of health and other information about members. Each participating provider and their office staff members must sign an employee confidentiality statement. The provider must then keep the signed statement in each employee's personnel file.

OBLIGATION TO PROVIDE ACCESS TO CARE

Patient Appointment Access Standards

Providers should meet these required standards for patients to get an appointment:

- Initial new patient visit — within 30 business days
- Preventive care – within 30 business days
- Urgently needed services or emergency — immediately
- Services that are not emergency or urgently needed, but require medical attention — within seven business days
- Annual physical exam — within 30 business days
- In-office wait time — 30 minutes or less

These standards apply to all medical, behavioral health and substance use disorder services, where applicable.

The Medicare Advantage plans will monitor whether providers are meeting member access standards through office site visits and through tracking of complaints/grievances the Medicare Advantage plans' Clinical Quality Improvement Committee reviews.

Prohibition Against Discrimination

The Medicare Advantage plans and all participating providers are prohibited from denying, limiting or placing conditions on coverage or furnishing of services to members based on their health status. That means coverage or services cannot be denied or limited based on:

- Medical condition, including mental or 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 or national origin
- Religion
- Sex or sexual orientation
- Age
- Mental or physical disability
- Source of payment

Participating providers must have practice policies that show they will accept for treatment any member who needs the health care services the provider offers.

Services Provided in a Culturally Competent Manner

The Medicare Advantage plans want to ensure services are provided to all members in a culturally competent manner. That means services must be provided to members with limited English proficiency or reading skills, and to members of diverse cultural and ethnic backgrounds. Participating providers must cooperate with the Medicare Advantage plans in making sure this happens.

The Medicare Advantage plans' Customer Service department, at **1-877-774-8592**, has the following services available for members:

- Teletypewriter services
- Language services
- Spanish–speaking Customer Service Representatives

PROVIDER PERFORMANCE STANDARDS AND COMPLIANCE OBLIGATIONS

Evaluating Performance of Participating Health Care Providers

When evaluating the performance of a participating provider, the Medicare Advantage plans will review, among other things, the following areas:

- Quality of Care: Measured by clinical data related to the appropriateness of member care and to health 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 and quality of health care, interpersonal relations with the provider and the comfort of the practice setting
- Administrative Requirements: Measured by the participating provider's methods and systems for keeping records and transmitting information, hours of operation, appointment waiting times and appointment availability
- Participation in Clinical Standards: Measured by the participating provider's involvement with national health panels that monitor quality of care standards

Health Care Provider Compliance to Standards of Care

Participating providers must:

- Comply with all applicable laws and licensing requirements
- Furnish covered services in a manner consistent with standards related to medical and surgical practices generally accepted in the medical and professional community at the time of treatment

Participating providers must also comply with the Medicare Advantage plans' standards, which include:

- Guidelines established by the Centers for Disease Control and Prevention
- All federal, state and local laws regarding the conduct of their profession

Participating providers must also comply with the Medicare Advantage plans' policies and procedures regarding the following:

- Participation on committees and clinical task forces to improve the quality and lower the cost of care
- Precertification requirements
- Credentialing requirements
- Care coordination referrals that are part of the care management and disease management program
- Appropriate release of inpatient and outpatient utilization and outcomes information
- Accessibility of member medical record information to fulfill the business and clinical needs of the Medicare Advantage plans
- Providing treatment to members at the appropriate level of care
- Providing equal access and treatment to all members

The Medicare Advantage plans encourage participating providers to advise their member patients about:

- The patient's health status, medical care or treatment options (including any alternative treatments that may be self-administered). Providers should give each patient all information needed for the patient to make an informed treatment decision from all treatment options.
- The risks, benefits and consequences of treatment or non-treatment
- The rights of 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 participating providers receive for furnishing services to members are, in whole or in part, from federal funds. Therefore, participating providers and any of their subcontractors must comply with laws that apply to individuals and entities receiving federal funds. Those include but are 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 providers may not develop or use any materials that market the Medicare Advantage plans without prior approval of the Medicare Advantage plans. Under Medicare Advantage law, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to select 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 HEALTH PROGRAMS AND STATE LAW

Participating providers must ensure they employ or subcontract with no one who has been convicted of criminal offenses related to that person's involvement in Medicaid, Medicare or other federal health care programs.

Participating providers must disclose to the Medicare Advantage plans whether the participating provider 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
- Violated the rules or regulations of the state of Oklahoma, the federal government or any public insurer

Section 4:
Member Eligibility and Covered Services

ELIGIBILITY AND BENEFITS

Member Eligibility and ID Cards

Each member will receive a Blue Cross Medicare Advantage (HMO) or Blue Cross Medicare Advantage (HMO SNP) identification card. The card includes the member's name, member ID number and information about the member's benefits and co-pays.

Providers should check a member's eligibility and benefit information at each visit. Providers can learn more about ID card information and procedures in Section 2 of this manual.

COVERED SERVICES

Preventive Services

Patients can lower their risk for disease, disability and death by using preventive health care services. Members may access the following preventive health care services directly from participating providers:

- Annual physical exam
- 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 programs
- Abdominal aortic aneurysm screening for high-risk individuals

Patients and providers can learn more about Medicare preventive services at the CMS Medicare Learning Network®.

Emergency Care for Emergency Medical Conditions

Emergency Care services are health care services provided in a hospital or comparable facility to evaluate and stabilize recent and severe medical conditions. Those conditions — called Emergency Medical Conditions — could include severe pain and any other conditions that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that failure to seek 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

The Medicare Advantage plans cover emergency care services needed to evaluate and stabilize an emergency medical condition. Providers should tell members with emergency medical conditions to go to the nearest emergency care provider. The member does not need prior authorization for evaluation and stabilization of an emergency medical condition.

Within one business day of the admission following treatment of an emergency medical condition, participating providers must notify the Medicare Advantage plans' utilization management department to get approval for post-stabilization care services. Failure to timely notify the Medicare Advantage plans and obtain pre-approval for post-stabilization care may result in denial of the claim for that care. Post-stabilization care that was not pre-approved and was denied cannot be billed to the member, pursuant to the participating provider agreement with the Medicare Advantage plans.

Cost sharing for necessary emergency care services furnished out-of-network is the same as for such services furnished in-network.

Out-of-Area Renal Dialysis Services

A member may obtain medically necessary dialysis services from any qualified health care provider when the member is temporarily away from the member's normal service area and the member cannot access a dialysis provider that is part of the Medicare Advantage plans. Prior authorization is not required.

Note: The Medicare Advantage plans do recommend the member notify their case manager of any such care, so the case manager can follow up to make sure all is going well. A member may voluntarily advise the Medicare Advantage plans if the member will be temporarily out of their service area. In those cases, a Medicare Advantage plan representative can help the member locate a qualified dialysis provider.

