

# Provider Administration Manual

Revised March 2018

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**Glossary**

## I. INTRODUCTION

BlueCross BlueShield of Tennessee, Inc. is an independent licensee of the BlueCross BlueShield Association consisting of some 60 BlueCross and/or BlueShield Plans throughout the United States.

BlueCross BlueShield of Tennessee is the state's largest and most experienced not-for-profit health plan, serving over 3.3 million Members in Tennessee and across the country with quality health care programs, products, and services. Founded in 1945, the Chattanooga-based company is focused on financing affordable health care coverage and providing peace of mind for all Tennesseans.

The following pages contain comprehensive information regarding operating policies and procedures established by BlueCross BlueShield of Tennessee and are incorporated by reference into the Participation Agreements.

This Manual is designed to provide information and guidelines for Facilities, Practitioners and other Providers who participate in one or more of the BlueCross BlueShield of Tennessee commercial Provider Networks listed below:

- **Blue Network M<sup>SM</sup>**
- **Blue Network P<sup>SM</sup> - Preferred**
- **Blue Network S<sup>SM</sup> - Select**
- **CoverTN – (See Section XXV)**

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### A. BlueCross BlueShield of Tennessee Statement of Purpose

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- **BUSINESS**  
Our Business is financing affordable health care coverage.
- **PURPOSE**  
Our Purpose is *Peace of Mind*.
- **LONG-TERM CORPORATE GOALS**  
Our Long-Term Corporate Goals are:
  - Affordability
  - Sustainability
  - Outreach

## Code of Conduct

BlueCross BlueShield of Tennessee has been a part of Tennessee families and businesses since 1945. We have built a bond of trust with the people we serve, as well as the vendors and suppliers with whom we do business.

To strengthen that bond of trust, the BlueCross BlueShield of Tennessee Board of Directors adopted a set of policies and Code of Conduct that applies to all employees, officers, contracted vendors, and members of the Board of Directors. We are willing to share our own Code of Conduct, along with related policies and procedures, with our business partners in order to relay our commitment to a corporate culture of ethics and compliance. The Code of Conduct sets an ethical tone for the organization and provides guidelines for how we and our business partners are expected to conduct business.

We encourage suppliers and third parties with which we do business to adopt and follow a Code of Conduct particular to their own organization that reflects a commitment to prevent, detect and correct any occurrences of unethical behavior. In addition, we embrace fraud prevention and awareness as essential tools in preserving affordable quality health care and actively work with our business partners and law enforcement agencies to combat health care fraud. More information regarding fraud, waste and abuse education and training can be found on the Centers for Medicare & Medicaid website at <https://www.cms.gov/site-search/search-results.html?q=fwa%20training>.

Included in our Code of Conduct are two sections entitled “Conflicts of Interest” and “Dealing with Customers, Suppliers, and Third Parties”. The primary focus of these sections is to help ensure business decisions are based on the merit of the business factors involved and not on the offering or acceptance of favors. Additionally, any activity that conflicts or is otherwise incompatible with our professional responsibilities should be avoided. You may review the Code of Conduct in its entirety online at <http://www.bcbst.com/docs/why-bcbst/about-us/corporate-responsibility/Code-of-Conduct.pdf>.

Please share this information with all your employees who interact with our company. If you should have any questions, or wish to report a suspected violation, please call the Confidential Compliance Hotline, 1-888-343-4221 or e-mail us at [compliancehotline@bcbst.com](mailto:compliancehotline@bcbst.com).

## B. Descriptions of Networks

The following grid is intended to serve as a general guide in defining basic characteristics of BlueCross BlueShield of Tennessee networks. For more detailed, plan-specific information, please contact your BlueCross BlueShield of Tennessee Provider Network Manager.

| Network                                   | Characteristics  |
|---|--|
| Blue Network M <sup>SM</sup>              | The Blue Network M Provider Network was created to be used with the clinical management services provided to self-funded employers by our partner, MissionPoint Health Partners (MPHP). MPHP is an Accountable Care Organization (ACO) affiliated with St. Thomas Health in Nashville. Blue Network M is only available to self-funded accounts in the Middle Tennessee market.  |
| Blue Network P <sup>SM</sup><br>Preferred | The Blue Network P Provider Network offers a wide variety of credentialed Practitioners, hospitals and other health care Providers as well as all participating pharmacies.  |
| Blue Network S <sup>SM</sup><br>Select    | Like Blue Network P, the Blue Network S Provider Network is based on a variety of credentialed Practitioners, hospitals and other health care Providers as well as all participating pharmacies; It is available for Plans purchased on and off the Health Insurance Marketplace and focuses more on affordability. This is achieved, in most Tennessee markets, with a narrower Network of Providers than Blue Network P. |
| Nationwide                                | Benefits vary, to obtain benefit information, see Section III in this manual, <i>How to Identify a BlueCross BlueShield of Tennessee Member</i> .  |

## C. Individual Product and Plan Options

BlueCross BlueShield of Tennessee offers a variety of health benefits plans to meet the needs of individuals who are not covered under an employer-sponsored health care plan.

The following summary is intended to assist you in identifying BlueCross BlueShield of Tennessee individual products and their supporting networks. Although Members' ID cards reflect network/copay information, Providers are encouraged to call the customer service telephone number on the Member ID card to verify benefits, deductible/copay amounts, and prior authorization requirements.

### Marketplace Plans – Group number 127600

The first open enrollment period for Marketplace plans began on 10/1/13, and Members enrolled in these plans beginning 1/1/14. In order to apply for, and receive financial assistance from Advance Premium Tax Credits or Cost Sharing Reductions, individuals must purchase through the Marketplace.

All options on the Marketplace are offered in six (6) different regions across the state on Blue Network S. These six (6) regions are:

|                                |                         |
|--------------------------------|-------------------------|
| Region 1 - East                | Region 5 - West         |
| Region 2 - Knoxville           | Region 7 - East Central |
| Region 3 - Greater Chattanooga | Region 8 - West Central |



## BlueCross BlueShield of Tennessee Provider Administration Manual

These plans are Affordable Care Act (ACA) compliant.

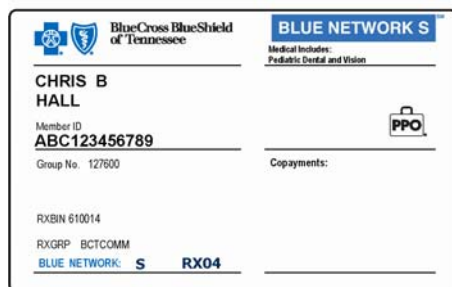
- Out-of-Pocket maximums cannot be greater than \$7,350 in 2018
- Pre-existing conditions cannot be excluded
- All plans cover the Essential Health Benefits package required by the law. These include:
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Treatment and services for mental illness and substance use disorders
  - Prescription medications
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care

All plans must meet one of the required metallic levels, bronze, silver, gold or platinum. Four base level plan designs will be available in 2018:

- Deductibles range from \$250 - \$5,650
- Out of Pocket Maximums range from \$5,100 - \$7,000
- One plan with office copays of \$35 primary and \$50 specialist visits is available. Other plans cover office visits at deductible/coinsurance.

### Marketplace Plans sample ID card

#### Blue Network S – Select



### Off-Marketplace Plans – Group number 129800

Open enrollment periods for Off-Marketplace plans matches that of the Marketplace, with the first open enrollment period having begun on 10/1/13, and members enrolled in these plans beginning 1/1/14. By choosing to enroll directly in one of these off-Marketplace plans, the consumers are not receiving any subsidies.

All options in these plans are offered in six (6) different regions across the state on Blue Network S. These six (6) regions are:

Region 1- East

Region 2 - Knoxville

Region 3 - Greater Chattanooga

Region 5 - West

Region 7 - East Central

Region 8 - West Central

## BlueCross BlueShield of Tennessee Provider Administration Manual

These plans are Affordable Care Act (ACA) compliant.

- Out of Pocket maximums cannot be greater than \$7,350 in 2018
- Pre-existing conditions cannot be excluded
- All plans cover the Essential Health Benefits package required by the law. These include:
  - Ambulatory patient services
  - Emergency services
  - Hospitalization
  - Maternity and newborn care
  - Treatment and services for mental illness and substance use disorders
  - Prescription medications
  - Rehabilitative and habilitative services and devices
  - Laboratory services
  - Preventive and wellness services and chronic disease management
  - Pediatric services, including oral and vision care

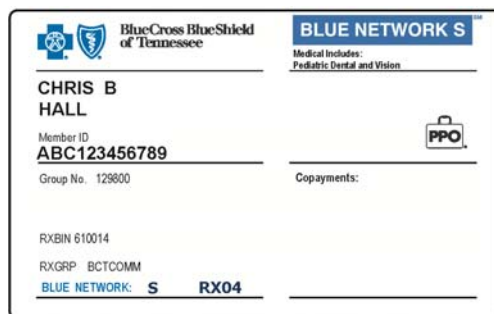
All plans must meet one of the required metallic levels, bronze, silver, gold or platinum. Four base level plan designs will be available in 2018:

Deductibles range from \$250 - \$5,650

- Out of Pocket Maximums range from \$5,100 - \$7,000
- One plan with office copays of \$35 primary and \$50 specialist visits is available. Other plans cover office visits at deductible/coinsurance.

### Off-Marketplace Plans sample ID card

#### Blue Network S – Select



### Regional Map



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## **D. Health Insurance Portability and Accountability Act of 1996**

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The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal act, which includes important protections for people who change jobs, are self-employed or who have pre-existing medical conditions. Its primary intent was to provide better access to health insurance, limit fraud and abuse, and reduce administrative costs within the health care system.

The element of the law labeled Administrative Simplification (HIPAA-AS) is intended to improve the efficiency and effectiveness of the health care system by standardizing the exchange of electronic, administrative and financial data. It is also intended to protect the security and privacy of patient health identifiable information (PHI).

### **1. Health Information Privacy Policies and Procedures**

BlueCross BlueShield of Tennessee Privacy Policies and Procedures implement its obligations to protect the privacy of individually identifiable health information that is created, received or maintained by BlueCross BlueShield of Tennessee. A major component of protecting health information is to adhere to the necessary data safeguards set forth in the Information Security's policies and procedures.

BlueCross BlueShield of Tennessee must promptly change these policies and procedures as necessary to comply with changes in federal and state law. Any changes in the policies and procedures will generate a revision to the Notice of Privacy Practices, which must be distributed within sixty (60) days of the effective date of change. The revised Notice will be available to anyone upon request on the effective date of the change.

BlueCross BlueShield of Tennessee may make changes to these policies and procedures at any time by amending the policies and procedures provided they remain in compliance with federal and state law. BlueCross BlueShield of Tennessee's Privacy Office will review and update (if necessary) these policies annually. If a change is made, BlueCross BlueShield of Tennessee will retain the former policies and procedures for at least six (6) years from their last effective date. The Privacy Office will, at all times, maintain a master list of all policies and procedures.

BlueCross BlueShield of Tennessee's Privacy Office will review and update the protected health information use and disclosure assessment every two (2) years.

BlueCross employees are obligated to follow these policies and procedures diligently. Failure to do so can result in disciplinary action, including termination of employment.

BlueCross BlueShield of Tennessee's Privacy Policies can be seen in their entirety on the company website at <http://www.bcbst.com/why-bcbst/about-us/corporate-responsibility/corporate-governance/legal/privacy-and-security>.

Any questions concerning these policies and procedures should be directed to the BlueCross BlueShield of Tennessee Privacy Office by calling 1-888-455-3824.

### **2. Protected Health Information-allowable disclosures under HIPAA**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule establishes national standards to protect individual's medical records and other personal health information and applies to 1) health plans, 2) health care clearinghouses, and 3) those health care Providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives rights to patients over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

## BlueCross BlueShield of Tennessee Provider Administration Manual

Members have the right to access their health information and to know how it is being protected. As such, **BlueCross requests Providers maintain a notice of privacy practices and encourages them to publish such notices prominently on their websites.**

Federal regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) may require some changes in the way BlueCross BlueShield of Tennessee operates, however, it will not prevent us from exchanging the information we need for **treatment, payment, and health care operations (TPO).**

BlueCross will continue to conduct business as usual in most circumstances. HIPAA regulations allow the disclosure and contractually, BlueCross BlueShield of Tennessee Providers (subject to all applicable privacy and confidentiality requirements) are obligated to make medical records of BlueCross BlueShield of Tennessee Members available to each Physician and/or Health Care Professional treating BlueCross Members and to BlueCross BlueShield of Tennessee, its agents, or representatives at no charge.

Privacy Regulations should not impact patient treatment and quality of care; it is vital for the benefit of our Members and your patients that quality of care is not negatively impacted due to misconceptions about allowable exchanges of information for TPO. Examples of TPO, include, but are not limited to:

**Treatment** - rendering medical services, coordinating medical care for an individual, or even referring a patient for health care.

**Payment** - the money paid to a covered entity for services rendered whether it is a health plan collecting premiums, a health plan fulfilling its responsibility for coverage, or a health plan paying a Provider for services rendered to a patient.

**Health care operations** - conducting quality assessment and improvement activities, underwriting, premium rating, auditing functions, business planning and development, and business management and general administrative activities.

For complete TPO definitions and a listing of examples, please review the federal regulations at <http://www.hhs.gov/hipaa/for-professionals/faq/treatment,-payment,-and-health-care-operations-disclosures>.

If you have any questions or concerns regarding privacy matters, you may call the BlueCross BlueShield of Tennessee Privacy Office at 1-888-455-3824 or e-mail us at [privacy\\_office@bcbst.com](mailto:privacy_office@bcbst.com).

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## E. General Information

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### 1. Fraud and Abuse Hotline

A special telephone hotline is available to report possible fraudulent activities involving the delivery or financing of health care. Anyone, whether or not they are a BlueCross BlueShield of Tennessee participating Provider or Member, can report suspected health care fraud by calling BlueCross BlueShield of Tennessee Fraud and Abuse Hotlines at 423-535-7900 or 1-888-343-4221, or e-mailing us at [ComplianceHotline@bcbst.com](mailto:ComplianceHotline@bcbst.com).

### 2. Interpretation Services

According to federal and state regulations of Title VI of the Civil Rights Act of 1964, translation or interpretation services due to Limited English Proficiency (LEP) is to be provided by the entity at the level at which the request for service is received. The Executive Order, signed August 11, 2000, by former President William Clinton, is a guidance tool including specific expectations designed to ensure that LEP clients receive meaningful access to federally assisted programs.

## BlueCross BlueShield of Tennessee Provider Administration Manual

The financial responsibility for the provision of the requested language assistance is that of the entity that provides the service. It is not permissible to charge BlueCross BlueShield of Tennessee Members, including a BlueCare or TennCareSelect Member, for these services. Full text of Title VI of the Civil Rights Act of 1964 can be found online at <http://www.justice.gov/crt/about/cor/13166.php>.

Providers can use the “I Speak” Language Identification Flash Card to identify the primary language of BlueCross BlueShield of Tennessee Members, including BlueCare and TennCareSelect Members. The flash card, published by the Department of Commerce Bureau of Census, containing 38 languages can be found online at <http://www.lep.gov/ISpeakCards2004.pdf>.

Additionally, the National Health Law Program and Access Project 2003 is an organization that assists Providers having patients with language issues by providing a Language Services Action Kit. The kit can be purchased by e-mailing [lepactionkit@accessproject.org](mailto:lepactionkit@accessproject.org).

The Department of Health and Human Services can also recommend resources for use when LEP services are needed or Providers can locate interpreters specializing in meeting needs of LEP clients by calling one of the following numbers listed below:

- |                          |                |
|--------------------------|----------------|
| ➤ Language Line          | 1-800-874-9426 |
| ➤ Hablamos Juntos Line   | 205-824-2360   |
| ➤ AVAZA Language Service | 1-866-452-6582 |
| ➤ Hablamos Juntos Line   | 1-205-824-2360 |

Providers may also consider:

- Training bilingual staff;
- Utilizing telephone and video services;
- Using qualified translators and interpreters; and
- Using qualified bilingual volunteers.

The Department of Health and Human Services can also recommend resources for Providers to use when limited English proficiency services are needed.

### 3. Provider Communications

BlueCross BlueShield of Tennessee produces the *BlueAlert* newsletter on a monthly basis to communicate important policy and benefit-related news to health care Providers. Also included are helpful tips and reminders on how to file claims and conduct other business more efficiently with BlueCross BlueShield of Tennessee. The newsletters are mailed to all BlueCross BlueShield of Tennessee participating Providers.

Providers are also encouraged to visit the company website, [www.bcbst.com](http://www.bcbst.com) to verify Member eligibility, benefit coverages and check claims status in a secure area.

### 4. Pre-existing Condition

*Group Health Coverage – Employer-funded or sponsored*

A pre-existing condition is defined as:

- any physical or mental condition that began prior to the enrollment date<sup>t</sup> of the Member's coverage;
- any physical or mental condition, which was present during a variable look back period immediately before the Member's enrollment date, for which medical advice, diagnosis, care or treatment was recommended or should reasonably have been received; and is
- **treatment** driven.

<sup>t</sup>Could be the effective date of contract, but can be the hire date, if a policy waiting period exists.

**5. Non-Discrimination**

BlueCross BlueShield of Tennessee participating Providers through their contracts with us and in compliance with existing federal and state laws, rules and regulations agree not to discriminate against Members in the provision of services on the basis of race, color, national origin, religion, sex, age or disability.

Section 1557 of the Affordable Care Act (ACA) and its implementing regulations (Section 1557) prohibits “*covered entities*” from discriminating against individuals on the basis of race, color, national origin, sex, age, or disability in any health program or activity. “*Covered entities*” include health insurance issuers and health care Providers that receive federal financial assistance.

Participating Providers who are ‘*covered entities*’ as defined in Section 1557 have identified compliance obligations under Section 1557 and must meet those compliance obligations with respect to interactions with and services rendered to BlueCross BlueShield of Tennessee Members. These include, without limitation, informing Members about non-discrimination and the availability of translation services and information in their own language for Members with limited English proficiency.

Participating Providers should review their respective obligations and the requirements of Section 1557 to ensure their respective compliance. Information about Section 1557 of the ACA and compliance with same is available from the Department of Health and Human Services at <http://www.hhs.gov/civil-rights/for-individuals/section-1557/index.html>.

Participating Providers agree to cooperate with reasonable requests from BlueCross BlueShield of Tennessee and/or the applicable Payor in the investigation of any Member complaints.

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## II. BLUECROSS BLUESHIELD OF TENNESSEE QUICK REFERENCE TELEPHONE GUIDE

| Contact                                    | Location/Description      | Telephone Number         | Address/Description   |
|--|---------------------------|--------------------------|---|
| <b>BlueCross BlueShield of Tennessee</b>   | Provider Service Line     | 1-800-924-7141           | General inquiries - voice response line – speak when prompted. Available Mon.-Thurs. 8 a.m. to 6 p.m. (ET), and Friday, 9 a.m. to 6 p.m. (ET)<br><br>Or write to:<br><br>BlueCross BlueShield of TN<br>Claims Service Center<br>1 Cameron Hill Cr, Ste 0002<br>Chattanooga, TN 37402-0002 |
| <b>eBusiness Solutions</b>                 | Technical Support         | 423-535-5717<br>Option 2 | BlueCross BlueShield of TN<br>eBusiness Solutions<br>1 Cameron Hill Circle<br>Chattanooga, TN 37402   |
| <b>Provider Relations</b><br>(Phone Local) | Chattanooga Office        | 423-535-6307             | BlueCross BlueShield of TN<br>ATTN: Provider Relations<br>1 Cameron Hill Circle<br>Chattanooga, TN 37402  |
|  | Johnson City /Knoxville   | 1-800-924-7141           | BlueCross BlueShield of TN<br>ATTN: Provider Relations<br>801 Sunset Drive, Bldg C<br>Johnson City, TN 37604<br><br>BlueCross BlueShield of TN<br>ATTN: Provider Relations<br>6305 Kingston Pike<br>Knoxville, TN 37919   |
|  | Nashville/Memphis/Jackson | 855-646-9258             | BlueCross BlueShield of TN<br>ATTN: Provider Relations<br>3200 West End Ave. Ste 102<br>Nashville, TN 37203<br><br>BlueCross BlueShield of TN<br>ATTN: Provider Relations<br>85 N. Danny Thomas Blvd-<br>Memphis, TN 38103  |
| <b>Fraud &amp; Abuse Hotline</b>           | Phone                     | 1-888-343-4221           | To report suspected fraudulent activity   |



**BlueCross BlueShield of Tennessee Provider Administration Manual**

| <b>Contact</b>  | <b>Location/Description</b>  | <b>Telephone Number</b>                    | <b>Address/Description</b>   |
|---|--|--|--|
| <b>Credentialing</b>  |  | 1-800-357-0395                             | BlueCross BlueShield of TN<br>Credentialing Dept.<br>1 Cameron Hill Cr, Ste 0007<br>Chattanooga, TN 37402-0007   |
| <b>Paper Claims Submission</b><br><i>Note: Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated.</i> | Blue Networks M, P, & S<br>BlueCross65 <sup>SM</sup><br>Federal Employee Program (FEP) |  | Submit paper claims to:<br>BlueCross BlueShield of TN<br>Claims Service Center<br>1 Cameron Hill Cr, Ste 0002<br>Chattanooga, TN 37402-0002  |
| <b>BlueCard®<br/>Benefits &amp; Eligibility<br/>All other inquiries</b>   | Phone<br>Phone   | 1-800-676-2583<br>1-800-705-0391           | Available Monday through<br>Friday, 8 a.m. to 6 p.m. (ET)  |
| <b>BlueAdvantage<br/>(Medicare Advantage product)</b>   | Phone  | 1-800-841-7434                             | Available Monday through<br>Friday, 8 a.m. to 6 p.m. (ET)  |
| <b>Provider Audit Inquiries</b>   |  |  | BlueCross BlueShield of TN<br>Provider Audit Department<br>1 Cameron Hill Cr, Ste 0018<br>Chattanooga, TN 37402-0018   |
| <b>Utilization Management (UM)</b>  | Phone<br><br>Fax   | 1-800-924-7141<br><br>1-866-558-0789       | Selected services require prior authorization. (See Sec. VIII. for a listing of those services.)<br><br>Prior authorization is required for all inpatient admissions and may be obtained Monday through Thursday, 8 a.m. to 6 p.m. (ET), Friday, 9 a.m. to 6 p.m. (ET). (See Sec. VIII for information on emergency and after-hours admissions.) |
| <b>UM Appeals<br/>Reconsideration<br/><br/>Standard Appeal and Retro Authorization Request</b>  | Phone<br><br>Written Only<br><br>Fax   | 1-800-924-7141<br><br><br><br>423-591-9451 | BlueCross BlueShield of TN<br>Clinical Review Supervisor<br>1 Cameron Hills Cr, Ste 0017<br>Chattanooga, TN 37402-0017   |

## BlueCross BlueShield of Tennessee Provider Administration Manual

| Contact  | Location/Description | Telephone Number                 | Address/Description   |
|--|----------------------|----------------------------------|---|
| <b>Case Management/<br/>Disease Management/</b>              | Phone<br>Fax         | 1-800-225-8698<br>1-888-328-0394 | To arrange coordination of care for Members with complicated needs, e.g., chronic illnesses and/or catastrophic illnesses or injuries. Available Mon.-Thurs. 8 a.m. to 6 p.m. (ET), and Friday, 9 a.m. to 6 p.m. (ET)   |
| <b>Transplant Case Management</b>                            | Phone<br>Fax         | 1-888-207-2421<br>423-535-5260   |   |
| <b>Pharmacy Program</b><br>BlueCross BlueShield of Tennessee | Phone<br>Fax         | 1-800-924-7141<br>1-888-343-4232 | To submit comments or suggestions regarding BCBST formulary, appeal a denial of a prior authorization, or quantity limitation request.  |
| ExpressScripts (ESI)   | Phone<br>Fax         | 1-877-916-2271<br>1-800-837-0959 | Prior authorization medication requests (for criteria visit the Pharmacy page on the company website, <a href="http://www.bcbst.com">www.bcbst.com</a> );<br>or<br>Requests to override pre-established quantities for drugs listed on the Quantity Limitation List |
| ESI Pharmacy Help Desk Enrollment                            | Phone                | 1-800-922-1557<br>1-800-314-8457 | Claims processing and technical assistance<br><br>Pharmacy network contract inquiries   |

We encourage you to logon to Availity®, the secure area on the company website, [www.bcbst.com](http://www.bcbst.com) to access real time information. If you are not registered, go to <http://www.Availity.com> and click on "Register" in the upper right corner of the home page, select "Let's get started" and follow the instructions in the Availity registration wizard.

