2026 Manual

Kansas Preferred Blue Medicare Advantage Manual

BlueCross BlueShield Kansas

bcbsks.com

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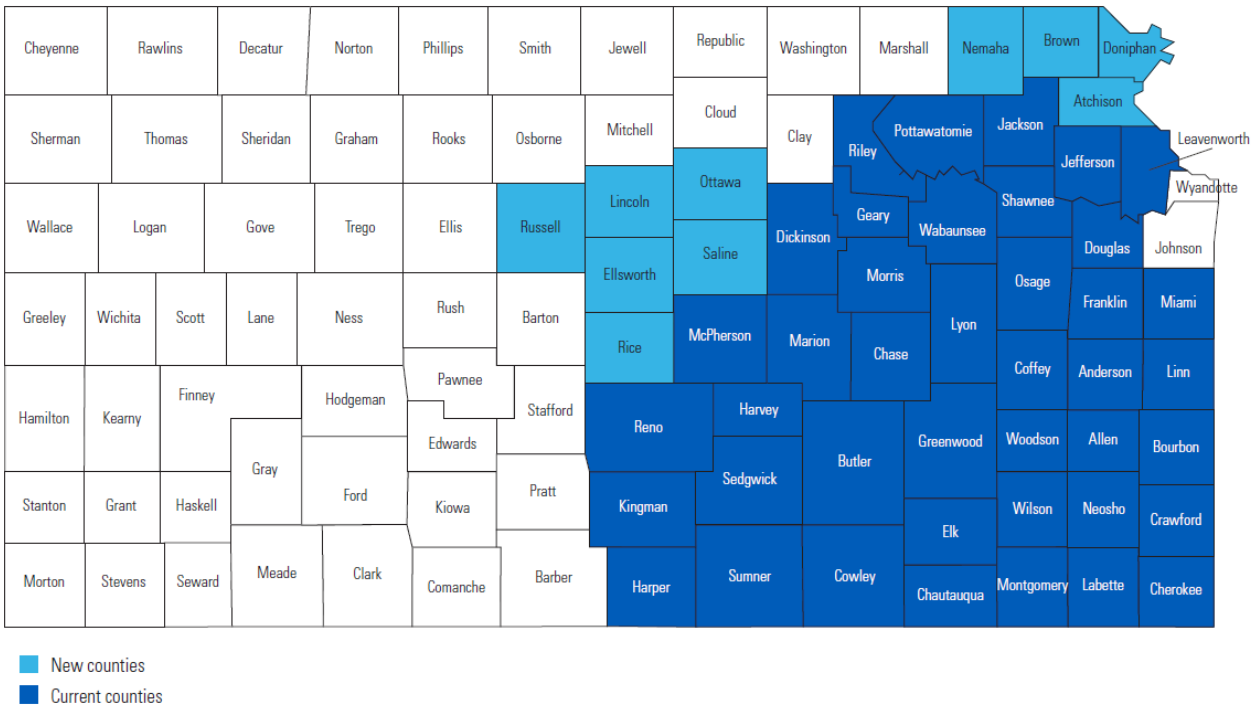
NOTE — The revision date appears in the footer of the document.

Chapter 1: Overview

Blue Cross and Blue Shield of Kansas (BCBSKS) Blue Medicare Advantage (Blue MA) is an authorized Medicare Advantage Organization that contracts with the Centers for Medicare and Medicaid Services (CMS) to offer Medicare Advantage (Part C) and Part D prescription drug insurance plans in the senior market. BCBSKS will offer Blue MA coverage to Medicare-eligible Kansas residents in the following counties according to the map below:



Blue MA plans provide at least the same level of benefit coverage as Original Medicare (Part A and Part B) and they provide enhanced benefits beyond the scope of Original Medicare within a single health care plan. This flexibility allows Blue MA to offer enriched plans by using Original Medicare as the base program and adding desired benefit options, including a Part D prescription drug benefit on most plans.

Disclaimer

Blue MA makes no representations or warranties with respect to the content of this publication. Blue MA reserves the right to revise this publication without obligation to notify any person of such revision or changes.

Updates to any part of this manual may be made by Blue MA or CMS at any time. Either Blue MA or CMS may give notice of such updates in a variety of ways – depending on the nature

of the update – including issuance of a letter to providers, publication in provider newsletters or other publications of Blue MA or CMS, or posting to either the Blue MA website, the CMS website or through other forms of CMS-approved communications.

Blue MA is a Preferred Provider Organization (PPO) plan that includes a network of doctors, other health care providers and hospitals. In a PPO, members pay less if utilizing doctors, hospitals and other health care providers that belong in the plan's network. The flexibility to go to doctors, specialists or hospitals that are not in the plan's network exists, but it usually costs more. Additionally, our PPO BlueCard Travel Program enables members traveling in certain states to use the networks of other participating Blue Cross MA PPO plans.

Note: This manual is provided for the convenience of providers participating in the Kansas Preferred Blue Medicare Advantage KPBMA network. Nothing in this manual shall be interpreted as guaranteeing coverage of any service, treatment, drugs or supplies. Coverage or no coverage is governed exclusively by the terms of the member's health benefit plan. In case of any question or doubt about coverage, providers should review the member's particular health benefit plan.

Chapter 2: General Information

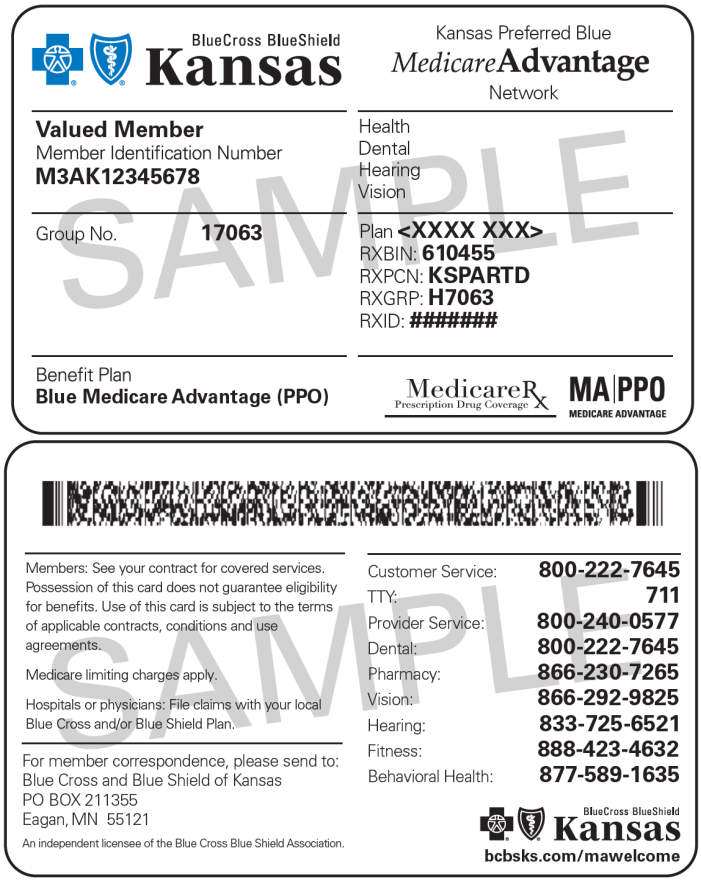
The table below provides important contact numbers to assist providers.

Provider Services and Requests for Organization Determinations			
	Phone	**Fax**	**Hours of Operation**
Provider Services	800-240-0577	800-976-2794	8 a.m. – 6 p.m. Monday-Friday
Prior Authorization			
	Phone	**Fax/Web Address**	**Hours of Operation**
Prior Authorization Program	800-325-6201	877-218-9089	8 a.m. – 6 p.m. Monday-Friday
Lucet Behavioral Health	877-589-1635	https://webpass.ndbh.com/	
Utilization Management and Care Transition			
	Phone	**Fax**	**Hours of Operation**
Utilization Management/ Care Transition	800-325-6201	877-218-9089	8 a.m. – 6 p.m. Monday-Friday
After Hours	800-331-0192	877-218-9089	6 p.m. – 8 a.m. Monday-Friday; 24 hours Saturday-Sunday

Blue MA Member ID Card

The Blue MA member ID card contains basic information needed to verify eligibility and file claims. Providers must use the three-character prefix found on the ID card when submitting paper and electronic claims. The prefix is critical for the electronic routing of claims to the appropriate processing areas, confirming member coverage and prompt claims payment.

Review the sample of the members' ID card. The BCBSKS Blue MA member Identification prefix is **M3A**.



Medicare Advantage PPO Network Sharing

All Blue Medicare Advantage PPO Plans participate in reciprocal network sharing. This network sharing allows all Blue MA PPO members to obtain in-network benefits when traveling or living in the service area of any other Blue MA PPO Plan, as long as the member sees a contracted MA PPO provider.

If you are a contracted Blue MA provider with BCBSKS and you see MA PPO members from other Blue Plans, these members will be extended the same contractual access to care and will be reimbursed in accordance with your contracted rate with BCBSKS. These members will receive in-network benefits in accordance with their member contract.

Do I need to provide services to Medicare Advantage PPO members from other Blue Plans?

If you are a contracted Medicare Advantage provider with BCBSKS then you should provide the same access to care as you do for BCBSKS Blue MA PPO members. You will receive the same contracted rates for such services. If you are not a Medicare Advantage contracted provider, then you are not required to provide services. Should you decide to provide

services to Blue Medicare Advantage members, you will be reimbursed for covered services at the Medicare allowed rate based on the member's out-of-network benefits and where the services were rendered. For urgent or emergency care, you will be reimbursed at the in-network benefit level.

What if my practice is not accepting new Blue Medicare Advantage PPO members?

If your practice is not accepting local Blue MA PPO members, then this will apply to Blue MA PPO out-of-area members also. The same contractual arrangements apply to both out-of-area network sharing members and your local MA PPO members.

Where do I submit the claim?

Submit the claim to your local Plan under your current billing practices. Do not bill Medicare directly for any services rendered to a Medicare Advantage member.

What will I be paid for providing services to out-of-area Medicare Advantage PPO network sharing members?

If you are a MA PPO contracted provider with BCBSKS, benefits will be based on your contracted MA PPO rate for providing covered services to MA PPO members from any MA PPO Plan.

What will I be paid for providing services to Medicare Advantage out-of-area members not participating in Medicare Advantage PPO network sharing?

When you provide covered services to Medicare Advantage PPO out-of-area members not participating in network sharing, benefits will be based on Medicare's allowed amount. Once you submit the MA claim and it processes, BCBSKS (or the local/host plan*)* will send you the payment. These services will be paid under the member's out-of-network benefits unless it reflects urgent or emergency care.

May I balance bill the member for differences in my fees vs. the Medicare allowance?

No, you may not balance bill the member for differences in your fees for services vs. Medicare reimbursement. Members may be balance billed for any deductibles, co-insurance and/or co-pays.

What if I have questions regarding reimbursement and network sharing?

If you have any questions regarding the MA program and/or products, contact BCBSKS Customer Service at 800-432-3990.

Eligibility and Coverage

Prior to services being rendered, verify eligibility and coverage on Availity.com.

BCBSKS Blue MA Member Benefits

Benefits are available in-network and out-of-network for urgent and emergency services only, and available in-network and out-of-network using the Blue Cross Blue Shield Association BlueCard providers outside of Kansas but within the U.S..

Plans offer coverage for the following services – beyond the scope of Original Medicare – with minimal or no member cost-share:

- Annual Physical Exam Policy
- Blood and Blood Components Policy
- Dental Care Benefit Policy
- Hearing Care Policy
- Inpatient Hospital Care Policy
- Meal Benefit Policy
- Medical Policy Hierarchy
- Organ Acquisition Costs Policy
- Over-the-Counter Benefit
- Transplant Travel Benefits Policy
- Vision Care Policy

Chapter 3: Claim Filing

Blue MA claims – including revisions or adjustments – must be filed within 365 days from date of service or discharge.

Appropriate Coding

Blue MA relies on the proper coding to process provider claims and adjudicate member benefits. The service codes selected and entered on claims are a representation of the member's treatment. Miscoded or improperly billed claims may constitute fraud and could be the basis for denial of claims, termination of provider network participation or other remedial action.

Filing Claims Electronically

Blue MA encourages the submission of claims electronically. Professional claims must be submitted using the revised CMS-1500 Health Insurance Claim Form (02/12) or ANSI ASC X12N 837p Health Care Claims transactions. Institutional claims must be submitted using the UB-04 claim form or 837p Health Care Claims transaction. Learn more about electronic claims at Ask-EDI.com.

UB-04 Claim Data Element Specifications

Information regarding the national Uniform Billing Data Element Specifications Manual, as developed by the National Uniform Billing Committee (NUBC), can be found at nubc.org.

Where to Submit Claims

- Kansas providers should submit electronic claims to BCBSKS
- Mail paper claims except dental to the following:

  Blue Cross and Blue Shield of Kansas
  Kansas Preferred Blue Medicare Advantage
  P.O Box 211421
  Eagan, MN 55121

- Mail paper dental claims to the following:

  Dominion National, ATTN: BCBSKS
  P.O. Box 211424
  Eagan, MN 55121

Non-Kansas providers should file with their local Blue plan. See the Ancillary Claims section for more information. Include the alpha prefix to ensure correct routing of the claim.

If you have problems submitting claims or have any billing questions, contact our technical billing resources:

Electronic Claims
Kansas Providers – Contact ASK-EDI at 800-472-6481.
Non-Kansas Providers – Contact your local Blue plan.
Paper Claims
Kansas Providers – Call Blue MA Customer Service at 800-240-0577.
Non-Kansas Providers – Contact your local Blue plan.

If you have questions about claim status or plan payments:

- Log onto Availity Essentials, from the BCBSKS payer space, in the resource tab, select the Blue Medicare Advantage link.
    - Claim status in Availity Essentials for Out-of-State/BlueCard claims
    - Blue MA Medical Portal for Kansas Blue MA members
- Kansas Providers – Call Blue MA Provider Services at 800-240-0577.
- Kansas Providers for Out-of-State/ITS Host Members – Call BlueCard Customer Service at 800-432-3990.
- Non-Kansas Providers – Contact your local Blue plan.

Ancillary Claims

The Blue Cross Blue Shield Association (BCBSA) has rules pertaining to how independent laboratories, durable medical equipment suppliers and specialty pharmacies should submit claims in certain circumstances.

- The following guidelines apply to referring providers: Independent labs should file claims with the plan in the state where the specimen was drawn, as determined by where the referring provider is located.
- Durable medical equipment suppliers should file claims with the plan in the state the equipment or supplies were shipped to – including mail order supplies – or purchased if it was purchased at a retail store.
- Specialty pharmacies should file claims with the plan in the state that the ordering provider is located.