Inpatient Hospital Admissions

All inpatient hospital admissions require prior authorization from the Medicare Advantage plans' utilization management department. The admitting health care provider or hospital personnel carry out the prior authorization process for admissions.

When a member arrives at any facility for an elective admission, providers should notify the utilization management department to assist in patient care coordination. Admitting health care providers must also contact the department to request prior authorization for additional days if an extension of the approved length of stay is required.

The admitting provider will give appropriate referrals for extended care. Staff from the utilization management department will help coordinate all needed services in the discharge planning process.

BEHAVIORAL HEALTH

Behavioral Health Services

Members needing to access behavioral health (mental health and substance abuse) services should contact the Medicare Advantage plans' Behavioral Health Customer Service number at **1-800-672-2378** to verify benefits and prior authorization requirements.

Behavioral Health Care Managers accessed through that number will provide:

- Reviews of medical necessity for services requiring prior authorization
- Case management
- Assistance in the selection of a participating health care provider
- Crisis intervention

Behavioral health services that require prior authorization include:

Inpatient Care

- Inpatient mental health
- Inpatient substance abuse
- Partial hospitalization program mental health
- Partial hospitalization program substance abuse

The Medicare Advantage plans must determine the services are Medically Necessary before a prior authorization number will be issued. Claims received that do not have a prior authorization number for a hospital admission or outpatient care will be denied.

Participating providers may not seek payment from the member when a claim is denied for lack of a prior authorization number. The member, a behavioral health professional, a physician or the member's authorized family member may make the call to seek prior authorization.

The Medicare Advantage plans encourage behavioral health providers to admit patients to a participating Medicare Advantage plans' facility unless an emergency exists that precludes safe access to a participating facility. Members can be admitted to a non-participating facility if the Medicare Advantage plan has approved the admission. The member will receive in-network benefits only when services are performed at a participating facility unless the Medicare Advantage plans have approved admission to a non-participating facility.

Section 5:
Pharmacy Benefits

PHARMACY BENEFITS MANAGER

The Medicare Advantage plans use Prime Therapeutics LLC as our pharmacy benefits manager. Our partnership with Prime Therapeutics maintains and improves the quality of care delivered to members, while helping to contain rising drug costs.

Prime Therapeutics is primarily responsible for claims processing, formulary development, clinical review and pharmacy network contracting.

Members can visit myPrime.com to:

- Search for prescription drugs.
- Find a network pharmacy.
- Download forms and pharmacy information for the Medicare Advantage plans.
- Submit coverage determinations.

PRESCRIPTION DRUGS

Prescription Drug List

The Medicare Advantage plans' pharmacy benefits include a list of covered drugs (formulary) the plans have been selected based on clinical recommendations of the Prime Therapeutics National Pharmacy and Therapeutics committee. The committee recommends drugs for the list based on safety, efficacy, uniqueness and cost. The Medicare Advantage plans encourage physicians to prescribe drugs on the list.

Exceptions for Prescription Drugs Not on List

A member may ask for a formulary exception if a drug prescribed to them is not on the list. They can do that through a coverage determination, redetermination or appeal. If the Medicare Advantage plans agree to make an exception and cover a drug not on the formulary list, the member will need to pay the cost-sharing amount that applies to drugs in Tier 4 of our plans. That tier is for non-preferred drugs that are often more expensive.

If a member or provider has any questions, they can call Customer Service at **1-877-774-8592**. They can also call Prime Therapeutics at **1-800-991-5643**.

Prior Authorization

Some drugs require prior approval before the Medicare Advantage plans cover them. This is so the plans can best guide the correct use of these drugs. Providers can help members get approval. Members and providers can learn more about prior authorization and access a prior authorization form.

Step Therapy

A member may be asked to start treatment with a drug that costs less but works just as well (for example, a generic drug) instead of starting with a drug that costs more. If the first drug doesn't work for the member, then the Medicare Advantage plans will cover the higher-priced drug. Members and providers can learn more about and access a form for Step Therapy.

Quantity Limits

There may be a limit on how much of a drug a member is allowed, including how many pills with each prescription. These limits are based on safety guidelines. Members and providers can learn more about quantity limits and access a quantity limits exception form. To do that, go to this link. Click on "Continue without Sign-in." Then select "BCBS Oklahoma" in the "health plan" dropdown and select "no" on the question of whether you're a Medicare Part D member. Then click "Continue."

PHARMACIES

Pharmacy Finder and Mail Order Options

The Medicare Advantage plans have contracts with pharmacies nationwide. To receive benefits, a member must use network pharmacies or our home delivery pharmacy service, except in emergencies.

Members can use the Pharmacy Finder tool to access the most up-to-date list of pharmacies. (When you go to that link, click on "Continue without Sign-in." Then select "BCBS Oklahoma" in the "health plan" dropdown and select "no" on the question of whether you're a Medicare Part D member. Then click "Continue.")

Preferred Network Pharmacies

A member can choose from a Medicare Advantage plan's preferred or standard pharmacies. Members usually will save money — through lower copays or coinsurance — when they use a preferred pharmacy. Preferred pharmacies include Walgreens, Walmart and other independent pharmacies. Select plans include only Walgreens and Walmart as preferred pharmacies. Members should check their plan's pharmacy directory for a full list of preferred pharmacies.

Home Delivery

Members can also use one of our home delivery pharmacies and have their medications delivered straight to their home. Our home delivery pharmacies offer:

- Three ways to order refills — online, by phone or by mail
- Up to a 90-day supply of medications at one time
- Choice of notification by text message, email or phone when their order is received and when their prescriptions are mailed
- Free standard shipping anyplace in the U.S., along with automatic refills

To get started, members can contact one of our home delivery pharmacies:

- AllianceRx Walgreens Pharmacy[1] at **1-877-277-7895** (TTY 711)
- Express Scripts® Pharmacy[2] at **1-833-599-0729** (TTY 711)
- Amazon Pharmacy[3] at **1-855-393-4279** (TTY 711)

Out-of-Network Pharmacies

Members can get covered drugs from out-of-network pharmacies in emergencies or unusual circumstances, or for non-routine access to drugs covered under Medicare's Part D drug plan. (For example, members can get out-of-network access while traveling outside the Medicare Advantage plans' service area, where there is no network pharmacy.) Members can contact us to get more information on these special circumstances for out-of-network coverage and about what pharmacies may be available.

Contact our MedicareRX℠ plans Customer Service at **1-888-285-2249** (TTY 711)

MEDICATION MANAGEMENT

Medication Therapy Management

The Medication Therapy Management program reviews the medicines members take to make sure that they're safe, they work well and they fit the member's lifestyle. The program is not considered a benefit, but it is offered at no additional cost to eligible members.