On this site you can:

- Check medical, behavioral health and dental claims status (excludes prescription drug claims);
- View your remittance advice;
- Submit prior authorization requests and receive online approvals when specific criteria are met;
- Verify benefits, including eligibility and coverage details; and much, much more....

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### III. HOW TO IDENTIFY A BLUECROSS BLUESHIELD MEMBER

#### A. Identifying a Member's ID Card

Each BlueCross BlueShield of Tennessee (BCBST) Member is issued an ID card. The ID card contains much of the information you will need to submit claims and coordinate your patient's care.

BCBST provides standard ID cards to support its commercial health care benefit plans. Some Members have access to more than one BCBST Network, which will be indicated on the Member's ID card. In the event that a Provider treats a Member who has access to more than one Network in which the Provider participates, BCBST will reimburse the Provider in accordance with the terms of the Network listed first on the Member's ID card.

**Note:** *In the event that a Member's ID card lists more than one Network, reimbursement will be paid in accordance with Section VI. Billing and Reimbursement in this Manual.*



While BCBST ID cards differ depending on the Member's health care benefit plan, there are some standard elements common to most BCBST ID cards.


- Member name;
- Member ID number (including three-letter alpha prefix);
- Group number (if applicable);
- Health Reimbursement Arrangement (HRA) Plan designation (if applicable);
- Member fee (co-pay);
- Prior authorization toll-free number;
- Mailing address for claims and inquiries (back of card);
- Behavioral Health Services telephone number (if applicable);
- Participating Provider network; and
- RX network (if applicable).

**If a Member presents without his or her ID card, Providers should verify health care benefits or eligibility by:**

- \* calling Provider Service at 1-800-924-7141; or
- \* logging on to Availity, the secure area on the company website, [www.bcbst.com](http://www.bcbst.com). If you are not registered, go to <http://www.Avality.com> and click on "Register" in the upper right corner of the home page, select "Let's get started" and follow the instructions in the Availity registration wizard.

The sample ID cards shown below are representative of some Member ID cards in use.

|   |  |   |  |
|---|--|---|--|
|  |  | <b>BlueCross BlueShield of Tennessee</b>  |  |
| <b>CHRIS B HALL</b>   |  | <b>MEDICAL/DENTAL/VISION</b>  |  |
| Subscriber ID<br><b>ABC123456789</b>  |  |  |  |
| Group No. 12345   |  | <b>Copayments:</b><br>OV 25<br>SPEC 55<br>ER 75<br>IPH 150<br>V 30                  |  |
| RXBIN 610014<br>RXGRP BCTCOMM<br><b>BLUE NETWORK: P</b>                             |  | RX \$10/\$35/\$50   |  |
| <b>RX04</b>   |  |   |  |

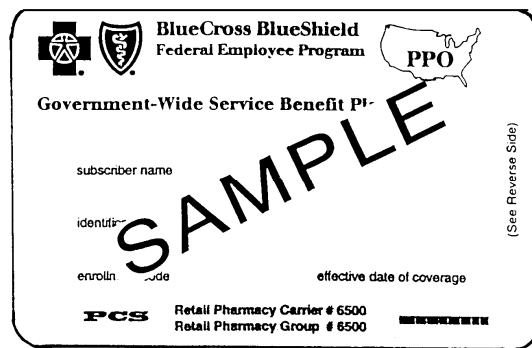
|   |  |  |  |
|---|--|--|--|
|  |  | <b>BlueCross BlueShield of Tennessee</b> |  |
| <b>CHRIS B HALL</b>   |  | <b>DENTAL COVERAGE</b>                   |  |
| Subscriber Identification Number<br><b>123456789</b>                                |  |  |  |
| Group No. 123456  |  |  |  |
|   |  |  |  |

## BlueCross BlueShield of Tennessee Provider Administration Manual

Some Member health care benefit plans may have customized ID cards\* which differ slightly from those shown above. The BlueCross BlueShield of Tennessee logo should appear on **all** BlueCross BlueShield of Tennessee ID cards, however, some national accounts may have the BlueCross BlueShield logo without the specific Plan designation, i.e., "of Tennessee".

\*The Federal Employees Program (FEP) ID card is a nationally recognized identification card that will aid in admissions to hospitals without having to verify benefits with the Member's employer. Members and Providers may call FEP Customer Service at 1-800-572-1003 or 423-535-5707 for claims filing procedures, requests for additional claim forms and/or benefit information.

All ID cards for federal employees are issued by FEP Operations Center in Washington, DC. For services rendered in Tennessee, Providers may submit claims to the following claims address for Members carrying a BlueCross BlueShield FEP ID card, regardless of the state in which the Member resides.



### Mail claims to:

BlueCross BlueShield of Tennessee, Inc.  
FEP Claims Department  
1 Cameron Hill Circle, Ste 0002  
Chattanooga, TN 37402-0002

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## B. Determining Eligibility

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Providers may obtain eligibility or Member health care benefits information by

- calling Provider Service at 1-800-924-7141; or
- logging on to Availity, the secure area on the company website, [www.bcbst.com](http://www.bcbst.com).

**Note: Verification of BlueCross BlueShield of Tennessee health coverage is not a guarantee of benefits or coverage (does not guarantee benefits will be paid for the Provider's services).** The Member's health care benefit plan may have terminated, self-insured or administrative services only (ASO) group may not pay for services, or benefits may be limited by the terms of the Member's contract or by pre-existing conditions. The Provider's services and course of treatment must also be deemed Medically Necessary and Medically Appropriate. BlueCross BlueShield of Tennessee reserves the right to determine whether, in its judgment, a service is Medically Necessary and Medically Appropriate for purposes of benefit determination. The fact that a Practitioner has prescribed, performed, ordered, recommended or approved a service does not in itself make it Medically Necessary and Medically Appropriate.

➤ **Availity**

Availity enables Providers to view information in a secure online environment. Using Availity Providers can:

- Check Claim Status;
- Verify Benefits, Eligibility and Coverage Details;
- Submit Claims (RTCA);
- View/Print Remittance Advice;
- Submit/Update Prior Authorizations; and
- Much More

➤ **Retroactive Member Termination Recoveries**

If BlueCross BlueShield of Tennessee verifies eligibility of an individual who is subsequently determined to have been ineligible at the time services were rendered, BlueCross BlueShield of Tennessee shall recover payments made to BlueCross BlueShield of Tennessee Providers for services rendered to that Member no more than ninety (90) days prior to the date that BlueCross BlueShield of Tennessee was notified the individual Member was ineligible. Such recovery will be based upon actual claim payment date. If the Member Benefit Agreement contains a lesser retroactive Member termination clause (e.g. seven (7) days), such clause shall apply.

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## **C. Member Fees**

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Members agree to pay certain cost-sharing fees for a Covered Service, depending upon the health care benefit plan under which he or she is enrolled. These cost-sharing fees are described below:

- **Co-insurance** - a pre-determined percentage of amount allowed;
- **Copayment** - a specified dollar amount that a Member pays each time he or she visits a Provider's office. A Provider can collect a copayment from the Member at the time of the office visit.
- **Deductible** - the amount of money the Member is required to pay in a given time period before BlueCross BlueShield of Tennessee starts to pay benefits. The deductible is usually a set amount or percentage determined by the Member's health care benefit plan.

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## IV. GROUP HEALTH CARE BENEFITS

### Commercial Products

BlueCross and BlueShield of Tennessee, Inc. offers a variety of products with network configurations to meet our Member needs for coordination of care and greater affordability. We have a variety of products for individuals, small and large groups on a fully insured and self-funded basis. These products may or may not have out-of-network benefits and may include broad or narrow network of participating Providers.

Our products and services are continually evolving to help ensure we stay true to our mission, to provide peace of mind by helping people and communities achieve better health. Coverage can also be purchased through the individual Health Insurance Marketplace.

Visit [www.bcbst.com](http://www.bcbst.com) for more information about our products in your area.

The health care benefits and exclusions information in this section are general. If there are specific differences between what is listed in this Manual and what is reflected in the Member's health care benefit plan, the terms and conditions of the Member's benefit plan control.

Member health care benefits may be verified by calling Provider Services at 1-800-924-7141, the BlueCross BlueShield of Tennessee Customer Service number listed on the Member's ID card or accessing *e-Health Services*® via Availity on the company website, [www.bcbst.com](http://www.bcbst.com). If you are not registered, go to <http://www.Avality.com> and click on "Register" in the upper right corner of the home page, select "Let's get started" and follow the instructions in the Availity registration wizard.

**The Member's health care benefit plan will pay the Maximum Allowable Charge for Medically Necessary and Medically Appropriate** services and supplies provided in accordance with the reimbursement schedules. Charges in excess of the reimbursement rates are not eligible for reimbursement or payment.

**To be eligible for reimbursement or payment**, all services or supplies must be provided in accordance with BlueCross BlueShield of Tennessee Medical Policies and Procedures. (See Sec. X. *Care Management* in this Manual for specifics.)

**Obtaining services not in accordance with BlueCross BlueShield of Tennessee Medical Policies and Procedures** may result in the denial of payment or a reduction in reimbursement for otherwise eligible Covered Services.



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## A. Eligible Providers of Service

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1. **Practitioners** - All services must be rendered by a Practitioner type listed in the *BlueCross BlueShield of Tennessee Referral Directory of Network Providers*, or as otherwise required by Tennessee law. The services provided by a Practitioner must be within his or her specialty or scope of practice.
2. **Network Provider**- A Provider who has contracted with BlueCross BlueShield of Tennessee to provide Covered Services at specified rates. Some Providers may have contracted with BlueCross to provide a limited set of Covered Services, such as only Emergency Care Services, and are treated as Network Providers for this limited set of Covered Services.
3. **Out-of-Network Provider**- A Provider who does not have a contract with BlueCross BlueShield of Tennessee to provide Covered Services, and who is not a Non-Contracted Provider.
4. **Other Providers of Service** - An individual or facility, other than a Practitioner, duly licensed to provide Covered Services.
5. **Assistant-at-Surgery**- Benefits will be provided for surgery performed by a Practitioner (see Section VI. for Assistant-at-Surgery specifics) who actively assists the operating surgical procedure, provided no intern, resident or other staff Practitioner is available.

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## B. Additional Services

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### Blue365 Program

**Providers can help their patients save money on a number of non-covered services by informing them about the Blue365 Program.** Our program is a value-added Member discount program for health and wellness products and services available to BlueCross Members located throughout the country. Members can receive discounts on a wide variety of national and local products and services to help Members and their families live a healthy balanced lifestyle.

Members are responsible for the entire cost of any services or products they receive through this program and the terms and conditions of the Member's health plan do not apply to these services. The program discounts are subject to change. Discounts for products and services include, but are not limited to:

- Wellness & Lifestyle including Fitness Center Discounts
- Weight Loss
- Healthy Eating
- Personal Care
- Vision, Dental and Hearing Care
- Financial Health
- Fitness Devices
- Baby Products

Members can take advantage of the Blue365 Program by logging on to [www.bcbst.com](http://www.bcbst.com) and clicking on the "My Health and Wellness" tab.

**Note:** Members of Tennessee Rural Health plans (TRH, Farm Bureau, First Farmers, Merchants Bank, the Federal Employee Program (FEP), BlueCare or TennCareSelect are not eligible for the Blue365 Program.

## Health Reimbursement Arrangement (HRA)

A Health Reimbursement Arrangement (HRA) is an employer-funded account made available to employees and their dependents to reimburse eligible medical expenses. Not all benefit plans have an HRA, and all HRAs are not set up with the same eligible expenses or allocation amounts.

- BlueCross BlueShield of Tennessee Members with HRAs are identified by the “[HRA Plan]” reflected on their ID cards.



- HRA information is reflected in Availity, BlueCross BlueShield of Tennessee's secure area on its website, [www.bcbst.com](http://www.bcbst.com) under the “Medical Plan Info” section.

### Administration –

- For Members with an HRA, when the medical claim is submitted for processing, the HRA benefits will automatically process at the same time.
- With BlueCross BlueShield of Tennessee's integrated HRA, the HRA payment is reimbursed directly to the Provider on the same remit but on a separate line item as the medical reimbursement.
- Because the HRA reimbursement is sent directly to the Provider, it may be administratively easier to collect from the Member a portion of the expected Member liability at the time of service. This will reduce the likelihood of an overpayment after the claim has been processed.
- As with medical claims, the HRA is processed on a first-in/first-out basis.

| Account Balance        |          |
|------------------------|----------|
| HRA Balance            |          |
| Remaining balance      | \$0.00   |
| Total paid this year   | \$500.00 |
| Employer annual pledge | \$500.00 |
| Prior Year Carryover   | \$0.00   |

## C. General Exclusions from Coverage

\*Exclusions or Non-Covered Services may vary between products and plans. Health care benefits for all Members should be verified by calling Provider Services at 1-800-924-7141, BlueCross BlueShield of Tennessee Customer Service number listed on the Member's ID card, or accessing e-Health Services® on the company website, [www.bcbst.com](http://www.bcbst.com).

Non-Covered Services\* include, but are not limited to,

- Services or supplies not listed as a Covered Service under the Member's health care benefit plan.
- Services or supplies that are determined to not be Medically Necessary and Medically Appropriate.
- Services or supplies that are Investigational in nature including, but not limited to, 1) drugs; 2) biologicals; 3) medications; 4) devices; and 5) treatments.
- Services or supplies provided by a Provider that is not accredited or licensed or are outside the scope of his/her/its license.
- Illness or injury resulting from war, that occurred before the Member's coverage began and that is covered by (1) veteran's benefit or (2) other coverage for which the Member is legally entitled.

## BlueCross BlueShield of Tennessee Provider Administration Manual

Non-Covered Services\* include, but are not limited to (cont'd),

- Self-treatment or training.
- Staff consultations required by hospital or other facility rules.
- Services rendered free of charge, except when rendered by a non-governmental, charitable research hospital that bills patients for services rendered but does not enforce collection from an individual patient.
- Services or supplies for the treatment of work-related illness or injury, regardless of the presence or absence of workers' compensation coverage. This exclusion does not apply to injuries or illnesses of an employee who is (1) a sole-proprietor of the Group, unless required by law to carry workers' compensation insurance; (2) a partner of the Group, unless required by law to carry workers' compensation insurance; or (3) a corporate officer of the Group, provided the officer filed an election not to accept workers' compensation with the appropriate government department.
- Personal, physical fitness, recreational or convenience items and services, even if ordered by a licensed Practitioner, including but not limited to, weight loss programs and equipment; physical fitness/exercise programs and equipment; devices and computers to assist in communication or speech, (e.g., Dynabox); air conditioners, humidifiers, air filters and heaters; saunas, swimming pools and whirlpools; water purifiers; tanning beds; televisions; barber and beauty services; and self-help devices that are not primarily medical in nature.
- Services or supplies received before the effective date of the Member's coverage.
- Services or supplies related to a hospital confinement, received before the Member's effective date of coverage.
- Services or supplies received after the Member's coverage ceases for any reason. This is true even though the expenses relate to a condition that began while the Member was Covered. The only exception to this is described under *Extended Benefits* under the Member's health care benefit plan.
- Services or supplies received in a dental or medical department maintained by or on behalf of the Member's employer, mutual benefit association, labor union or similar group.
- Services or charges to complete a claim form or to provide medical records or other administrative functions. BlueCross BlueShield of Tennessee does not charge the Member or his/her legal representative for statutorily required copying charges.
- Charges for failure to keep a scheduled appointment.
- Charges for telephone consultations, email or web-based consultations, except as may be provided for by specially arranged Care Management programs, health and wellness programs or emerging health care programs as described under *Prior Authorization, Care Management, Medical Policy and Patient Safety and Health and Wellness* or in accordance with the Covered Services for Telehealth under the Member's health care benefit plan.
- Court-ordered examinations and treatment, unless Medically Necessary.
- Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day.
- Charges in excess of the Maximum Allowable Charge for Covered Services.
- Any service stated in the Member's health care benefit plan as a non-Covered Service or limitation.
- Charges for services performed by the Member or his/her spouse, or the Member's/Member's spouse's parent, sister, brother or child.
- Any charges for handling fees.
- Safety items or items to affect performance primarily in sports-related activities.
- Services or supplies, including bariatric surgery, for weight loss or to treat obesity, even if the Member has other health conditions that might be helped by weight loss or reduction of obesity. This exclusion applies whether the Member is of normal weight, overweight, obese or morbidly obese.

Non-Covered Services\* include, but are not limited to (cont'd),

- Services or supplies related to treatment of complications (except complications of pregnancy) that are a direct or closely related result of a Member's refusal to accept treatment, medicines or a course of treatment that a Provider has recommended or has been determined to be Medically Necessary, including leaving an inpatient medical facility against the advice of the treating Physician.
- Services considered cosmetic except when Medically Appropriate per medical policy. This exclusion also applies to surgeries to improve appearance following a prior surgical procedure, even if that prior procedure was a Covered Service. Services that could be considered cosmetic include, but are not limited to, (1) breast augmentation; (2) sclerotherapy injections, laser or other treatment of spider veins and varicose veins; (3) rhinoplasty; (4) panniculectomy/abdominoplasty; and (5) Botulinum toxin.
- Services that are always considered cosmetic, including, but not limited to, (1) removal of tattoos; (2) facelifts; (3) body contouring, or body modeling; (4) injections to smooth wrinkles; (5) piercing ears or other body parts; (6) rhytidectomy or rhytidoplasty (Surgery for the removal or elimination of wrinkles); (7) thighplasty; (8) brachioplasty; (9) keloid removal; (10) dermabrasion; (11) chemical peels; (12) lipectomy; and (13) laser resurfacing.
- Blepharoplasty and browplasty.
- Charges related to surrogate pregnancy when the surrogate mother is not a Covered Member under the Member's health benefit plan.
- Sperm preservation.
- Services or supplies for orthognathic surgery, a discipline to specifically treat malocclusion. Orthognathic surgery is not surgery to treat cleft palate, or TMJ/TMD.
- Services or supplies for maintenance care.
- Private duty nursing.
- Unless Covered by a supplemental Prescription Drug Rider, services or supplies to treat sexual dysfunction, regardless of cause, including, but not limited to, erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido.
- Charges for injuries due to chewing or biting or received in the course of other dental procedures.
- Services or supplies related to complications of cosmetic procedures.
- Services or supplies related to complications of bariatric surgery, re-operation of bariatric surgery or body remodeling after weight loss.
- Cranial orthosis, including helmet or headband, for the treatment of non-synostotic plagiocephaly.
- Chelation therapy, except for (1) control of ventricular arrhythmias or heart block associated with digitalis toxicity; (2) emergency treatment of hypercalcemia; (3) extreme conditions of metal toxicity, including thalassemia with hemosiderosis; (4) Wilson's disease (hepatolenticular degeneration); and (5) lead poisoning.
- Vagus nerve stimulation for the treatment of depression.
- Balloon sinuplasty for treatment of chronic sinusitis.
- Treatment for benign gynecomastia.
- Treatment for hyperhidrosis.
- Intradiscal annuloplasty to treat discogenic back pain. This procedure provides controlled delivery of heat to the intervertebral disc through an electrode or coil.
- Methadone not received at a pharmacy.
- Human growth hormones, unless Covered by a supplement Prescription Drug Rider.
- Prescription Drugs that are illegal under federal law such as marijuana.
- Immunizations required for sports, camp, employment, travel, insurance and marriage or legal proceedings.

Non-Covered Services\* include, but are not limited to (cont'd),

- Narcotics (including opioids), psychoactive drugs (including benzodiazepines) and any other controlled substance prescribed by Providers that BlueCross has suspended or removed from its network(s) due to abusive prescribing of such a drug or drugs.
- Compound drugs, unless Medically Necessary and Medically Appropriate.
- Office visits and physical exams when required solely for participation in sports.

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## V. MEMBER POLICY

### A. Introduction

BlueCross BlueShield of Tennessee, Inc. is dedicated to the prevention and treatment of diseases by promoting access to quality medical services to its Members. Members and participating Providers share a partnership for quality health care. Members have the right to receive covered medical services and have certain responsibilities to aid in receiving them.

### B. Member Access-to-Care

To ensure quality and continuity of care for BlueCross BlueShield of Tennessee Members after regular clinic hours, Practitioners will provide 24-hour-a-day, 7-days-a-week service. Practitioners must be able to respond to Member calls or calls from an Emergency Department or Hospital concerning their BlueCross BlueShield of Tennessee patients within the time limits described in the *BlueCross BlueShield of Tennessee Member Access and Availability Standards* for routine or urgent care.

Arrangements for 24-hour access to equally qualified Practitioners participating in the same BlueCross BlueShield of Tennessee network as the Member's Practitioner are the responsibility of all contracted Practitioners who participate in BlueCross BlueShield of Tennessee networks.

#### **Standards for telephone access after regular clinic hours:**

1. A telephone number or pager answered by covering Practitioner;
2. A non-automated, "live" answering service that directs Members' calls to an "on-call" covering Practitioner; or
3. An automated answering machine that directs the Member to the Practitioner or appropriate covering Practitioner.