Durable Medical Equipment, Prosthetics and Orthotics, medical suppliers and pharmacists

Blue Medicare Advantage plans include coverage for medically necessary durable medical equipment (DME), prosthetics and orthotics (P&O), medical supplies and pharmacy – including Part B drugs that are all covered under Original Medicare.

DME providers do require credentialing for each DME location/NPI – this includes physicians and non-physician practitioner (NPP) groups providing DME under one billing/type 2 NPI. In addition to the ancillary guidelines, claims for services listed on the CMS DMEPOS fee schedule should be billed to Blue MA in a manner consistent with Medicare guidelines and local and national coverage articles – including appropriate place of service codes and with appropriate billing and rendering NPIs for the DMEPOS provider.

Rural Health Clinic and Federally Qualified Health Center Billing

If a service is performed at a Rural Health Clinic (RHC) or Federally Qualified Health Center (FQHC) and the service is payable as a RHC or FQHC, the service is billed to Blue MA on a UB-04 form.

If a service is performed at an RHC outside of its CMS all-inclusive rate, the service should be billed on a CMS-1500 form.

The place of service code should represent where the service was performed. The following codes are examples of codes RHCs may use for the place of service:

- 72 – Rural Health Clinic (RHC) if the service was performed in the facility
- 32 – Skilled Nursing Facility (SNF)
- 19 or 22 – Outpatient hospital
- 21 – Inpatient hospital

For more information on RHC and FQHC billing guidelines for Medicare beneficiaries, reference the Medicare Claims Processing Manual.

Coordination of Benefits

When Blue MA is the secondary carrier, the benefits will be reduced by the amount paid by the primary carrier. The allowable expense is a service that is covered in full or in part by any of the plans covering the person. Non-covered expenses are not coordinated. Medicare

secondary-payer laws are followed. It is the member's responsibility to ensure delivery of the Explanation of Benefits (EOB) from the primary carrier to Blue MA. If the provider receives the EOB from the primary carrier, he or she may forward it to Blue MA for processing.

When Blue MA is secondary, a provider has the right to collect the copayment, deductible and/or coinsurance. Providers should not submit a claim until they have received notice that the primary carrier has completed processing.

If the provider receives payment in excess of actual charges and has collected a copayment, deductible or coinsurance from the member, the provider should reimburse the member up to but not exceeding the amount of the copayment, deductible or coinsurance. Any additional overpayment for that date of service should be refunded to the secondary carrier.

If the provider contractually participates with other health plan(s), the privilege to collect a co-payment may be affected by the agreement with the other health plan(s).

Timely Filing Requirement

Medicare law prescribes specific time limits in which claims for benefits must be submitted. The timely filing period for both paper and electronic Medicare claims is 12 months or one full calendar year from the date the services were provided.

When the last day for timely filing falls on a Saturday, Sunday, federal non-workday or legal holiday the claim will be considered filed timely if filed on the next working day.

Advanced Directives

Blue MA plans provide members information on the right to complete an Advance Directive. This is written instruction – recognized under state law – advising how to provide health care when an individual is incapacitated. As part of the medical record requirements for Blue MA, providers must document within the medical record whether a member has completed an Advance Directive. If presented, the Advanced Directive must be included in the member's medical record.

Claims for Unlisted and Not Otherwise Classified Procedure Codes

To ensure timely, accurate and efficient claim processing, supporting documentation should be attached to all Blue MA claims submitted with an unlisted or Not Otherwise Classified (NOC) procedure code(s), and/or services with modifier 22 appended.
If documentation supporting the service(s) is not included with the initial claim submission, the

claim may be denied requesting the supporting documentation.

MA claims with attachments should be submitted via mail. When submitting claims for NOC codes, the documentation needed is dependent on the type of service performed. Refer to the following table for minimum necessary documentation for each type of service:

Unlisted Code Type	Documentation Needed	Examples
Anesthesia Unlisted Service or Procedure	Special report Adequate definition or description of the nature, extent and need for the procedure - Time - Effort - Equipment necessary to provide service	CPT code 01999: Unlisted anesthesia procedure
Imaging/Radiology Procedures	- Diagnosis - Imaging report including test(s) and test results	CPT code 76999: Unlisted Ultrasound procedure
Lab/Pathology Procedures	Lab/pathology report Note: Item 19 of the CMS- 1500 claim form must include the specific name of the lab test(s) and/or a short descriptor of the test(s).)	CPT code 86849: Unlisted immunology procedure
Medical Service or Procedure	Office notes and any reports	CPT code 96999: Unlisted special dermatological service or procedure CPT code 95999: Unlisted neurological or neuromuscular diagnostic procedure
Surgical Procedures	- Description of the extent and need for the procedure - Operative or procedure reports, office notes - Explanation as to why a standard coded - CPT procedure is not appropriate; Comparable CPT/HCPCS service code(s), value in comparable RVU and/or a percentage of a reasonably comparable CPT/C6HCPCS that would reflect services performed.	CPT codes 48999: Unlisted pancreas surgery procedure
Unlisted Durable Medical Equipment (DME) – DME HCPCS Codes	Narrative/description included on claim, including the name of the item, manufacturer and product Number (UPN); If applicable a copy of the invoice.	HCPCS codes A9999: Misc. DME supply or accessory, not otherwise specified E1399: Misc. DME

Unlisted Code Type	Documentation Needed	Examples
Unlisted Services for E/M	Special report - Adequate definition or description of the nature, extent and need for the procedure - Time - Effort - Equipment necessary to provide service Note: additional items may be provided such as complexity of symptoms, final diagnosis, pertinent physical findings, diagnostic and therapeutic procedures, concurrent problems and follow-up care.	CPT code 99499: Unlisted E/M service
Unclassified/Unlisted Drug Codes	Necessary information needed to process valid unlisted drug codes: • NDC qualifier (N4) • NDC billing number –11-digit billing format, with no spaces, no hyphens and no special characters. If the NDC on the package label is less than 11 digits, a leading zero must be added to the appropriate segment to create a 54-2 configuration • NDC product package size unit of measure (e.g., UN, ML, GR, F2) • The NDC must be submitted along with the accurate HCPCS/CPT code(s) and the number of HCPCS/CPT units. ○ NDC unit to reflect the quantity of drug product administered. We'll accept up to three decimals in the NDC units – quantity of number of units field. Failure to include appropriate decimals in the NDC units' field may lead to incorrect payments subject to review or audit. • The NDC must be active for the date of service. • Note: Providers should list one unit of service in the 2400/SVI -04 data element or in item 24G of the CMS 1500 form or in field 46 of the UB-04. Do not quantity bill CPT/HCPCS units for NOC drugs or biologicals even if multiple units	HCPCS codes: J3490: Unclassified drugs J3590: Unclassified biologicals J3590: Unclassified biologicals J7999: Compounded drug, not otherwise classified J9999: Not otherwise classified, antineoplastic drugs C9399: Unclassified drugs or biologicals

Unlisted Code Type	Documentation Needed	Examples
	are provided unless otherwise directed for specific products.	

Medical Policy Hierarchy

In terms of the sequence of prior authorization review, Blue MA will first reference existing National Coverage Determinations (NCD) or Local Coverage Determinations (LCD). If neither of these exist, Blue MA will reference InterQual criteria – Acute Adult, Subacute/SNF, Long-Term Acute Care Rehabilitation.

Chapter 4: Claims Payment, Refunds and Offsets
Reimbursement Methodology

Blue MA reimburses network providers at the reimbursement level stated in the provider's Medicare Advantage Agreement – minus any member required cost sharing – for all medically necessary services covered by Original Medicare or an enhanced Blue MA benefit. BCBSKS will reimburse the RHC and FQHC encounter rate at the Medicare level.

Clean claims are processed and paid within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, interest will be paid in accordance with CMS regulations.

Claims are processed in accordance with Original Medicare guidelines. Providers must bill Blue MA in the same manner they bill Original Medicare. For example, if it's an RHC or FQHC with Original Medicare, you must file Blue MA Claims as an RHC or FQHC. Blue MA will not reimburse providers for services that are not covered under Original Medicare unless such services are specifically listed as covered services under the member's particular Blue MA health benefit plan.

Blue MA must also comply with all applicable CMS Original Medicare manuals, instructions, directives and guidance, including Medicare national coverage determinations, general coverage guidelines and written coverage decisions of the local Medicare Administrative Contractor.

Providers should follow all applicable Original Medicare guidelines and include the following on all claims:

- Diagnosis code to the highest level of specificity. When a fourth or fifth digit exists for a code, you must supply all applicable digits.
- Services coded with Not Otherwise Classified (NOC) codes – or without an associated fee – will be priced at 65 percent of charge.
- National coding guidelines.
- Medicare Part B supplier number, national provider identifier and federal tax identification number.
- The member's Blue MA number, including the **M3A** alpha prefix on the member's ID card.

Critical Access Hospitals and Rural Health Clinics

Reimbursement for inpatient and outpatient services will be based on the critical access hospital's or rural health clinic's most recent interim rate letter from their A/B Medicare Administrative Contractors. To ensure appropriate reimbursement, a copy of the current interim rate letter needs to be provided at initial contracting and every time CMS provides updated interim rate letters. These letters must be timely because the system is set to pay according to the letter. Email the rate letters to marateletters@bcbsks.com.

To ensure proper reimbursement throughout the year, hospitals must retrieve their current year rates from the Fiscal Intermediary/MAC and submit the rate letter or system equivalent to BCBSKS.

BCBSKS will conduct cost settlements for critical access hospitals (CAH) and qualifying rural health clinics (RHC) for BCBSKS Preferred Blue Medicare Advantage members – members with card prefix M3A. During the first year, the provider may choose to accept or forego the settlement process. This determination will apply as long as the contracting agreement remains in effect.

BCBSKS will review the Medicare cost report and the BCBSKS Medicare Advantage claims. Settlements will be based on the Medicare cost report for service dates within the cost reporting period.

If the settlement option is chosen, the provider must submit the filed Medicare Cost Report and the letter acknowledging the outcome of the settlement from Medicare to BCBSKS. We will review the information and will provide written determination of funds owed – either to the provider from BCBSKS or funds owed to BCBSKS from the provider. Payment of the settlement will be due from either party within 60 days after final terms of the BCBSKS Medicare Advantage settlement are completed.

Member Financial Obligations

In most situations, Blue MA members will be responsible for part of a provider's bill for services, and – as the provider agreement with Blue MA outlines – providers will not waive these member financial responsibilities, such as the member co-payment, coinsurance and deductible as specified in the member's health plan or contract.

Non-Covered Services

Members will be exclusively responsible for any services provided that are not listed as covered under their health plan. As specified in the provider agreement, providers may not bill members for services that are not reasonable, necessary or do not meet Medicare

Coverage Criteria, such as experimental/investigational services, unless a waiver is first obtained. The Advanced Beneficiary Notice of Non-Coverage Waiver is available at bcbsks.com for the provider notice and member agreement information regarding billing for non-covered services.

Note that except for applicable co-payment, co-insurance or deductible, providers are not permitted to request or require payment in advance by any Blue MA members or from anyone else as a condition of providing services to members.

Billing

Providers are not permitted to "balance bill" members for amounts in excess of the Medicare allowance. Member co-payment, co-insurance and deductibles are considered part of the allowance for this purpose and should be billed to the member for covered services, in accordance with the conditions of the contracting provider agreement, CMS regulations and 42 CFR § 422.214 for providers not participating in the Kansas Preferred Blue Medicare Advantage network. Providers are also responsible for any billing or collection service activities, as well as any accounts receivable or other claims a provider may assign against Blue MA members.

Providers or any agents engaged by a provider that have improperly attempted to bill any member and/or collect any amounts in violation of the provider agreement or guidelines of this manual are obligated to immediately halt any such activity. Providers must ensure any expenses and/or losses incurred in responding to and/or defending the claims or collection actions must be reimbursed directly to the Blue MA member. Providers also may be excluded from the network for failure to adhere to the member “hold harmless” agreement.

Dual Eligible

CMS prohibits billing members in the Qualified Medicare Beneficiary (QMB) program. The QMB program serves members enrolled in Original Medicare or a Medicare Advantage plan with a supplemental State Medicaid plan covering Medicare deductibles, coinsurance and co-payments under certain circumstances. Federal law prohibits Medicare Advantage (MA) providers from collecting Medicare Part A and Medicare Part B deductibles, coinsurance or co-payments from those enrolled in the QMB program.

Cost-Sharing

CMS Medicare Managed Care Manual provides guidance on acceptable cost-sharing. The following indicates benefits and beneficiary protections:

The 50% cap on Original Medicare services: In order for an Original Medicare in-network or

out-of-network item or service category to be considered a plan benefit, plans may not pay less than 50% of the contracted or Medicare allowable rate, and cost-sharing for services cannot exceed 50% of the total MA plan financial liability for the benefit.

Consequently:

- If a plan uses a coinsurance method of cost-sharing, then the coinsurance for an in-network or out-of-network service category cannot exceed 50%.
- If a plan uses a copay method of cost-sharing, then the copay for an out-of-network Original Medicare service category cannot exceed 50% of the average Medicare rate in that area.
- If a plan uses a copay method of cost-sharing, then the copay for an in-network Original Medicare service category cannot exceed 50% of the average contracted rate of that service.
- The 50% cap is in addition to any other caps. For service categories subject to fee-for-service cost-sharing limits – such as 20% coinsurance – the plan may not charge more than the fee-for-service cost-sharing limit.

Refunds

While all parties strive for accurate claim adjudication on the first pass, occasionally adjudication mistakes are detected that result in the need to adjust the amount paid. When the adjustment results in a reduction of the claim payment amount, Blue MA sends the provider notice of any overpayments through a refund request letter, as well as on the Explanation of Payment (EOP) in the section called “Adjustments”. The notice contains patient and claim information, including the patient account number for ease of tracking.

Blue MA requires providers allow recovery of the overpayment from a future remittance.

If the provider does not have claim payments sufficient to cover the overpayment during a 90-day period, Blue MA will send a follow-up requesting a check for the overpaid amount.

Note: If Blue MA must offset to recoup duplicate or erroneous overpayments, then providers must ensure the member is held harmless.

Providers must file a corrected claim to notify Blue MA of an overpayment, duplicate payment or to request a claim be voided.

Explanation of Payment

An Explanation of Payment (EOP) will accompany reimbursement. Providers receiving paper checks will receive a paper EOP. The check must be cashed or deposited within 180 days.

BCBSKS MA electronic remittance advices (ERAs) – also known as 835 files – are delivered by Zelis. To receive ERAs and ACH payments, register via the Zelis ePayment Center. For additional information, see the ePayment Center Training Guide, found in the MA Provider section of bcbsks.com.

Health Equity

BCBSKS is committed to addressing disparities in care by recognizing environmental and societal conditions that impact health, and by working to advance and improve health equity and inclusion. BCBSKS is committed to ensuring equitable access to MA services that are provided in a culturally competent manner.