The goal is to help members get the best results from their medicines, at the lowest possible price.

The Medicare Advantage plans automatically enroll members in the program if they have certain conditions and take a certain number of medications. The program is voluntary and members can opt out.

Prescription Drug Transition

If a member is new to one of our Medicare Advantage plans, they might be taking medications the plans don't cover. Members can get a limited supply of uncovered medications if they:

- Are enrolled in a prescription drug plan during the open enrollment period
- Became eligible for Medicare after the first of the year
- Switched from another plan to one of our plans after the first of the year
- Were affected by a level of care change (for example, admitted or discharged from a long-term facility)
- Were recently affected by formulary changes

If one of the above situations applies to a member, they can either:

- Ask their physician to change their prescription to a different medication covered by the Medicare Advantage plans, or
- Send an exception request to keep using their current medications. Members can access forms and documents related to the drug transition plan at our Prescription Drug Plan Documents webpage

MEDICARE CONTACT INFORMATION

Members can contact Medicare for more information about benefits and services, including information about Medicare Advantage prescription drug coverage.

Phone:

1-800-MEDICARE (**1-800-633-4227**) — 24 hours per day, seven days per week. Members who are hearing or speech impaired can call **1-877-486-2048**.

Online:

www.medicare.gov

If members would like to submit feedback directly to Medicare, they should use the Medicare Complaint Form or contact the Office of the Medicare Ombudsman.

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1. AllianceRx Walgreens Pharmacy, a central specialty and home delivery pharmacy, is contracted to provide mail pharmacy services to members of Blue Cross and Blue Shield of Oklahoma.
2. Express Scripts® Pharmacy is contracted to provide mail pharmacy services to members of Blue Cross and Blue Shield of Oklahoma. Express Scripts® Pharmacy is a trademark of Express Scripts Strategic Development, Inc.
3. Amazon Pharmacy is contracted to provide pharmacy home delivery services to Blue Cross and Blue Shield of Oklahoma.

Section 6:
Utilization Management and Quality Improvement

UTILIZATION MANAGEMENT

We Follow Medicare Policies

As Medicare Advantage plans, Blue Cross Medicare Advantage (HMO) and Blue Cross Medicare Advantage Dual Care Plus (HMO SNP) must cover all services and benefits covered by Medicare.

Participating providers should refer directly to Medicare coverage policies when making coverage decisions.

Our Clinical Review Criteria

The Medicare Advantage plans use a combination of Medicare guidance, internal policies and other guidelines in determining whether and how we pay for medical services. We use Medicare National Coverage Determinations and Local Coverage Determinations as guides. We also use MCG Care Guidelines® and other guidelines.

The Medicare Advantage plans' Clinical Quality Improvement Committee reviews and approves the utilization management processes and clinical review criteria the plans use to determine whether services are medically necessary.

Here are details on our clinical review criteria:

National Coverage Determinations and Local Coverage Determinations

There are two types of Medicare coverage policies — National Coverage Determinations and Local Coverage Determinations.

- **National Coverage Determinations**

  NCDs are decisions the Centers for Medicare and Medicaid Services makes on whether Medicare will pay for a certain medical treatment, service, item or technology.

  Providers and members can see details on all NCDs on the CMS website. You can also visit the CMS online manual webpage to see a range of other manuals that can help you understand Medicare coverage.

  CMS continually offers online updates to program manuals. It also provides updated information through articles on the Medicare Learning Network.

- **Local Coverage Determinations**

  CMS also provides LCDs to offer guidance to patients and providers in specific geographical areas. An LCD might add detail to an NCD, or it might explain when a service or item might be covered if there is no NCD on the topic. But an LCD should never contradict an NCD; if it does, the NCD has final authority.

  Here are webpages that provide more information:

- Providers can get general info about Medicare Coverage here.
- Providers can get information about LCDs here.
- Providers can search the Medicare coverage database here.

MCG Care Guidelines

The Medicare Advantage plans also use MCG Care Guidelines®, which are a set of widely used, evidence-based guidelines for health care. For more information or to receive a copy of these guidelines, please contact the Medicare Advantage plans' UM department at **1-877-774-8592**.

Other Guidance on Coverage

In coverage situations where there is no 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.

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The Medicare Advantage plans' determinations on coverage must be based on:

- The medical necessity of services – including emergency, urgent care and post-stabilization care after an emergency. Determinations on whether something is medically necessary must be based on NCDs, LCDs or internal policies. The Medicare Advantage plans' medical director must review and approve those policies. Those policies must include coverage rules that are no more restrictive than Medicare's coverage rules. Before a possible treatment is scheduled, a provider, member or designated representative of a member can request a medical necessity review relating to the treatment.
- The member's medical history. That would include any conditions, diagnoses and doctor's recommendations and clinical notes, along with how the member is functioning.
- When appropriate, review and analysis by the Medicare Advantage plans' medical director.

Recommendations on Specific Diagnoses and Drugs

The Medicare Advantage plans may also develop recommendations or clinical guidelines for the treatment of specific diagnoses, or for the use of specific drugs. We will communicate these guidelines to providers through the Medicare Advantage plans' monthly Blue Review newsletter.

PRIOR AUTHORIZATION TOOLS AND REQUIREMENTS

Provider Portals

The Medicare Advantage plans encourage participating providers to use two provider portals that can help with prior authorizations, referrals and other processes.

Availity

The Availity portal helps providers with a number of services for patients, including prior authorizations.

How to access and use the Availity tool:

1. Go to the Availity website and create an account.
2. Log in.
3. Select the Patient Registration menu option, then choose Authorizations and Referrals.
4. Select Authorizations.
5. Select Payer BCBSOK, then choose your organization.
6. Select a Request Type and start request.
7. Review and submit your request.

Providers can learn more about and get free webinar training on the Availity tool.

You can also call Availity for help and more information, at **1-800-282-4548.**

eviCore

The eviCore tool also helps providers upload clinical documents and with prior authorizations in specific circumstances. The tool manages prior authorization requests for the following specialized clinical services:

- Radiology
- Medical oncology
- Molecular genetics
- Musculoskeletal
- Joint surgery
- Spine surgery
- Interventional pain
- Radiology therapy
- Sleep
- Specialty drug

Providers can call eviCore for more information at **1-855-252-1117** from 6 a.m. to 6 p.m. CT Monday through Friday and from 9 a.m. to noon Saturday, Sunday and legal holidays.

For all other conditions and services, providers should use the Availity tool.

Prior Authorization Requirements

Providers can learn more about prior authorization requirements and get materials at our utilization management webpage.