#### **Standards for responding to Member telephone calls after regular hours:**

1. The Member, or Member's representative, must be able to speak directly with an appropriate Practitioner;
2. It is acceptable for the answering service to take a message and have the Practitioner return the call to the Member;
3. At a minimum, the live answering service should request the following from the Member:
  - Reason for call
  - Name
  - Telephone number
  - Name of Practitioner
4. Practitioners providing on-call coverage after regular office hours must respond directly to Members or Members' representative within the following time frames:
  - **If Urgent**, within 30 minutes of receipt of the message from the answering service/machine; or
  - **If routine**, within 90 minutes of receipt of the message from the answering service machine.

A survey of compliance with BlueCross BlueShield of Tennessee's call coverage policy is performed during office site visits. Noncompliance is addressed through the company's Medical Corrective Action Plan (See Section XII.). BlueCross BlueShield of Tennessee uses these guidelines when credentialing and recredentialing its Practitioners.

## BlueCross BlueShield of Tennessee Provider Administration Manual

Specific ambulatory encounters that BlueCross BlueShield of Tennessee will monitor are:

| Appointment Type                        | Definition  | Standard  |
|---|---|---|
| Routine Adult Physical Examination      | Routine exam of a patient who has no acute symptoms which includes Medically Necessary and Medically Appropriate health screenings and immunizations, if a covered benefit.   | Annually – within 1 year of last scheduled physical after coverage becomes effective, or if last physical is greater than one year, within 3 months |
| Children Preventive                     | Counseling, coordination, and treatment of an anticipatory nature to include guidance and risk reduction interventions. (E.g., vaccinations, immunizations) according to the American Academy of Pediatrics periodicity schedule.   | According to the American Academy of Pediatrics periodicity schedule  |
| Prenatal Care                           | Counseling, diagnosis, treatment and coordination of care for pregnancy for all Members to prevent complications, and to decrease the incidence of maternal and prenatal mortality.<br><br>1st Trimester<br>2nd Trimester   | <br><br>≤ 6 weeks<br>≤ 15 weeks   |
| Urgent Care for Adult and Child         | 1. Urgent Examination: Medically Necessary and Appropriate services and supplies to diagnose and treat acute symptoms of sufficient severity that cannot wait until the next available appointment. These services may be provided by facility-based Providers.<br><br>2. Urgent Specialty: Coordination of care which is diagnostic or confirmatory in nature and needed when an expert opinion is required to determine appropriate care for a patient with an acute condition which is moderate to severe in complexity. If not treated, this condition could lead to harmful outcomes and emergency care.   | ≤ 48 hours  |
| Emergency Care                          | Medically Necessary services that are required to evaluate, treat, and stabilize a patient's emergency condition. An emergency is defined as a sudden and unexpected medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect to result in: serious impairment of bodily functions; serious dysfunction of any bodily organ or part; or placing the prudent layperson's health in serious jeopardy. These services may be provided by facility-based providers. It is understood that in those instances where a Physician makes emergency care determinations, the Physician shall use the skill and judgment of a reasonable Physician in making such determinations. | Immediate   |
| Specialty Care for both Adult and Child | Coordination of care, which is diagnostic or confirmatory in nature and needed when an expert is required to perform or determine appropriate follow-up care for a patient. (E.g., cardiology, orthopedics, urology, neurology)   | As Practitioner deems appropriate for condition or follow-up  |
| Wait Times                              | 1. Office Wait Time (including lab and X-ray).....<br>2. Member Telephone Call (during office hours):<br>• Urgent.....<br>• Routine.....<br>3. Member Telephone Call (after office hours):<br>• Urgent.....<br>• Routine.....   | ≤ 45 minutes<br><br>≤ 15 minutes<br>≤ 24 hours<br><br>≤ 30 minutes<br>≤ 90 minutes  |

References: Thomas, Clayton L. MD(ED.) 1993 *Tabor's Cyclopedic Medical Dictionary*. (Edition 17) Philadelphia: F.A. Davis Company. American Medical Association. (1998) *Practitioner's Current Procedural Terminology*.  
Rev 03/13

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## C. Member Rights and Responsibilities

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BlueCross BlueShield of Tennessee educates its Members on their rights and responsibilities. As a participating network Provider, you should know what our Members are being told to expect from you and what you have the right to expect from those Members. To comply with regulatory and accrediting requirements, BlueCross BlueShield of Tennessee periodically reminds Members of their rights and responsibilities. These reminders are intended to make it easier for Members to access quality medical care and to attain services.

### Member Rights

Members have the right to:

- Be treated with respect and dignity, and need for privacy.
- Receive information about policies and services of their Plan network, including structure, operation, quality improvement activities, Practitioners and Providers, and Member rights and responsibilities.
- Participate with Practitioners in the decision-making regarding their health care.
- Voice complaints or appeals about the organization or the care it provides.
- A candid discussion of appropriate Medically Necessary treatment options for their condition regardless of cost or benefit coverage.
- Make recommendations regarding the organization's Member rights and responsibilities.

### Member Responsibilities

Members are expected to:

- Provide, to the extent possible, all information that the organization and its Practitioners and Providers need in order to provide care.
- Follow plans and instructions for care that they have agreed to with their Practitioners.
- Understand their health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.

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## D. Member Grievance Process

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BlueCross BlueShield of Tennessee has incorporated formal mechanisms to address Member concerns and complaints or grievances. Concerns raised by Members and Providers will be utilized to continuously improve product lines, processes and services. All employees are alert for and responsive to inquiries, complaints and concerns and address such issues promptly and professionally. All other written concerns or complaints are considered grievances and will be processed through BlueCross BlueShield of Tennessee's usual grievance procedure described in Sec. VIII and Sec. XIII In this Manual.

Member concerns, complaints, and resolutions, if applicable, are documented and maintained by BlueCross BlueShield of Tennessee in accordance with its corporate policies. If a Member has an inquiry, concern or complaint regarding any aspect of services received, the Member may contact the designated Customer Service Representative of BlueCross BlueShield of Tennessee to discuss the matter. If a Member feels that the Customer Service Representative has not resolved a problem, it is his/her right to submit a written grievance or suggestion for improvement to the Grievance Committee.



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## E. Financial Responsibility for the Cost of Services

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If a BlueCross BlueShield of Tennessee Network Provider renders a service which is Investigational or does not meet Medically Necessary and Appropriate criteria, the Provider must obtain a written statement from the Member, **prior** to the service(s) being rendered, acknowledging that the Member understands he/she may be responsible for the cost of the specific service(s) and any related services. Providers may also utilize this form in the event a Member requests non-emergency, cosmetic or elective services that are specifically excluded under the Member's health benefits plan. It is essential the signed statement be kept on file, as it may be necessary to provide a copy of the signed statement to BlueCross BlueShield of Tennessee verifying the Member's agreement to the financial responsibility.

To help assist in this process, BlueCross BlueShield of Tennessee developed the *Acknowledgement of Financial Responsibility for the Cost of Services* form for Provider use. This form meets the contractual obligations of BlueCross BlueShield of Tennessee Provider Agreements. **Providers are strongly encouraged to use this form.** Providers using their own form should insure their form includes the following:

1. The name of the specific service/procedure the Provider will perform;
2. The reason why the Provider believes that BlueCross BlueShield of Tennessee will not provide benefits for the service/procedure; i.e., BlueCross BlueShield of Tennessee considers the service/procedure to be Investigational, Cosmetic or not Medically Necessary and Appropriate;
3. The approximate cost of the service/procedure and associated costs;
4. A statement acknowledging the Member understands that BlueCross BlueShield of Tennessee will not provide benefits for the service/procedure;
5. A statement acknowledging the Member has been advised why BlueCross BlueShield of Tennessee will not cover the service/procedure and that he/she understands and agrees that he/she will be responsible for all the costs and any associated costs;
6. A statement indicating the form is only valid for one (1) service/procedure; and
7. A specific expiration date.

**Note:** *Some out-of-state plans have different coverage provisions. Please make sure that the out-of-state plan does not cover the service in question prior to the Member signing the waiver agreement. The Acknowledgement of Financial Responsibility for the Cost of Services form can only be used in the event the Member does not have coverage for the service in question as determined by verification of the Member's coverage.*

A sample copy of the *Acknowledgement of Financial Responsibility for the Cost of Services* form follows:

**BlueCross BlueShield of Tennessee  
Acknowledgement of Financial Responsibility  
for the Cost of Services  
(For use with Blue Networks E, M, S, and P)**

To: \_\_\_\_\_;

Re: (Identification of Prescribed Service)

I have been informed that my health care benefits insurer or administrator, BlueCross BlueShield of Tennessee, may determine that the above referenced service(s) may be an Investigational Service, Cosmetic, may not be a Covered Service or may not be Medically Necessary or Medically Appropriate as those terms are defined in my Member health care benefits plan from BlueCross BlueShield of Tennessee. Therefore, the service would be excluded from coverage by my health care benefits plan. My provider has also informed me about alternative treatments, if any, that may be covered by BlueCross BlueShield of Tennessee.

I understand that my provider may request that BlueCross BlueShield of Tennessee reconsider that determination by presenting evidence that the referenced service(s) is not an Investigational Service, is a Covered Service or the service is considered to be Medically Necessary or Medically Appropriate. I also understand that I have the right to request reconsideration of that determination, as described in the Member grievance section of my health care benefits plan, either before or after receiving the service(s).

I have been informed that the potential costs of the referenced service(s) will be approximately \$\_\_\_\_\_. I understand that, if I elect to receive the service(s) and BlueCross BlueShield of Tennessee determines that the service(s) is an Investigational Service, is not a Covered Service or the service is not considered to be Medically Necessary or Medically Appropriate, I will be responsible to pay for all costs associated with the service(s), including, but not limited to, practitioner costs, facility costs, ancillary charges and any other related expenses. I acknowledge that BlueCross BlueShield of Tennessee may not pay for the service(s).

In the event of multiple procedures, this form is valid only for one (1) unit of the prescribed service(s), unless specifically provided for otherwise.

This form will expire and will no longer be valid six (6) months from the date of execution.

Signature of Patient or Responsible Person

\_\_\_\_\_

Date: \_\_\_\_\_

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## **F. Member/Practitioner Relationship Termination**

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Whether the termination of the Practitioner and Member relationship is initiated by the Practitioner or by BlueCross BlueShield of Tennessee's termination of the Practitioner, it is the responsibility of the Practitioner to notify the Member prior to the effective date of the termination.

## VI. BILLING AND REIMBURSEMENT

During 2014, the State of Tennessee launched a state-wide initiative, **Tennessee Health Care Innovation Initiative (THCII)**, to begin transitioning its TennCare health care payment system to an episode-based payment system that rewards outcomes and quality care (i.e. value-based care), rather than for the amount of services provided (i.e. volume-based). As part of this initiative, the Episodes of Care program was implemented to reward providers for delivering high-quality and efficient care for an acute health care event without making changes to the current fee-for-service payment method that most providers use.

Effective January 1, 2017, BlueCross BlueShield of Tennessee expanded the THCII Episode of Care program to our State Employee Health Plan (SEHP) and Fully Insured Members who utilize Blue Network S<sup>SM</sup>. However, there are a couple of modifications to the program that will be specific only to these two populations:

- The Principle Accountable Provider (PAP) a.k.a. Quarterback must have forty or more episodes to be eligible for any gain or risk sharing
- Up to sixty episodes of care will be established through year 2019

The first year includes the following episodes:

- Perinatal
- Total Joint Replacement (hip and knee)
- Colonoscopy
- Percutaneous Coronary Intervention (PCI) – Acute
- Percutaneous Coronary Intervention (PCI) – Non Acute

To help you learn more about the Tennessee Health Care Innovation Initiative, we developed a number of Frequently Asked Questions and a Provider Guide that can be accessed on the Provider page on the company websites, <http://www.bcbst.com/providers/episode-of-care.page>. The THCII Provider Guide is also found in Attachment I – THCII in this Manual.

Episodes of care reports are available on Availity, BlueCross BlueShield of Tennessee's secure web portal. Just log on and scroll to the link "Tennessee Health Care Innovation Initiative". Select the reporting period and line of business to review. If you are not registered, go to <http://www.Availity.com> and click on "Register" in the upper right corner of the home page, select "Let's get started" and follow the instructions in the Availity registration wizard. Providers can also find more information on the State of Tennessee's website at <https://www.tn.gov/tenncare/health-care-innovation.html>.

### A. How to File a Claim

**NOTE:** The reference to "Institutional" and "Professional" claims throughout this section of the Manual is defined below:

#### **Institutional Claims**

*(Hospital or Facility claims)*

CMS-1450

UB-04

ANSI-837I

#### **Professional Claims**

*(Medical or Practitioner claims)*

CMS-1500

ANSI-837P

BlueCross BlueShield of Tennessee ("BCBST") is prepared to accept claims electronically in the ANSI 837 format or in paper; the required method is electronically. An acceptable alternative for the Centers for Medicare & Medicaid Services (CMS) CMS-1500 or CMS-1450 claims is the Optical Character Recognition (OCR) scannable format. Electronic and OCR scannable claims promote effective processing and timely payment. Where neither of the above methods is practical, paper claims will be accepted.

## BlueCross BlueShield of Tennessee Provider Administration Manual

Professional charges should be submitted on the CMS-1500/ANSI-837 Professional Transaction and Institutional charges on the CMS-1450/ANSI-837 Institutional Transaction. Complete claims data should be filed for all services regardless of whether those services are covered. All services for the same patient, same date of service, same place of service, and same Provider must be billed on a single claim submission.

Claims data is utilized for administrative measurement needed for the Healthcare Effectiveness Data and Information Set (HEDIS) and NCQA requirements.

BCBST commercial timely filing period is **180 days** from the date of service or, for facilities, within **180 days** from the date of discharge.

If the Provider has documented evidence the Member did not provide BCBST insurance information, the timely filing provision shall begin with receipt of insurance information, subject to the limitations of the Member's benefit agreement.

On paper claims that are returned to the Provider for additional information, **it is important that Providers send back the form that was attached as proof of timely filing.** If BCBST is secondary, the timely filing period is **60 days** from the date of service or, for facilities, within **60 days** from the date of discharge or **60 days** from the primary carrier's notice of payment.

Proof of timely filing for a returned paper claim is the black and white copy of the claim with error codes listed at the top of the claim that was returned to the Provider. Providers should always maintain a copy of the returned claim in case there is a question about timely filing. With new imaging technology images of all rejected and accepted claims are maintained in BlueCross's archives for future reference.

BCBST generates the 277CA Health Care Information Status Notification (277CA) as proof of timely filing for electronically submitted claims. The 277CA supplies providers with the assigned payer claim control number of each claim received electronically. This control number should be maintained by the Provider for proof of timely filing. Providers submitting electronic claims either directly or through a billing service/clearinghouse will automatically receive the 277CA in their electronic mailbox. To learn more about retrieving your electronic reports, call eBusiness Solutions at 423-535-5717 (Option 2), Monday through Thursday, 8 a.m. to 6 p.m. (ET) and Friday, 9 a.m. to 6 p.m. (ET).

**Note:** *Submission dates of claims filed electronically that are not accepted by BlueCross BlueShield of Tennessee due to transmission errors are not accepted as proof of timely filing.*

### 1. Filing Electronic Claims (Required Method)

BCBST implemented an electronic claims processing system in 2003 to be in compliance with federal Health Insurance Portability and Accountability Act of 1996-Administrative Simplification (HIPAA-AS) requirements. This system is used for processing of American National Standards Institute (ANSI) 837 claims and other ANSI transactions, and to verify HIPAA compliancy of those transactions. BCBST business edits have been modified to recognize the required ANSI formats. These edits apply to both electronic and scannable paper claims.

#### a. **Provider Number/National Provider Identifier (NPI) Number for Electronic Claims:**

Claims submitted electronically must include the Provider's appropriate individual BCBST Provider number and/or NPI in the required data elements as specified in the Implementation Guide. This guide is available online via the Washington Publishing Company website at <http://www.wpc-edi.com/>. Additional companion documents needed for BCBST electronic claims submission can be accessed at <http://www.bcbst.com/providers/ecommerce/technical-information.shtml>.

**Note:** BCBST follows the CMS guidelines for filing the National Provider Identifier (NPI) Number.

#### **Electronic Enrollment and Support**

Enrollment of new Providers, changes to existing Provider or billing information (address, tax ID, Provider number, NPI, name), or any changes of software vendor should be communicated to

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eBusiness Provider Solutions via the *Provider Electronic Profile* form. The Provider Electronic Profile form can be downloaded from the company website, [www.bcbst.com](http://www.bcbst.com) or obtained upon request. (See contact numbers listed below.)

**Mail** *Provider Electronic Profile* forms to:

BlueCross BlueShield of Tennessee  
Provider Network Services  
1 Cameron Hill Circle, Ste 0007  
Chattanooga, TN 37402-0007

**Technical Support**

call: 423-535-5717  
e-mail: [eBusiness\\_Service@bcbst.com](mailto:eBusiness_Service@bcbst.com)

**Enrollment**

call: 1-800-924-7141  
fax: 423-535-7523  
e-mail: [eBusiness\\_SysConfig@bcbst.com](mailto:eBusiness_SysConfig@bcbst.com)

**b. Electronic Data Interchange (EDI)**

HIPAA standards require Covered Entities to transmit electronic data between trading partners via a standard format (ANSI X12). EDI allows entities within the health care system to exchange this data quickly and securely. Currently, BCBST uses the ANSI 837 version, 5010 format.

American National Standards Institute has accredited a group called “X12” that defines EDI standards for many American industries, including health care insurance. Most electronic standards mandated or proposed under HIPAA are X12 standards.

**c. Secure File Gateway (SFG)**

The Secure File Gateway allows trading partners to submit electronic claims and download electronic reports using multiple secure managed file transfer protocols. The SFG provides the ability to transmit files to BCBST using HTTPS, SFTP, and FTP/SSL connections. The below grid reflects a short description of each protocol:

| Protocol  | Description  |
|---|--|
| HTTPS Website,<br><a href="https://mftweb.bcbst.com/myfilegateway">https://mftweb.bcbst.com/myfilegateway</a> | The BCBST secure website allows individuals to login with their secure credentials and submit electronic claims or download electronic reports.                    |
| SFTP (server mftstftp.bcbst.com)  | The BCBST SFTP server allows trading partners to automate their processes to submit electronic claims or download electronic reports.                              |
| FTP/SSL (server mftstftp.bcbst.com)   | The BCBST FTP/SSL server is an additional option to allow trading partners to automate their processes to submit electronic claims or download electronic reports. |

**d. ANSI 837 (Version 5010)**

The ANSI 837 format is set up on a hierarchical (chain of command) system consisting of loops, segments, elements, and sub-elements and is used to electronically file professional, institutional and/or dental claims and to report encounter data from a third party\*.

For detailed specifics on the ANSI 837 format, Providers should reference the appropriate guidelines found in *the National Electronic Data Interchange Transaction Set Implementation Guide*. This guide is available online via the Washington Publishing Company website at <http://www.wpc-edi.com/>. Additional companion documents needed for BCBST electronic claims submission can be accessed at <http://www.bcbst.com/providers/ecommm/technical-information.shtml>.

\*Coordination of Benefits (COB) is part of the ANSI 837, which provides the ability to transmit primary and secondary carrier information. The primary payer can report the primary payment to the secondary payer. For detailed specifics on the ANSI 837 format, Providers should reference the appropriate guidelines found in *the National Electronic Data Interchange Transaction Set Implementation Guide*. This guide is available online via the Washington Publishing Company website at <http://www.wpc-edi.com/>. Additional companion documents needed for BCBST electronic claims submission can be accessed at <http://www.bcbst.com/providers/ecommm/technical-information.shtml>.

## 2. Filing Paper Claims

**Note:** Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated.

When completing a paper claim, please reference the most recent editions of the manuals or refer to the Data Elements required for submitting CMS-1500 claims included later in this section.

- |   |                            |
|---|----------------------------|
| ➤ CMS-1500 Practitioner's Manual            | ➤ CMS-1450 Hospital Manual |
| ➤ Tennessee Uniform Procedure Coding Manual | ➤ ICD Code Manual          |

Also refer to the Data Elements required for submitting CMS-1500 claims included later in this section. In order to assure precise control and timely and accurate payment of claims and to reduce the potential of fraud, BCBST will not accept claims faxed, photocopied or altered; claims which do not meet exception criteria listed below will be returned to the Provider:

- Faxed and Photocopied Claims: All faxed and photocopied claims must be approved by BCBST management or faxed at the request of BCBST.
- Altered Claims: All altered claims are returned to the Provider with an attachment stating BCBST does not accept claims that have been altered.

**Altered claims are claims with whiteout or which BCBST Operations determines are suspicious.**

## 3. Tips for Completing CMS-1500 and CMS-1450 Claim Forms

Listed below are some tips that will help ensure claims are processed rapidly and accurately.

### a. General tips whether submitting OCR or paper:

- Use red standard claim form;
- Type all letters in upper case (capital letters);
- Align all print in appropriate blocks;
- Use a black typewriter ribbon (if typed) or block letters (if handwritten) to reflect a clear impression;
- Enter insured's ID number including the three-letter alpha prefix, exactly as shown on ID card;
- Review each claim to ensure all required fields have been provided;
- Send only original claims and supporting documentation;
- Securely staple any attachments or receipts;
- Do not use Correction Tape or Whiteout when submitting paper claims;

### b. Billing Requirements for Faxed Paperwork (PWK) Attachments

When paper documentation is necessary to support an electronically submitted claim, you can utilize the PWK06 (paperwork) segment (Loop 2300) to indicate that documentation will be sent to BCBST separately from the electronic claim. The actual supporting documentation would be faxed accompanied with a PWK Fax Cover Sheet. BCBST will match the documentation to your electronic claim using the information supplied from the PWK06

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segment and PWK Fax Cover Sheet and utilize that documentation during claims processing and payment. To ensure BCBST matches the documents to an electronic claim for processing; the **documentation and fax sheet should be submitted no later than the day of claims submission.**

**BCBST will only match on the first iteration of PWK06 (ACN) from the ANSI 837 data.**

Ensure your first iteration at claim or line level matches the PWK06 (ACN)

| ANSI 837 Loop | Field Description   | 837P/I Segment |
|---------------|---|----------------|
| 2300          | <b>Attachment Report Type Code</b><br>Use the values indicated in the IG to identify the type of attachment.  | PWK01          |
| 2300          | <b>Attachment Transmission Code</b><br>Use the values indicated in the IG to identify how the attachment will be sent. BCBST accepts supporting documentation by fax only, the value of <b>FX (By Fax)</b> in this data element is the only value accepted. | PWK02          |
| 2300          | <b>Identification Code Qualifier</b><br>Use code value of <b>AC</b> (Attachment Control Number). This data element is required if PWK02 = FX.   | PWK05          |
| 2300          | <b>PWK06 Attachment Control Number</b><br>This is a value assigned by the provider to uniquely identify the attachment. This number must also be included on the "Attachment Fax Sheet".  | PWK06          |

**Example: PWK\*M1\*FX\*\*\*AC\*BCBS1234~**

- Only include your attachment control number (ACN) reported in the PWK06 segment of the claim.
- Complete **ONE (1)** Fax Cover Sheet for each electronic claim for which documentation is being submitted.