Social Determinants of Health (SDoH) are socioeconomic factors that may affect a person's health, including environmental and societal conditions such as education and literacy, employment, health behaviors, housing, lack of adequate food or water, occupational exposure to risk factors, social support, transportation and violence.

Providers are encouraged to establish a process to improve the collection of SDoH data though submission of SDoH-related Z codes from the ICD-10-CM categories Z55-Z65. Accurate and complete documentation of SDoH is critical in identifying health disparities and developing interventions to address them in order to improve patient quality of care.

Chapter 5: Medical Records Requirements and Requests

Patient medical records and health information shall be maintained in accordance with current federal and state regulations, including prior consent when releasing any information contained in the medical record.

Blue MA providers must maintain timely and accurate medical, financial and administrative records related to services they render Blue MA members. The provider shall maintain such records and any related contracts for 10 years from date of service, unless a longer time period is required by applicable statutes or regulations.

The provider shall give without limitation – BCBSKS, Blue MA, U.S. Department of Health and Human Services and U.S. General Accounting Office or their designees – the right to audit, evaluate and inspect all books, contracts, medical records and patient care documentation maintained by the provider, which will be consistent with all federal, state and local laws. Such records will be used by CMS and Blue MA to assess compliance with standards that include, but are not limited to the following:

1. Complaints from members and/or providers;
2. HEDIS, STARs and other reviews, quality studies/audits or medical record review audits;
3. CMS and Blue MA reviews of risk adjustment data;
4. Post-pay reviews to determine whether services are reasonable and medically necessary and billed correctly to the plan.
5. Pre-service organization determinations, redeterminations and appeals decisions;
6. Medical, disease and utilization management-specific medical record reviews;
7. Suspicion of fraud, waste and/or abuse;
8. Periodic office visits for contracting purposes, and other reviews contracting appropriate and/or necessary.

Medical record content and requirements for all providers. For behavioral health providers, see the Behavioral Health Provider subsection in the Clinical Records section.

Clinical Record

Patient name and identification number must be on each page; address; date of birth or age; sex; marital status; home and work telephone numbers; emergency contact telephone number; guardianship information – if relevant; signed informed consent for immunization or invasive procedures; documentation of advance directives discussion – 18 and older; and a copy of the advance directive.

Medical Documentation

- History and physical; allergies; adverse reactions; problem list; medications; documentation of clinical findings evaluation for each visit; preventive services and other risk screening.
- Documentation of the offering or performance of a health maintenance exam within the first 12 months of membership. The exam includes:
  - Past medical, surgical and behavioral history, if applicable; chronic conditions; family history; medications; allergies; immunizations; social history; baseline physical assessment; age and sex specific risk screening exam; relevant review of systems, including depression and alcohol screening.
- Documentation of patient education – age and condition specific, if applicable; injury prevention; appropriate dietary instructions; lifestyle factors and self-exams.

Clinical Record – Progress Notes

- Identification of all providers participating in the member's care and information on services furnished by these providers.
- Reason for visit or chief complaint; documentation of clinical findings and evaluation for each visit; diagnosis; treatment/diagnostic tests/referrals; specific follow-up plans; follow-up plans from previous visits that have been addressed and follow-up report to referring provider, if applicable.

Clinical Record – Reports Content

All reviewed, signed and dated within 30 days of service or event

Lab; X-ray; referrals; consultations; discharge summaries; and consultations and summary reports from health care delivery organizations such as skilled nursing facilities, home health care, free-standing surgical centers and urgent care centers.

Behavioral Health Providers

- Chief complaint, review of systems and complete history of present illness
- Past psychiatric history
- Social history
- Substance use history
- Family psychiatric history
- Past medical history
- A medication list including dosages of each prescription, the dates of the initial prescription and refills
- At least one complete mental status examination, usually done at the time of initial

evaluation and containing each of the items below:

- Description of speech
- Description of thought processes
- Description of associations such as loose, tangential, circumstantial or intact
- Description of abnormal or psychotic thoughts
- Description of the patient's judgment

- Complete mental status examination
- Subsequent mental status examinations are documented at each visit and contain a description of orientation, speech, thought process, thought content – including any thoughts of harm, mood, affect and other information relevant to the case.
- A DSM-IV diagnosis consistent with the presenting problems, history, mental status examination and other assessment data
- Thorough assessment of risk of harm to self or others
- Informed consent indicating the member's acceptance of the treatment goals. Formal signed consent is not required except where required by law.
- To ensure coordination of the member's care, the treatment records shall reflect continuity and coordination of care with the member's primary care provider and as applicable; consultants, ancillary providers and health care institutions involved in the member's care.
  - Where it is required by law, proper documented written and signed consent for any release of information to outside entities has been obtained.
  - Progress notes shall describe the member's strengths and limitations in achieving the treatment goals and objectives.
  - Evidence that members who become homicidal, suicidal or unable to conduct activities of daily living are promptly referred to the appropriate level of care.

Other Medical Record Requirements

The provider of service for all face-to-face encounters must be identified on the medical record that includes signature and credentials for each date of service – can be located anywhere on record, including stationery. Stamped signatures are not acceptable.

Electronic signatures on electronic health records (EHR) are acceptable if authenticated at the end of each note in accordance with CMS authentication requirements. Electronic signatures must contain the following key elements: practitioner's name; credentials; date and a printed attestation statement, such as "accepted by;" "acknowledged by;" "approved by;" "authenticated by;" "closed by;" "digitally signed by;" "electronically authored by;" "finalized by;" "generated by;" "released by;" reviewed by;" "signed by;" or "validated by."

Provider signatures must meet the following criterion. Handwritten signatures may be used on handwritten, transcribed or dictated reports. Handwritten signatures are NOT valid on reports generated from an EHR system. The CMS Medicare Program Integrity Manual (Ch.3) states that a provider's handwritten signature is acceptable if it is:

- A fully legible signature, including credential.
- A legible first initial, last name and credential when letterhead, addressograph or other information on the page indicates the identity of the signer.
- An illegible signature, or initials when over a typed or printed name and credential.
- An illegible signature when the letterhead, addressograph or other information on the page indicates the identity and credential of the signer.

As stated by the CMS Medicare Program Integrity Manual, "Medicare requires that services provided/ordered be authenticated by the author." This means without a proper signature on the medical record entry, the record can be deemed invalid, thus hindering patient care. If using an EHR, you can consult with technical staff and software vendors to ensure the integrity of your documentation and signatures.

Confidentiality of Member Information

In accordance with the highest standards of professionalism – and as a requirement of provider contracts with BCBSKS – providers are obligated to protect the personal health information of Blue MA members from unauthorized or inappropriate use. All participating providers agree to follow applicable Health Insurance Portability and Accountability Act (HIPAA) privacy and security regulations, as well as any other confidentiality standards outlined in their provider agreements.

Routine Needs for Member Information

At the time of enrollment, members permit Blue MA to use and disclose their personal health information for routine needs such as:

- Bona fide research purposes
- Claims processing – payment, denial, investigation
- Coordination of care
- Customer service
- Data processing
- Fraud/Abuse investigations or reports
- Health care operations
- Medical management

- Performance measurement
- Provider credentialing or quality evaluation
- Quality assessment and measurement
- Regulatory audits or inquiries, subpoenas or other court or law enforcement procedures
- Required regulatory reports
- Risk Adjustment and HEDIS
- Routine audits
- Utilization review

Patient Assessment Forms (PAF)

The Patient Assessment Form (PAF) is a vital tool used to collect comprehensive information about our patients' health status. This form is sent to Blue MA providers to gather data on various aspects of a patient's medical history, current conditions and specific needs. The form includes a carefully curated list of health conditions that patients may be experiencing and chronic conditions that have been addressed at least once per year based on our thorough analysis and past diagnoses from providers.

We ask that you prioritize the completion of the PAF during patient visits. To complete the form, mark “confirm", “reject” or “N/A” on each diagnosis listed. Return the form to ProRiskAdjustment@bcbsks.com or fax to 785-290-0853. Providers should use their clinical judgment when completing. A claim for services rendered at the time of service, along with the confirmed diagnoses and any other diagnoses addressed during the visit, should still be submitted. Providers should follow documentation guidelines, including MEAT. Should you have any questions about the PAF or need further assistance, reach out to ProRiskAdjustment@bcbsks.com.

If Information is Needed for Other Reasons

If member-specific and identifiable information is needed for reasons other than those listed under “routine needs,” the member must sign specific authorization to release the information. If a member is unable to give prior authorization personally, Blue MA has a process to obtain this consent through a parent's or legal guardian's signature, signature by next of kin or attorney-in-fact. While specific authorizations are issued, the member has the right to limit the purposes for which the information can be used – and all concerned are obligated to respect expressed limitation.

Members Rights to Medical Records

Members have the right to access their medical records; therefore, each provider must have a mechanism in place to provide access. Members must not be interviewed about medical, financial or other private matters within the hearing range of other patients. Providers must have procedures in place for informed consent, storage and protection of medical records. Blue MA may verify these policies/procedures are in place as part of an on-site review process.

Blue MA Employees

As a condition of employment, all Blue MA employees must sign a statement agreeing to hold member information in strict confidence. Providers and all other Blue MA participating providers are bound by their contracts to comply with all state and federal laws protecting the privacy of members' personal health information.

Chapter 6: Network Terms, Conditions and Participation Guidelines

Providers requesting participation in the KPBMA network must agree to follow the CMS policies and procedures, terms and conditions and meet applicable credentialing standards. Network participation includes all eligible services provided by the legal business entity identified on the contract. The legal business entity is identified by the entities tax identification number, which may have multiple billing NPIs.

Providers who have questions about participation should contact their provider relations representative.

Section 1: Introduction

BCBSKS Blue MA allows members to use any provider, health professional, hospital or other Medicare provider in the U.S. who agrees to treat the member after having the opportunity to review these terms and conditions of payment, as long as the provider is eligible to provide health care services under Original Medicare or is eligible to be paid by Blue MA for benefits that are not covered under Original Medicare.

If you have an opportunity to review these terms and conditions of payment and you treat a Blue MA member, you will be “contracting” with Blue MA. Section 2 explains how the contracting process works. The rest of this document contains the contract between you as the provider and Blue MA. Any provider in the United States that meets the criteria in Section 2 is contracting with Blue MA for the services furnished to the member when the contracting conditions are met.

No prior authorization, prior notification or referral is required as a condition of coverage when medically necessary – plan-covered services are furnished to a member. However, a member or provider may request an Organization Determination before a service is provided to confirm the service is medically necessary and will be covered by the plan. Section 7 describes how a provider can request an Organization Determination.

Providers that have signed the Blue MA agreement are considered in-network providers. Members can still receive services from non-network providers who do not have a signed contract with us, as long as the provider meets the contracting criteria described in Section 2. These contracting providers are subject to all terms and conditions of payment described in this document.

The amount of cost-sharing a member pays an out-of-network provider may be more than the cost-sharing the member pays an in-network provider. Services the cost-sharing amount differs between in- and out-of- network providers are indicated in the Blue MA member Evidence of Coverage (EOC).

Section 2: When a Provider is Contracted to Accept Blue MA Terms and Conditions

A provider is considered contracted with Blue MA when the following three criteria are met:

- The provider is aware in advance of providing health care services that the patient is a member of Blue MA. All Blue MA members receive an ID card that includes a logo which clearly identifies them as members. The provider may validate eligibility by logging into Availity.com and selecting Blue MA from the resource tab on the BCBSKS payor space or calling BlueCard Eligibility at 800-676-BLUE (2583).
- The provider either has a copy of – or has reasonable access to – the Blue MA terms and conditions of payment in this document.
- The provider delivers covered services to a Blue MA member.

If all conditions are met, the provider is considered contracting and has agreed to the Blue MA terms and conditions of payment for that member specific to that visit. For example, if a patient shows an enrollment card identifying him or her as a Blue MA member and you provide services to that member, then you will be considered a contracting provider. It is the provider's responsibility to obtain and review the terms and conditions of payment before providing services, except in the case of emergency services as outlined in this document.

Note: Non-contracting providers can decide each time you see a Blue MA member whether to accept the Blue MA terms and conditions of payment. The decision to treat one plan member does not obligate you to treat other Blue MA members, nor does it obligate you to accept the same member for treatment at a subsequent visit.

If you DO NOT wish to accept the Blue MA terms and conditions of payment, then you should not provide services to a Blue MA member – except for emergency services. If you do provide non-emergency services, then you will be subject to these terms and conditions whether you agree with them or not. Emergency services will be treated as non-contracting providers and paid at the Original Medicare rate.

Section 3: Provider Qualifications and Requirements

In order to be paid by Blue MA for services provided to a member, you must do the following:

- Have a National Provider Identifier (NPI) to submit electronic transactions to Blue MA, in accordance with HIPAA requirements.
- Submit all claims – electronic or paper – to your local Blue plan.
- Provide services to Blue MA members within the scope of your licensure or certification.
- Only provide services that are covered by Blue MA and that meet Medicare's definition of medically necessary.
- Meet applicable Medicare certification requirements if you are an institutional provider, such as a hospital or skilled nursing facility.
- Not opted out of participation in the Medicare program under §1802(b) of the Social Security Act, unless providing emergency or urgently needed services.
- Not on the HHS Office of Inspectors General excluded and sanctioned provider list.
- Not a federal health care provider, except when providing emergency care.
- Comply with all applicable Medicare and other applicable federal health care program laws, regulations and program instructions that apply to covered services furnished to members, including laws protecting patient privacy rights and HIPAA.
- Agree to work with Blue MA to resolve any member grievance involving the provider – within the time frame required under federal law.
- Providers who are hospitals, home health agencies, skilled nursing facilities or comprehensive outpatient rehabilitation facilities must provide applicable beneficiary appeals notices. See Section 10 for specific requirements.
- Not charge more than the cost-sharing allowed under these terms and conditions – under any condition, including bankruptcy.

Section 4: Payment to Providers

- Blue MA reimburses contracting providers by the rate specified in the contract minus any member required cost-sharing for all medically necessary services covered by Medicare.
- Blue MA will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, then Blue MA will pay interest on the claim according to Medicare guidelines. See Section 5 for more information on prompt payment rules.
- Contracting providers furnishing services to Blue MA members must accept the specified amount in the contract minus applicable member cost-sharing as payment in full.

Member Benefits and Cost-Sharing

The member is responsible for cost-sharing fees. Providers should collect the applicable cost-sharing fees at the time of the service if possible. Providers can only collect the appropriate Blue MA co-payments or coinsurance amounts described in these terms and conditions. After collecting cost-sharing from the member, providers should bill Blue MA for covered services. Section 5 provides instructions on how to submit claims. **Note:** Blue MA may not hold members accountable for any cost-sharing – including deductibles, co-payments and coinsurance – for Medicare-covered preventive services that are subject to zero cost-sharing.