Prior Authorization Checklist

Providers should include the following information when requesting a prior authorization:

- **Patient/Member**
  - First, middle and last name
  - Date of birth
  - Gender
  - Address
  - Home and cellphone numbers
  - Health plan, member and group ID numbers
- **Ordering Provider and Facility/Site**
  - Name
  - Primary specialty
  - Tax identification number
  - National provider identifier
  - Phone and fax numbers
  - Office contact and email address
- **Procedure**
  - Valid CPT codes
- **Diagnosis**
  - Diagnosis, if known or ruled out
  - Valid ICD-10 codes
  - Date of last visit
- **Clinical Information**
  - Primary reason for the service request
  - Date of the first office visit with any physician for the current condition
  - Date of the most recent office visit for the current condition
  - Current symptoms
  - Length of physician-directed treatment or observation for the current condition
  - How symptoms have changed with physician-directed treatment or observation since onset of the current condition
  - What conditions have been found by a medical professional on a physical exam performed for the current condition
  - Any other conditions present in the medical history
- **Submitter**
  - Ordering physician, facility or other

Inpatient Prior Authorization

The admitting health care provider or hospital or other inpatient facility should notify the Medicare Advantage plans' utilization management department, at **1-877-774-8592**, if they are admitting a member to a hospital or other inpatient facility.

The utilization management department will review the initial hospitalization request to confirm the hospitalization and/or procedures are medically necessary. In some cases, the department may conclude that hospitalization or certain services are not medically necessary. If that happens, the physician reviewer working for the Medicare Advantage plans will attempt to contact the admitting provider to discuss the treatment plan and options before issuing the denial determination.

Concurrent Hospital Review

If an extension of the initially approved length of stay in a facility is required, the admitting provider or facility should contact the utilization management department to request the extension.

Discharge Planning

Clinical staff with the utilization management department will help providers and facilities with the inpatient discharge planning process. When the member is admitted to the hospital and during the hospitalization, the department clinical staff will discuss discharge planning with the provider, the member and the member's family.

QUALITY IMPROVEMENT

Quality Improvement Program

Quality improvement is an essential element in delivering effective health care and services. To define and help monitor quality improvement, the Medicare Advantage plans' Quality Improvement Program measures the care and services participating providers deliver. We measure care against established goals.

We also formally evaluate the program every year to assess how effective it is. Here are some key components of the program:

- **Chronic Care Improvement Program**

  CCIP assesses interventions designed to improve the health of individuals who live with multiple or certain severe chronic conditions. The program uses evidence-based practice guidelines and collaborative practice models involving physicians and support-service providers. It also includes patient self-management techniques.

- **Quality Improvement Project**

  QIP focuses on improving performance, member care, patient safety, health care operations and overall wellbeing. It does this through systematic, data-driven processes for both clinical and non-clinical areas.

- **Healthcare Effectiveness Data and Information Set (HEDIS®)**

  HEDIS is a widely used set of health plan performance measures. Government and private health care plans use these measures to promote accountability and assess the quality of care that managed care organizations provide.

- **Consumer Assessment of Healthcare Providers and Systems (CAHPS®)**

  CAHPS is a broad national survey of patients conducted annually. The survey asks patients who are members of various health care plans for their views on their health care. The survey:

  - Allows for meaningful comparisons among providers
  - Creates incentives for providers to improve their quality of care
  - Improves accountability in health care by providing information to the general public about the quality of care

- **Health Outcomes Survey**

  The HOS survey assesses both the physical and mental health of a sample of members from each Medicare Advantage organization. Two years after members are surveyed, those same members are surveyed again to check on any changes in their health.

Quality of Care Issues

The Quality Improvement Program also analyzes trends in quality-of-care issues through the work of Quality Improvement Organizations.

QIOs, overseen by Medicare, review complaints from Medicare patients about the quality of care they've received. QIOs determine whether the quality of services that a Medicare health plan provides meets recognized standards. QIOs are made up of physicians and other health care experts.

CMS Star Ratings

CMS posts quality ratings of Medicare Advantage plans to give Medicare beneficiaries additional information about the various plans offered in their area. CMS rates Medicare Advantage plans on a scale of one to five stars. It defines the star ratings in this way:

- 5 stars — Excellent performance
- 4 stars — Above average performance
- 3 stars — Average performance
- 2 stars — Below average performance
- 1 star — Poor performance

CMS bases the quality scores on performance measures from four sources:

- HEDIS
- CAHPS
- HOS
- CMS administrative data, including information about member satisfaction, health plans' appeals processes, audit results and customer service.

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 summary scores and overall scores. The summary score is used to provide quality-based payments and an overall measure of a plan based on indicators specific to quality and access to care. The overall score combines a plan's summary score with its Part D plan rating.

Cooperation

Participating providers must comply and cooperate with all policies and procedures that are part of the Medicare Advantage plans' medical management, quality assurance and performance improvement programs. Participating providers also must cooperate with the independent quality review and improvement organizations, including QIOs, working on behalf of the Medicare program.

Utilization Management Program

The Medicare Advantage plan's utilization management program does not prohibit participating providers from advocating on behalf of members within the utilization management process.

Patient Readmission

How often patients are readmitted to an acute care facility within 30 days of discharge from that same facility is an important quality-of-care metric. Tracking the metric encourages facilities to improve patient care.

The Medicare Advantage plans will review readmissions to an acute care facility that occur within 30 days of discharge from the same facility. We will review those readmissions consistent with the CMS Medicare Claims Processing Manual and the Medicare Quality Improvement Organization Manual.

We will perform a clinical validation of acute care facility claims to determine if any readmissions are related to the patient's earlier hospital stay. The plans may deny payment to the facility for related readmissions.

Certain readmissions are excluded from this policy:

- 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:
    - Chemotherapy
    - Staged surgical procedures
    - Procedures involving malignancies
    - Burns procedures
    - Cystic fibrosis procedures
    - Certain other treatments
    - Patient non-compliance, if documented in medical records

Section 7:
Initial Decisions, Appeals and Grievances

INITIAL DECISIONS

The initial decision is the first decision the Medicare Advantage plans make regarding coverage or payment for care. In some cases, a participating provider, acting on behalf of the member, may make a request for an initial inquiry regarding whether a service will be covered.

Here are some types of initial decisions:

- If a member asks the Medicare Advantage plans 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 a participating provider 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.
- If a member asks for a specific type of treatment from a participating provider, this is a request for an initial decision about whether the treatment the member wants is covered.

Generally, the Medicare Advantage plans will make decisions about payment for care that members have already received within 30 days.

A preservice determination about whether the Medicare Advantage plans will cover medical care can be a standard decision that is made within a standard time frame, typically within 14 days, or can be an expedited decision, typically made within 72 hours. A member can ask for an expedited decision only if the member or a participating provider believes waiting for a standard decision could jeopardize the life or health of the member, or the member's ability to regain maximum function.