**Note:** The PWK Fax Cover Sheet can be found on the company website at <http://www.bcbst.com/docs/providers/PWK-Coversheet.pdf>. Complete the form and fax with documentation to (423) 591-9481.

## 4. CMS-1500 Health Insurance Claim Form

**Note:** *Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated.*

The 1500 Health Insurance Claim Form is the basic paper claim for use by Practitioners and suppliers, and in some cases, for ambulance services. The National Uniform Claim Committee released a revised CMS-1500 (02/12) claim form replacing the CMS-1500 (08/05) version. Effective 4/1/14, **only** use the CMS-1500 (02/12) version.

All professional services need to be filed on the CMS-1500 claim form. These include:

- Professional Outpatient Services;
- Emergency Room Practitioner Fees-must be filed with Location Code 23 (Emergency Room, Hospital); and
- Clinic Visits (professional fees)

**Note:** *BCBST follows CMS guidelines for filing the National Provider Identifier (NPI) Number.*

A sample copy of the CMS-1500 (02/12) claim forms and block descriptions follow:



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## HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

|  |  |  |  |
|--|--|--|--|
| 1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> OTHER <input type="checkbox"/><br><small>(Medicare#) (Medical#) (ID#/DoD#) (Member ID#) (ID#)</small> |  | 1a. INSURED'S I.D. NUMBER (For Program in Item 1)  |  |
| 2. PATIENT'S NAME (Last Name, First Name, Middle Initial)  |  | 3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>   |  |
| 5. PATIENT'S ADDRESS (No., Street)<br><br>CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( )  |  | 4. INSURED'S NAME (Last Name, First Name, Middle Initial)<br><br>7. INSURED'S ADDRESS (No., Street)<br><br>CITY STATE ZIP CODE TELEPHONE (Include Area Code) ( )   |  |
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)  |  | 10. IS PATIENT'S CONDITION RELATED TO:<br>a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO<br>b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) <input type="text"/><br>c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO<br>10d. CLAIM CODES (Designated by NUCC) |  |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER<br>b. RESERVED FOR NUCC USE<br>c. RESERVED FOR NUCC USE<br>d. INSURANCE PLAN NAME OR PROGRAM NAME  |  | 11. INSURED'S POLICY GROUP OR FECA NUMBER<br>a. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/><br>b. OTHER CLAIM ID (Designated by NUCC)<br>c. INSURANCE PLAN NAME OR PROGRAM NAME<br>d. IS THERE ANOTHER HEALTH BENEFIT PLAN?<br><input type="checkbox"/> YES <input type="checkbox"/> NO If yes, complete items 9, 9a, and 9d.     |  |
| 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.<br><br>SIGNED DATE  |  | 13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.<br><br>SIGNED  |  |
| 14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.   |  | 15. OTHER DATE MM DD YY QUAL.  |  |
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE   |  | 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES<br>FROM MM DD YY TO MM DD YY   |  |
| 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)  |  | 20. OUTSIDE LAB? <input type="checkbox"/> YES <input type="checkbox"/> NO \$ CHARGES   |  |
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.   |  | 22. RESUBMISSION CODE ORIGINAL REF. NO.  |  |
| A. B. C. D. E. F. G. H. I. J. K. L.  |  | 23. PRIOR AUTHORIZATION NUMBER   |  |
| 24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER E. DIAGNOSIS POINTER F. \$ CHARGES G. DAYS OR UNITS H. EPSDT Family Plan I. ID. QUAL. J. RENDERING PROVIDER ID. #   |  |  |  |
| 1  |  | NPI  |  |
| 2  |  | NPI  |  |
| 3  |  | NPI  |  |
| 4  |  | NPI  |  |
| 5  |  | NPI  |  |
| 6  |  | NPI  |  |
| 25. FEDERAL TAX I.D. NUMBER SSN EIN  |  | 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO   |  |
| 31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)   |  | 32. SERVICE FACILITY LOCATION INFORMATION<br>a. NPI b.   |  |
| SIGNED DATE  |  | 28. TOTAL CHARGE \$ 29. AMOUNT PAID \$ 30. Rsvd for NUCC Use   |  |
| 33. BILLING PROVIDER INFO & PH # ( )   |  |  |  |

NUCC Instruction Manual available at: [www.nucc.org](http://www.nucc.org)

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

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### **a. CMS-1500 Form Field Descriptions (02/12)**

|             |  |
|-------------|--|
| Block 1     | Type of Plan   |
| Block 1a    | Insured's ID Number (include three-letter alpha prefix)                                |
| Block 2     | Patient's Name   |
| Block 3     | Patient's Date of Birth  |
| Block 4     | Insured's Name   |
| Block 5     | Patient's Address and Telephone Number   |
| Block 6     | Patient's Relationship to Insured  |
| Block 7     | Insured's Address  |
| Block 8     | Reserved for NUCC Use  |
| Block 9     | Other Insured's Name   |
| Block 9a    | Other Insured's Policy or Group Number   |
| Block 9b    | Reserved for NUCC Use  |
| Block 9c    | Reserved for NUCC Use  |
| Block 10abc | Is Patient's Condition Related To  |
| Block 10d   | Claim Codes  |
| Block 11    | Insured's Policy Group or FECA Number  |
| Block 11a   | Insured's Date of Birth  |
| Block 11b   | Other Claim ID   |
| Block 11c   | Insurance Plan Name or Program Name  |
| Block 11d   | Is There Another Health Benefit Plan   |
| Block 12    | Patient's or Authorized Person's Signature (Information Release/Government Assignment) |
| Block 13    | Insured's or Authorized Person's Signature (Payment Authorization)                     |
| Block 14    | Date of Current Illness, Injury, or Pregnancy (LMP)                                    |
| Block 15    | Other Date   |
| Block 16    | Dates Patient Unable to Work in Current Occupation                                     |
| Block 17    | Name of Referring Provider or Other Source   |
| Block 17a   | ID Number of Referring Provider or Other Source  |
| Block 17b   | NPI (National Provider Identifier) of Referring Provider                               |
| Block 18    | Hospitalization Dates Related to Current Services                                      |
| Block 19    | Additional Claim Information   |
| Block 20    | Outside Lab?   |
| Block 21A-L | Diagnosis or Nature of Illness or Injury; ICD Ind                                      |
| Block 22    | Resubmission Code/Original Reference Number (Identifies Corrected Bill)                |
| Block 23    | Prior Authorization Number (If Applicable)   |
| Block 24A   | Dates of Service   |
| Block 24B   | Place of Service   |
| Block 24C   | EMG (if emergency indicator required, enter "Y" for yes; leave blank if No)            |
| Block 24D   | CPT® or HCPCS code, modifiers  |
| Block 24E   | Diagnosis Pointer  |
| Block 24F   | Charges  |
| Block 24G   | Days or Units  |
| Block 24H   | EPSDT/Family Plan (TENnderCARE)  |
| Block 24I   | ID Qualifier   |
| Block 24J   | Rendering Provider ID Number   |
| Block 25    | Federal Tax ID Number or SSN   |
| Block 26    | Patient's Account Number   |
| Block 27    | Accept Assignment  |
| Block 28    | Total Charge   |
| Block 29    | Amount Paid  |
| Block 30    | Reserved for NUCC Use  |
| Block 31    | Signature of Physician or Supplier   |
| Block 32    | Service Facility Location Information (address where service provided)                 |
| Block 32a   | NPI (National Provider Identifier) of Service Facility                                 |
| Block 32b   | Non-NPI ID Number (unique identifier of the facility)                                  |
| Block 33    | Billing Provider Info and Telephone Number   |
| Block 33a   | NPI (National Provider Identifier) of Billing Provider in Block 33)                    |
| Block 33b   | Non-NPI Number (unique identifier number of professional)                              |

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### b. Data Elements Required for Submitting CMS-1500 Claims

To avoid delays in receiving payments and to avoid unnecessary claim denials, all required information must be provided. The following lists data required when filing a CMS-1500 Claim Form. **Note:** (+) indicates if format or data is not valid, the claim will be rejected and returned to the Provider for correction and resubmission.

|  |             |
|--|-------------|
| • +Insured's I.D. number (include three-letter alpha prefix) | Block 1A    |
| • +Patient's Name  | Block 2     |
| • +Patient's Date of Birth                                   | Block 3     |
| • Insured's Name   | Block 4     |
| • Patient's Address  | Block 5     |
| • +Patient's Relationship to Insured                         | Block 6     |
| • Another Health Plan  | Block 11d   |
| • +Patient's or Authorized Person's Signature                | Block 12    |
| • Insured's or Authorized Person's Signature                 | Block 13    |
| • + Date of Current Illness, Injury, or Pregnancy (LMP)      | Block 14    |
| • Name of Referring Practitioner                             | Block 17    |
| • ID Number of Referring Provider                            | Block 17a   |
| • NPI (National Provider Identifier) of Referring Provider   | Block 17b   |
| • +Diagnosis   | Block 21A-L |
| • +Dates of Service  | Block 24a   |
| • +Place of Service  | Block 24b   |
| • +Procedure Codes/Modifiers                                 | Block 24d   |
| • +Diagnosis Pointer   | Block 24e   |
| • +Charges   | Block 24f   |
| • +Days/Units  | Block 24g   |
| • +Federal Tax ID Number                                     | Block 25    |
| • Patient's Account Number                                   | Block 26    |
| • +Total Charges   | Block 28    |
| • Signature of Physician/Supplier                            | Block 31    |
| • +Billing Provider Info and Telephone Number                | Block 33    |
| • +NPI (National Provider Identifier) of Billing Provider    | Block 33a   |

## 5. Completing CMS-1500 Claim Form

This section incorporates information from the National Uniform Claim Committee 1500 Health Insurance Claim Form Reference Instruction Manual for the 08/05 Version into the *BlueCross BlueShield of Tennessee Provider Administration Manual* to help provide information on how to complete claim forms in compliance with CMS regulations.

Included is a description of how each block of the CMS-1500 claim form is to be completed, what type of data should be entered, and the proper format for entering the data. Since detailed discussions or explanations of all the codes, rules and options go beyond the scope of this document, please refer any questions to the payor organization with which you are dealing.

Information and codes contained herein are accurate at the time of publication. Payor-issued mailings (newsletter, bulletins, etc.), workshop sessions and Provider Relations Consultant visits are sources of information for keeping this Manual current.

To avoid delays in receiving payments and to avoid unnecessary claim denials, it is important that all of the required information is provided in the specified formats.

The printing specification sections are among the most important parts of this manual. The CMS-1500 form makes it possible for payors to continue adding the use of Optical Character Recognition equipment to their claims entry operations, making faster and more accurate claim payments possible. However, incomplete data, or data not properly aligned in the proper block will be rejected by OCR equipment, creating delays in processing or the return of the claim for correction and resubmission.

The following general instructions are intended to be a guide only for completing the CMS-1500 claim form. Providers should refer to the most current federal, state, or other payer instructions for specific requirements applicable to the 1500 Claim Form. The 1500 Health Insurance Claim Form Reference Instruction Manual for 02/12 Version can be found on the National Uniform Claim Committee (NUCC) website, [www.nucc.org](http://www.nucc.org).

### a. General Instructions

The form designated CMS-1500 is approved by CMS, TRICARE/CHAMPUS on Medical Services, and BCBST.

#### **A summary of suggestions and requirements needed to complete the CMS-1500 claim form follows:**

- Only one line item of service per claim line (Block #24) can be reported. If more than 6 lines per claim are needed, additional claim forms will be required.
- "Super bills," statements, computer printout pages, or other sheets listing dates, service, and/or charges cannot be attached to the CMS-1500 claim form.
- The form is aligned to a standard typing format of 10 pitch (PICA) or standard computer-generated print of 10 characters per inch. Vertical spacing is 6 lines per inch.
- The form is designated for double spacing with the exception of Blocks #31, 32 and 33, which may be single-spaced.
- Use standard fonts: do not intermix font styles on the same claim form.
- Do not use italics and script on the form.
- In completing all claim information COLOR OF INK should be as follows:
  1. Computer generated color of black
  2. Manual typewriter standard of Sinclair and Valentine J6983
- Use upper case (CAPITAL) letters for all alpha characters.
- Do not use dollar signs (\$), decimals (.), or commas (,) in any dollar amount blocks.
- Enter information on the same horizontal plane.
- Enter all information within the boundaries of the designated block.

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- Extraneous data (handwritten or stamped) may not be printed on the form except to mark as "Corrected Bill".
- Pin feed edges should be evenly removed prior to submission.

### 1. Form Alignment

The CMS-1500 is designed for printing or typing 6 lines per inch vertically and 10 characters per inch horizontally. On the title line of the form above Block #1 and Block #1A are 6 boxes labeled "PICA". These boxes should be considered Line 1, Columns 1,2 and 3, and Line 1, Columns 77,78 and 79. Form alignment can be verified by printing "X's" in these boxes.

### 2. Entering All Dates

In Blocks 3, 9B, and 11A please include a space between each digit. The blank space should fall on the vertical lines provided on the form.

Unless otherwise indicated, all date information should be shown in the following format:

For Blocks 3, 9B, and 11A

MMblankDDblankCCYY

MM=month (01-12)

1 blank space

DD=day (01-31)

1 blank space

CC=century (20, 21)

YY=year (00-99)

The blank space should fall on the vertical lines provided on the form.

Do NOT exclude leading zeros in the date fields.

(Correct: January 1, 2012 = 01 01 12; Incorrect: 1112).

**Note:** *Omit spaces in Block 24A (date of service). By entering a continuous number, the date(s) will penetrate the dotted vertical lines used to separate month, day, and year. This is acceptable. Ignore the dotted vertical lines without changing font size.*

For Block 24A

MMDDCCYY

MM=month (01-12)

DD=day (01-31)

CC=century (20, 21)

YY=year (00-99)

### b. Physical Claim Form Specifications

While CMS-1500 claim forms can be ordered from the Government Printing Office, some Providers may elect to deal with independent form vendors. All CMS-1500 claim forms MUST conform to the following print specifications; submitting non-standard forms that do not conform to these specifications can result in delayed processing and payment of the claim:

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### PAPER

OCR bon - JCP25  
20 pound  
217 mm x 281mm (+ or - 2mm)  
Cut square, corners 90 degrees (+ or -.025)

### INK

Standard is Sinclair and Valentine J6983  
Same ink front and back of form  
Multipart forms must have same ink on all copies

### MARGIN

Top to typewriter alignment bar is 34mm  
Right to left margin is 9mm

### ASKEWITY

No greater than .15mm in 100mm

X and Y OFFSET for MARGINS must not vary by more than + or - 0.010 inches from page to page  
(x= horizontal distance from left margin to print, y= vertical distance from top to print).

NO MODIFICATIONS may be made to the CMS-1500 without the prior approval of the CMS.

## Form Content and Description

Below is a description of each block on the form for completing each area.

### BLOCK 1 - TYPE COVERAGE

|                                       |                                       |   |                                      |                                      |                                |                               |
|---------------------------------------|---------------------------------------|---|--------------------------------------|--------------------------------------|--------------------------------|-------------------------------|
| 1. MEDICARE                           | MEDICAID                              | TRICARE<br>CHAMPUS                        | CHAMPVA                              | GROUP<br>HEALTH PLAN                 | FECA<br>BLK LUNG               | OTHER                         |
| <input type="checkbox"/> (Medicare #) | <input type="checkbox"/> (Medicaid #) | <input type="checkbox"/> (Sponsor's (SSN) | <input type="checkbox"/> (VA File #) | <input type="checkbox"/> (SSN or ID) | <input type="checkbox"/> (SSN) | <input type="checkbox"/> (ID) |

Description: Place an "X" in the box to indicate the type of health care

### BLOCK 1a - INSURED'S I.D. NUMBER

|  |                         |
|--|-------------------------|
| 1a. INSURED'S I.D. NUMBER<br><b>AAA123456789</b> | (For Program in Item 1) |
|--|-------------------------|

Description: Enter the insured's identification number (**including the 3-letter alpha prefix**) as shown on the Member's ID card. Correctly and completely record the number in your file, including all alphabetic (alpha) and numeric characters.

### BLOCK 2 - PATIENT'S NAME

|  |
|--|
| 2. PATIENT'S (Last Name, First Name, Middle Initial)<br><b>ONEAL TIM L</b> |
|--|

Description: Place the full name of the patient receiving service (**LAST, FIRST, MIDDLE INITIAL**) in this block. List only one patient per claim form.

Example: Tim L. O'Neal, Jr. = ONEAL TIM L

**BLOCK 3 - PATIENT'S BIRTH DATE AND SEX**

|                         |    |      |                          |                          |
|-------------------------|----|------|--------------------------|--------------------------|
| 3. PATIENT'S BIRTH DATE |    |      | SEX                      |                          |
| MM                      | DD | YY   | M                        | F                        |
| 01                      | 03 | 2015 | <input type="checkbox"/> | <input type="checkbox"/> |

**Description** Enter the patient's date of birth and sex. Enter the patient's birth date in numerical format, using two (2) digits for the month, two (2) digits for the day and four (4) digits for the year for a total of eight (8) digits. Check the box that indicates the sex of the patient. Enter 8 positions (MMDDCCYY) indicating the date on which the patient was born.

**Examples:** January 3, 2015 = 01032015

To indicate SEX, place an "X" in the appropriate box to denote if the patient is male (M) or female (F).

**BLOCK 4 - INSURED'S NAME**

|   |
|---|
| 4. INSURED'S NAME (Last Name, First Name, Middle Initial) |
| ONEAL MARY  |

**Description:** For patients with coverage through private insurance (BCBST, etc.) or Medicaid, FEP, TRICARE/CHAMPUS, etc., the patient's name may be different from the "insured". As the payor also needs the insured's name, place the full name of the "insured", "subscriber," or "contract holder" in this block (see Block 2). If the subscriber's name on the identification card is the same as the patient's name, you may use the word SAME or SELF.

ALL CAPITAL LETTERS. No special characters, no titles and no imbedded spaces except to separate last and first names, and middle initial. (Must be filed as Last Name first, then First Name followed by Middle Initial, if applicable.)

**BLOCK 5 - PATIENT'S ADDRESS (multiple fields)**

|                                    |                |
|------------------------------------|----------------|
| 5. PATIENT'S ADDRESS (No., Street) |                |
| 123 MAIN STREET                    |                |
| CITY                               | STATE          |
| ANYTOWN                            | TN             |
| ZIP CODE                           | TELEPHONE      |
| 30400                              | (423) 535 5600 |

**Description:** Enter patient's permanent mailing address and telephone number:  
 Line 7 = street address, including apt #  
 Line 9 = city and state  
 Line 11 = ZIP code and telephone #

Special character "-" (dash) may be used, No imbedded spaces except to separate street number/name, and to separate city/state.

**BLOCK 6 - PATIENT'S RELATIONSHIP TO INSURED**

|                                    |                                 |                                |                                |
|------------------------------------|---------------------------------|--------------------------------|--------------------------------|
| 6. PATIENT RELATIONSHIP TO INSURED |                                 |                                |                                |
| Self <input type="checkbox"/>      | Spouse <input type="checkbox"/> | Child <input type="checkbox"/> | Other <input type="checkbox"/> |

Description: Place an "X" in the block that describes the family relationship between the patient (Block 2) and the insured (Block 4).

**BLOCK 7 - INSURED'S ADDRESS (multiple fields)**

|                                    |                                      |
|------------------------------------|--------------------------------------|
| 7. INSURED'S ADDRESS (No., Street) |                                      |
| <b>SAME</b>                        |                                      |
| CITY                               | STATE                                |
| ZIP CODE                           | TELEPHONE (Include Area Code)<br>( ) |

Description: Enter insured's (Block 4) permanent address and telephone number.  
If the patient and the insured are the same, enter "SAME."  
Line 7 = street address, including apt #  
Line 9 = city and state  
Line 11 = ZIP code and telephone #

ALL CAPITAL LETTERS. No special characters, except "-" (dash) may be used. No imbedded blanks except to separate street number/name, and city/state.

**BLOCK 8 – RESERVED FOR NUCC Use (02/12)**

|                          |
|--------------------------|
| 8. RESERVED FOR NUCC USE |
|--------------------------|

**BLOCK 9 - OTHER INSURED'S NAME**

Description: Enter the name of the insured individual who is enrolled in any other policy if the name is different from that shown in Block 2. Enter the word "SAME" if the name is the same for Block 2. If no other policy benefits are assigned, leave this block blank. The name of the insured individual is entered in the order of the last name, first name and middle initial. If the "insured" under the additional coverage is the same as the person listed in Block 4, enter "SAME".

ALL CAPITAL LETTERS. No imbedded spaces except to separate last and first names, and middle initial.



## BLOCKS 9a-9d - COORDINATION OF BENEFITS

|  |
|--|
| 9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial ) |
| a. OTHER INSURED'S POLICY OR GROUP NUMBER                        |
| b. RESERVED FOR NUCC USE   |
| c. RESERVED FOR NUCC USE   |
| d. INSURANCE PLAN NAME OR PROGRAM NAME                           |

Coordination of benefits is a very important cost containment feature for payers. Providing complete and accurate information about a patient's health care coverage will help your office receive prompt and accurate claim payments.

Blocks 9a-9d pertain to the coverage not shown in Block 1a. For the company receiving the original claim (the company whose identification data is included in Block 1a), this information pertains to the "other" coverage.

**Note:** Refer to *Third Liability (TPL)* section for additional information regarding other insurance information.

### BLOCK 9a - OTHER INSURED'S POLICY OR GROUP NUMBER

Description: Enter the policy or group of the other insurance coverage for the patient. If the patient does not have other coverage, leave this block blank.

Payer organizations may use different wording to signify the policy or group number (e.g. "insured's identification number," "contract number" or "certificate number").

(Do not repeat the same number listed in block 1a.)

### BLOCK 9b - RESERVED FOR NUCC USE

### BLOCK 9c - RESERVED FOR NUCC USE

### BLOCK 9d - INSURANCE PLAN NAME OR PROGRAM NAME

Description: Enter the name of the other insured's health insurance organization plan name or program for the person shown in Block 9.

**Note:** Medicare carriers require you to attach an additional page to the claim form providing the complete mailing address for the company/organization listed in Block 9d. Enter "ATTACHMENT" in Block 10d to indicate this required page is provided.