If a member is a dual-eligible Medicare beneficiary – enrolled in Blue MA and a State Medicaid program – the provider cannot collect any cost-sharing for Original Medicare services from the member at the time of service when the State is responsible for paying amounts such as nominal co-payments authorized under the Medicaid State plan. The provider may only accept the Blue MA payment – plus any Medicaid co-payment amounts – as payment in full, or must bill the appropriate State source.

To view a complete list of covered services and member cost-sharing amounts under Blue MA, log onto Availity.com or call 800-240-0577 to obtain more information about covered benefits, plan payment rates and member cost-sharing amounts. Be sure to have the member's ID number, including the three-character alpha prefix.

Blue MA follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by Blue MA, unless specified by the plan. Information on obtaining a Coverage Determination can be found in Section 7. BCBSKS Blue MA does not require members or providers to obtain prior notification or referrals from the plan as a condition of coverage.

Note: Medicare supplemental policies – commonly referred to as Medigap plans – cannot cover cost-sharing amounts for MA plans. All cost-sharing is the member's responsibility.

Hold-harmless Requirements

In no event, including but not limited to non-payment by Blue MA, insolvency of Blue MA and/or breach of these terms and conditions, shall a contracting provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse

against a member or persons acting on their behalf for plan-covered services provided under these terms and conditions. This provision shall not prohibit the collection of any applicable coinsurance, co-payments or deductibles billed in accordance with the terms of the member's benefit plan.

If any payment amount is mistakenly or erroneously collected from a member, a refund of that amount must be made to the member.

Section 5: Filing a Claim

- You must submit a claim to Blue MA for an Original Medicare-covered service within the same time frame you would have to submit under Original Medicare, which is within 365 days after the date of service. Failure to be timely with claim submissions may result in non-payment.
- Submit claims using the standard CMS-1500, UB-04 or the appropriate electronic filing format.
- Use the same coding rules and billing guidelines as Original Medicare, including Medicare CPT Codes, HCPCS codes and defined modifiers. Bill diagnosis codes to the highest level of specificity. Some exceptions may apply. Visit our Medicare Advantage Provider web page to see specific billing guidelines that do not follow Medicare’s guidelines.
- Include National Provider Identifier (NPI), the member's ID, including three-digit prefix and the date(s) of service.
- Include valid taxonomy code for all claims.
- For providers that are paid based upon interim rates, include a copy of your current interim rate letter with your claim – if the interim rate has changed since your previous claim submission.
- Coordination of Benefits: All Medicare secondary payor rules apply. Providers should identify primary coverage and provide information to Blue MA at the time of billing.
- Submit both electronic and paper claims to your local Blue Plan.
- If you have problems submitting claims to BCBSKS or have any billing questions, contact our technical billing resource at 800-240-0577.

Section 6: Maintaining Medical Records and Allowing Audits

Contracting providers shall maintain timely and accurate medical, financial and administrative records related to services rendered to Blue MA members. The provider shall maintain records for at least 10 years from the date of service – unless additional time is required by applicable statutes or regulations.

Contracting providers must provide Blue MA, the Department of Health and Human Services, the Comptroller General or their designees access to any books, contracts, medical records, patient-care documentation and other records maintained by the provider pertaining to services rendered to Medicare beneficiaries enrolled in an MA plan, consistent with federal and state privacy laws. Such records will be used for CMS audits of risk adjustment data, upon which CMS capitation payments to Blue MA are based. Providers are required to furnish member medical records without charge when the medical records are required for government use.

Blue MA also may request records for activities in the following situations: audits of risk adjustment data; HEDIS validation; determinations of whether services are covered under the plan, whether services are reasonable and medically necessary and whether the plan was billed correctly for the service; to investigate fraud and abuse; and in order to make Coverage Determinations.

Blue MA will not use these records for any purpose other than the intended use. Providers are required to furnish these member medical records without charge.

Blue MA will not use medical record reviews to create artificial barriers that would delay payments to providers. Both mandatory and voluntary provision of medical records must be consistent with HIPAA privacy law requirements.

Section 7: Getting a Pre-Service Coverage/Organization Determination

BCBSKS Blue MA plans do not require predetermination, pre-service authorization or prior authorization for covered outpatient services – Original Medicare Part B services. See Chapter 13: Authorizations and Clinical Review for information on services requiring prior-authorization.

Providers with pre-service coverage or benefits questions should call Blue MA Provider Services at 800-240-0577, BlueCard Eligibility at 800-676-BLUE (2583) or the number on the back of the member's identification card for out-of-state members.

Members or their authorized representative may choose to obtain a written pre-service Organization Determination (Medical/Part C) or Coverage Determination (Pharmacy/Part D) from Blue MA before furnishing a service in order to confirm whether the service is medically necessary and will be covered by Blue MA. Members should contact Blue MA member services for additional information. Blue MA will notify the provider and member of the decision within 14 days for an Organization Determination and 72 hours for Coverage

Determination, with a possible 14-day extension either because of the member's request or Blue MA justification that the delay is in the member's best interest.

In the absence of a pre-service Determination, Blue MA may retroactively deny payment for a service furnished to a member if the service is determined not covered or was not medically necessary.

Network Exception

Members may have a higher cost-share for services or items received from an out-of-network provider. Members have the option of requesting a network exception for specialized services when there is limited or no access to network providers.

To request a network exception, members should refer to their evidence of coverage and/or contact Blue MA members services or contact the plan in writing.

Exceptions include emergency care, urgently needed services when the network is not available and out-of-area dialysis services.

Section 8: Provider Appeals/Payment Dispute Resolution Process

If you believe that the payment amount you received for a service is less than the amount indicated in the Blue MA terms and conditions of payment, you have the right to dispute the payment amount by following the Blue MA Appeals and Payment Dispute process.

Note: In cases where Blue MA re-adjudicates a claim, the provider has an additional 65 days from the date you are notified to dispute the re-adjudicated claim.

If Blue MA agrees with the reason for your payment dispute, Blue MA will pay you the additional amount you are requesting, including any interest that is due. Blue MA will inform you in writing if the decision is unfavorable and no additional amount is owed.

Section 9: Member and Provider Appeals and Grievances

Members have the right to file appeals and grievances with Blue MA when concerns or problems arise related to coverage or care. Members may appeal a decision made by BlueMA to deny coverage or payment for a service or benefit they believe should be covered. Members should file a grievance for all other types of complaints not related to the provision or payment for health care.

A provider who is providing treatment may – upon notifying the member – appeal pre-service Determination denials to the plan on behalf of the member. The provider may also appeal post-service Determination denials as a representative, or sign a Waiver of Liability – promising to hold the member harmless regardless of the outcome – and appeal the denial

using the appeal process. There must be potential member liability such as an actual claim for services already rendered as opposed to a pre-service Organization/Coverage Determination in order for a provider to appeal utilizing the member-appeal process.

A non-contracting provider may appeal Organization/Coverage Determinations on behalf of the member as a representative or sign a Waiver of Liability – promising to hold the member harmless regardless of the outcome – and appeal post-service Organization Determinations such as claims using the member-appeal process. There must be potential member liability in order for a provider to appeal utilizing the member-appeal process.

If a provider appeals using the member-appeal process, the provider agrees to abide by the statutes, regulations, standards and guidelines applicable to the Medicare PPO Member appeals and grievance processes. See Chapter 14: Appeals and Payment Disputes for a complete outline of the Appeals process.

Section 10: Providing Members with Notice of Appeal Rights – Requirements for Hospitals, SNFs, CORFs and HHAs

Hospitals must notify all Medicare beneficiaries – including Blue MA members – who are hospital inpatients about discharge appeal rights and comply with the requirements for providing the Important Message from Medicare About Your Rights form. Skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities must notify Medicare beneficiaries – including Blue MA members – about their right to appeal a termination of services decision and comply with the requirements for providing the Notice of Medicare Non-Coverage (NOMNC). As directed in the instructions, the NOMNC should contain Blue MA contact information somewhere on the form.

Hospitals, home health agencies, comprehensive outpatient rehabilitation facilities and skilled nursing facilities must provide members with a detailed explanation if a member notifies the Quality Improvement Organization (QIO) that the member wishes to appeal a decision regarding a hospital discharge – Detailed Notice of Discharge – or termination of home health agency, comprehensive outpatient rehabilitation facility or skilled nursing facility services – Detailed Explanation of Non-Coverage – within the time frames specified by law.

Chapter 7: Pharmacy

Pharmacy Formulary

Providers may access the Medicare Advantage Formulary by using the online search tool.

Blue MA Part D Prescriber Requirements

CMS has made changes for any provider or other eligible provider who prescribe Medicare Advantage (Part D) covered drugs. Providers must either enroll in the Original Medicare program or “opt out” to prescribe covered medications to patients who have a Part D prescription drug benefit plan. Providers who are not enrolled should do so as soon as possible to allow for the processing of applications and to ensure enrollees will continue to receive their Part D covered prescriptions.

Note: Part D benefit plans will not be allowed to cover drugs that are prescribed by providers who have not enrolled in or have not opted out of the Medicare program.

To comply with the CMS change, Blue MA will require all providers to be enrolled in Original Medicare before they can be considered for participation in the Blue MA network.

Utilization Management

Certain drugs must undergo a criteria-based approval process before a coverage decision. Blue MA's pharmacy and therapeutics committee reviews medications based on safety, efficacy and clinical benefit, and may make additions or deletions to the list of drugs requiring prior authorization and to the list of drugs that have quantity limits. Drugs requiring prior authorization or quantity limits will be noted on the formulary.

Call 866-230-7265 with questions related to coverage for a specific drug.

Excluded Medications

Blue MA does not cover all prescription drugs. Here are three general rules about drugs that Medicare plans will not cover under Part D.

1. Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
2. Blue MA cannot cover a drug purchased outside the United States and its territories.
3. “Off-label use” is any use other than those indicated on a drug’s label, as approved by the Food and Drug Administration. Generally, coverage for “off-label use” is allowed only when the use is supported by certain reference books, such as the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its

successor. If the use is not supported by any of these reference books, the plan cannot cover its “off-label use.”

By law, these categories of drugs are not covered by Medicare drug plans:

- Non-prescription drugs
- Drugs used to promote fertility
- Drugs used for the relief of cough or cold symptoms
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs used for the treatment of sexual or erectile dysfunction
- Drugs used for treatment of anorexia, weight loss or weight gain
- Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

For additional information about prescription drug coverage, call 800-240-0577.

Chapter 8: Provider Information

Information Changes/Updates

CMS requires providers to attest to the accuracy of directory data every 90 days with the health plan. Providers who are contracted as a Blue MA provider are required to attest to their information through the secure BCBSKS Provider Portal known as BlueAccess. Using both the “Provider Portal” attestation and “CMS Demographics” attestation, providers will be satisfying both the CMS requirement and the Blue MA requirement.

Requests to Term from Blue MA

The request to term network status with Blue MA must be received in writing by Sept. 2 for the upcoming year. This CAP time frame does not follow the same time frame as the CMS renewal process.

Provider Communication

Communication is an important factor in delivering quality services to members and educating providers. In an effort to communicate updates, improvements in policies and procedures, topics of interests and other pertinent information, Blue MA will make available on the bcbsks.com MA website resources to assists providers, and will send an email notice to providers enrolled in eNews notifications when new information is available. Like Original Medicare, the Blue MA communications will be conducted electronically.

Fraud, Waste and Abuse

Fraud is the intentional misrepresentation that an individual makes that could result in an unauthorized benefit to himself or herself, or to another person. The most frequent kind of fraud arises from a false statement or misrepresentation made regarding entitlement or payment under Medicare.

Waste includes actions that may directly or indirectly result in the following: unnecessary costs to the Medicare program, improper payment, payment for services that fail to meet professionally recognized standards of care or services that are medically unnecessary.

Abuse involves payment for items or services when there is no legal entitlement to that payment and the provider has not knowingly and/or intentionally misrepresented facts to obtain payment.

Anti-Fraud, Waste and Abuse Policy Statement

As an integral part of the compliance plan, Blue MA supports and maintains provisions for the prevention, detection and correction of fraud, waste and abuse related to all benefits of the plan, including Medicare operations. Under the direction of the Board, CEO, compliance officer and compliance committees, comprehensive written policies, procedures and standards of conduct are implemented to comply with all applicable federal and state standards.

Annual Compliance Training for Providers

As a contracted provider, first-tier, downstream and related entities (FDR) that provide services to our Blue MA and Medicare Part D members, you are required to complete annual Medicare compliance training. It also is the provider's responsibility to ensure that all staff serving Medicare Beneficiaries completes the annual compliance training. This includes front office, lab techs, nurses, billing and any other ancillary staff. Compliance training should be completed annually no later than Dec. 31 or within 90 days of hire for any new employees.

To ensure this requirement is met and to largely reduce the duplicative training required of FDRs by multiple organizations, CMS developed web-based compliance training. FDRs have two options for ensuring its entities and employees have satisfied the general compliance and Fraud, Waste and Abuse training requirement as described in the regulations and sub-regulatory guidelines.

1. FDRs /DEs and their employees can complete the general compliance and/or FWA training modules located on the CMS Medicare Learning Network (MLN). Once an individual completes the training, the system will generate a certificate of completion. The MLN certificate of completion must be retained by all FDRs/DEs for 10 years. This training is also available as a pdf at cms.gov.
2. FDRs/DEs may download, view, or print the content of the CMS standardized training modules from the CMS website to incorporate into their organization's existing compliance training materials/systems. To ensure the integrity and completeness of the training, CMS training content cannot be modified; however, an organization can add to the CMS training to cover topics specific to their organization.

Training materials are available on CMS's MLN Network. All training documents – including a copy of the training materials and training logs – must be retained by your organization for 10 years, in accordance with CMS record retention guidelines. All documentation is subject to random audit by Blue MA or may be requested as part of a Compliance Program Audit by CMS or CMS designees.

Chapter 9: HEDIS and Stars
Quality Improvement Program

Blue MA is committed to improving the quality of health care for members. Blue MA maintains a quality improvement program that continuously reviews and identifies clinical care and services members receive and routinely measures the results to ensure members are satisfied and expectations are met.

The Blue MA Quality Improvement (QI) unit develops an annual quality improvement program that includes specific improvement initiatives and measurable objectives. Activities that are monitored for QI opportunities include:

- Appointment and after-hours access monitoring
- Quality of care concerns
- Member satisfaction
- Chronic care management
- Utilization management
- Health outcomes
- Medical record documentation compliance
- Quality improvement projects
- Healthcare Effectiveness Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Provider and Systems Survey (CAHPS) and Health Outcomes Survey (HOS)
- Regulatory compliance

Healthcare Effectiveness Data and Information Set

Healthcare Effectiveness Data and Information Set (HEDIS) is a set of nationally standardized measures commonly used in the managed care industry to measure a health plan's performance during the previous calendar year. Blue MA follows HEDIS reporting requirements established by the National Committee for Quality Assurance (NCQA) and CMS. Audited HEDIS reports are used to identify quality improvement opportunities and develop quality-related initiatives.