If the Medicare Advantage plans do not make a decision within the typical timeframe and do not inform the member about why the timeframe must be extended, the member can treat the failure to respond as a denial. The member can then appeal, as detailed 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 providers must cooperate with the Medicare Advantage plans' appeals and grievances processes.

Appeals

An appeal is a complaint a member makes when the member wants the Medicare Advantage plans to reconsider and change an initial decision — by the plans or by a participating provider — about what services are needed or covered. A member might also appeal what the Medicare Advantage plans will pay for a service. In some cases, a provider, acting on behalf of the member, may make a request for an appeal regarding whether a service will be covered.

Contact Info for Appeals

Providers or members with questions about appeals should call **1-877-774-8592**.

You can also find more contact info relating to appeals in the Quick Reference section of this manual.

Resolving Appeals

A member may appeal an adverse initial decision the Medicare Advantage plans make concerning payment for a health care service. In general, the Medicare Advantage plans must resolve within 30 days a member's appeal of an initial decision about authorizing health care or terminating coverage of a service. In general, the Medicare Advantage plans must resolve within 60 days an appeal concerning payment.

If the normal time period for an appeal could jeopardize the life or health of the member or the member's ability to regain maximum function, the member can request an expedited appeal. Such appeals are generally resolved within 72 hours, unless it is in the member's interest to extend this period. The Medicare Advantage plans automatically expedite an appeal if a member or participating provider asks for one.

A special type of appeal applies only to hospital discharges. If the member believes the Medicare Advantage plans' coverage of a hospital stay is ending too soon, the member can appeal directly and immediately to a Medicare Quality Improvement Organization. The member must make the appeal no later than noon on the first business day after the day the member gets notice that the Medicare Advantage plans' coverage of the stay is ending. If the member misses this deadline, they can request an expedited appeal from the plans.

Another special type of appeal applies only to a member dispute when coverage will end for services from a skilled nursing facility, home health agency or comprehensive outpatient rehabilitation facility. These facilities must provide members with written notice at least two days before their services are scheduled to end. If the member thinks their coverage is ending too soon, the member can appeal directly and immediately to the QIO.

If the member receives the notice two days before coverage ends, the member must request an appeal to the QIO no later than noon of the first business day after the day the member received the notice. If the member receives the notice more than two days before coverage ends, the member must make the request no later than noon the day before the day coverage is scheduled to end. If the member misses the deadline for appealing to the QIO, the member can request an expedited appeal from the Medicare Advantage plans.

Further Appeal Rights

If the Medicare Advantage plans deny the member's appeal in whole or part, the plans will forward the appeal to an independent review entity that has a contract with the federal government and is not part of the Plan. This organization will review the appeal. If the appeal involves a prior authorization for health care, the organization will make a decision within 30 days. If the appeal involves payment for care, it will make a decision within 60 days. If the appeal involves an expedited reconsideration decision, the organization will make a decision within 72 hours.

If the independent review entity 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 administrative law judge'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 judicial review by a federal district court.

Grievances

A grievance is a complaint a member makes regarding any other type of problem with the Medicare Advantage plans or a participating provider. For example, complaints about quality of care, waiting times for appointments or in the waiting room, and the cleanliness of the participating providers' facilities are grievances.

Resolving Grievances

If a member has a grievance about the Medicare Advantage plans, a provider, or other issue, they should contact the members' custom sererice department at the number listed on the back of the member's ID card.

Participating Provider Obligations – Organization Determinations

At each patient encounter with a member, the participating provider must notify the member of their right to receive, upon request, a detailed written notice from the Medicare Advantage plans regarding covered services for the member. The provider's notification must give the member the information needed to contact the Medicare Advantage plans. That notification must also comply with any other requirements CMS specifies.

Participating Provider Obligations – Appeals

Participating providers must cooperate with the Medicare Advantage plans and their members in providing needed information to resolve appeals within the required time frames. Participating providers must furnish pertinent medical records and any other relevant information. In some cases, providers must furnish the records and information quickly to allow the Medicare Advantage plans or the other appeal groups to make an expedited decision.

Section 8:
Care Management

CARE MANAGEMENT

The Medicare Advantage plans help manage the care of members with acute or chronic conditions who can benefit from care coordination and assistance. Participating providers should work with the Medicare Advantage plans' Care Management program to help.

With help from providers, the Care Management program:

- Informs members of any of their specific health care needs that require follow-up and trains members in self-care and other measures they may take to promote their health
- Works with our Welcome Program to conduct a health assessment of all members within 90 days of their becoming members and annually thereafter
- Identifies members with complex or serious medical conditions so care coordinators can provide timely interventions that can improve members' health
- Implements care management plans for each engaged member that:
    - Are age appropriate
    - Help with direct visits to specialty care physicians or other providers
    - Are time specific and updated periodically
    - Help coordinate health care providers who work with the member
    - Consider each member's input

The Care Management program also:

- Coordinates and integrates services with community and social service programs
- Identifies and addresses barriers to members complying with prescribed treatments or regimens

An important goal of the Care Management program is to help members improve overall health and wellness. Our care managers coordinate, monitor and evaluate the services that can help meet members' needs. They ensure care is provided in the right place and at the right time.

How We Inform Members About Care Management

The Medicare Advantage plans inform members of available programs through the enrollment process, marketing materials and participating providers' conversations with each member. We proactively identify members who could benefit from care management and encourage them to enroll in the Care Management program or disease management programs for certain chronic conditions. (See details below on our disease management programs.)

Coordinating Health Assessments and Programs

The Care Management program also helps to coordinate risk screenings and health assessments, and other resources and programs. Those include:

- **Health Risk Questionnaire**

  The Medicare Advantage plan will send a health risk assessment questionnaire to each member as part of the plans' enrollment materials. Staff will evaluate answers on that questionnaire and:
    - Identify health care needs
    - Assist with access to health care services
    - Assist with coordination of care
    - Provide help by telephone or through written materials as needed
    - Refer members to appropriate case and disease management programs as needed. (See details below.)

- **Initial Health Risk Assessment**
  CMS requires that Medicare Advantage organizations make a good faith effort to conduct an initial health assessment of all new members within 90 days of them becoming members and annually thereafter. Examples of visits that would fulfill this obligation include:
    - The original Medicare initial preventive visit, known as a “Welcome to Medicare” preventive visit
    - An annual wellness visit
    - A recent previous physical examination in a commercial health insurance plan (to which the Medicare Advantage organization has access)

  CMS also requires that Medicare Advantage organizations follow up after initial unsuccessful attempts to reach a member.
- **Annual Health Assessment**
  The Medicare Advantage plan’s Annual Health Assessment helps identify a member’s essential clinical and care management needs. It meets the requirements of Medicare’s initial preventive and annual visits. Components of the AHA include: the member’s medical history, social history, family history, review of symptoms, physical exam (including noting body mass index), preventive screenings and chronic disease monitoring. These assessments can occur in a participating provider’s office or in the member’s home to remove barriers to completion.
- **Annual Wellness Visit Resources**
  The Medicare Advantage plans have two new resources to help providers care for members during their annual wellness visits:
    - An Annual Wellness Visit Guide
    - An 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 providers’ use only; you do not need to submit them 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 coded correctly
    - Coding for other evaluation and management services, such as lab tests
    - Preventive services and screenings
    - Closing care gaps by performing HEDIS measurements
    - Coding tips to help minimize requests for medical records and help expedite claims processing

  You may use the 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.