**BLOCK 10 – IS PATIENT’S CONDITION RELATED TO**

|  |                             |
|--|-----------------------------|
| 10. IS PATIENT’S CONDITION RELATED TO: |                             |
| a. EMPLOYMENT? (CURRENT OR PREVIOUS)   |                             |
| YES <input type="checkbox"/>           | NO <input type="checkbox"/> |
| b. AUTO ACCIDENT?                      | PLACE (State)               |
| YES <input type="checkbox"/>           | NO <input type="checkbox"/> |
| c. OTHER ACCIDENT?                     |                             |
| YES <input type="checkbox"/>           | NO <input type="checkbox"/> |

Description: Indicate whether the patient’s condition is related to his or her employment and is applicable to one (1) or more of the services described in Block 24. If the patient’s condition is related to employment, put an “X” in the “YES” box and indicate whether it is related to the patient’s “current” or “previous” employment by circling the appropriate term. If the injury or illness is related to an automobile accident, place an “X” in the “YES” box. Enter the date of the accident in Block 14 in eight (8)-digit format. If the patient’s condition is related to an “other accident”, place an “X” in the “YES” box. Enter the date of the accident in Block 14.

File the claim with the other insurer as the primary payer (Block 11). Once a response (either a payment or denial notice) is received from the primary insurer, file the secondary claim with TennCare MCO/BHO.

**BLOCK 10d – CLAIM CODES (DESIGNATED BY NUCC)**

|                                       |
|---------------------------------------|
| 10d. CLAIM CODES (Designated by NUCC) |
|---------------------------------------|

**BLOCK 11 - INSURED’S POLICY GROUP OR FECA NUMBER**

|   |  |
|---|--|
| 11. INSURED’S POLICY GROUP OR FECA NUMBER   |  |
| <b>G12345</b>   |  |
| a. INSURED’S DATE OF BIRTH  |  |
| MM     DD     YY     SEX  |  |
| <b>01     03     2015     M <input type="checkbox"/> F <input type="checkbox"/></b>           |  |
| b. OTHER CLAIM ID (Designated by NUCC)  |  |
| c. INSURANCE PLAN NAME OR PROGRAM NAME  |  |
| <b>RETIRED</b>  |  |
| d. IS THERE ANOTHER HEALTH BENEFIT PLAN?  |  |
| YES <input type="checkbox"/> NO <input type="checkbox"/> If yes, complete items 9, 9a. and 9d |  |

**BLOCK 11a - INSURED’S DATE OF BIRTH, SEX**

Description: Enter the 8-digit date of birth of the insured (if insured is not the patient) and the sex of the insured. Place an “X” in the appropriate box to indicate the insured’s sex.

(See previous example under BLOCK 11 - INSURED’S POLICY GROUP OR FECA NUMBER)

## **BLOCK 11b — OTHER CLAIM ID (DESIGNATED BY NUCC)**

## **BLOCK 11c — INSURANCE PLAN NAME OR PROGRAM NAME**

Description: Enter complete name of the insurance plan or program that provides health care benefits for the person listed in Block 4.

ALL CAPITAL LETTERS.

(See previous example under **BLOCK 11 - INSURED'S POLICY GROUP OR FECA NUMBER**)

## **BLOCK 11d — IS THERE ANOTHER HEALTH BENEFIT PLAN?**

Description: Enter if the patient (Block 2) is or may be entitled to benefits under any other health care coverage program other than the coverage identified in Block 1a. A definitive answer is required. A "YES" answer requires completion of Blocks 9, 9a, and 9d.

## **BLOCK 12 — PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE (INFORMATION RELEASE/GOVERNMENT ASSIGNMENT)**

### **READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED \_\_\_\_\_ DATE \_\_\_\_\_

Description: This block contains the signature of the patient or the patient's representative and the date in eight (8)-digit format. The signature authorizes the release of medical information necessary to process the claim and the payment of benefits to the physician or supplier if the physician/supplier accepts assignment. In lieu of a signature on the claim, enter "SOF" in this block if there is a "signature on file" agreement with the Provider.

ALL CAPITAL LETTERS,

Print "SOF" if release/assignment is being kept in patient's file

## **BLOCK 13 — INSURED'S OR AUTHORIZED PERSON'S SIGNATURE (NON- GOVERNMENT PROGRAMS)**

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED \_\_\_\_\_

Description: For non-governmental programs, an assignment of benefits separate from the information release (Block 12) is required if benefits are to be sent to the Provider. The patient must sign in this block if payment to the Provider is desired, or, the patient/insured's signature on a separate document must be maintained in the patient's file (enter "ON FILE"). Some Provider Agreements (PPOs, HMOs, etc.) specifically address how payments are to be handled, in which case, leave this block blank. However, it is still advisable to obtain an assignment of benefits from

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the patient or patient's representative if payment is to go to your office. Do not make any notation in this space if payment is to go to the patient. Signature on file will also be accepted here.

ALL CAPITAL LETTERS,  
Print "ON FILE" if signature is kept in the patient's file.

### BLOCK 14 — DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY

#### 14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)

MM DD YY  
01 : 01 : 2015 QUAL :

Description: If an accident date is provided, complete Block 10b or 10c. For chiropractic services, enter the date of the initiation of the course of treatment and the eight (8)-digit X-ray date in Item 19.

Enter the six (6)-digit (MM | DD | YY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. Enter the qualifier to the right of the vertical, dotted line.

Example January 1, 2015 = 01012015

There are only two valid qualifiers for this block, these qualifiers and their guidelines are listed below:

- 431 (Onset of Current Symptoms or Illness) – This information is required for the initial medical service or visit performed in response to a medical emergency when the date is available and is different than the date of service. The date entered in this block should not be the same as the date of service, if the dates entered are the same the claim will be returned unprocessed.
- 484 (Last Menstrual Period) – This information is required when, in the judgment of the Provider, the services on this claim are related to the patient's pregnancy.

### BLOCK 15 — OTHER DATE

#### 15. OTHER DATE.

QUAL : : MM : DD : YY  
: : : : :

### BLOCK 16 — DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

#### 16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

MM DD YY MM DD YY  
FROM 02 : 15 : 2015 TO 02 : 22 : 2015

Description: This block identifies the dates that the patient was employed but unable to work in his or her current occupation and may indicate employment-related insurance coverage. The eight (8)-digit format must be used in this block. Completion of this field is important for worker's compensation cases. An entry in this block may indicate employment-related insurance coverage.

**BLOCK 17 — NAME OF REFERRING PROVIDER OR OTHER SOURCE****BLOCK 17a — OTHER ID NUMBER****BLOCK 17b – NPI NUMBER**

|  |      |     |               |
|--|------|-----|---------------|
| 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE<br>RALPH SMITH MD | 17a. | 1B  | ABC1234567890 |
|  | 17b. | NPI | 0123456789    |

Description: The name of the referring Provider, ordering Provider, or other source who referred or ordered the service(s) or supply (s) on the claim. Do not use periods or commas within the name. A hyphen can be used for hyphenated names.

The Other ID number of the referring Provider, ordering Provider, or other source is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. The non-NPI ID number of the referring Provider, ordering Provider, or other source refers to the Payer assigned unique identifier of the professional. The NUCC defines the applicable qualifiers, which can be found on the National Uniform Claim Committee (NUCC) website, [www.nucc.org](http://www.nucc.org).

Enter the NPI number of the referring Provider, ordering Provider, or other source in 17b.

**BLOCK 18 — HOSPITALIZATION DATES RELATED TO CURRENT SERVICES**

| 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES |    |    |      |    |    |    |      |
|---|----|----|------|----|----|----|------|
|   | MM | DD | YY   |    | MM | DD | YY   |
| FROM  | 02 | 15 | 2015 | TO | 02 | 17 | 2015 |

Description: Enter the applicable month, day and year of the hospital admission and discharge using an eight (8)-digit date format. This block is to be completed when medical services are rendered as a result of, or subsequent to, a related hospitalization. If services were rendered in a facility other than the patient's home or a physician's office, provide the name and address of that facility in Block 32.

**BLOCK 19 — ADDITIONAL CLAIM INFORMATION (DESIGNATED BY NUCC)**

|   |
|---|
| 19. ADDITIONAL CLAIM INFORMATION (DESIGNATED BY NUCC) |
|---|

**BLOCK 20 — OUTSIDE LAB? \$CHARGES**

|                              |                             |            |
|------------------------------|-----------------------------|------------|
| 20.                          | OUTSIDE LAB?                | \$ CHARGES |
| <input type="checkbox"/> YES | <input type="checkbox"/> NO |            |

Description: Indicate whether any diagnostic tests subject to purchase price limitations were performed outside the physician's office, and enter the charges for those purchased services. Place an "X" in the "YES" box when a Provider other than the Provider billing for the service performed the diagnostic test. When "YES" is checked, Block 32 must be completed with the name and address of the clinical laboratory or other supplier that performed the service. If billing for multiple purchased diagnostic tests, each test must be submitted on a separate claim form. Enter the purchase price of the tests in the charges column. Show dollars and cents, omitting the dollar sign. Place an "X" in the "NO" box when diagnostic tests are performed in the physician's office or supervised by the physician (e.g., no purchased tests are included on the claim).

**BLOCK 21 — DIAGNOSIS OR NATURE OF ILLNESS OR INJURY**

|   |          |          |         |  |
|---|----------|----------|---------|--|
| 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) |          |          | ICD Ind |  |
| A. _____  | B. _____ | C. _____ | D.      |  |
| E. _____  | F. _____ | G. _____ | H.      |  |
| I. _____  | J. _____ | K. _____ | L.      |  |

**BLOCK 22 —RESUBMISSION CODE/ORIGINAL REFERENCE NUMBER**

|      |                   |                   |
|------|-------------------|-------------------|
| 22.  | RESUBMISSION CODE |                   |
| CODE |                   | ORIGINAL REF. NO. |

- Description: This block is to be used when submitting a corrected claim. "Resubmission" means the code and original reference (claim) number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter.
- A Resubmission Code should be filed in the first portion of Block 22. The valid values for this field are "7" Replacement of prior claim and "8" Void/Cancel of prior claim. These codes should be left-justified in the box so that they will be processed correctly.
  - The original claim number issued to the claim being corrected should be filed in the Original Ref. No. portion of Block 22.
  - This block is not intended for use for original claim submissions.
  - Failure to include the proper "Resubmission Code" and "Original Ref. No." may result in a claim rejection or denial.

**BLOCK 23 — PRIOR AUTHORIZATION NUMBER**

|                                |
|--------------------------------|
| 23. PRIOR AUTHORIZATION NUMBER |
| <b>009876</b>                  |

Description: The "Prior Authorization Number" is the payer assigned number authorizing the services(s) for plans that require them.

**NOTE** - For Air Ambulance services submitted on the CMS1500 claim form the Pick-up Location Zip Code should be submitted in Block 23. Multiple Zip Codes should not be submitted in this block. If the points of pick-up are located in different Zip Codes a separate claim form should be submitted for each trip. The correct ZIP Code is five numeric digits; if a nine-digit ZIP Code is submitted the last four digits are ignored. **If Pick-up Location Zip Code is missing, invalid, or submitted in an incorrect format the claim will be returned unprocessed.**

**BLOCK 24A. – 24J. – SUPPLEMENTAL INFORMATION**

The following lists qualifier codes and description of supplemental information that can be entered in the **shaded** lines of Block 24:

- Anesthesia information
- ZZ Narrative description of unspecified code
- N4 National Drug Codes (NDC)

Description: To enter supplemental information, begin at 24A by entering the qualifier and then the information. Do not enter a space between the qualifier and the number/code/information. Do not enter hyphens or spaces within the number/code.

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The following qualifiers are to be used when reporting NDC units:

- F2 International Unit
- ME Milligram
- ML Milliliter
- GR Gram
- UN Unit

More than one supplemental item can be reported in the **shaded** lines of Block 24. Enter the first qualifier and number/code/information at Block 24A. After the first item, enter three blank spaces and then the next qualifier and number/code/information.

The following qualifiers are to be used when reporting these services:

**ZZ** Narrative description of unspecified code

**N4** National Drug Codes (NDC)

**Example:** N450242006101 ME1.25 ZZAvastin

**Note:** Supplemental information entered in shaded area will be ignored if a valid qualifier does not precede the data.

The following examples define how to enter different types of supplemental information in Block 24. These examples demonstrate how the data are to be entered into the fields and are not meant to provide direction on how to code for certain services:

### Example 1: Anesthesia Services, when payment based on minutes as units

| 24. A. DATE(S) OF SERVICE |    |    |    |    |    | B.               | C.  | D. PROCEDURES, SERVICES, OR SUPPLIES |  |    |  | E.                | F.         | G.            | H.               | I.        | J.                       |
|---------------------------|----|----|----|----|----|------------------|-----|--------------------------------------|--|----|--|-------------------|------------|---------------|------------------|-----------|--------------------------|
| From To                   |    |    |    |    |    | PLACE OF SERVICE | EMG | (Explain Unusual Circumstances)      |  |    |  | DIAGNOSIS POINTER | \$ CHARGES | DAYS OR UNITS | EPST Family Plan | ID. QUAL. | RENDERING PROVIDER ID. # |
| 7 Begin 1245 End 1415     |    |    |    |    |    |                  |     |                                      |  |    |  |                   |            |               |                  | 1B        | 12345678901              |
| 10                        | 01 | 05 | 10 | 01 | 05 | 22               |     | 00770                                |  | P2 |  | 134               | 875.00     | 90            | N                | NPI       | 0123456789               |

### Example 2: Anesthesia Services, when payment based on 15-minute units

| 24. A. DATE(S) OF SERVICE             |    |    |    |    |    | B.               | C.  | D. PROCEDURES, SERVICES, OR SUPPLIES |  |    |  | E.                | F.         | G.            | H.               | I.        | J.                       |
|---------------------------------------|----|----|----|----|----|------------------|-----|--------------------------------------|--|----|--|-------------------|------------|---------------|------------------|-----------|--------------------------|
| From To                               |    |    |    |    |    | PLACE OF SERVICE | EMG | (Explain Unusual Circumstances)      |  |    |  | DIAGNOSIS POINTER | \$ CHARGES | DAYS OR UNITS | EPST Family Plan | ID. QUAL. | RENDERING PROVIDER ID. # |
| 7 Begin 1245 End 1415 Time 90 minutes |    |    |    |    |    |                  |     |                                      |  |    |  |                   |            |               |                  | 1B        | 12345678901              |
| 10                                    | 01 | 05 | 10 | 01 | 05 | 22               |     | 00770                                |  | P2 |  | 134               | 875.00     | 6             | N                | NPI       | 0123456789               |

### Example 3: Unspecified Code

| 24. A. DATE(S) OF SERVICE |    |    |    |    |    | B.               | C.  | D. PROCEDURES, SERVICES, OR SUPPLIES |  |  |  | E.                | F.         | G.            | H.               | I.        | J.                       |
|---------------------------|----|----|----|----|----|------------------|-----|--------------------------------------|--|--|--|-------------------|------------|---------------|------------------|-----------|--------------------------|
| From To                   |    |    |    |    |    | PLACE OF SERVICE | EMG | (Explain Unusual Circumstances)      |  |  |  | DIAGNOSIS POINTER | \$ CHARGES | DAYS OR UNITS | EPST Family Plan | ID. QUAL. | RENDERING PROVIDER ID. # |
| ZZKaye Walker             |    |    |    |    |    |                  |     |                                      |  |  |  |                   |            |               |                  | 1B        | 12345678901              |
| 10                        | 01 | 05 | 10 | 01 | 05 | 12               |     | E1399                                |  |  |  | 12                | 165.00     | 1             | N                | NPI       | 0123456789               |

### Example 4: NDC Code

| 24. A. DATE(S) OF SERVICE       |    |    |    |    |    | B.               | C.  | D. PROCEDURES, SERVICES, OR SUPPLIES |  |  |  | E.                | F.         | G.            | H.               | I.        | J.                       |
|---------------------------------|----|----|----|----|----|------------------|-----|--------------------------------------|--|--|--|-------------------|------------|---------------|------------------|-----------|--------------------------|
| From To                         |    |    |    |    |    | PLACE OF SERVICE | EMG | (Explain Unusual Circumstances)      |  |  |  | DIAGNOSIS POINTER | \$ CHARGES | DAYS OR UNITS | EPST Family Plan | ID. QUAL. | RENDERING PROVIDER ID. # |
| N450242006001 ME1.25 ZZ Avastin |    |    |    |    |    |                  |     |                                      |  |  |  |                   |            |               |                  | 1B        | 12345678901              |
| 10                              | 01 | 05 | 10 | 01 | 05 | 11               |     | J1563                                |  |  |  | 13                | 500.00     | 20            | N                | NPI       | 0123456789               |

## BLOCK 24A. – 24E. —DATE(S) OF SERVICE, PLACE OF SERVICE, EMG, PROCEDURES, SERVICES OR SUPPLIES, DIAGNOSIS POINTER

| 24. A. DATE(S) OF SERVICE |    |      |    |    |      | B.               | C.  | D. PROCEDURES, SERVICES, OR SUPPLIES |  |          |   | E.                |
|---------------------------|----|------|----|----|------|------------------|-----|--------------------------------------|--|----------|---|-------------------|
| From To                   |    |      |    |    |      | PLACE OF SERVICE | EMG | (Explain Unusual Circumstances)      |  |          |   | DIAGNOSIS POINTER |
| MM                        | DD | YY   | MM | DD | YY   |                  |     | CPT/HCPCS                            |  | MODIFIER |   |                   |
| 03                        | 06 | 2015 | 03 | 10 | 2015 |                  |     |                                      |  |          | : | 1                 |
|                           |    |      |    |    |      |                  |     |                                      |  |          |   |                   |

**BLOCK 24F. – 24J. - CHARGES, DAYS OR UNITS, EPSDT, ID QUALIFIER, AND RENDERING PROVIDER ID NUMBER**

|   | F.<br>\$CHARGES | G.<br>DAYS<br>OR<br>UNITS | H.<br>EPSDT<br>Family<br>Plan | I.<br>ID<br>QUAL | J.<br>Rendering<br>Provider Id. # |
|---|-----------------|---------------------------|-------------------------------|------------------|-----------------------------------|
| 1 |                 |                           |                               | NPI              |                                   |
| 2 |                 |                           |                               | NPI              |                                   |
| 3 |                 |                           |                               | NPI              |                                   |
| 4 |                 |                           |                               | NPI              |                                   |
| 5 |                 |                           |                               | NPI              |                                   |
| 6 |                 |                           |                               | NPI              |                                   |

**BLOCK 24A — DATE(S) OF SERVICE**

**Description:** This block indicates the beginning and ending dates of service for the entire period reflected by the procedure code, using six (6) -digit formats, excluding all punctuation. Do not use slashes between dates. If the date or month is a single-digit, precede it with a zero (0). Make sure the dates shown are no earlier than the date of the current illness shown in Block 14. If the same service is furnished on different dates, each date should be listed on the claim. For services performed on a single day, the “from” and “to” dates are the same.

Up to 6 services (line items) may be reported on any one document. If more than 6 services (line items) need to be reported, additional forms must be completed.

The six (6) service lines in BLOCK 24 have been divided horizontally to accommodate submission of both the NPI and another/proprietary identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service.

The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service. Supplemental information can only be entered with a corresponding, completed line and is to be placed in the shaded section of 24A through 24G.

**Example:** March 6, 2015 = 03062015

**BLOCK 24B — PLACE OF SERVICE**

**Description:** Enter the appropriate two (2) -digit Place of Service Code for each item used or service performed. If services were provided in the emergency department, use code 23. If services were provided in an urgent care center, use code 22. If services were rendered in a hospital, clinic, laboratory or other facility, show the name and the address of the facility in Block 32. To see all POS codes and descriptions, go to [https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place\\_of\\_Service\\_Code\\_Set.html](https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html).



**BLOCK 24C — EMG (This field was originally titled “Type of Service”. “Type of Service” is no longer used and has been eliminated)**

Description: If required, enter Y for “Yes” or leave blank if “No” in the bottom, unshaded area of the field. An emergency is defined as a sudden and unexpected medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect to result in: serious impairment of bodily functions; serious dysfunction of any bodily organ or part; or placing the prudent layperson’s health in serious jeopardy. These services may be provided by facility-based Providers. It is understood that in those instances where a Physician makes emergency care determinations, the Physician shall use the skill and judgment of a reasonable Physician in making such determination.

**BLOCK 24D — PROCEDURES, SERVICES, OR SUPPLIES**

Description: Enter the CPT<sup>®</sup> code applicable to the services, procedures or supplies rendered. Include the CPT<sup>®</sup> modifiers when necessary. The codes and modifiers selected must be supported by medical documentation in the patient’s record. Link each CPT<sup>®</sup> code with the appropriate ICD code listed in Block 21 by line item. See Block 24E for further instruction. The codes and modifiers selected must be supported by medical documentation in the patient’s record. Link each HCPCS code with the appropriate ICD code listed in Items 21 and 24E. Enter the specific procedure code without a descriptive narrative. If no specific procedure codes are available that fully describe the procedure performed, and an “unlisted” or “not otherwise classified” procedure code must be used, include the narrative description in description in the shaded area for Block 24. See Block 24 Supplemental Information for further instruction.

Modifiers: A modifier is a 2-digit combination of numeric, alpha and/or numeric that may be added to a procedure code. Modifiers may be used to indicate that:

- A service or procedure is either a professional or technical component.
- A service or procedure was performed by more than one Practitioner and/or in more than one location.
- A service or procedure has been increased or reduced.
- Only part of a service was performed.
- An adjunctive service was performed.
- A service or procedure was provided more than once.

**BLOCK 24E — DIAGNOSIS POINTER**

Description: Indicate reference numbers linking the ICD codes listed in Block 21 (alpha A – L) to the dates of service and CPT<sup>®</sup> codes listed in Blocks 24A and 24D. This information is used to document that the patient’s diagnosis warranted the Physician’s services. **Do not enter 01, 02, 03, or 04.** When multiple services are performed, the primary reference letter (A-L) for each service should be listed first, other applicable services should follow. (ICD diagnosis codes must be entered in Block 21 only. Do not enter them in 24E.) Numeric entries in Block 24E are no longer valid for this block. Minimum of 3 alpha characters required.

Enter each applicable diagnosis at the line item level. If the service is for three (3) diagnosis codes, it should be keyed as ABC. Do not enter a span such as A-C.

**NOTE:** *Per NUCC guidelines, submit diagnosis pointer ONLY. Failure to follow instructions will result in claim being returned unprocessed.*

## BLOCK 24F — CHARGES

Description: Enter the amount charged by the Practitioner for each of the services or procedures listed on the claim. If multiple occurrences of the same procedure are being billed on the same line, indicate the inclusive dates of service in Block 24A. List the separate charge for each service in this block and the number of units or days in Block 24G. Do not bill a flat fee for multiple dates of service on one line

Always print 2 digits in cents columns.

## BLOCK 24G — DAYS OR UNITS

Description: This block shows the number of days or units of procedures, services or supplies listed in Block 24D. This block is most commonly used to report multiple visits, units of supplies, minutes of anesthesia and oxygen volume. The number “1” must be entered if only one service is performed. For some services (e.g., hospital visits, tests, treatments, doses of an injectable drug, etc.), indicate the actual quantity provided. When the number of days is reported, it is compared with the inclusive dates of service listed in Block 24A. Days usually are reported when the patient has been hospitalized. When billing radiology services, do not provide the number of X-ray views. However, when the same radiology procedure is performed more than once on the same day, the number of times should be shown in this block. Anesthesia claims must be reported in minutes. *(Refer to Anesthesia Specifics for billing procedures).* Numeric characters only.