HEDIS measures Blue MA focuses on may include but are not limited to the following:

- Acute hospital utilization
- Adults access to preventive/ambulatory health services
- Annual flu vaccine
- Antidepressant medication management

- Breast cancer screening – women 50-74 years of age
- Care of older adults
- Colorectal cancer screening – members 45-75 years of age
- Controlling high blood pressure
- Continuous Beta Blocker Treatment
- Diabetes care – eye exam
- Diabetes care – blood sugar controlled
- Fall risk management
- Flu vaccinations for adults age 65 and older
- Follow-up after emergency department visit for alcohol and other drug dependence – within seven and 30 days
- Follow-up after emergency department visit for mental illness – within seven and 30 days
- Follow-up after emergency department visit for people with high risk chronic conditions – within seven and 30 days
- Follow-up after hospitalization for mental illness – within seven and 30 days
- Follow-up after Emergency Department visit for people with multiple high-risk chronic conditions
- High risk medications
- Improving bladder control
- Inpatient utilization – general hospital/acute care
- Kidney health evaluation for patients with diabetes
- Medication reconciliation post-discharge
- Medication therapy management
- Monitoring physical activity
- Concurrent use of opioids and benzodiazepines
- Osteoporosis management in women who had a fracture – women age 67-85
- Pharmacotherapy management of COPD exacerbation
- Polypharmacy use of multiple anticholinergic or CNS active medications in older adults
- Plan all-cause re-admissions
- Statin therapy for patients with cardiovascular disease
- Statin therapy for patients with diabetes
- Substance use disorder treatment
- Transitions of care

CMS Quality Star Ratings Program

CMS evaluates health insurance plans and issues star ratings annually. The CMS plan rating uses quality measurements widely recognized within the health care and health insurance industry to provide an objective method for evaluating health plan quality. The overall plan rating combines scores for the types of services Blue MA offers. CMS compiles its overall score for quality of services based on measures such as:

- How Blue MA helps members stay healthy through preventive screenings, tests and vaccines, and how often they receive preventive services to help them stay healthy
- How Blue MA helps members manage chronic conditions
- Scores of member satisfaction with Blue MA
- How often members filed a complaint against Blue MA
- How well Blue MA handles calls from members

In addition, because Blue MA offers prescription drug coverage, CMS also evaluates Blue MA prescription drug plans for the quality of services covered such as:

- Drug plan customer service
- Drug plan member complaints and Medicare audit findings
- Member experience with drug plan
- Drug pricing and patient safety

CMS Star Ratings

CMS developed a set of quality performance ratings for health plans that includes specific clinical, member perception and operational measures. The quality performance ratings include approximately 40 measures in five domains of care. Each of the measures has a defined “weight” used in calculating the star ratings. Percentile performance is converted to stars – based on CMS specifications – as one through five stars, where five stars indicate high performance. This rating system applies to all Medicare Advantage lines of business: health maintenance organizations, preferred provider organizations and prescription drug plans. In addition, the ratings are posted on the CMS consumer website medicare.gov to help beneficiaries choose an MA plan offered in their area.

How are Star Ratings Derived?

A health plan's star rating is based on measures in five categories:

Data source	Description	# of Metrics
HEDIS Part C	Subset of broad HEDIS data set used to measure health plans ability to drive compliance with preventive care guidelines and evidence-based medical treatment guidelines related to clinical measures.	10
HEDIS Part D	Subset of broad HEDIS data set used to measure health plans ability to drive compliance with preventive care guidelines and evidence-based medical treatment guidelines related to pharmacy measures.	4
CAHPS	Survey of randomly selected members focusing on member perception of their ability to access quality medical care.	9
HOS	Survey of randomly selected members focusing on member perception of their ability to access quality medical care.	4
CMS	Administrative data collected by CMS related to health plan service capabilities and performance.	9
Independent review entity	Timeliness and fairness of decision associated with appeals.	4

The methodology used by CMS is subject to change. Final guidelines are released each fall.

The star rating was developed to:

- Help consumers choose plans on medicare.gov.
- Strengthen CMS' ability to distinguish stronger health plans for participation in Medicare Parts C and D.
- Penalize consistently poor performing health plans.
- Strengthen beneficiary protections.

What is the Star Measurement Timeline?

CMS uses the Star rating system to validate data results as a new method of reviewing operational systems and verifying validity of data. Blue MA is accountable for the care provided to their enrollees by providers, hospitals and other care providers. The measures included in the Star measurement timeline and demonstrated clinical, perception, operations and the published CMS rating for the review period. The data is a tool for quality improvement of internal and external processes.

Benefits

In most instances, the value of improving performance is well worth the investment for the health plan, the members, the provider community and the individual's needs.

Member benefits	Provider benefits	Blue MA benefits
Ensure members receive quality care that leads to positive health outcomes.	Improve care quality and health outcomes.	Improve care quality and health outcomes.
Greater health plan focus on access to care.	Improved patient relations.	Improved provider relations.
Improved relations with doctors.	Improved health plan relations.	Improved member relations.
Increased levels of customer service.	Increased awareness of patient safety issues.	Process improvement.
Early detection of disease and health care that matches.	Greater focus on preventive medicine and early disease detection.	Key component in financing health care benefits for MA plan enrollees.
	Strong benefits to support chronic condition management.	
	Partner with MA providers to encourage patients to get preventive screenings and procedures, and to provide support in achieving certain disease.	

Goals for the Five-Star Ratings System

Blue MA is strongly committed to providing high-quality Medicare health plans that meet or exceed all CMS quality benchmarks. Through the Medicare Advantage Five-Star Rating Goals, Blue MA works with providers and members to ensure members received appropriate and timely care, chronic conditions are well-managed, members are pleased with the level of service from their health plan and care providers, and health plans follow CMS operational and marketing requirements.

Blue MA uses mailings and personal and automated phone calls to remind members about needed care and how to help maintain optimal health.

Blue MA partners with our providers by identifying Blue MA patients who need specific medical services so providers can contact those patients and schedule necessary services.

Provider Tips for Improving Star Ratings and Quality Care

- Continue to encourage patients to obtain preventive screenings annually or when recommended.
- Create office practices to identify noncompliant patients at the time of their appointment.
- Submit complete and correct encounters/claims with appropriate codes.
- Understand the metrics in the CMS rating system because some are part of Blue MA's Provider Performance Excellence Program (PEP) and you may be eligible to participate.
- Review the gap in care files listing members with open gaps.
- Ensure documentation includes assessment of cognitive and functional status.
- Identify opportunities for you or your office to have an impact.

Chapter 10: Case Management Services

The Blue MA Case Management program promotes cost-effective and medically appropriate care and services. Components include case management, care coordination, wellness and chronic condition management programs.

Examples of services provided by the care management team include:

- Case management activities.
- Wellness programs – tobacco cessation, weight and stress management.
- Chronic disease management – diabetes, CAD, CHF, COPD, Asthma, HTN, HL.
- Coordination of health care services with chronic condition management programs.
- Coordination of care among medical care providers and between medical and behavioral health care providers.
- Member health care education.
- Discharge planning.
- Health risk assessments.

Contacting Case Management

Providers can contact Case Management during normal business hours at the number listed, unless directed to use another number in this chapter. Normal business hours are 8 a.m. to 4:30 p.m., Monday through Friday. The department is closed on all major holidays.

- **Case Management** – 800-432-0216 ext. 6673
- **Care Transitions to Home (Discharge Call Outreach)** – 800-432-0216 ext. 6677 Confidential voice messages can be left any time and will be returned within one business day.
- **Contacting Disease Management and Wellness**
  Providers can contact Disease Management and Wellness during normal business hours at the number listed, unless directed to use another number in this chapter. Normal business hours are 8 a.m. to 4:30 p.m., Monday through Thursday, and 7 a.m. to 3:30 p.m. on Friday. The department is closed on all major holidays. Provider referral form can be located on our website.
- **Disease Management and Wellness Programs** – 800-520-3137. Confidential voice messages can be left any time and will be returned within one business day.

Chapter 11: Utilization Management

Monitoring Utilization

Blue MA uses various mechanisms to monitor and identify potential underutilization and overutilization of services. This helps ensure Blue MA members receive the medical services required for health promotion, as well as acute and chronic illness management. Examples of these mechanisms include:

- Review of HEDIS data.
- Results of member satisfaction surveys.
- Rate of inpatient admissions.
- Rate of emergency services.
- Review of alternative levels of care such as observation.

Affirmation Statement

Blue MA bases its utilization decisions about care and service solely on their appropriateness in relation to each member's specific medical condition. Blue MA review staff have no compensatory arrangements that encourage denial of coverage or service. Clinicians employed by Blue MA do not receive bonuses or incentives based on their review decisions. Blue MA bases all clinical review decisions on medical necessity by applying approved clinical criteria and ensures that the care provided is within the limits of the member's plan coverage.

Appropriate Professionals

Blue MA continues to demonstrate its commitment to a fair and thorough utilization decision process by working collaboratively with its participating providers. A plan medical director reviews all medical necessity determinations that cannot be approved through the application of decision criteria by Blue MA Care Management nurses. It may be necessary for the plan medical director to contact providers for additional information about their patients to assist in making a determination. Providers are encouraged to discuss any decision with a plan medical director by contacting Care Management at 800-325-6201 between 8 a.m. and 6 p.m. Monday through Friday. To contact a plan medical director after normal business hours, call 800-331-0192.

Contacting Utilization Management

Providers can contact Care Management during normal business hours at the number listed, unless directed to use another number in this chapter. Normal business hours are 8 a.m. to 6 p.m., Monday through Friday. The department is closed for lunch from 11 a.m. to noon daily and on all major holidays.

Utilization Management – 800-325-6201

After Hours – 800-331-0192

Chapter 12: Authorizations and Clinical Review

Blue MA clinical review process is established to do the following:

- Ensure uniformity in the provision of medical care.
- Ensure the medical appropriateness and cost effectiveness of certain services.
- Improve the overall quality of care Blue MA members receive.
- Lower the cost of coverage for Blue MA members.

Blue MA determines which services are subject to clinical review by analyzing the plan's utilization data and comparing it with the following:

- Internal goals.
- External benchmarks such as HEDIS.

Other factors taken into consideration include:

- Procedures high in cost or volume.
- Trends toward increasing use of a procedure or service.
- Evidence of or reason to suspect actual or potential misuse.
- Variations in practice patterns.

In deciding which services require clinical review, Blue MA looks carefully at the following:

- The negative impact the proposed review program might have on providers.
- The acceptability of any existing criteria, such as InterQual criteria, Medicare guidelines or information from the medical literature.
- Administrative impacts to the health plan and providers.
- Market analysis or benchmarking to determine whether the procedure is within the range of reasonable or accepted practices.
- Net cost savings – considering any possible administrative cost offset.

Criteria and Guidelines for Decisions

The criteria adopted by the plan are updated annually and include CMS Medicare Guidelines, as well as the following:

Criteria	Application
InterQual Acute – Adult	• Inpatient admissions • Continued stay and discharge readiness
InterQual Level of Care – Sub-acute and Skilled Nursing Facility	• Sub-acute and skilled nursing facility admissions

Criteria	Application
InterQual Rehabilitation – Adult	• Inpatient admissions • Continued stay and discharge readiness
InterQual Level of Care – Long-term Acute Care	• Long-term acute care facility admissions
InterQual Procedures – Adult	• Inpatient surgery and invasive procedures

Clinical Review Determination

In addition to reviewing clinical information, Blue MA evaluates the following:

- The member's eligibility coverage and benefits.
- The medical need for the service.
- The appropriateness of the service and setting.

If additional clinical information is required to approve the service, a Blue MA Care Management representative calls the provider to ensure that all needed information is received in a timely manner. A written request may also be sent to the member or provider receiving the authorization.

Clinical Review Required

Blue MA must review and approve select services before they are provided. The primary reason for clinical review is to determine whether the service is medically necessary, whether it is performed in the appropriate setting and whether it is a benefit. Clinical information is necessary for all services that require clinical review to determine medical necessity.

A complete list of the clinical criteria and required information that apply to each requested service for BCBSKS Blue MA plans can be found in this section:

- Acute Hospital Admissions – Notification required next business day.
- 14-Day Bundling for Re-admissions – Notification required next business day.
- Skilled Nursing Facility Admissions – Notification required before admission and before exhausted days for concurrent review.
- Long-Term Acute Care Hospital Admissions – Notification required before admission and before exhausted days for concurrent review.
- Inpatient Rehabilitation – Notification required before admission and before exhausted days for concurrent review.

Inquiries Related to Clinical Review Determinations

Providers wanting to discuss a Clinic Review Determination should contact Medical Management, 800-240-0577. The Medical Information Specialist will gather information related to the inquiry. The call will be forwarded to a clinic staff person to review and discuss details

with the provider clinical staff. If the request is to have a peer-to-peer conversation about the case, a call will be arranged with physician peer. If after the peer-to-peer conversation the Clinical Review Determination is upheld, the provider may begin the appeals process that is outlined in Chapter 14.

Submit Required Clinical Information with the Initial Review Request

Providers are encouraged to submit the required clinical information with the initial request for clinical review sent via fax.

Clinical information for acute and post-acute hospital admissions can be submitted by faxing it to Care Management at 877-218-9089.

Blue MA is required by Medicare and other regulatory agencies to notify members as to what clinical information is needed to process a request for clinical review. When providers submit the clinical information with the initial request, it decreases the number of letters Blue MA is required to send to members.

Guidelines for Observations and Inpatient Hospital Admissions

Contracted facilities must notify Blue MA of all admissions and provide clinical information within one business day of the admission. Timely notification helps ensure that Blue MA members receive care in the most appropriate setting, that Blue MA is involved in the evaluation and coordination of discharge planning and that there are appropriate referrals to case management for members who need those services – including those managing active disease processes, those demonstrating high use of health resources or those who are at high risk for health complications.

Providers should notify Blue MA of admissions by phone at 800-325-6201, by fax at 877-218-9089 or through the Symphony portal available through Availity Essentials > Payer Spaces > BCBSKS > BlueMA Medical > Office Management > Authorizations.

Post-service requests can also be initiated by contacting Blue MA Care Management.

Blue MA nurses conduct admission reviews via telephone or fax by obtaining information from the hospital's utilization review staff. Blue MA nurses also speak to attending providers when necessary to obtain information.

Once authorization is obtained, the facility will be provided with an authorization number that is valid for the entire length of stay for the acute-care admission.

Emergency Admissions

When an admission occurs through the emergency room, Blue MA asks that the facility use best efforts to contact the primary care provider before admission or soon after admission to discuss the member's medical condition and to coordinate care.

Elective Admissions

Primary care and specialist providers are required to notify Blue MA at least 14 days before arranging elective inpatient, whenever possible.