Second Medical or Surgical Opinion

A member may get a second opinion about a treatment recommendation or procedure if any of the following applies:

- The member disputes the reasonableness of the treatment recommendation
- The member disputes the need for the recommended procedure
- The member does not respond to treatment after a reasonable period

Disease Management Programs

The Medicare Advantage plans also operate specific disease management programs for members. These programs include:

- Medical
    - Diabetes
    - Chronic obstructive pulmonary disease
    - Chronic kidney disease
    - Congestive heart failure
- Behavioral Health:
    - Depression
    - Substance abuse
    - Schizophrenia/psychotic disorders
    - Bipolar
    - Anxiety/panic disorders
    - Alzheimer's disease/dementia

Member participation in these disease management programs is voluntary. Members receive educational information through the telephone and through materials we send to them. That info can help members self-manage their condition. The treating provider is an integral part of the disease management programs.

For additional information on these programs, members or providers can call Customer Service at **1-877-774-8592.**

Section 9:
Claims and Billing

CLAIMS PROCESS

Participating providers must submit claims to the Medicare Advantage plans within 180 calendar days of the date of service. Providers should use the standard claim form or submit claims electronically as outlined below.

Services billed beyond 180 calendar days from the date of service are not eligible for reimbursement. Participating providers may not seek payment from a member for claims submitted after the 180th calendar-day filing deadline.

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

- Member's name
- Member's date of birth and sex
- Member's plan ID number, including a three-character prefix (for example: YUB)
- Member's policy number
- Indication of whether member has job-related injury or illness, or accident-related illness or injury, including details
- ICD-10 diagnosis codes
- CPT® procedure codes
- Date(s) of service(s)
- Charge for each service
- Provider's Tax Identification Number
- Provider's name and address
- Provider's signature
- Place of service code
- National Provider Identifier number

Claims Submission Information

Providers can submit claims to the Medicare Advantage plans electronically or by mail.

- **Electronically**

  Providers can submit claims electronically through the Availity website. Include the Electronic Payor ID #: 66006.

  With electronic claims, providers should use the CMS National Standard Format or the current version of the ANSI 837 format.

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

  Providers can get more information about Availity at the Availity Health Information Network, at **1-800-282-4548**.

- **By Mail**

  Providers can also submit claims to the Medicare Advantage plans by mail. They should use a completed version of the applicable CMS-1500 claim form and mail it to:

  Blue Cross Medicare Advantage HMO
  c/o Medical Claims Payment Request
  PO Box 4195
  Scranton, PA 18505

Important claim reminders for paper forms:

- Use the standard Health Care Financing Administration form — also known as the CMS-1500 form — for all paper claims submissions
- Include the name of the referring provider in Box 17
- Add the prior authorization number to Box 23
- If the claim is for laboratory services, make sure that you include the Clinical Laboratory Improvement Amendments number in Box 23. The claim will be denied otherwise.

Claims containing the required information and submitted according to these guidelines will be paid within 45 days for paper claims and 30 days for electronic claims.

Duplicate Claims

Providers who submit electronic claims may get duplicate claim rejections if they submit a claim with the same information for the patient and date of service as a previously processed claim. 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)

Providers should not submit duplicate paper claims before the 45-day payment period ends for paper claims.

Coordination of Benefits

If a member has coverage with another insurance plan that is primary to the Medicare Advantage plan, providers should submit a claim to that plan first. The amount the primary plan pays for such claims will affect what the Medicare Advantage plans pay on the claims. We will follow Medicare secondary payer law and policies.

Claim Disputes

Providers may dispute a claims payment decision by requesting a claim review. If providers have questions regarding claims or claims appeals, they should contact the Medicare Advantage plans' provider customer service department at **1-877-774-8592**. More contact information for claims and appeals is in Section 2 of this manual.

Process Used to Recover Overpayments on Claims

If an overpayment occurs on a claim, the Medicare Advantage plans will use a process called auto-recoupment to recover the overpayment. Providers with questions can call provider customer service at **1-877-774-8592**.

If you would like to refund the payment for an overpaid claim, you can submit it to the Claims Overpayments Address:

First Class Mail Remittance Address:

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

Overnight Courier Address:

Claims Overpayments for Blue Cross and Blue Shield of Oklahoma
PO Box 14212
5505 North Cumberland Ave., Ste. 307
Chicago, IL 60656-1471

Important note: The Electronic Refund Management tool is not available to process.

Balance Billing

Providers may not bill a member for a non-covered service unless:

- They have informed member in advance the service is not covered, and
- The member has agreed in writing to pay for the services.

Section 10:
Members' Rights and Responsibilities

MEMBERS' RIGHTS

Members have the right to timely, high-quality care and treatment with dignity and respect. Participating providers must respect the rights of all members.

Members have specific rights to:

- Their choice of a qualified participating provider and contracting hospital
- Candid discussions with their providers about appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage
- Timely access to their provider and recommendations for specialty care providers when medically necessary
- Receive emergency services when the member believes an emergency medical condition exists
- Participate in decisions regarding their health and treatment options
- Receive urgently needed services when traveling outside of the Medicare Advantage plans' service area or when unusual circumstances prevent the member from obtaining care from a participating provider
- Request the aggregate number of grievances and appeals and dispositions
- Receive information when requested regarding care provider compensation
- Receive information when requested regarding the financial condition of the Medicare Advantage plans
- Have their right to privacy recognized
- 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
- Confidential treatment of all communications and records pertaining to the member's care
- Access, copy and/or request amendment to the member's medical records consistent with the terms of the Health Insurance Portability and Accountability Act
- 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
- Refuse treatment or leave a medical facility, even against the advice of providers (with the member accepting the responsibility and consequences of the decision)
- Complete an advance directive, living will or other directive to the member's health care providers

Nondiscrimination

The Medicare Advantage plans may not deny, limit or place conditions on enrollment in the Medicare Advantage plans based on health status. That means enrollment cannot be denied based on:

- Medical condition, including mental or physical illness
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Mental or physical disability

The Medicare Advantage plans also cannot discriminate based on a range of other factors. They must comply with all provisions of:

- The Civil Rights Act
- The Age Discrimination Act
- The Rehabilitation Act of 1973
- The Americans with Disabilities Act
- The Genetic Information Nondiscrimination Act of 2008

The Medicare Advantage plans must also have procedures in place that ensure members are not discriminated against in the delivery of health care services based on:

- Race
- Ethnicity
- National origin
- Religion
- Gender
- Age
- Sexual orientation
- Source of payment

MEMBERS' RESPONSIBILITIES

Responsibilities

Members have the following responsibilities:

- To become familiar with their coverage and the rules they must follow to get care as a member
- To give their primary care provider and other providers the information needed to care for them
- To follow the treatment plans that they and their providers agree upon
- To ask their providers any questions they might have about conditions and treatments
- To act in a way that supports the care given to other patients and to help the smooth running of their provider's office, along with hospitals and other offices
- To pay their Medicare Advantage plans' premiums and any copayments and coinsurance payments they may owe
- To let Medicare Advantage plans' staff know if they have questions, concerns, problems or suggestions

Surveying Member Satisfaction

The Medicare Advantage plans periodically survey members to measure satisfaction with the health care participating providers are giving and overall satisfaction with the plans. The Medicare Advantage plans review those survey results and share them with providers.

Advance Directive

Members have the right to complete an advance directive statement. This statement indicates, in advance, the member's choices for medical treatment if the member becomes incapacitated or otherwise unable to make treatment decisions. The Medicare Advantage plans recommend participating providers have Advance Directive forms in their offices and available to members.

Member Complaints and Grievances

The Medicare Advantage plans track all member complaints and grievances to identify areas of our work we can improve. Our Quality Improvement Committee also reviews these complaints and grievances.

Section 11:
Plan Responsibilities

PLAN RESPONSIBILITIES TO MEMBERS

Confidentiality

The Medicare Advantage plans must safeguard any information that identifies a particular member. All of our employees follow state and federal laws in strictly maintaining the confidentiality of the private health information of each member. We limit how we share that information internally. We also have procedures that detail the limited circumstances when information can be shared externally.

Basic Rule

Any Medicare Advantage plan, including our plans, must provide the following to members:

- All Part A and Part B of original Medicare services, if the member is entitled to benefits under both parts. (Original Medicare is sometimes called traditional Medicare. It is the basic Medicare plan for people aged 65 and older, paid for by the federal government.)
- Part B services if the member is a grandfathered Part B only enrollee

The Medicare Advantage plans meet our obligation of providing original Medicare benefits by furnishing the benefits directly through arrangements with providers, or by paying for the benefits on behalf of members.

Here are important aspects of how the Medicare Advantage plans cover the costs of original Medicare:

- **Benefits:** The Medicare Advantage plans must provide or pay for medically necessary items and services in Part A (for those entitled) and Part B.
- **Access:** Members of the Medicare Advantage plans must have access to all medically necessary Parts A and B services. The Medicare Advantage plans are *not* required to provide members with the same access to providers that is provided under original Medicare.
- **Cost-Sharing:** The Medicare Advantage plans may impose cost-sharing requirements for a particular item or service that is above or below original Medicare cost-sharing for that service. That can only happen when overall cost-sharing under our Medicare Advantage plans is actuarially equivalent (comparable in value) to the cost-sharing under original Medicare. Also, our cost-sharing structure cannot discriminate against sicker beneficiaries.

There are exceptions where Medicare Advantage organizations are not required to cover the costs of original Medicare benefits. Here are those exceptions:

- **Hospice:** Original Medicare (rather than our Medicare Advantage plans) will pay for hospice services for a member who has elected hospice.
- **Clinical Trials:** Original Medicare pays for the costs of routine services for a member who joins a qualifying clinical trial. The Medicare Advantage plans will pay the member the difference between what original Medicare pays for services related to the clinical trial and what the Medicare Advantage plans would normally pay in-network for the same services.

Note: Medicare Advantage organizations must continue to cover inpatient services of a non-plan enrollee if the individual was a plan member at the beginning of an inpatient stay.

In addition to providing original Medicare benefits, the Medicare Advantage plans also furnish, arrange or pay for some supplemental and prescription drug benefits.

Uniform Benefits

All Medicare Advantage plan benefits must be offered uniformly to all members in the service area of the plan. We must also offer those benefits at uniform costs for premiums and cost-sharing.

Benefits During Disasters and Catastrophic Events

Medicare Advantage plans have special requirements whenever there is a Presidential emergency declaration or a Presidential disaster declaration. They also have special requirements when a state governor declares an emergency or disaster, or when the U.S. Secretary of Health and Human Services declares a public health emergency.

Also, certain regular requirements of Medicare, Medicaid and the Children's Health Insurance Program can be waived during such emergencies. That happens only when the HHS Secretary waives these requirements through something called an "1135 waiver." You can learn details here.

Access and Availability Rules

A Medicare Advantage organization may specify the providers through whom members may obtain services if it ensures all services covered by original Medicare are available and accessible under Medicare's coordinated care requirements.

That means the organization must meet certain requirements. It must:

- Maintain a network of appropriate providers, supported by written arrangements, that provides members with adequate access to covered services. This means ensuring services are spread throughout geographic areas and are consistent with local community patterns of care.
- Establish and maintain provider network standards that define the types of providers members can use when more than one type of provider can furnish a particular item or service. That also means identifying types of mental health and substance abuse providers in a network. And it means specifying the types of providers who may serve as a member's primary care provider.
- Use written standards for the timeliness of access to care and services for members that meet or exceed the standards set by CMS. These standards must ensure providers' hours of operation are convenient to members and do not discriminate against any group of members. Medically necessary services must also be available 24 hours per day, seven days per week. This includes requiring PCPs to have appropriate backup for their absences. The standards must consider members' needs and common waiting times for comparable services in the community. (You can read more about time standards for services in Section 3.)
- Validate and monitor credentials for PCPs and SCPs.
- Provide or arrange for necessary specialist care, and in particular give female members direct access to a women's health specialist within the network for women's routine and preventive health care services. The plans 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 all services — 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. (You can read more about this in Section 3.)
- Establish and maintain written standards that allow for determinations of medical necessity in individual cases. These standards should include coverage rules, practice guidelines, payment policies and utilization management protocols. The standards also must be easily available to members and providers.
- Provide coverage for ambulance services, emergency and urgently needed services and post-stabilization care services. Ambulance services include those dispatched through 911, or its local equivalent, when either an emergency situation exists or when other means of transportation would endanger the member's health.
- A continuation of enrollment option is not offered to enrollees when they no longer reside in the service area of their MA plan.

Cost-Sharing for In-Network Preventive Services

Medicare Advantage organizations must cover all in-network preventive services without cost-sharing if there is no cost-sharing for those services under original Medicare.