## BLOCK 24H — EPSDT

Description: Enter “Y” for “Yes” and “N” for “No” to indicate that early and periodic screening, diagnosis and treatment (EPSDT) services were provided. EPSDT applies only to children who are under age 21 and receive medical benefits through public assistance.

## BLOCK 24I — ID QUALIFIER (This field was originally titled “EMG”. However, “EMG” is now located in Block 24C)

Description: If the Provider does not have an NPI number, enter the appropriate qualifier and identifying number in the shaded area. (See the National Uniform Claim Committee (NUCC) website, [www.nucc.org](http://www.nucc.org) for this information.)

The rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where substitute Provider (Locum Tenens) was used, enter that Provider’s information here. Report the identification number in Blocks 24I and 24J only when different from data recorded in Blocks 33a and 33b.

## BLOCK 24J —RENDERING PROVIDER ID # (This field was originally titled “COB”)

Description: The individual rendering the service is reported in 24J. The original fields for 24J and 24K have been combined and re-numbered as 24J. Enter the non-NPI number in the shaded area of the field. Enter the NPI number in the unshaded area of the field.

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The rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute Provider (locum tenens) or delegated was used, enter that Provider's information here. Report the identification number in Blocks 24I and 24J only when different from data recorded in Blocks 33a and 33b. If a Nurse Practitioner, Physician's Assistant, CRNA, etc. is billing a service that does not require supervision, the actual rendering professional's ID number can be filed as the rendering Provider in Block 24J with a Group Name and NPI submitted as the Billing Provider in Blocks 33-33a.

**Note:** When Block 24J, line item rendering Provider is used:

- it should be an individual, never a group identity
- it must be the individual who performed the service(s)
- it must be an identity that BCBST recognizes as a valid Provider of health care services
- multiple rendering Providers may NOT be submitted on the same claim
- Block 24J and 33a do NOT have to match

### BLOCK 25 — FEDERAL TAX I.D. NUMBER OR SSN

|     |                         |                          |                          |
|-----|-------------------------|--------------------------|--------------------------|
| 25. | FEDERAL TAX I.D. NUMBER | SSN                      | EIN                      |
|     | 612123456               | <input type="checkbox"/> | <input type="checkbox"/> |

Description: Enter the Federal Tax I.D. Number or Social Security Number of the Provider identified in Block 33. Designate whether number listed is SSN or EIN by placing an "X" in the appropriate box.

### BLOCK 26 — PATIENT'S ACCOUNT NUMBER

|     |                      |
|-----|----------------------|
| 26. | PATIENT'S ACCOUNT NO |
|     | M123456              |

Description: Enter the patient's account number (medical record number used in your office to identify the patient's account). In most cases, payors will list that number on your remittance.

### BLOCK 27 — ACCEPT ASSIGNMENT?

|                              |  |
|------------------------------|--|
| 27.                          | ACCEPT ASSIGNMENT?                                   |
| (For govt. claims, see back) |  |
| YES                          | <input type="checkbox"/> NO <input type="checkbox"/> |

### Private and Federal Programs

Description: Place an "X" in the box indicating whether you are accepting assignment.

**BLOCK 28 — TOTAL CHARGE**

|                  |    |
|------------------|----|
| 28. TOTAL CHARGE |    |
| \$ 1150          | 00 |

Description: Enter the total of all charges for services listed in Block 24.  
The total amount should be the sum of the individual amounts shown in Block 24F. DO NOT use dollar signs (\$) or decimals (.) since both are reflected on the printed document.

Always print 2 positions in the cents field.

**BLOCK 29 — AMOUNT PAID**

|                 |    |
|-----------------|----|
| 29. AMOUNT PAID |    |
| \$ 50           | 00 |

Description: Enter the amount that has been paid on the charges listed in Block 24.

**BLOCK 30 — RESERVED FOR NUCC USE**

|                           |
|---------------------------|
| 30. RESERVED FOR NUCC USE |
|---------------------------|

**BLOCK 31 — SIGNATURE OF PRACTITIONER OR SUPPLIER (OR AN AUTHORIZED REPRESENTATIVE FOR THE SUPPLIER)**

|   |      |
|---|------|
| 31. SIGNATURE OF PRACTITIONER OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) |      |
| SIGNED  | DATE |

Description: The form should be signed by the Practitioner or Supplier (or an authorized representative for the supplier). (See Special CMS-1500 Billing Guidelines Section.)

Enter the current date when signing the form.

**BLOCK 32 — SERVICE FACILITY LOCATION INFORMATION**

|  |    |
|--|----|
| 32. SERVICE FACILITY LOCATION INFORMATION                  |    |
| GENERAL HOSPITAL<br>123 EAST STREET<br>THIS TOWN, TN 37000 |    |
| a. NPI   | b. |

Description: Enter the name and address of the facility where the services were rendered if they were rendered in a hospital, clinic, laboratory, or any facility other than the patient's home or Physician's office. A complete address includes the zip code, which allows carriers to determine the correct pricing locality for purposes of claims payment. When the name and the address of the facility where services were rendered is the same as the name and address shown in Block 33, enter the word "SAME".

### BLOCK 32a — NPI #

Description: Enter the NPI number of the service facility location.

### BLOCK 32b — OTHER ID #

Description: Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.

### BLOCK 33 — BILLING PROVIDER INFOR & PH #

|   |    |
|---|----|
| 33. BILLING PROVIDER INFO & PH # ( )  |    |
| <b>RALPH S SMITH MD</b><br><b>124 EAST STREET</b><br><b>THIS TOWN, TN 37000</b> |    |
| a. NPI  | b. |

Description: Enter the Provider's or supplier's billing name, address, zip code, and phone number. The phone number is to be entered in the area to the right of the field title.

### BLOCK 33a — NPI #

Description: Enter the NPI number of the billing Provider.

**Note:** When Block 33, billing Provider is used:

- submit the Individual NPI for Billing Provider in Block 33a **only** when the Provider is an individual, unincorporated entity;
- submit the supervising Physician as the Billing Provider **only** when billing delegated services or locum tenens; and
- Otherwise, the Group NPI should always be filed as the Billing Provider.

### BLOCK 33b — OTHER ID #

Description: Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.

#### c. CMS-1500 Specific

- Multi-page Claims:
  - List diagnosis code(s) for all conditions related to the patient's illness on **each** page.
  - Place the total amount **only on the last page of the claim**. The total on the last page should reflect the sum of the line items for all pages.
  - Use the words "Continued on next page" or "Page X of X" in Block 28 on each page (except on the last page, which reflects the total charge in Block 28).
  - Staple each page of the multi-page claim together. (This will help us identify multi-page claims.)
  - Staple only the pages of the individual claim together as one. **Do not** staple several multi-page claims together as one.

- Donor/Recipient information when filing transplant claims:
  - Block 2 should contain the patient information of the person that received the service. “In this case it will be the Donor”.
  - Block 19 should be marker “Donor” and contain the “Recipient’s” name.

The National Uniform Claim Committee (NUCC) maintains the 1500 form. Visit the NUCC “1500 Health Insurance Claim Form Reference Instruction Manual” at <http://www.nucc.org> for additional information. From the top of the website, select “1500 Claim Form,” then “1500 Instructions.”

**Note:** Beginning January 1, 2014, the National Drug Code (NDC) was required on all CMS-1500 claims for Provider-administered medications for all BCBST Members, including commercial Members. This requirement for Provider-administered medications applies to all lines of business.

**d. Special CMS-1500 Claim Billing Guidelines – Blocks 31 and 33**

Professional claim forms submitted by Providers in Tennessee and contiguous counties must have the Provider’s BCBST designated Provider number and/or NPI in Block 33 PIN# and tax ID# or Group # field based on the following criteria. If not, the CMS-1500 claim forms will be returned to the Provider for correct submission.

**1. Physician**

Practitioners should use their individual Provider number assigned by BCBST. Some Practitioners may have multiple Provider numbers. Practitioners should use the appropriate Provider number based on a unique tax, pay to, or physical location.

Block 31 Signature of Practitioner or Supplier including degrees and credentials

Block 33 Provider’s or supplier’s billing name, zip code, and phone number. The phone number is to be entered in the area to the right of the field title.

33a NPI # of the billing Provider. **This number should represent the Practitioner’s signature in Block 31 unless billing via Delegated Services Policy.**

33b Two-digit qualifier identifying the non-NPI number followed by the ID number.

**2. Health Care Professional**

All contract-eligible Health Care Professionals should follow the Practitioner previously noted guidelines.

**3. Medical Service Provider**

Durable Medical Equipment (DME) suppliers, Home Infusion Therapy services, and laboratories should bill on the CMS-1500/ANSI-837P for all BCBST commercial business using the following billing requirements:

***Specific Billing Requirements:***

Block 31 Signature of Supplier (or an authorized representative of the same) including degrees or credentials.

Block 33 Provider’s or supplier’s billing name, zip code, and phone number. The phone number is to be entered in the area to the right of the field title.

33a NPI # of the billing Provider.

33b Two-digit qualifier identifying the non-NPI number followed by the ID number.

**Note:** *Home Health Agencies and Hospice Providers should bill charges on the CMS-1450/ANSI-837I.*

Any questions concerning the use of the appropriate Provider number should be addressed to BCBST’s Provider Management Department at 1-800-899-2640.

## 6. Staff Supervision Requirements for Delegated Services

This policy defines BCBST requirements for supervision by eligible Physicians and Chiropractors of their associates and assistants. Supervision by itself does not create eligibility for the services of associates and assistants. Such Practitioners must be supervised as specified in the categories below for a service to be eligible for reimbursement. The policy also describes requirements for billing delegated services. To the extent that state or federal law or regulation exceeds these internal requirements, these laws or regulations will control.

Licensed Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Chiropractic (DC), Doctor of Podiatric Medicine (DPM), Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), and Licensed Pharmacist are examples of autonomous Providers. Their services do not require the supervision of another profession. These Practitioners should bill their services under their own Provider number, NPI, or the Provider number, NPI of their facility. (Refer to clarification of term “autonomous” under ***Clarification of terms used within this policy.***)

### a. Provider Categories/Billing and Supervision Requirements

#### 1. Licensed Providers Requiring Supervision by Retrospective Review

Supervision by Retrospective Review is defined as supervision that does not take place during the time that a service is performed, but after the service has been rendered. This form of supervision may take place several days or even weeks after a service was rendered and may merely involve a review of an individual’s medical record (e.g., complaints, signs, symptoms, diagnostics and subsequent treatment[s]). The supervising Practitioner is typically not within the place of service (e.g., facility, office) during the time that a delegated service is performed.

Licensed Providers requiring supervision by Retrospective Review include Certified Nurse Midwife, Certified Registered Nurse Anesthetist, Licensed Resident Physician, Nurse Practitioner, and Physician Assistant.

Supervising Physicians or Chiropractors are required to perform a review of the services they delegate to this category of Practitioner. Providers in this category are required to complete the full credentialing process with BCBST, and they are required to bill directly under their own BCBST Provider billing number or the Provider number of their group or facility. This does not apply to Providers rendering services at health departments or licensed residents when performing services that are a part of their residency program.

#### ***Supervising Physicians and Chiropractors must:***

- Annually review and document the licensure or certification of any office staff or employee to whom they delegate medical services.
- Review the patient records and certify by signed notation that evaluations and treatment plans are appropriate, as prescribed by law.
- Only delegate services that are within the scope of the delegated Practitioner’s license.

#### **Specific Billing Requirements:**

Block 31 Practitioner rendering the service

Block 33 Provider’s or supplier’s billing name, zip code, and phone number. The phone number is to be entered in the area to the right of the field title.

33a NPI # of the billing Provider.

33b Two-digit qualifier identifying the non-NPI number followed by the ID number.

## 2. Licensed Physicians Requiring Minimal Supervision

Minimal Supervision requires that the supervising/treating Physician evaluate the patient at some reasonable time prior to receiving a delegated service, that a specific written order for the service be issued prior to the service being performed, and that a notation be made of the results obtained from the delegated service. The supervising/treating Practitioner may or may not be within the place of service (i.e., facility, office) during the time that a delegated service is rendered.

However, Senate Bill No.1144 and House Bill No. 964 allows for direct patient access to licensed physical therapists without an oral or written referral from a licensed doctor of medicine, chiropractic, dentistry, podiatry or osteopathy under the conditions set forth in T.C.A. Section 63-13-303.

Licensed Physicians requiring Minimal Supervision include Certified Athletic Trainer, Certified Audiologist, Certified Occupational Therapist, Chiropractic Radiology Technician, Licensed Physical Therapist, Licensed Physical Therapy Assistant, Licensed Practical Nurse, Licensed Psychological Examiner, Medical Laboratory Technologist, Orthopedic Physician Assistant, Radiologic Technician, Registered Dietitian/Registered Nutritionist, Registered Nurse, Registered Respiratory Therapist, Speech and Language Pathologist. Some Practitioners within these health care fields may be eligible for a BCBST Provider ID number.

Supervising Physicians, Chiropractors, or Psychologists are required to supervise the provision of delegated services for this category of Providers. If the actual Provider of the service needs the direction or supervision of a Chiropractor, Physician or Psychologist to legally perform a service and is ineligible to bill under their own number, then the Chiropractor, Physician or Psychologist will be allowed to bill those services under their name, Provider number and/or NPI. The actual Provider of service must also be listed on the billing form (i.e., in Block number 31 of the CMS-1500 claim form).

### ***Supervising Physicians, Chiropractors and Psychologists must:***

- Annually review and document the licensure or certification of any office staff or employees to whom they delegate medical services;
- Only delegate services that are within the scope of the Practitioner's certification or license as determined by law. Such services should not require the exercise of independent professional judgment;
- Include the following documentation: 1) an evaluation of the patient prior to delegating or ordering any services, 2) a specific order for the service to be delegated, and 3) notation of the results obtained from the service ordered.
- Use treatment protocols from nationally recognized professional sources and have them available on-site for review by BCBST.

### **Specific Billing Requirements:**

Block 31 Practitioner rendering the service

Block 33 Provider's or supplier's billing name, zip code, and phone number. The phone number is to be entered in the area to the right of the field title.

33a NPI # of the billing Provider.

33b Two-digit qualifier identifying the non-NPI number followed by the ID number.

## 3. Certified Providers Requiring Direct and Close Supervision

Direct and Close Supervision requires that the supervising Physician have, at a minimum, face-to-face contact with the patient immediately before and after a service is received. Material participation by the supervising Practitioner must include evaluation of the patient immediately prior to the service, a detailed written order, and a final evaluation of the patient and the service performed prior to the



patient leaving the facility. The supervising Practitioner must be within the place of service (e.g., facility, office) and readily available during the time that a delegated service is rendered.

(Note: See Extenuating Circumstances.) Being available via telephone does not constitute direct and close supervision.

Certified Providers requiring Direct and Close Supervision include Certified Chiropractic Therapy Assistant, Certified Medical Assistant, Certified Nursing Assistant, Certified Occupational Therapy Assistant, Certified Podiatric Assistant, and Medical Laboratory Technician. These health care Practitioners are **not** eligible for a BCBST Provider ID number.

***Supervising Physicians, Chiropractors and Therapists must:***

- Annually review and document certification of any office staff or employees to whom they delegate medical services.
- Only delegate services in which the supervising Practitioner materially participates. "Materially participate" means the supervising Practitioner must evaluate the patient immediately prior to the service, prepare a detailed written order, and perform a final evaluation of the patient and the service performed prior to the patient leaving the facility. The final evaluation should ensure that the service was delivered appropriately and was clinically effective. The supervising Practitioner must be on-site and available at all times.

Documentation in the patient medical record must reflect that these steps occurred.

- Follow required treatment protocols from nationally recognized sources. Protocols must be kept on-site and be made available for review by BCBST. Only delegate services that do not require clinical judgment or could not be Construed as a service requiring the expertise of Practitioners in categories 1 & 2.

**Extenuating Circumstances**

Under extenuating circumstances (e.g., network inadequacy in rural areas) a licensed/ certified therapy assistant may render services through a home health Provider in the home health setting under the general supervision of a licensed therapist. Under these conditions, a licensed therapist must evaluate the patient, develop a treatment plan, and implement the plan. General supervision requires initial direction and periodic re-evaluation by the registered therapists; however, the supervisor does not have to be physically present or on the premises.

**Specific Billing Requirements:**

Block 31 Physician rendering the service

Block 33 Provider's or supplier's billing name, zip code, and phone number. The phone number is to be entered in the area to the right of the field title.

33a NPI # of the billing Provider.

33b Two-digit qualifier identifying the non-NPI number followed by the ID number.

**4. Clarification of terms used within this policy:**

- a. **Autonomous Providers** – Providers who by their state license are qualified to diagnose and initiate treatment independently. For example, a Doctor of Chiropractic (DC) is licensed to diagnose and initiate chiropractic treatment without an order to treat from another profession. A DC is an autonomous Provider and as such, does not require supervision or orders from another profession.

- b. **Supervision by retrospective review** – Supervision that does not take place during the time that a service is performed, but after the service has been rendered. This form of supervision may take place several days or even weeks after a service was rendered and may merely involve a review of an individual's medical record (i.e., complaints, signs, symptoms, diagnostics and subsequent treatment[s]). The supervising Practitioner is typically not within the place of service (i.e., facility, office) during the time that a delegated service is performed.
- c. **Minimal supervision** – Requires that the supervising/treating Practitioner evaluate the patient at some reasonable time prior to receiving a delegated service, that a specific written order for the service be issued prior to the service being performed, and that a notation be made of the results obtained from the delegated service. The supervising/treating Practitioner may or may not be within the place of service (i.e., facility, office) during the time that a delegated service is rendered.
- d. **Direct and close supervision** – Requires that the supervising Practitioner has, at a minimum, face-to-face contact with the patient immediately before and after a service is received. Material participation by the supervising Practitioner must include evaluation of the patient immediately prior to the service, a detailed written order, and a final evaluation of the patient and the service performed prior to the patient leaving the facility. The supervising Practitioner must be within the place of service (i.e., facility, office) and readily available during the time that a delegated service is rendered. (Note: Extenuating circumstances above.) Being available via telephone does not constitute direct and close supervision.

## 7. Locum Tenens Policy

A "locum tenens" is a temporary Practitioner who fills in for a Practitioner on a short-term basis. A Practitioner who is to be a permanent member of a practice or who performs services for over sixty (60) days does not meet the definitions of a "locum tenens" and must initiate contracting and credentialing with BCBST. Any Practitioner that has been denied credentials by BCBST and has not successfully appealed that denial cannot serve as a locum tenens and treat BCBST Members as an in-network Provider or bill under an in-network Provider's ID number.

The substitute Practitioner generally does not have a practice of his/her own and moves from area to area as needed. The regular practitioner generally pays the substitute practitioner or an agency a fixed amount per diem, giving the substitute practitioner the status of independent contractor rather than an employee.

A BCBST Participating Practitioner may submit a claim for a Member's Covered Services (including emergency visits and related services) of a "locum tenens" Practitioner who is not an employee and whose services for Members of the regular Practitioner are not restricted to the regular Practitioner's office, if:

- The Member has arranged or seeks to receive services from the regular Practitioner;
- The regular Practitioner is unavailable to provide the visit services due to leave of absence for illness, vacation, pregnancy, continuing medical education, etc.;
- The regular Practitioner has left a group practice and the group has engaged a "locum tenens" Practitioner as a temporary replacement until a permanent replacement Practitioner is obtained. In this case, group must select a member of the group as an oversight Practitioner.
- The regular Practitioner, or group practice acting on his behalf, sends a letter to the appropriate BCBST Provider Network mailbox, [PNS\\_GM@bcbst.com](mailto:PNS_GM@bcbst.com) stating the reason for "locum tenens". The letter should state the date the services will begin and the estimated end date;

- The regular Practitioner, or group practice acting on his behalf, has ascertained that the “locum tenens” is qualified by training and experience to temporarily maintain the regular Practitioners’ practice;
- The regular Practitioner pays the “locum tenens” for his/her services on a per diem or similar fee-for-time basis; Compensation paid by a group to the “locum tenens” Practitioner is considered paid by the regular Practitioner for purposes of this policy.
- The services are not provided over a continuous period of longer than sixty (60) days. The regular Practitioner, or group practice acting on his behalf, must keep on file a record of each service provided by the substitute Practitioner and make the records available to BCBST upon request;
- Professional claims should be submitted with BCBST Participating Practitioner’s name, individual Provider number, and/or NPI in Block 33 and “locum tenens” name in Block 31 as the servicing Provider. In case of regular Practitioner who has left group practice, claims should be submitted with BCBST Participating Oversight Practitioner name, individual Provider number, and/or NPI in Block 33 and “locum tenens” name in Block 31 as the servicing Provider.

## **8. CMS-1450 Facility Claim Form**

Institutional claims submitted to BCBST must be filed on the CMS-1450 (UB-04) or its electronic equivalent.

The UB-04 contains a number of improvements and enhancements that include better alignment with the electronic HIPAA ASC X 12N 837-Institutional Transaction Standard. The UB-04 paper billing form accommodates the reporting of the National Provider Identifier Number (NPI). The NPI is a single Provider identifier, replacing the different Provider identifiers health care systems previously used for each health plan with which you do business. The NPI Identifier, which implements a requirement of Health Insurance Portability and Accountability Act of 1996 (HIPAA), must be used by all HIPAA covered entities, which are health plans, health care clearinghouses, and health care Providers.