Blue MA reviews the request to determine whether the setting is appropriate and, if required, meets criteria. Blue MA notifies the member, primary care provider, attending provider and facility of the determination.

Facilities must provide clinical information to Care Management within one business day of the elective admission.

Obstetrical Admissions

Blue MA requires facilities provide both admission and discharge information on deliveries via fax or phone to the Care Management Department. For all deliveries, the facility should notify Blue MA one day after discharge. The following information must be provided:

- Admission date, delivery date and discharge date.
- Type of delivery.
- Whether the baby was born alive.
- Whether both mother and baby were discharged alive.

Observation Care

Observation care is a well-defined set of specific, clinically appropriate services that are described as follows:

- Services include ongoing short-term treatment, assessment and reassessment.
- Services are furnished while a decision is being made regarding whether a member requires further treatment as a hospital inpatient or is able to be discharged from the observation bed.

Observation stays of up to 48 hours may be eligible for reimbursement when providers need more time to evaluate and assess a member's needs in order to determine the appropriate level of care.

Requirements for Observation Stays

Observation stays do not require any prior authorization or pre-notification requirements.

Options Available Beyond the Observation Period

For members who require care beyond the observation period, the options available are:

- Contact Care Management clinical staff to discuss alternate treatment options such as home care or home infusion therapy.
- Request an inpatient admission.

Note: If the member is not discharged within the 48-hour observation stay limit covered by the plan, the provider should re-evaluate the member's need for an inpatient admission. Approval of an inpatient admission is dependent upon criteria review and plan determination.

Two-Midnight Rule

The Two-Midnight Rule, which also applies to inpatient psychiatric care, states that coverage for an inpatient admission must be provided when – based on consideration of complex medical factors documented in the medical record – the admitting physician expects the patient to require hospital care that crosses two or more midnights. Exceptions include the following situations: the admitting physician does not expect care will cross two midnights, but inpatient care is nonetheless deemed to be necessary based on complex medical factors documented in the medical record with case-by-case exception; admission is for a procedure on the Inpatient Only List; new mechanical ventilation.

Medical Necessity Considerations – Inpatient vs. Observation Stays

When Blue MA members are admitted for inpatient care, the process that is used to determine whether their stay is medically necessary is different than the process Original Medicare uses. Guidelines that clarify how medical necessity is determined:

- InterQual criteria is used to make determinations of medical necessity for all members.
- Blue MA does not require provider certification of inpatient status to ensure that a member's inpatient admission is reasonable and necessary. For Original Medicare patients; however, this certification is mandated in the Original Medicare rule found in the Code of Federal Regulations, under 42 CFR Part 424 subpart B and 42 CFR 412.3.
- When the application of InterQual criteria results in a member's inpatient admission is changed to observation status, all services should be billed as observation, including all charges. No services should be billed as ancillary only (TOB 0121).
- The clinical review process takes precedence ahead of the Original Medicare coverage determination process. This applies to requests related to any inpatient vs. observation stay, including a denied inpatient stay billed as observation, inpatient-only procedures and the "two midnight" rule.

Review of Inpatient Re-admissions

Inpatient re-admissions that occur within 14 days of discharge from a facility reimbursed by diagnosis-related groups (DRGs) when the member withthe same or a similar diagnosis are reviewed. Each re-admission is reviewed to determine whether it resulted from one or more of the following:

- A premature discharge or a continuity of care issue.
- A lack of or inadequate discharge planning.
- A planned re-admission.
- Surgical complications.

In some instances, two admissions are combined into one for purposes of the DRG reimbursement.

Guidelines for Submitting Skilled Nursing, Long-Term Acute Care and Inpatient Rehabilitation Facilities

Facilities must notify Blue MA of all post-acute admissions and provide clinical information before the admission for initial requests and before the expiration of approved days for continued stay review requests. Timely notification helps ensure members receive care in the most appropriate setting, Blue MA is involved in the evaluation and coordination of discharge planning and appropriate referrals to Case Management for members who need those services – including those managing active disease processes, those demonstrating high use of health resources or those who are at high risk for health complications.

Providers should notify Blue MA of admissions by phone at 800-325-6201 or by fax at 877-218-9089.

Requests for transitional or discharge planning services are required to be handled during the business hours..

In the event that an emergent need arises after hours or on weekends or holidays, providers can call 800-331-0192 to reach an after-hours care manager.

Case Management nurses conduct admission and concurrent reviews via telephone or fax by obtaining information from the hospital’s utilization review staff. Nurses also speak to attending providers when necessary to obtain information.

For post-acute admissions, if authorization is obtained it will be valid for a defined length of time. If additional days are needed, a continued stay review will be required before the

expiration of the initial approved days.

Prior Authorization for Behavioral Health Services

All mental health and substance use inpatient admissions or concurrent reviews require prior authorization. This process includes acute detoxification admissions, which are processed as a medical service and follow the same prior authorization requirements for inpatient admission. Blue MA partners with Lucet to perform utilization and medical necessity determinations for behavioral health claims.

All mental health and substance use inpatient admissions or concurrent reviews should be submitted using WebPass. Services that require authorization through the WebPass system include:

- Initial admissions for inpatient mental health/psychiatric and substance use services, including inpatient detoxification in behavioral health settings and inpatient ECT.
- Extensions of inpatient mental health/psychiatric and substance use services

Discharges should also be communicated through WebPass Outpatient behavioral health services for Blue MA. Members do not require prior authorization.

Lucet may be reached at 877-589-1635 for general assistance with behavioral health services including:

- Arranging services or requesting authorization for services.
- Obtaining criteria used to make an authorization decision.

Decision Criteria and Guidelines

Criteria for certifying services are based on input from appropriate providers, nationally recognized criteria adopted by the plan or a combination of both. Individual circumstances of a member are taken into consideration when applying the criteria, as are characteristics of the local delivery system such as the following:

- Availability of skilled nursing facilities, sub-acute care facilities or home care in the network to support the member after discharge.
- Member's coverage of benefits for skilled nursing facilities, sub-acute care facilities or home care, where needed.
- Ability of network hospital(s) to provide all recommended services within the established length of stay.

The review criteria are available to providers upon request by calling Utilization Management at 800-325-6201.

Discharge Planning

Discharge planning begins at the time of admission and is a collaborative effort involving:

- Member
- Family members
- Primary care provider
- Specialist
- Hospital discharge planning staff
- Ancillary providers, as necessary

Blue MA monitors all hospitalized members to assess their readiness for discharge and assist with post-hospital arrangements to continue their care. The goal is to begin discharge planning before or at the beginning of the hospital stay. Nurses work in conjunction with members' primary care providers to authorize and coordinate post-hospital needs, such as home health care, durable medical equipment and skilled nursing placement. For these members, providers should follow the processes described in the "Guidelines for Transitional Care" section.

Note: Only acute care, skilled nursing long-term acute care and inpatient rehabilitation facilities require prior authorization.

Standard Time Frames for Decisions

The Care Management staff conducts timely reviews of all requests according to the type of service requested. Decisions are made according to the following standard time frames:

Type of Request	Decision	Initial Notification	Written Notification	Type of Service
Pre-service urgent/concurrent	Within 72 hours from receipt of request	Within 72 hours from receipt of request	Within three days of initial notification	Acute and Post-Acute Admissions
Pre-service non-urgent	Within 14 days of receipt of request	Within 14 days of receipt of request	Within 14 days of receipt of request	Part B Medications and members already admitted
Post-service	Within 30 days of receipt of request	N/A	Within 30 days of receipt of request	Services already provided

Requests for Information

Pre-service non-urgent requests – An extension of up to 14 calendar days is allowed if the member asks for the extension or if Blue MA needs more information to make a decision about the request. A provider can request an extension on the member's behalf by calling Utilization Management at 800-325-6201.

Post-service requests – An extension of up to 30 calendar days is allowed if Blue MA needs more information to make a decision.

If …	Then …
The service is approved.	For all service requests, the members and the providers receive written notification. Providers also will receive verbal notification for inpatient and post-acute services.
The service is denied.	Blue MA sends the member, provider and facility a letter within the time frames stated. The letter includes the reason(s) for the denial, informs the member and provider of their right to appeal and explains the process. Blue MA also notifies the provider verbally of all denied determinations.

Steps to Take Before Rendering Services That may not be Covered

It is recognized that the member may consent to receive services that are not or may not be covered and may be payable by the member. Providers are encouraged to verify member benefits before service by contacting Provider Services at 800-240-0577 or by logging on to Availity Essentials. From the Blue MA payor space, in the resource tab, select the Blue Medicare Advantage link.

Requesting an Expedited Decision

Either the provider or the member may request an expedited decision if they believe waiting for a standard decision could or would do one of the following:

- Seriously harm the life or health of the member.
- Seriously compromise the ability of the member to regain maximum function.
- Subject the member to severe pain that cannot be adequately managed with the care or treatment that is being requested.

Blue MA relies on the provider to determine conditions that warrant expedited decisions.

- If the provider requests an expedited decision, the decision is made according to pre-service urgent time frames.
- If the member requests an expedited decision, Blue MA calls the provider to determine whether the member's medical condition requires a fast decision.
  - If the provider agrees, Blue MA makes a decision to approve or deny the request according to pre-service urgent time frames – see "Standard time frames for members".
  - If the provider disagrees, Blue MA makes a decision according to standard time frames.
  - Blue MA will not make an expedited decision about payment for care the member has already received.

Expedited requests must be submitted during normal business hours at 800-325-6201 and after hours by calling 800-331-0192.

How to Request an Expedited Decision

Providers may request an expedited decision by calling Utilization Management at 800-325-6201.

Medical Necessity Considerations – General

As a Medicare Advantage organization, Blue MA is required by CMS to provide coverage to enrollees for all Original Medicare covered services. CMS does not require that Medicare Advantage organizations follow the same payment determination rules or processes as Original Medicare does for providers.

While medical necessity criteria do apply to determine coverage, the criteria do not have to be applied in the same manner as is required under Original Medicare. Specifically:

- Benefits – Medicare Advantage plans must provide or pay for medically necessary covered items and services under Part A – for those entitled – and Part B.
- Access – Medicare Advantage enrollees must have access to all medically necessary Part A and Part B services; however, Medicare Advantage plans are not required to provide enrollees the same access to providers that is provided under Original Medicare.
- Billing and payment – Medicare Advantage plans need not follow Original Medicare claims processing procedures. Medicare Advantage plans may create their own billing and payment procedures, as long as providers – whether contracted or not – are paid accurately, in a timely manner and with an audit trail.

When determining medical necessity, both Blue MA and Original Medicare coverage and payment are contingent upon a determination that all three of the following conditions are met:

- A service is in a covered benefit category.
- A service is not specifically excluded from Medicare coverage by the Social Security Act.
- The item or service is “reasonable and necessary” for the diagnosis or treatment of an illness or injury, is a covered preventive service or will improve functioning of a malformed body member.

Members Held Harmless

In accordance with the provider agreement, CMS and regulations in the social security act, BCBSKS Blue MA members and out-of-area Blue MA members must be held harmless when a provider fails to prior authorize a service that requires prior authorization under the plan. CMS requirements may be found in the Medicare Managed Care Manual (#100-16), Chapter 4, Section 160, which is available on cms.gov (Internet Only Manuals) , and 42 CFR 422.105(a).

Providers may not seek further payment from members for elective services that have not been approved by Blue MA through the organizational determination process or unless the

member is informed in advance and has signed an Advanced Beneficiary Notice of Non-Coverage detailing the services that are not covered and the cost of the services to be rendered. Some of the circumstances in which members are held harmless for denied covered services include:

- Urgent/emergent admission denials.
- Partial denial of a hospital stay.
- Requests for elective services provided by contracted providers that require clinical review but were not forwarded to Care Management before the service was rendered.

Denials are issued for post-service requests for services provided by contracted providers when the information submitted is not substantiated in the medical record.

Members at Risk

In certain instances, members are held at financial risk for denied services. These instances occur when:

- The member's contract was not in effect on the date of service.
- The member refuses to leave an inpatient setting after the attending provider has discharged the member.
- A denial has been issued for pre-certified services.
- Services are rendered that are not a covered benefit under the member's certificate.
- Services are rendered at a non-contracted facility.

Medical Records Requests

Medical records may be requested to render a medical management decision or to investigate potential quality concerns. The member's contract allows review of all medical records. Blue MA must receive all records within 10 days of the request. Providers shall not charge a copying fee for medical records requested.

Emergency Room and Urgent Care Services

Emergent Care Defined

Members are provided coverage for emergency and urgent care services necessary to screen and stabilize their condition without pre-certification.

Emergency Care Definitions

Medical emergency – The sudden onset of a medical condition that manifests itself by signs and symptoms of sufficient severity, including severe pain such that the absence of immediate medical attention could reasonably be expected to result in serious jeopardy to a member's health, pregnancy – in the case of a pregnant woman or serious impairment to bodily

functions or serious dysfunction of any bodily organ or part.

Accidental injury – A traumatic injury that – if not immediately diagnosed and treated – could be expected to result in permanent damage to the member's health.

Members should not be referred to emergency rooms or urgent care centers for services that do not meet emergency or urgent care definitions or can be performed in the primary care provider's office during regular business hours.

Coordination of Emergent and Urgent Care Services

Members are encouraged to contact their primary care provider to assist in arranging urgent care services required after hours. Emergency and urgent care providers should send a written summary of the services provided and the treatment plan to the primary care provider within 30 days of the date of service.

Excessive use of Emergency Services

All members receive information on the appropriate use of emergency room services, as well as guidelines to follow when a situation does not require emergency care.

After-Hours Care Manager Program

Blue MA has care managers available after hours, 6 p.m. to 8 a.m. Monday through Friday with 24-hour service on weekends and holidays to assist providers and other care providers for urgent requests. Call 800-331-0192 and follow the prompts to reach a care manager for any of the following needs:

- Determining alternatives to inpatient admissions and triaging members to alternate care settings.
- Coordinating and obtaining authorization for emergent service requests.

Note: Pre-certifications for admission to skilled nursing facilities and other types of transitional care services should be called in during normal business hours unless there are extenuating circumstances that require emergent placement.

The after-hours care manager phone number can also be used after normal business hours to discuss any urgent or emergent determinations with a plan medical director. It should not be used to notify of acute care hospitalizations.

Admission notification should be done by fax or phone the next business day.

Appealing Care Management Decisions

Providers have the right to appeal any Initial Determination. The provider appeals process for

Blue MA members is governed by Medicare regulations. For more information on the Appeals process, see Chapter 14: Appeals and Payment Disputes on pages 68-71.

Quality Improvement Organization

A Quality Improvement Organization (QIO) consists of groups of doctors who are paid by the federal government to review the medical necessity, appropriateness and quality of hospital treatment provided to Medicare patients, including those enrolled in a managed care plan.