Medicare Advantage organizations also may not charge for facility fees, professional services or doctor's office visits if the only service provided during the visit is a preventive service that is covered with no cost-sharing under original Medicare. However, if the provider furnishes other non-preventive services during the visit, regular cost-sharing standards apply.

Drug Coverage

The Medicare Advantage plans cover a number of prescription drugs for members who are part of the Medicare Care Advantage Pharmacy Drug Program. (See Section 5 for more info.) These drugs are generally not covered under original Medicare Part B. Covered prescription drugs include:

- Injectable drugs that Medicare considers not usually self-administered and are instead administered by a provider
- Durable medical equipment supply drugs. These are drugs that require administration by the DME (for example, a nebulizer or external or implantable pump)
- Certain vaccines, including for 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 factor drugs
- Drugs used in immunosuppressive therapy for a member 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

Medical Supplies Associated with the Delivery of Insulin

Medical supplies directly associated with delivering insulin may satisfy the definition of a Part D drug — so the Medicare Advantage plans cover those supplies. That would include syringes, needles, alcohol swabs and gauze. It would also include insulin injection delivery devices not otherwise covered under Medicare Part B — such as insulin pens, pen supplies and needle-free syringes.

Test strips, lancets and needle disposal systems are not considered medical supplies directly associated with the delivery of insulin. The member's Part B or medical benefit would cover those supplies.

Clinical Trials

Medicare covers the routine costs of qualifying for clinical trials that are covered under the National Coverage Determinations for clinical trials. Medicare also covers the reasonable and necessary items and services used to diagnose and treat complications arising from participating in qualifying clinical trials.

The clinical trial NCDs define what routine costs means and clarify when items and services are reasonable and necessary. You can learn more at the Medicare Clinical Trial Policies web page.

Advance Directives

At the time of initial enrollment, each Medicare Advantage organization must give its adult enrollees written information on their rights 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. The Medicare Advantage organization provides information relevant for the state where the member lives.

PLAN RESPONSIBILITIES TO CMS

Cooperation in CMS Requirements

The Medicare Advantage plans must provide CMS with the information CMS needs to administer and evaluate the Medicare Advantage program and to help current and prospective members exercise their choice in obtaining Medicare services. That includes information on:

- Plan quality
- Performance indicators such as disenrollment rates
- Member satisfaction
- Health outcomes

Participating providers must provide information the Medicare Advantage plans need in their data reporting obligations.

Certification of Diagnostic Data

CMS requires the Medicare Advantage plans to submit data needed to characterize the context and purpose of each encounter between a member and a provider. Participating providers must furnish that data and must certify the data are accurate and complete.

Glossary

Appeal

A formal action a member files when the member wants the Medicare Advantage plans to reconsider and change an initial decision — by the plans or by a participating provider —about what services are needed or covered. A member might also appeal what the Medicare Advantage plans will pay for a service.

Benefits

The health care items or services covered by a health plan. Your health plan may sometimes be referred to as a benefits package.

Centers for Medicare and Medicaid Services

The federal agency responsible for administering Medicare and Medicaid.

Covered Services

A service covered according to the terms in your member's health plan.

Emergency Care

Health care services provided in a hospital or comparable facility to evaluate and stabilize recent and acute medical conditions considered emergency medical conditions.

Emergency Medical Condition

A recent and severe medical condition, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe their condition, sickness or injury is of such a nature that failure to receive immediate medical care could result in any of these:

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

Grievance

A formal action a member files regarding any type of problem with the Medicare Advantage plans or a participating provider that is not appropriate as an individual appeal. For example, complaints about quality of care, waiting times for appointments or in the waiting room, and the cleanliness of the participating providers' facilities would be a grievance.

Health Insurance Portability and Accountability Act

A federal law that outlines the rules and requirements health plans must follow to provide health care insurance coverage for individuals and groups. The law also establishes rules for how organizations must maintain the privacy of a person's health care information.

Home Health Agency

A Medicare-certified agency that provides intermittent skilled nursing care and other therapeutic services in the member's home. This happens when members are confined to their home and a participating provide authorizes the care.

Hospice

An organization or agency, certified by Medicare, that primarily provides pain relief, symptom management and supportive services to terminally ill people and their families.

Hospital

A Medicare-certified institution licensed in the state of Oklahoma that provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term hospital does not include a convalescent nursing home or facility for the aged that furnishes primarily custodial care.

Institutional Provider

A provider that is not an individual health care professional but an institution. Examples would be a hospital, surgical center or other medical facility.

Medically Necessary

Services or supplies that: are proper and needed for the diagnosis or 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 program that provides health care coverage for eligible senior citizens and certain eligible disabled persons under age 65.

Medicare Part A

Hospital insurance benefits, including for inpatient hospital care or care in a skilled nursing facility. It also covers care through a home health agency or hospice.

Medicare Part B

Supplemental medical insurance that is optional and requires a monthly premium. Part B covers physician services and services furnished by certain non-physician health care providers. Part B also covers lab testing, durable medical equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, certain other health and therapy services and blood not covered under Part A.

Medicare Advantage Plan

A set of health benefits a Medicare Advantage organization offers at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries in a geographic service area. A Medicare Advantage organization may offer more than one MA plan in the same area.

Member

The person to whom health care coverage has been extended by the policyholder (generally their employer). Members are also covered family members of the person. Members are sometimes called the insured or insured person.

Participating Health Care Provider or Participating Provider

Any health care provider or organization that has a written agreement with the Blue Cross Medicare Advantage plans to provide services to members pursuant to the agreement's terms. A participating provider can be a health facility or other institution or person who is licensed or certified by Oklahoma and Medicare to deliver health care services.

Prior Authorization

This is a process where your provider must get approval for a specific health care treatment or service before they can be covered by your Medicare Advantage plan. The plans will determine whether the treatment or service is medically necessary. Not all treatments require prior authorization.

Primary Care Provider

The physician a member chooses to be their primary source for medical care. A PCP coordinates all medical care for a member, including hospital admissions and referrals to specialists. Not all health plans require a PCP.

Protected Health Information

A term created by HIPAA, this is information held by an entity covered by HIPAA that relates to a person's health, medical treatment or payment for treatment. It also includes any information in the same set of data that could identify that person – like a name, address, birth date or Social Security number.

Provider Network

The doctors, hospitals and other health care professionals that contract with a health plan to deliver medical services to its members.

Quality Improvement Organization

An independent group of practicing physicians and other health care experts that CMS pays to check and improve the care for Medicare patients. The QIO for Oklahoma is called KEPRO.

Specialty Care Provider

A health care provider who has a specialty outside of internal medicine, family practice medicine, pediatrics, geriatrics and OB/GYN.

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