**Note:** BCBST follows CMS guidelines for filing the National Provider Identifier (NPI) Number.

A sample copy and field description of the UB-04 claim form follows:

# BlueCross BlueShield of Tennessee Provider Administration Manual

CMS 1450-UB04

|                |  |     |  |   |  |                   |  |
|----------------|--|-----|--|---|--|-------------------|--|
| 1              |  | 2   |  | 3<br>KEY<br>CNTL #<br>S. MED.<br>RCD. #<br>S. PEO TAX NO. |  | 4<br>DATE<br>OBS. |  |
| 5 PATIENT NAME |  |     |  | 6 PATIENT ADDRESS   |  |                   |  |
| 7              |  |     |  | 8   |  |                   |  |
| 9              |  | 10  |  | 11  |  | 12                |  |
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| 441            |  | 442 |  | 443   |  |                   |  |

**a. CMS-1450 (UB-04) Form Locators and Field Description:**

|                    |   |
|--------------------|---|
| Form Locator 1     | Provider Name, Address, Telephone Number***   |
| Form Locator 2     | Pay-to Name, Address, City, State, and ID   |
| Form Locator 3     | 3a>Patient Control Number*** 3b>Medical Record Number***  |
| Form Locator 4     | Type of Bill***   |
| Form Locator 5     | Federal Tax Number***   |
| Form Locator 6     | Statement Covers Period***  |
| Form Locator 7     | Unlabeled Field   |
| Form Locator 8     | 8a>Patient Name-ID 8b>Patient Name***   |
| Form Locator 9     | 9a>Patient Address-Street 9b>Patient Address-Other<br>9b>Patient Address-City 9c>Patient Address-State 9d>Patient<br>Address-Zip 9e>Patient Address-Country Code*** |
| Form Locator 10    | Patient Birthdate***  |
| Form Locator 11    | Patient Sex***  |
| Form Locator 12    | Admission Date*** (Inpatient)   |
| Form Locator 13    | Admission Hour*** (except for Bill Type 02X)  |
| Form Locator 14    | Type of Admission/Visit***  |
| Form Locator 15    | Source of Admission***  |
| Form Locator 16    | Discharge Hour*** (final inpatient claim only)  |
| Form Locator 17    | Patient Discharge Status***   |
| Form Locator 18    | Condition Codes   |
| Form Locator 19    | Condition Codes   |
| Form Locator 20    | Condition Codes   |
| Form Locator 21    | Condition Codes   |
| Form Locator 22    | Condition Codes   |
| Form Locator 23    | Condition Codes   |
| Form Locator 24-28 | Condition Codes   |
| Form Locator 29    | Accident State  |
| Form Locator 30    | Unlabeled Field   |
| Form Locator 31    | a-b Occurrence Code/Date  |
| Form Locator 32-34 | a-b Occurrence Codes and Dates  |
| Form Locator 35    | a-b Occurrence Span Code/From//Through  |
| Form Locator 36    | a-b Occurrence Span Code/From/Through   |
| Form Locator 37    | a-b Unlabeled Fields  |
| Form Locator 38    | 1-5 Responsible Party Name/Address  |
| Form Locator 39    | a-d Value Code-Code   |
| Form Locator 39    | a-d Value Code-Amount   |
| Form Locator 40    | a-d Value Code-Code   |
| Form Locator 40    | a-d Value Code –Amount  |
| Form Locator 41    | a-d Value Code-Code   |
| Form Locator 41    | a-d lines Value Code-Amount   |
| Form Locator 42    | Revenue Code***   |
| Form Locator 43    | 1-22 Revenue Code Description***  |
| Form Locator 43-44 | Line 23 Page_of_Creation_Date   |
| Form Locator 44    | HCPCS/Rates/HIPPS/Rate Codes***   |
| Form Locator 45    | 1-22 Service Date   |
| Form Locator 45    | Line 23 Creation Date   |
| Form Locator 46    | Units of Service***   |
| Form Locator 47    | Total Charges***  |
| Form Locator 48    | Non-Covered Charges   |
| Form Locator 49    | Unlabeled Field   |
| Form Locator 50    | Payer Identification***   |
| Form Locator 51    | Health Plan ID  |

**a. CMS-1450 (UB-04) Form Locators and Field Description (cont'd):**

|                 |   |
|-----------------|---|
| Form Locator 52 | Release of Information Certification Indicator  |
| Form Locator 53 | Assignment of Benefits Certification Indicator  |
| Form Locator 54 | Prior Payments -- Payer   |
| Form Locator 55 | Estimated Amount Due  |
| Form Locator 56 | NPI   |
| Form Locator 57 | Other Provider ID-Primary/Secondary***  |
| Form Locator 58 | Insured's Name***   |
| Form Locator 59 | Patient's Relationship to Insured   |
| Form Locator 60 | Certificate/Social Security Number/Health Insurance<br>Claim/Identification Number*** |
| Form Locator 61 | Insured Group Name  |
| Form Locator 62 | Insurance Group Number  |
| Form Locator 63 | Primary/Secondary/Third   |
| Form Locator 64 | Document Control Number   |
| Form Locator 65 | Employer Name   |
| Form Locator 66 | DX Version Qualifier  |
| Form Locator 67 | Principal Diagnosis Code***   |
| Form Locator 67 | A-Q Other Diagnosis Codes   |
| Form Locator 68 | Unlabeled Field   |
| Form Locator 69 | Admitting Diagnosis Code*** (Inpatient)   |
| Form Locator 70 | Patient's Reason for Visit Code   |
| Form Locator 71 | PPS Code*** (if in Provider contract with payor)                                      |
| Form Locator 72 | A-C External Cause of Injury Code   |
| Form Locator 73 | Unlabeled   |
| Form Locator 74 | ICD Code/Date*** (if surgical procedure performed)                                    |
| Form Locator 74 | a-e Other Procedure Code/Date   |
| Form Locator 75 | Unlabeled Field   |
| Form Locator 76 | 1- Attending –NPI/QUAL/ID   |
| Form Locator 76 | 2-Attending-Last/First  |
| Form Locator 77 | 1-Operating-NPI/QUAL/ID   |
| Form Locator 77 | 2-Operating-Last/First  |
| Form Locator 78 | 1-Other ID-QUAL/NPI/ID  |
| Form Locator 78 | 2-Other ID-Last/First   |
| Form Locator 79 | 1-Other ID- QUAL/NPI/QUAL/ID  |
| Form Locator 79 | 2-Other ID-Last/First   |
| Form Locator 80 | 1-4 Remarks   |
| Form Locator 81 | a-d Code-Code-QUAL/CODE/VALUE   |

\*\* Required Fields by Pre Adjudication Edits

\*\*\* Required Fields by BCBST Electronic Billing

**b. Revenue Code (FL42)**

Complete this field with the revenue code related to the services that are being billed to BCBST. For specific instructions regarding each revenue code, refer to the billing guidelines defined below:

- **Billing Guidelines (Form Locator 42) Field Definitions**  
Each field contains specific billing information critical to understanding how to file a claim with BCBST. By following these guidelines the facility will maximize reimbursement.
- **Revenue Code** – The Revenue Code is the initial indicator to the claims administration system as to what type of services were performed. Revenue Codes for inpatient and outpatient services are included in the billing guidelines.
- **Category** – The Category defines a general description of the type of service provided under the Revenue Code. Some Revenue Codes fall into several Categories such as Revenue Code 110. Revenue Code 110 is generally used to file services under Medical, Surgical, Orthopedic, Trauma, Trauma Medical and Trauma Surgical, among others. The participating Provider Contract outlines which Revenue Codes can be filed under each Category.
- **Reimbursement Rule** - The Reimbursement Rule explains what type of reimbursement the facility should expect if billed properly. It is extremely important to have the facility's contract on hand when reviewing how a claim should be reimbursed. BCBST claims administration system in some cases will default to another Category in the event that there is no specifically contracted rate for a service. In addition, some services are ineligible as "Not Medically Necessary," or there is no negotiated fee.
- **Principal Diagnosis** - The Principal Diagnosis determines the Category for reimbursement. The Principal Diagnosis should always be billed in Form Locator 67 on the CMS-1450 claim form. This field indicates to our system the primary reason for the services rendered to the patient.
- **Principal Procedure Code** – The Principal Procedure Code is an ICD Procedure Code. This code will help determine the Category of service. The facility should bill the correct Principal Procedure Code in Form Locator 74 of the CMS-1450.
- **CPT®/HCPCS Required** – CPT® Codes should always be billed on the CMS-1450 in Form Locator 44. This field indicates when a Revenue Code must be filed with a CPT®/HCPCS Code. If a required CPT®/HCPCS Code is missing, the claim may be denied and returned to the facility for proper coding.

**c. HCPCS Codes/Rates (FL44)**

Complete this field with the CPT®/HCPCS Code related to the service being provided. To determine which CPT®/HCPCS Codes are to be filed with a related Revenue Code, refer to the FL44 – BCBST CPT®/HCPCS Code Requirement.

**Note:** *For the related contract, BCBST accepts only valid CPT®/HCPCS Codes that can be billed in a hospital acute care setting. Prior to payment, unlisted procedures must be filed hard copy with the supporting medical record.*

- **Billing Guidelines (Form Locator 44) Field Definitions**  
Each field contains specific billing information critical to understanding how to file a claim with BCBST. By following these guidelines, the facility will maximize reimbursement. These guidelines only apply to Revenue Codes stated in the Billing Guidelines (Form Locator 42) as requiring a CPT®/HCPCS Code.

- **CPT®** – The CPT® *Field* lists the CPT®/HCPCS Code or Range of Codes eligible to be filed in Form Locator 44 of the CMS-1450.
    - Codes ranging from 10000-69999 are generally surgical codes and require individual negotiated rates for outpatient services. Please refer to the correct Network Attachment for reimbursement schedules.
    - Codes ranging from 70000-79999 are generally radiology codes. Please refer to the Provider Network Attachment for any Procedure Codes that have individual negotiated rates.
    - Codes ranging from 80000-89999 are generally laboratory or pathology codes. Please refer to your Provider Network Attachment for any Procedure Codes that have individual negotiated rates.
  - **MOD** – The *Modifier (MOD) Field* states any code that must be filed with a modifier in addition to a CPT®/HCPCS Code.
  - **Required Revenue Code(s)** - The *Required Revenue Code(s) Field* is provided so the facility will know exactly what Revenue Codes are eligible to bill BCBST for each CPT®/HCPCS Code. Without the correct Revenue Code and CPT®/HCPCS Codes, BCBST will not accept the claim for consideration of benefits. Incorrectly filed claims may be returned to the Provider for correction.
  - **Billing Instructions** – The *Billing Instruction Field* explains the requirements to bill the selected CPT®/HCPCS Code. This field also provides an insight as to how BCBST adjudicates the claim.
- d. **Service Units (FL46)**  
In general, report the quantitative measure of service, by revenue category, to or for the patient; such as, the number of accommodation days, visits, miles, pints of blood, units or treatments. Units for related CPT®/HCPCS Codes are to be based on the number of times the service or procedure was performed, as defined by the CPT®/HCPCS Code. Visit codes are not to be reported as units.
- e. **Principal Diagnosis Code (FL67)**  
Depending on your contract, the Principal Diagnosis Code may be required for proper adjudication of an inpatient claim. For specific instructions, see Billing Guidelines (Form Locator 42). If applicable, report the full ICD Code that describes the principal diagnosis.
- f. **Principal Procedure Code and Date (FL74)**  
Depending on your contract, the Principal Procedure Code may be required for proper adjudication of an inpatient claim. For specific instructions refer to Billing Guidelines (Form Locator 42). If applicable, report the ICD Code for the principal procedure performed during the period covered by the bill and the date that the principal procedure was performed.
- g. **Attending Physician (FL76)**  
Report the name and UPIN Number of the licensed Physician who is expected to certify the Medical Necessity of the services rendered and who is primarily responsible for the patient's care. (If UPIN is NOT available, enter "OTH000" in this field.)



**h. CMS-1450 Specific**

- All date information should be shown in the following format (except Form Locator 10 –Birth Date):  
MMDDYY  
MM=month (01-12)  
DD=day (01-31)  
YY=year (00-99)  
Example: January 1, 2004 = 010404  
Form Locator 10 must be a continuous 8-digit number (Correct: January 1, 2004 = 01042004)
- Do not exclude leading zeros in the date fields;
- Multi-page Claims:
  - All diagnosis code(s) listed on first page must be listed on **each** page.
  - Place the total amount and 0001 Total Revenue Code **only on the last page of the claim**. The 0001 Total Revenue Code line on the last page of the claim should reflect the sum of the line items for all pages.
  - Use the words “Continued on next page” or “Page X of X” on line 23 on each page (except on the last page, which reflects the total charge on the 0001 Total Revenue Code line).
  - Staple only the pages of the individual claim together as one. Do not staple several multi-page claims together as one.
- Donor/Recipient information when filing transplant claims:
  - Block 8 should contain the name of patient that received the service. “In this case it will be the Donor”.
  - Block 58 should contain the Subscriber, the Recipient “if different from the Subscriber” and the Donor (the Donor should only be listed if there is other insurance coverage for the donor charges making the Recipient’s plan “BCBST” Secondary).
  - Block 59 on the Subscriber/Recipient lines should contain the patient Relationship code “39”. 39=“Organ Donor”.

BCBST updated the OCR scanning processes for CMS-1500 and CMS-1450 paper claims. Following the *2012 Official UB-04 Data Specifications Manual* guidelines, this update did not require any changes related to the CMS-1500 claim form, however the following changes will be required when submitting CMS-1450 paper claims:

- **Form Locator 12 - Admit Date:** Admit date should only be populated for inpatient, home health, and hospice claims. A rejection will occur for any other claim type.
- **Form Locator 13 - Admit Hour:** Admit hour should only be populated for inpatient claims, excluding type of bill 021x. A rejection will occur for any other claim type.
- **Form Locator 15 - Admission Source:** Admission source should be populated for ALL institutional claims except those with a TOB 014X. Any UB-04 (or its successor) claim form submitted without an Admission Source will be rejected and returned for correction.
- **Form Locator 69 - Admitting Diagnosis Code:** Admitting diagnosis code is only required for inpatient claims. A rejection will occur for any other claim type.
- **Form Locator 74 - Principal Procedure Code:** Principal procedure code should only be submitted for inpatient claims. A rejection will occur for any other claim type.
- **Form Locator 74a-e - Other Procedure Code:** Other procedure codes should only be submitted for inpatient claims. A rejection will occur for any other claim type.

**Note:** NDC requirements must also be fulfilled by facilities filing Outpatient UB claims on a CMS-1450 claim form or submitted electronically in the ANSI-837 Institutional version format. NDC information is not required on Inpatient UB claims. When an NDC code is required, all of the following NEW data elements are required, in addition to the HCPCS/CPT® code. Any missing element may result in the claim being returned unprocessed.

| Element                   | Description  |
|---------------------------|--|
| 1. NDC Qualifier          | N4   |
| 2. NDC Number             | Eleven digit number  |
| 3. NDC Quantity Qualifier | F2 - International Unit<br>GR – Gram<br>ME - Milligram<br>ML - Milliliter<br>UN - Unit |
| 4. NDC Quantity           | Numeric value  |
| 5. NDC Unit Price         | (ANSI-837 only)  |

As a reminder, to help ensure compliance with National Uniform Billing Committee (NUBC) guidelines, claims submitted with a discharge status 20, 40, 41, or 42 must also include an Occurrence Code 55 and date of death.

NUBC is responsible for the design and printing of the UB-04. Additional information for the UB-04 is available to subscribers. If you are interested in additional information please visit the NUBC website at [www.nubc.org](http://www.nubc.org).

## 9. Instructions for Returned Claims and Processed Claims needing Correction

**Note:** Corrected bills must be submitted within two years of the end of the year the claim was originally submitted. For example, if a claim was filed on 2/15/15, any corrected bill must be submitted by 12/31/17.

### a. Incomplete Claims

Incomplete claims are claims that do not conform to the billing guidelines. These claims have **NOT** been processed and will be returned to the Provider. When an incomplete paper claim is returned, Providers will receive a black and white reproduction of the claim submitted with the error(s) listed on the form. For CMS-1500 claims, errors will be listed at the top of the form and for CMS-1450 claims, the errors will be listed at the bottom of the form.

Providers should correct the error(s) and resubmit the claim as a new claim on a **new** claim form. **DO NOT WRITE OR STAMP “CORRECTED CLAIM” ON THE NEW CLAIM.** Correcting the error(s) and resubmitting on a **new** claim form will help ensure quicker turnaround.

Incomplete electronic claims are reflected on the Provider's 277CA Health Care Information Status Notification Report. Providers should correct the error and resubmit the claim electronically.

**Note:** Since incomplete returned claims have not been processed (Providers have not received a Remittance Advice for these claims), the claim will not be denied “duplicate” when resubmitted. Images of all rejected and accepted claims will be maintained in BCBST's archives for future reference.

**b. Corrected Bills**

Claims that have been **processed** (Providers receive a Remittance Advice that includes the claim) and were paid incorrectly because of an error or omission on the claim may be filed as a “**Corrected Bill**”. A true corrected bill includes additional/changed dates of service, codes, units, and/or charges that were not filed on the original claim.

**Note:** *Claims returned or rejected should not be submitted as corrected claims. Only claims that have completed adjudication should be submitted as corrected bills. When sending a Corrected/Replacement Claim you must re-send the claim in its entirety including the corrections.*

*Also, when a Corrected Bill is filed, BCBST will recover any payment previously made under the original claim submission from the Provider's remittance advice (a refund request letter will not be sent). Any applicable new payment will be based on the services submitted on the Corrected Bill claim.*

**1. Corrected Electronic Claims (Required Method)**

If a claim is rejected, it requires correction and resubmission electronically.

**Corrected Bills** for facility and professional claims can be filed electronically in the ANSI-837, version 5010 format. The following guidelines are based on National Implementation

Guides found at <http://www.wpc-edi.com> and BCBST Companion Documents found at <http://www.bcbst.com/providers/ecommm/technical-information.shtml> when filing these claims.

**2. ANSI-837P - (Professional) and ANSI-837I - (Institutional)**

In most instances, claims correction should be submitted in an electronic format.

- In the 2300 Loop, the CLM segment (claim information), CLM05-3 (claim frequency type code) must indicate the third digit of the Type of Bill being sent. The third digit of the Type of Bill is the frequency and can indicate if the bill is an Adjustment, a Replacement or a Voided claim as follows:
  - “7” – REPLACEMENT (Replacement of Prior Claim)
  - “8” – VOID (Void/Cancel of Prior Claim)
- In the 2300 Loop, the REF segment (claim information), must include the original claim number issued to the claim being corrected. The original claim number can be found on your electronic remittance advice.
  - REF01 must contain ‘F8’
  - REF02 must contain the original BCBST claim number

**Example: REF\*F8\*1234567890~**

- In the 2300 Loop, the NTE segment (free-form ‘Claim Note’), must include the explanation for the Corrected/Replacement Claim.
  - NTE01 must contain ‘ADD’
  - NTE02 must contain the free-form note indicating the reason for the corrected replacement claim.

**Example: NTE\*ADD\*CORRECTED PROCEDURE CODE ON LINE 3**

For Technical Support assistance, contact eBusiness Technical Support at 423-535-5717 or via e-mail at Ecomm\_TechSupport@bcbst.com. Technical support is available Monday through Thursday, 8 a.m. to 6 p.m. (ET), and Friday, 9 a.m. to 6 p.m. (ET).

### 3. Method for Filing Corrected Paper Claims

**Note:** Paper claims will only be an accepted method of submission when technical difficulties or temporary extenuating circumstances exist and can be demonstrated.

There are two methods that can be used to submit corrected paper claims. The first method listed below is preferred because it allows the automatic scanning of the new claim for quicker turnaround. The alternate method requires marking on the original claim and can result in errors and delay processing of the claim if the handwritten information is not clear or extends beyond the form fields.

- **Submit a new claim form with the correct data.**

- Attach correspondence behind the claim form indicating what information was originally submitted and what was changed on the new claim form. Example: "Procedure code in Block 24D of first line item was submitted as 99201; corrected to 99202 on new claim".
- Write (using pen with black ink) or type qualifier "7" (Replacement of prior claim), or "8" (Void/Cancel of prior claim) in Block 22 on the CMS-1500 claim form. Our Optical Character Recognition (OCR) equipment will not recognize red ink. Do not use a thick marker or crayon that may cover other form fields.
- On the **CMS-1450 (UB-04)** claim form, if the third digit in the Type of Bill field (form locator 4) ends in a "7" or "8", the claim is considered a corrected bill.

| If third digit in type of bill is: | it indicates:              |
|------------------------------------|----------------------------|
| 7                                  | Replacement of prior claim |
| 8                                  | Void/cancel of prior claim |

- If filing a corrected claim as a new claim submission, the claim number originally used by BCBST to process the claim should be included in the Original Ref. No. field – FL64. This item number is not intended for use for original claim submissions. Failure to include the proper indicator and original claim number may result in a claim denial.

- **Alternate Method for Filing Corrected Paper Claims**

- Draw a thin line through the original information and **clearly** list the new information above, below or beside the original information.
- Keep within the boundaries of the form field when adding the correct information. Do not use a thick marker or crayon that may cover other form fields.
- Do not use correction tape or fluid (White Out) – the original information **MUST** be visible.
- Write (using pen with black ink) or type qualifier "7" (Replacement of prior claim), or "8" (Void/Cancel of prior claim) in Block 22 on the CMS-1500 claim form.
- Use the appropriate Type of Bill on the CMS-1450 claim form to identify the claim as a corrected bill. (See code definitions above.)

- If filing a corrected claim as a new claim submission, the claim number originally used by BCBST to process the claim should be included in the Original Ref. No. field – FL64. This item number is not intended for use for original claim submissions. Failure to include the proper indicator and original claim number may result in a claim denial.

## 10. Coordination of Benefits

BCBST Provider Contracts include the provision for Coordination of Benefits (COB), which applies when a Member has coverage under more than one group contract or health care benefits plan. Claims should be submitted to the primary carrier prior to submission to BCBST. Upon claim submission to BCBST, please provide a copy of the Remittance Advice from the primary carrier.

## 11. Maintenance of Benefits

Maintenance of Benefits (MOB) is a form of Coordination of Benefits (COB). When BCBST's health care coverage is secondary to another plan, Maintenance of Benefits ensures that the combined payments of the two health care plans do not exceed what BCBST would have paid if it had been the only coverage. MOB is often referred to as "preservation" COB, because it preserves the secondary plan's deductibles, copayments and coinsurance amounts.

If the primary insurance carrier's payment amount is the same or more than what BCBST would have paid, BCBST will not make any additional payment. If the primary insurance carrier's payment is less than what BCBST would have paid, BCBST will only pay the difference in what it would have paid and what the primary insurance carrier did pay. Even if BCBST does not make payment, and a BCBST participating Provider rendered the services, the Member is not liable for any amount over the Provider's negotiated reimbursement amount, which is the maximum allowable charge. The Provider cannot bill the Member for any amount over the maximum allowable charge.

**Note:** *If the Member is a Medicare beneficiary, routine waiver of deductible and copayments by the charge-based Providers, Practitioners or suppliers is unlawful because it results in (1) false claims, (2) violations of the anti-kickback statute, and (3) excessive utilization of items and services paid for by Medicare.*

## 12. Right of Reimbursement and Recovery (Subrogation)

The Right of Reimbursement and Recovery (Subrogation) is a provision in the Member's health care benefits plan that permits BCBST to pay the Provider when a third party causes the Member's condition. BCBST handles subrogation cases on a "pay and pursue" basis. If a Provider becomes aware that the services rendered result from the actions of a third party, he/she should contact us at the following address and telephone number:

BlueCross BlueShield of Tennessee  
Subrogation Department  
1 Cameron Hill Circle, Ste 0008  
Chattanooga, TN 37402-0008  
423-535-5847

If there is a payment from a third party carrier that results in an overpayment, it is the responsibility of the Provider to reimburse BCBST the overpaid amount. If a Provider receives more than he/she should have when benefits are provided by an auto insurance or a homeowner's plan, the Provider will be expected to repay any overpayment to the appropriate insurer. The Provider will not pursue any third party recoveries, nor accept any payments from other parties after payment by BCBST. This does not apply to copayments, deductible or coinsurance amounts.