The QIO for Kansas is Livanta, a Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO). BFCC-QIOs are responsible for medical case review, which supports the rights of people on Medicare. BFCC-QIOs assists Medicare patients with concerns about the care they have been receiving or if they want to request a review (appeal) of their discharge from a health care facility.

Contacting the QIO

Members may request a QIO review from Livanta if they disagree with the decision of an inpatient facility, skilled nursing facility, comprehensive outpatient rehabilitation facility or home health agency to discharge them.

Medicare beneficiaries may contact Livanta at 888-755-5580; 888-985-9295 (TTY). Visit the Livanta website at https://livantaqio.com/en/states/kansaslivantaqio.com.

Member Appeal Rights for Hospital Discharge

Members who are hospitalized at an inpatient facility have special appeal rights if they are dissatisfied with the discharge plan or believe that coverage of their hospital stay is ending too soon.

Hospitals are required to notify all members who are admitted of their hospital discharge appeal rights. Hospitals must issue the standard CMS form "An Important Message from Medicare About Your Rights" twice — the first time within two calendar days of admission and the second time no more than two days and no less than four hours before discharge. Each time, the hospital must obtain the signature of the member or his or her representative and provide a copy.

Members have the right to appeal to the QIO for immediate review when a hospital and Blue MA – with provider concurrence – determine that inpatient care is no longer necessary.

Hospital discharge appeal process

If the member is dissatisfied with the discharge plan:

1. A member who chooses to exercise his or her right to an immediate review must submit a

request to the QIO – following the instructions on the An Important Message from Medicare About Your Rights notice.

2. If Blue MA is driving the discharge, the QIO notifies the health plan that the member has requested an immediate review.
3. Blue MA or the facility is responsible for providing the member a Detailed Notice of Discharge as soon as possible, but no later than noon on the day after the QIO's notification. The standardized notice includes a detailed explanation of the reason that services are either no longer reasonable and necessary or are otherwise no longer covered. The Detailed Notice of Discharge must be completed and submitted by the entity that determines that covered services are ending, whether it is Blue MA or the facility.
4. Blue MA or the facility must supply any other information that the QIO needs to make its determination as soon as possible, but no later than the close of business on the day that Blue MA notifies the facility of the request for information. This includes copies of both the "An Important Message from Medicare About Your Rights" notice, the "Detailed Notice of Discharge" and written records of any information provided by phone.
5. The QIO makes a determination and notifies Blue MA, the member, the hospital and the provider of its determination within one calendar day after it receives the requested information.
6. Blue MA continues to be responsible for paying the costs of the member's stay until noon of the next calendar day following the day that the QIO notifies the member of their coverage decision.
7. If the member is late or misses the noon deadline to file for an immediate review by the QIO, he or she may still request an expedited appeal.

Member Responsibilities Related to Hospital Discharges

The chart below summarizes the effect on member responsibilities of appeal decisions related to hospital discharges.

If …	Then …
The QIO agrees with the doctor's discharge decision.	The member is responsible for paying the cost of his or her hospital stay beginning at noon of the calendar day following the day that the QIO notifies the member of the coverage decision.
The QIO disagrees with the doctor's discharge decision.	The member is not responsible for paying the cost of additional hospital days, except for certain convenience services or items not covered by KPBMA.

Circumstances When the Immediate Review Process Does Not Apply

The immediate review process does not apply in the following circumstances:

- Care provided in a provider clinic
- Observation care
- Inpatient-to-inpatient transfers
- Admissions for services that Medicare never covers
- When the member has exhausted all Medicare days

QIO Immediate Review of SNF, CORF and HHA Discharges

Special Expedited Appeal Rights for Members Being Discharged

Members receiving skilled nursing facility care, home health agency services or services at a comprehensive outpatient rehabilitation facility have special appeal rights that allow an expedited review if they disagree with the decision to end covered services.

The Medicare form Notice of Medicare Non-Coverage (NOMNC) is delivered to members by the providers of SNF, HHA or CORF services in one of the following situations:

- When medical necessity criteria are no longer met and no additional days are authorized by Blue MA or the facility/provider.
- At least two days before a scheduled discharge date.

The NOMNC contains detailed instructions about how members may request an immediate appeal directly to the QIO if they disagree with the decision to end services.

NOMNC Appeal Process

Medicare regulations require the provider deliver the standard NOMNC to all members when covered services are ending, whether or not the member agrees with the plan to end services. Here's how:

1. The provider delivers the NOMNC to members at least two calendar days before coverage ends. If the member is receiving home health agency services and the span of time between services exceeds two days, the provider may deliver the NOMNC at the next-to-last time that services are furnished. The form must be delivered whether or not the member agrees with the plan to end services.

   Special considerations related to delivery of the NOMNC include:

   - Providers are encouraged to deliver the notice no sooner than four calendar days before discharge. If the notice is delivered too early, it could result in a premature request for a review by the QIO.

- If services are expected to be less than two days in duration, the provider may deliver the NOMNC at the start of service. A member who receives the NOMNC and agrees with the termination of services before the end of the two days may waive the right to request the continuation of services.
- If the member is not mentally competent to receive the notice, the provider must deliver it to the member's authorized representative.

2. The provider requests that the member sign and date the NOMNC, acknowledging receipt of his or her appeal rights. If the member refuses to sign the form, the facility must record the date and time it was delivered to the member.
3. The provider must fax the signed NOMNC for Skilled Nursing Facilities back to Care Management at 877-218-9089, Attention: Medical Records.
4. The provider is expected to retain a signed copy of the NOMNC form with the member's medical record. The member is responsible for contacting the QIO by noon of the day before services end if he or she wishes to initiate an expedited review by following the detailed instructions on the form.
5. When the member initiates an expedited review, the Detailed Explanation of Non-Coverage (DENC) is delivered to the member by the close of business on the same day that the QIO is notified of the member's request for appeal. The DENC provides specific and detailed information as to why the member's SNF, HHA or CORF services are ending.
   Note: The DENC must be completed and submitted by the entity that determines that covered services are ending, whether it is Blue MA or the SNF, HHA or CORF provider.
6. Blue MA may request medical records or other pertinent clinical information from the provider to assist with the completion of this step within the short time frames mandated by CMS regulations.
7. A copy of the DENC is also sent to the QIO.
8. The expedited review process conducted by the QIO is usually completed within 48 hours. The provider, the member and Blue MA are notified of the decision by the QIO.
9. If the member is late or misses the noon deadline to file for an immediate review by the QIO, he or she may still request an expedited appeal from Blue MA.

Other Considerations in the NOMNC Process

Providers also should be aware of the following when notifying a member that his or her services are ending:

- Contracted facilities should be using the appropriate NOMNC forms. Providers should insert their name, address and phone number in the spaces provided at the top of the form.
- Blue MA may issue a next review date when authorizing SNF services. The next review

date does not mean further coverage is denied.

- Providers should submit an updated clinical review on the next review date. If upon review of the updated clinical information a denial decision is given, Blue MA will allow for two additional days for the provider to supply the member with the NOMNC.
- The form should only be given to members when SNF criteria are no longer met and no further days are authorized or two days before a scheduled discharge date.
- If there is a change in the member's condition after the NOMNC is issued, both Blue MA and providers should consider the new clinical information. If there is a change in the effective date that coverage ends, the provider should inform the member that services will continue. The provider must then inform the member of the new coverage end date either through delivery of a new or amended NOMNC at least two days before services end.

Member Responsibilities When Appealing SNF, CORF or HHA Discharges

The chart summarizes the effect on member responsibilities of appeal decisions related to discharges from SNF, CORF or HHA services.

If …	Then …
The QIO agrees with the doctor's decision to end covered services.	The member is financially responsible for services on the date indicated on the NOMNC.
The QIO disagrees with the doctor's decision to end covered services.	Blue MA will continue to cover the services.

Chapter 13: Health Education and Management Program

Blue MA has developed a chronic condition management program to help members manage chronic diseases through a partnership among providers, members and the plan.

Health care management strategies include education about staying healthy while living with an illness. The objective of these strategies is to improve clinical outcomes, reduce costs and improve member and provider satisfaction.

Goals for Chronic Condition Management

Members with chronic conditions are identified and may benefit from chronic condition management interventions designed to:

- Promote early diagnosis and appropriate treatment according to recognized clinical practice guidelines.
- Provide tools to simplify member self-management efforts.
- Improve member adherence to a treatment plan.
- Provide continuity of care through specialty Case Management when indicated.
- Integrate health promotion and wellness initiatives across the continuum of care.
- Educate members about the purpose and importance of advance directives. Blue MA's role in chronic condition management includes:
  - Analyzing plan data and targeting conditions appropriate for program development.
  - Researching, developing and distributing clinical practice guidelines.
  - Developing and implementing comprehensive chronic condition management programs.
  - Using predictive modeling to determine individual member interventions.
  - Mailing educational materials to members about self-management, preventive health issues, relevant medical tests, lifestyle issues and medication compliance.
  - Offering registered nurse chronic condition managers who make outreach calls to identified members.
  - Providing educational resources to providers.
  - Studying outcomes to determine the impact of chronic condition management programs.

Member Participation

Members identified as eligible for specific chronic condition management programs are automatically enrolled – member identification criteria are consistent with clinical practice guidelines. Members can decline participation in a program at any time.

Source of Information	Description
Health Education & Management Program 800-240-0577, 8 a.m. to 6 p.m. Monday through Friday – except holidays	A toll-free number staffed by experienced registered nurses. Blue MA encourages members and providers to ask questions and request additional information.

Health Risk Assessments

A health assessment completed by the member is encouraged as part of an annual wellness visit for Medicare Advantage members, according to the Patient Protection and Affordable Care Act and CMS.

Blue MA may contract with a vendor to complete Health Risk Assessments for Blue MA members. In such cases, a member may meet in-person or virtually with a vendor practitioner and a document will be sent to the patient's primary care provider informing of data collected during the health assessment for incorporation in to the patient's medical records. Patients will be counseled to continue to see their primary care provider for their annual wellness visit and/or physical exam.

Providers should also remind patients to bring a copy of their member health assessment or the response letter to their annual wellness visit. The results of the member's health assessment need to be available during the wellness visit so they can be considered when a care plan is created.

Quality Management

All Medicare Advantage (MA) organizations are required to have a quality improvement (QI) program as described in the federal regulations at 42 CFR §422.152, "Quality Improvement program". The requirements for the PDP Quality Assurance program are based in regulation as per 42 Code of the Federal Regulations § 423.153(c).

The primary goal of the MA organization's QI program is to effect sustained improvement in patient health outcomes. As provided under 42 CFR §422.152(c) and §422.152(d), KPBMA's QI program must include at least one chronic care improvement program (CCIP) for one chronic condition and a quality improvement project (QIP) that measures and demonstrates improvement in health outcomes and beneficiary satisfaction.

Chapter 14: Appeals and Payment Disputes

Pre-Service Appeals/Organization and Coverage Determinations

Providers may appeal on behalf of the member if they are dissatisfied with an Initial Determination of a service or item that has not been provided.

Providers should follow these guidelines when submitting an appeal for pre-service requests:

1. Part C – Call Provider Services at 800-240-0577.
   Part D – Call Prime Customer Service at 866-230-7265.
   Most provider disputes can be resolved with a quick phone call.
2. Submitting a First-Level Appeal – A provider unsatisfied with the decision can submit a First-Level Appeal within 65 days of the Initial Determination. Kansas providers appealing non-Kansas claims should submit appeals directly to the Kansas plan. While non-Kansas providers should submit Part C appeals to their local Blue Plan. The appeal should include appropriate supporting documentation and should be submitted to:

Appeal Type	Appeal/Dispute by Phone	Appeal/Dispute by Fax	Appeal/Dispute by Mail
Part C	800-240-0577	800-800-6438	Blue MA Provider Correspondence PO Box 21792 Eagan, MN 55121
Part D	866-421-5077	855-212-8110	Prime Therapeutics LLC Attn: Medicare D Clinical Reviews 2900 Ames Crossing Road Suite 200 Eagan, MN 55121

The appeal will be reviewed and responded to within the following time frames:

Type of Appeal	Medical (Part C)	Medical (Part C) with Extension	Pharmacy (Part D)
Standard	30 days	44 days	7 days
Expedited - see page 62	72 hours	17 days	72 hours

3. Submitting a Level 2 Appeal – All partially favorable or adverse medical (Part C) First-Level Appeals are automatically sent to an Independent Review Entity (IRE) for a Second-Level Appeal. A provider or member does not have to request the appeal. For partially favorable or adverse pharmacy (Part D) First-Level Appeals, the member and/or prescribing provider will be notified and informed of the right to a Second-Level Appeal. The pharmacy (Part D) Second-Level Appeal should include appropriate supporting documentation AND a copy of the First-Level Appeal decision, and should be submitted within 60 days to the fax or mail address listed. The Second-Level Appeals will be reviewed by an IRE and responded to within the appropriate time frame as outlined:

Type of Appeal	Medical (Part C)	Pharmacy (Part D)
Standard	30 days	7 days
Expedited (see page 62)	72 hours	72 hours

4. Subsequent appeals are available if the Amount in Controversy (AIC) is greater than or equal to $170.
5. Third-, Fourth- and Fifth-Level Appeals – If the AIC is greater than or equal to $170, the provider and member have subsequent appeal rights for medical (Part C) services, while only members have subsequent appeal rights for pharmacy (Part D) services. The Third-Level Appeal is an Administrative Law Judge (ALJ) hearing and must be filed within 60 days of Second-Level Appeal notification. The Fourth-Level Appeal is a Medicare Appeals Council and must be filed within 60 days of the Third-Level Appeal notification. The Fifth-Level Appeal is a Federal Court Judicial Review and is only allowed if the AIC is greater than or equal to $1,670. It must be filed within 60 days of the Fourth-Level Appeal notification.

Post-Service Appeals and Payment Disputes

Providers have appeals and payment dispute resolution rights if they are dissatisfied with an Initial Determination. Both contracting and non-contracting providers may dispute determinations on denied claims, such as denial of a service related to medical necessity and appropriateness.

Blue MA Providers should follow these guidelines when submitting an appeal for Part C claim denials and payment disputes:

1. Call Provider Services – 800-240-0577. The majority of provider disputes can be resolved with a quick phone call.
2. Submitting a First-Level Appeal – A provider unsatisfied with the decision can submit a First-Level Appeal within 60 days of the Initial Determination. The appeal should include appropriate supporting documentation and should be submitted to:

Appeal/Dispute by Phone	Appeal/Dispute by Fax	Appeal/Dispute by Mail
800-240-0577	800-976-2794	Blue MA Provider Correspondence PO Box 21792 Eagan, MN 55121
Kansas providers appealing non-Kansas MA member claims should submit appeals directly to the Kansas plan. Non-Kansas providers should submit Part C appeals to their local Blue plan.		

   The First-Level Appeal will be reviewed and responded to within 60 days of receipt.

3. Submitting a Second-Level Appeal – A provider unsatisfied with the First-Level Appeal

decision can submit a Second-Level Appeal within 60 days of the Initial Determination. The appeal should include appropriate supporting documentation and should be submitted in writing to:

Appeal/Dispute by Fax	Appeal/Dispute by Mail
800-868-6438	Blue MA Provider Second-Level Appeals PO Box 21792 Eagan, MN 55121
Kansas providers appealing non-Kansas MA member claims should submit appeals directly to the Kansas plan. Non-Kansas providers should submit Part C appeals to their local Blue plan.	

The decision from the Second-Level Appeal will be final and binding.

4. Appropriate supporting documentation needed for First- and Second-Level Part C Appeals includes the following:
   - Provider or supplier contact information including name and address.
   - Pricing information, including NPI number – and CCN or OSCAR number for institutional providers, zip code where services were rendered and provider specialty.
   - Reason for dispute and a description of the specific issue.
   - Copy of the provider's submitted claim with disputed portion identified.
   - Documentation and any correspondence that supports your position that the plan's denial was incorrect – including clinical rationale, Local Coverage Determination and/or National Coverage Determination documentation and interim rate letters when appropriate.
   - Appointment of provider or supplier representative authorization statement, if applicable.
   - Name and signature of the provider or provider's representative.
   - Waiver of Liability.

Non-contracted providers should follow the First- and Second-Level Appeals processes for Part C payment disputes. Both levels should be submitted to BCBSKS. Non-contracted providers appealing Part C claim/medical necessity denials may submit an appeal in writing to:

Appeal/Dispute by Fax	Appeal/Dispute by Mail
800-868-6438	Blue MA Provider Second-Level Appeals PO Box 21792 Eagan, MN 55121

The appeal must include a signed Waiver of Liability that indicates that you formally agree to

waive any right to payment from the member for the service in question regardless of the outcome of the appeal.

Questions, Additional Information and Contacts

If you have general questions about BCBSKS Medicare Advantage, call Provider Services at 800-240-0577 from 8 a.m. to 6 p.m. For questions regarding BlueCard MA claims, call Customer Service at 800-432-3990 from 7 a.m. to 4:30 p.m.

Revisions

01/01/2020	Introduced manual
10/20/2020	Page 6 – Added Host Customer Service contact information
10/20/2020	Page 17 – Adjusted language regarding interim rate letters
06/15/2021	Page 77&78 – Clarified language on the appeal process
	Page 31 – Added prompt pay exclusions
07/27/2021	Page 17 – Added cost settlement information
08/25/2021	Page 79&80 – Clarified language on Post-Service Appeals and Payment Disputes
03/09/2022	Page 8 – Updated image of ID cards
	Page 15 – Updated the Medical Policy Hierarchy section
	Page 16 – Added language on RHC reimbursement rate
	Page 33 – Added language and link for Specific Billing Guidelines
03/01/2023	Page 4 – Chapter 1, updated counties listed
	Page 12 – Updated information regarding questions for claim status or plan payments under Where to Submit a Claim section
	Page 13 – Added DME, P&O, Medical Suppliers and Pharmacists sections
	Page 13 – Added Federally Qualified Health Center to the Rural Health Clinic Billing section
	Page 14 – Updated Coordination of Benefits section to reflect current practices
	Page 15 – Added Claims for Unlisted and Not Otherwise Classified (NOC) Procedure Codes section
	Page 18 – Updated Medical Policy Hierarchy section to reflect current processes
	Page 19 – Updated Chapter 4: Claims Payment, Refunds and Offsets Reimbursement Methodology section to include information on RHC and FQHC reimbursement
	Page 19 – Updated bullet regarding Services Coded with NOC Codes to reflect current practices
	Page 20 – Added Settlement information to Critical Access Hospitals and Rural Health Clinics
	Page 21 – Updated Billing section to reflect current practices
	Page 22 – Added last two bullets to the Co-Pays section
	Page 23 – Updated Explanation of Payment section to reflect current practices
	Page 29 – Updated Other Medical Record Requirements to add clarification and reflect current practices
	Page 38 – Updated second bullet to reflect current practices
	Page 45 – Updated Requests to Term from Blue MA header to reflect how we receive requests
	Page 49 – Updated HEDIS measures to reflect current measures
	Page 51 – Updated CMS Star Ratings section to reflect current measures
	Page 53 – Added 2023 CMS Quality Star Measures header and information
	Page 54 – Updated Helpful Links to reflect current links and information
	Page 59 – Updated Clinical Review required header to reflect current information
	Page 85 – Added Questions, Additional Information and Contacts sections
01/01/2024	Throughout manual – Updated Availity to Availity Essentials
	Throughout manual – Updated NDBH to Lucet
	Page 4 – Updated Overview to reflect current counties and plans
	Page 7 – Updated Helpful Reminders to reflect current process if a member does not have ID
	Page 8/9 – Updated information regarding ID cards to reflect current details
	Page 11 – Updated MA Member Benefits to reflect current policies
	Page 12 – Added last bullet in Most Common Errors

	Page 13 – Updated information on Where to Submit a Claim to reflect current practices
	Page 16 – Updated address under Claims for unlisted and NOC procedure codes
	Page 19 – Added Health Equity section
	Page 21 - Updated Critical Access Hospitals and Rural Health Clinics to reflect current practices
	Page 22 – Updated Non-Covered Services to reflect current practices
	Page 24 – Added last paragraph and steps under Refunds section
	Page 35 – Updated 8th bullet under Section 3: Provider Qualifications and Requirements
	Page 36 – Updated where to find member benefits and cost-sharing information
	Page 39/40 – Updated Section 7: Getting Pre-Service Coverage/Organization Determination to reflect current practices
	Page 45 – Updated sections: Information Changes/Updates, Requests to Term from Blue MA, Provider Communication, and Fraud, Waste and Abuse to reflect current information
	Page 47 – Updated last paragraph to reflect current trainings
	Page 48 – Updated HEDIS measures bullets to reflect current guides
	Page 53 – Removed 2023 CMS quality star measures
	Page 59 – Updated where providers should notify Blue MA of admissions
	Page 61 – Added section “Two-Midnight Rule”
	Page 76&77 – Consolidated Obtaining a Pre-Service Organization Determination and Network Exception into section 7
	Page 77,79,80 – Updated address in table
	Page 80 – Added MA Institutional Relations contact information
03/25/2024	Pages 6, 7, 54, 55, 62, 66, 69 – Updated CM/UM after hours phone number
	Page 80 – Updated Institutional Relations contact information
10/28/2024	Page 80 – Updated contact information
11/07/2024	Page 55 – Added Utilization Management Medical Policies header and information
	Page 57 – Added Utilization Management information after table under Criteria and Guidelines for Decisions header
01/01/2025	Page 4 – Updated counties
	Page 8 – Added information about submitting claims
	Page 9 – Added all FAQs
	Page 11 – Verifying Eligibility and Coverage for Out-of-Area Members information to reflect current process
	Page 13 – Updated Professional Claims information
	Page 27 – Added Medicare Forms link
	Page 31 – Updated link to Medicare Program Integrity Manual
	Page 32 – Added Patient Assessment Form (PAF) section
	Page 34 – Updated contact information
	Page 35 – Updated contact numbers under Section 2 header
	Page 37 – Updated paragraph before note to reflect current requirements
	Page 40 – Updated what Blue MA can request records for
	Page 40 – Updated contact information under Section 7 header
	Page 44 – Updated links under Pharmacy Directory and Pharmacy Formulary
	Page 44 – Updated Utilization Management section to reflect current place to find auth and quantity limits
	Page 46 – Updated Information Changes/Updates section. Added CMS Demographics Attestation and Provider Information Portal Attestation sections
	Page 51 – Updated bullets under HEDIS measures to reflect current practices

	Page 57 – Added Appropriate Professionals section from earlier section/chapter
	Page 66 – Updated how to access WebPass
	Page 74 – Updated Members Held Harmless section to reflect current agreements and regulations
	Page 79 – Updated Health Risk Assessments to reflect current practices
	Page 83 – Removed Contact Information
	Page 4 – Updated counties
	Page 8 – Added information about submitting claims
	Page 9 – Added all FAQs
	Page 11 – Verifying Eligibility and Coverage for Out-of-Area Members information to reflect current process
	Page 13 – Updated Professional Claims information
	Page 27 – Added Medicare Forms link
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	Page 37 – Updated paragraph before Note to reflect current requirements
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	Page 44 – Updated Utilization Management section to reflect current place to find auth and quantity limits
	Page 46 – Updated Information Changes/Updates section. Added CMS Demographics Attestation and Provider Information Portal Attestation sections.
	Page 51 – Updated bullets under HEDIS measures to reflect current practices
	Page 57 – Added Appropriate Professionals section to here from earlier section/chapter
	Page 66 – Updated how to access WebPass
	Page 74 – Updated Members Held Harmless section to reflect current agreements and regulations
	Page 79 – Updated Health Risk Assessments to reflect current practices
	Page 83 – Removed Contact Information
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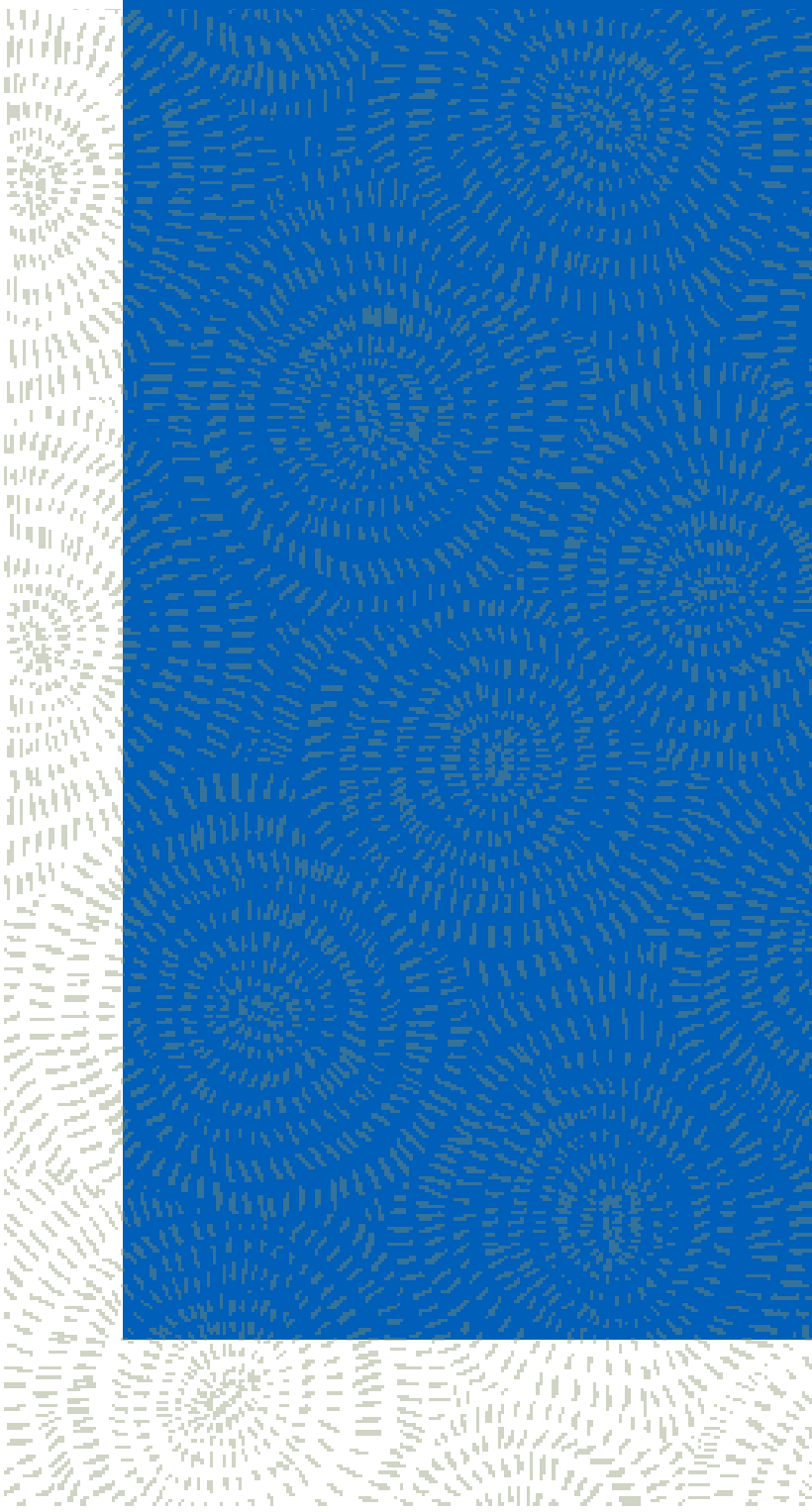
	Page 51 – Updated bullets under HEDIS measures to reflect current practices
	Page 57 – Added Appropriate Professionals section from earlier section/chapter
	Page 66 – Updated how to access WebPass
	Page 74 – Updated Members Held Harmless section to reflect current agreements and regulations
	Page 79 – Updated Health Risk Assessments to reflect current practices
	Page 83 – Removed Contact Information
05/13/2025	Page 80 – Updated Appeal table information to reflect current information
01/01/2026	Removed links throughout
	Removed duplicate information throughout manual – sections Helpful Reminders, throughout Chapter 3: Claim Filing, Chapter 5: Coverage Policy and Chapter 9: Provider Information
	Page 4 - Updated county listing to map
	Page 8 - Updated Blue MA Member ID Card section
	Page 12 - Updated Eligibility and Coverage section for clarity

	Page 15 - Updated Chapter 3, Claim filing for clarity
	Page 18 - Updated Ancillary claims for clarity
	Page 19 - Updated Coordination of benefits for clarity
	Page 20 - Updated Timely Filing Requirement, Advanced Directives and Claims for Unlisted and Not Otherwise Classified (NOC) Procedure Codes for clarity
	Page 26 - Updated Billing information for clarity and current processes.
	Page 28 - Updated Refunds and Explanation of Payment subsections for clarity and removal of duplicate information
	Page 43 - Updated Section 5: Filing a Claim for clarity and current processes
	Page 47 - Removed last paragraph in Section 9: Member and Provider Appeals and Grievances
	Page 47 - Updated information in Section 10 for clarity: Providing Members with Notice of Appeal Rights - Requirements for Hospitals SNFs, COREs and HHAs
	Page 48 - Removed Section 11: Additional Information
	Page 49 - Removed Pharmacy Directory
	Page 69 - Removed examples
	Page 71 - Removed what clinical information includes
	Page 72 - Removed accessing WebPass information
	Page 79 - Removed Note in Member Appeal Rights for Hospital Discharge
01/26/2026	Page 6 – Updated the change made to the table in Nov. 2025 to reflect current contact information
	Page 10 – Updated claims mailing address that was originally updated in June 2025



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