### 13. Balance Billing

Providers agree to accept reimbursement made in accordance with the terms of their Provider Contract with BCBST, plus any applicable Member copayment/deductible, and coinsurance amounts as the maximum amount payable to the Provider for Covered Services rendered to Members.

Providers **may not** seek payment from a BCBST Member when:

- The Provider failed to comply with BCBST medical management policies and procedures or provided a service which does not meet BCBST standards for medical necessity or does not comply with BCBST medical policy;
- The Provider failed to submit or resubmit claims for payment within the time periods required by BCBST (timely filing guidelines); or
- Services rendered are considered Investigational by BCBST and are therefore non-reimbursable, unless **prior** to rendering such services to the Member, Provider has entered into a **procedure-specific** written agreement with the Member, which advised Member of his/her payment responsibilities.

Providers **may** bill the Member for:

- Non-Covered Services\*;
- Any applicable Deductible/Copay Amounts; and
- Any applicable Co-Insurance Amounts.

When seeking payment from a BCBST Member, please refer to the *Patient Owes* column on your Provider Remittance Advice. This column includes *the Non-covered* total, *Deductible/Copay* total and *Coinsurance* total. It may also reflect the *Other Insurance* total, which is the amount paid by the patient's other insurance carrier.

Before billing the Member, check both the *Deductible/Copay* and the *Other Insurance* columns to make sure that any applicable copayment or other insurance payments haven't already been received.

**\*When billing Members for non-covered services due to benefit limitations, i.e. dollar limits or service limits, network Providers** may bill the Member the difference between the limit amount and the allowed amount. The difference between the billed amount and the allowed amount is considered a Provider write-off.

#### **Example: Dollar Limit**

The Member has a \$250 limit on wellness services with no copayment. The Member has already used \$100 on wellness services. This leaves a remaining benefit of \$150.

|                            |   |
|----------------------------|---|
| Billed amount              | \$450   |
| Allowed amount             | \$325   |
| Remaining wellness benefit | \$150   |
| Provider write-off         | \$125 (difference between billed amount and allowed amount)     |
| Member liability           | \$175 (difference between allowed amount and remaining benefit) |

#### **Example: Service Limit**

The Member's coverage allows for one Pap smear per calendar year. The Member has already used this benefit for the year.

|                    |  |
|--------------------|--|
| Billed amount      | \$65   |
| Allowed amount     | \$30   |
| Provider write-off | \$35 (difference between billed amount and allowed amount) |
| Member liability   | \$30 (allowed amount)                                      |

**Note:** BCBST Members shall be held harmless for any contractual difference between billed charges and BCBST and Member payment obligations unless noted above.

## 14. Provider Overpayment Recovery Policy/Process

If a Provider identifies that a payment made by BCBST results in an overpayment, it is the responsibility of the Provider to reimburse BCBST the overpaid amount. The Provider should return the overpayment with a copy of the Remittance Advice (RA) and a cover letter explaining why the payment is being refunded. A sample copy of the Commercial Remittance Advice can be found on the company website at <http://www.bcbst.com/providers/Sample-Copies-of-Remittance-Advices.page>.

Mail to: BlueCross BlueShield of Tennessee  
Receipts Department  
1 Cameron Hill Circle  
Chattanooga, TN 37402

In the event that a Provider receives a BCBST overpayment notification, no action is required unless records conflict with the findings. BCBST will recover the overpayment through an offset to the remittance advice within 30 days from the date of the notification. Please do not send a check for the overpayment. Checks received for solicited overpayments will be returned to the payee.

### a. Overpayment Notifications

An overpayment notification is sent on all overpayments that are identified on claims submitted by Physicians, non-participating facilities and par facilities requiring notification.

Requests for reimbursement of overpayment shall be made no later than eighteen (18) months after the date that BCBST paid the claim submitted by the Provider, except in the case of Provider fraud, in which case no time limit shall apply. In addition, the limited period shall not apply to any federal governmental program, including the Federal Employee Program (FEP).

Notwithstanding anything to the contrary, BCBST's review of relevant financial and/or medical records shall not be limited for the time period of eighteen (18) months nor shall BCBST be prohibited to pursue any other available remedy, either at law or in equity.

The following instructs Providers how to read BCBST's Remittance Advice transactions when overpayment recovery activity is reflected:

### b. Automatic Overpayment Recovery

- **Auto-recovery adjustment/moneys recovered:** (when full recovery of overpayments is taken from **current** BCBST Remittance Advice):
  - If there is a negative amount in the "Amount Paid" column on the remit, this indicates an overpayment adjustment has occurred on the Member's account.
  - For each account that is being adjusted, there will be a second line entry immediately following the adjustment line. This line entry reflects the corrected net amount paid for the claim (adjusted amount subtracted from the original payment).

**Exception:** *If the overpayment was the result of 1) payment made to an incorrect Provider, 2) a duplicate payment, 3) a claim billed in error, or 4) payment made on an incorrect Member, the negative adjustment line will indicate the recovery and there will **not** be a second line entry.*

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- The second line entry has the corrected amounts listed in the “Covered Charges”, “Provider Contract Adjustment” and “Patient Owes” columns. Please use the corrected amount in these columns to adjust the Member’s account accordingly.
- The explanation code reflected in the “Note” column indicates the reason for the adjustment.
- On the last page of the Remittance Advice, (bottom of page), the columns are totaled, including any negative adjustments listed on the remit. In the “Amount Paid” column, the amount listed should equal the amount of payments and adjustments listed in the “Remittance Advice Detail”.

**Note:** The “Amount Paid” column will not always equal the amount of the check when BCBST recovery amounts are carried from one Remittance Advice to the next.

*It is important that Providers post all negative adjustments to a “payables” account when posting from the remit. By posting to a “payables” account, the Provider’s records will show funds owed to BCBST. This account can then be adjusted when the moneys are actually recovered by BCBST.*



### **Auto-recovery adjustment/credit balance remains:**

- On the last page of the Remittance Advice, (bottom of page), the columns are totaled, including any negative adjustments listed on the remit. A negative amount in the “Amount Paid” column indicates there were insufficient funds on the remit to recover all the funds owed to BCBST. In this situation, the credit balance will be forwarded to the next remit and deduction will be made from the total payment due the Provider on that remit.

**Note:** If there is a negative amount in the “Amount Paid” column, no check will be issued. However, the Remittance Advice detail should be used to post all Member accounts listed on the remit.

- When a credit balance is created, a “Remittance Adjustment” and “Adjustment Details” section will be added to the remit. These sections list any negative balances that have been carried over from any previous remits. These sections also indicate how much of the negative balance was applied to the current remit payment. Any remaining negative balance will continue to be recorded in this section until the negative balance is satisfied.
- The “Adjustment Details” section reflects the overpayments deducted from the current remit and those carried forward for deduction from a future remit. The dollar value of overpayments deducted from the current remit will be reflected in the “Currently Applied” field. The dollar amount still owed BCBST to be recovered from future remits will be reflected in the “Balance Outstanding” field.
- The “Activity Date” under the Adjustment Details” section is critical to posting Member accounts. The “Activity Date” communicates the remit date of the original adjustment transaction. In order for the Provider to identify Member-specific details required to post accounts due to overpayment recoveries carried forward from previous remits, the remit with a date matching the date listed in the “Activity Date” field must be retrieved. (It is important to retain copies of all BCBST remits for future reference.) To obtain the Member-specific claim



payment details, refer to the claim number listed under the “Adjustment Details” section on previous remits.

**c. Manual Overpayment Recovery**

BCBST utilizes a manual recovery transaction to recover overpayment dollars from the Provider’s check and Remittance Advice when normal activities are not successful in resolving an overpayment situation.

This process can involve transferring of overpayment dollars from one line of business to another, one Provider number and/or NPI to another, or one tax identification number to another involving the same Provider. This is effective for all overpayment dollars currently due BCBST regardless of when the overpayment was created.

**Note:** *Prior to a manual recovery transaction, all actions required by BCBST Corporate Provider Overpayment Recovery Policy have been exhausted.*

These manual overpayment recoveries will appear on the last page of the Provider’s remittance advice with a narrative description of “Manual Reduction”. Instructions on the remittance advice state “Manual Recovery Detail Sent Separately”. These claim details are mailed to the Provider’s office in advance of the BCBST check and Remittance Advice.

An overpayment claim detail fax hotline telephone number is listed on the Provider’s remit beside the “Manual Reduction Transaction” narrative. Provider’s office staff can call this hotline telephone number to request claim details supporting the manual reduction. The additional information will assist Providers when posting their BCBST Member accounts.

## **15. Electronic Funds Transfer**

Beginning January 1, 2015, BCBST began executing the July 2013 electronic claims filing requirement pursuant to the BCBST Minimum Practitioner Network Participation Criteria, which requires all network Providers to enroll in the Electronic Funds Transfer (EFT) process. EFT is a free service that sends payments directly to the Provider’s financial institution and increases the speed at which they receive payment.

Key advantages to receiving payments electronically are:

- Earlier payments;
- More secure payment process;
- Reduced administrative costs; and
- Less paper storage.

BCBST accepts electronic funds transfer (EFT) enrollment through CAQH Solutions, who offers a universal enrollment tool for providers that provides a single point of entry for adopting EFT and ERA. The CAQH process facilitates compliance with the 2014 EFT/ERA Administrative Simplification mandate under the Affordable Care Act, eliminates administrative redundancies and creates significant time and cost savings. Enrollment information is available on the CAQH Solutions website at <https://solutions.caqh.org>.

To view/print a copy of your remittance advices, ensure you have access to Availity, BCBST’s secure area on its websites, [www.bcbst.com](http://www.bcbst.com) and <http://bluecare.bcbst.com>.

For more information regarding the EFT Program Process, or for assistance with Availity, please call eBusiness Service at 423-535-5717, Option 2, Monday through Thursday, 8 a.m. to 6 p.m., Friday 9 a.m. to 6 p.m. (ET), or e-mail [eBusiness\\_Service@bcbst.com](mailto:eBusiness_Service@bcbst.com).

**EnrollHub™** is the new name for the CAQH EFT and ERA enrollment tool.

**Phone:** 1-844-815-9763 available Monday through Thursday 7 a.m. to 9 p.m. (ET)  
Friday 7 a.m. to 7 p.m. (ET)

**Email:** [eftenrollhub@caqh.org](mailto:eftenrollhub@caqh.org)

**Website:** [http://www.caqh.org/eft\\_enrollment.php](http://www.caqh.org/eft_enrollment.php)

**CAQH ProView™** is now the provider data collection tool formerly the Universal Provider Datasource®.

**Phone:** 1-844-259-5347 available Monday through Thursday 7 a.m. to 9 p.m. (ET)  
Friday 7 a.m. to 7 p.m. (ET)

**Email:** [proview@caqh.org](mailto:proview@caqh.org)

**Website:** <https://proview.caqh.org>

**Note:** Vendor and BCBST shall be bound by the National Automated Clearing House Association rules relating to corporate trade payment entries (the "Rules") in the administration of these ACH Credits.

## 16. Federal Employees Plan (FEP) Claims Filing Guidelines

BCBST commercial timely filing period is **180 days** from the date of service or, for facilities, within 180 days from the date of discharge. Exception, for claims filed by out-of-network Providers, all claims must be submitted no later than December 31 of the calendar year following the year during which the service or supply is received. For example, if a Member receives Covered Services on May 8, 2015 a claim for reimbursement must be submitted no later than December 31, 2016. Claims for long hospital stays or other long-term care should be submitted every 30 days.

The BlueCross BlueShield Plan serving the area where the services are received or where the Member resides processes most FEP Member claims. All Plans are responsible for processing claims within their FEP service area. A claim for services obtained outside the Plan's service area can only be processed by that Plan if the claim is for outpatient services for a Member residing in the Plan's service area. However, to take advantage of Participating Provider arrangements when possible, claims should be processed by the Plan that serves the area where the services were rendered. Claims not meeting those criteria should be forwarded (by the Plan) to the Plan where the services were rendered. Claims for Covered Services provided to FEP Members are submitted by Providers in the same manner as other local BCBST contracts.

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## B. General Billing Information

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Unless otherwise indicated, the information in this section is common for both Professional and Institutional Services. (See also Professional or Institutional sections for more specific guidelines.) All billing and reimbursement guidelines included in this section also apply to Blue Network E, BCBST's limited regional Provider network offered on the Marketplace. These billing guidelines, however, may not apply to our Medicare lines of business. **Please refer to Section XXIV. MedAdvantage, in this Manual where specific guidelines may apply.**

### 1. Medical Clinical Code Sets and Maintenance

Unless specified otherwise in this Manual, medical/clinical codes including modifiers should be reported in accordance with the governing coding organization. The following update schedules reflect the addition, revision, or deletion of codes only and do not relate to reimbursement updates. See Acute Care Fee Schedules section for Reimbursement Update information.

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- a. **Current Dental Terminology (CDT)** –These codes should be reported in accordance with the American Dental Association guidelines (e.g., CDT manual).

### Addition/Deletion/Revision CDT Codes

CDT codes are updated and maintained by the American Dental Association. CDT updates include addition, deletion, and/or revision of codes. Currently, CDT codes are subject to updates on a periodic basis.

| Effective Date of Change by the American Dental Association | Effective Date of Change by BCBST (Date of Service) |           |           |
|---|---|-----------|-----------|
|   | Addition  | Revision  | Deletion  |
| January 1   | January 1   | January 1 | January 1 |

**BCBST will implement updates to CDT codes according to the following schedule:**

In the event the American Dental Association modifies the schedule for coding updates, the BCBST schedule will be modified accordingly. CDT codes billed prior to the effective date of the code will be rejected or returned by BCBST as an invalid code for the date of service.

Due to the short American Dental Association publication schedule, it is not possible for BCBST to notify Providers of changes to CDT codes. The Provider is responsible for ensuring codes billed are valid for the date of service. CDT codes can be obtained from the American Dental Association.

- b. **Current Procedural Terminology (CPT®)** –These codes should be reported in accordance with the American Medical Association guidelines including the *CPT® Manual*, *CPT® Coding Changes*, *CPT® Assistant*, *CPT® Clinical Examples*, *CPT® Companion* and other coding resources authorized by the American Medical Association.

### Addition/Deletion/Revision CPT® Codes

CPT® codes are used to report physician, radiology, laboratory, evaluation and management, and other medical diagnostic procedures.

CPT® codes are updated and maintained by the American Medical Association. Currently, CPT® codes are subject to updates effective January 1 and July 1 of each year. CPT® updates include the addition, revision and/or deletion of codes.

**BCBST will implement updates to CPT® codes according to the following schedule:**

| Effective Date of Change by the American Medical Association | Effective Date of Change by BCBST (Date of Service) |           |           |
|--|---|-----------|-----------|
|  | Addition  | Revision  | Deletion  |
| January 1  | January 1   | January 1 | January 1 |
| July 1   | July 1  | July 1    | July 1    |

In the event the American Medical Association modifies the schedule for coding updates, the BCBST schedule will be modified accordingly. CPT® codes billed prior to the effective date of the code will be rejected or returned by BCBST as an invalid code for the date of service.

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Due to the short American Medical Association publication schedule, it is not possible for BCBST to notify Providers of changes to CPT® codes. The Provider is responsible for ensuring codes billed are valid for the date of service. CPT® codes and CPT® coding resources can be obtained from the American Medical Association. CPT® code updates may also be located on the American Medical Association website at [www.ama-assn.org](http://www.ama-assn.org).

- c. **HealthCare Common Procedural Coding System (HCPCS)** – These codes should be reported in accordance with the Department of Health and Human Services guidelines including, but not limited to, the *HCPCS Manual*, *Federal Register*, *Centers for Medicare & Medicaid Program Memorandums and Transmittals*, *Medicare Part B Bulletins*, *Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for Jurisdiction C* guidelines (e.g., the *DMEPOS Supplier Manual and Revisions*, *DME MAC Jurisdiction C Fee Schedule*, *Pricing, Data Analysis and Coding Contractor (PDAC\*\*)* *Product Classification Lists* and *Pricing, Data Analysis and Coding Contractor (PDAC\*\*)* *Coding Bulletins*.

### Addition/Deletion/Revision HCPCS Codes

HCPCS codes are used to report transportation, medical supplies, durable medical equipment, injectable drugs, orthotic, prosthetic, hearing (e.g. hearing aids and accessories) and vision (e.g. frames, lens, contact lens, and accessories) services.

HCPCS codes are updated and maintained by the Department of Health and Human Services. Currently, HCPCS codes are subject to updates effective January 1, April 1, July 1, and October 1 of each year. HCPCS updates include addition, deletion, and/or revision of codes.

**BCBST will implement updates to HCPCS codes according to the following schedule:**

| Effective Date of Change by the Department of Health and Human Services | Effective Date of Change by BCBST (Date of Service) |           |           |
|---|---|-----------|-----------|
|   | Addition  | Revision  | Deletion  |
| January 1   | January 1   | January 1 | January 1 |
| April 1   | April 1   | April 1   | April 1   |
| July 1  | July 1  | July 1    | July 1    |
| October 1   | October 1   | October 1 | October 1 |

In the event the Department of Health and Human Services modifies the schedule for coding updates, the BCBST schedule will be modified accordingly. HCPCS codes billed prior to the effective date of the code will be rejected or returned by BCBST as an invalid code for the date of service.

Due to the short Department of Health and Human Services' publication schedule, it is not possible for BCBST to notify Providers of changes to HCPCS codes. The Provider is responsible for ensuring codes billed are valid for the date of service. HCPCS codes, HCPCS code updates, and HCPCS coding resources include, but are not limited to the following:

- Federal Register
- Center for Medicare and Medicaid Program Memorandums and Transmittals
- Medicare Part B Educational Materials
- Durable Medical Equipment Medicare Administrative Contractor (DME MAC\*) for Jurisdiction C guidelines including, but are not limited to the following:
  - DMEPOS Supplier Manual and Revisions
  - DME MAC Jurisdiction C Fee Schedules

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- Pricing, Data Analysis and Coding Contractor (PDAC\*\*) Product Classification Lists
- Pricing, Data Analysis and Coding Contractor (PDAC\*\*) Advisory Articles

\*This document is located on the CGS Administrators, LLC website at <http://www.cgsmedicare.com>.

\*\*This document is located on the Noridian Administrative Services, LLC (NAS) website at <http://www.dmepdac.com>.

- d. **International Classification of Diseases (ICD)** –These codes should be reported in accordance with the Department of Health and Human Services guidelines (e.g., *ICD Manual*).

**Note:** Effective 10/1/15, ICD codes should be filed in accordance with CMS guidance issued in MLN Matters Article SE1408 found at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1408.pdf>.

### Addition/Deletion ICD Codes

ICD -9 includes:

- Volume 1 and 2 ICD codes are used to report diseases, injuries, impairments, their manifestations, and causes of injury, disease, impairment, or other health problems
- Volume 3 ICD codes are used to report prevention, diagnosis, treatment, and management

ICD-10 includes:

- ICD-CM codes are used to report diseases, injuries, impairments, their manifestations, and causes of injury, disease, impairment, or other health problems
- ICD-PCS codes are used to report prevention, diagnosis, treatment, and management

ICD codes are updated and maintained by the Department of Health and Human Services. ICD codes are subject to updates effective with discharges on or after April 1 and October 1 of each year. ICD updates include addition, deletion, and/or revision of codes.

**BCBST will implement updates to ICD codes according to the following schedule:**

| Effective Date of Change by the Department of Health and Human Services | Effective Date of Change by BCBST (Date of Discharge) |           |           |
|---|---|-----------|-----------|
|   | Addition  | Revision  | Deletion  |
| April 1   | April 1   | April 1   | April 1   |
| October 1   | October 1   | October 1 | October 1 |

In the event the Department of Health and Human Services modifies the schedule for coding updates, the BCBST schedule will be modified accordingly. ICD codes billed prior to the effective date of the code will be rejected or returned by BCBST as an invalid code for the date of service.

Due to the short Department of Health and Human Services' publication schedule, it is not possible for BCBST to notify Providers of changes to ICD codes. The Provider is responsible for ensuring codes billed are valid for the date of service. ICD codes can be obtained from the Department of Health and Human Services.

BCBST has made available online an educational tool to assist Providers in utilizing ICD codes appropriately. The tool can be accessed from the Provider page on the company website, [www.bcbst.com](http://www.bcbst.com).

## 2. Miscellaneous, Non-Specific and Not Otherwise Classified (NOC)

**Procedures/Services** (Refer to “How to File a Claim” in this section for billing information)

Unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) procedures/services should only be used when a more specific CPT® or HCPCS code is not available or appropriate. The maximum allowable for eligible procedures/services reported using an unlisted, miscellaneous, non-specific CDT, CPT® or HCPCS code will be based on “Individual Consideration”.

When an unlisted, miscellaneous, non-specific code is reported, the procedure or service should be adequately described in order to determine eligibility and the appropriate maximum allowable. To make this determination, it may be necessary to provide one or more of the following types of supplemental information:

- A description of the procedure or service provided;
- Documentation of the time and effort necessary to perform procedure or service;
- An operative report for surgical procedures;
- An anesthesia flow sheet for anesthesia procedures;
- The name of the drug/immune globulin/immunization/vaccine/toxoid, National Drug Code (NDC), dosage, and number of units provided;
- The name of the manufacturer, name of product, product number, and quantity of durable medical equipment, medical supplies, orthotics and prosthetics; and

### For radiopharmaceuticals and contrast materials:

- The name of the radiopharmaceutical and or contrast material, NDC, dosage and quantity; Or
- The manufacturer’s invoice listing the name of the patient, name of the specific diagnostic radiopharmaceutical or contrast material, dosage and number of units. If multiple patients are listed on the manufacturer’s/supplier’s invoice, the diagnostic radiopharmaceutical imaging agent or contrast material, dosage and number of units for the patient being billed should be clearly indicated.

If an unlisted, miscellaneous, non-specific CDT, CPT® or HCPCS code is reported without the needed supplemental information, the procedure or service will be non-covered or returned to the Provider.

## 3. Special Report

A service that is rarely provided, unusual, variable, or new, may require a special report in determining medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for procedure; and time, effort, and equipment necessary to provide service.

- Complexity of symptoms;
- Final diagnosis;
- Pertinent physical findings (such as size, locations, and number of lesion[s], if appropriate);
- Diagnostic and therapeutic procedures (including major and supplementary surgical procedures, if appropriate);
- Concurrent problems;
- Follow-up care.

Providers should send an appropriate "Special Report" documenting the service or procedure designated by the "Unlisted Procedure" code. Undocumented "Unlisted Procedure" code claims will be denied or developed when appropriate. Unlisted services or procedures must be submitted on a paper copy claim.

For services billed with an unlisted, miscellaneous, non-specific, or not otherwise classified code, refer to the Unlisted Service or Procedure Guidelines.

#### 4. Code Edits

Code edits are performed during the initial claim processing phase, **when feasible**, and are based on nationally recognized code bundling guidelines including:

- National Correct Coding Initiative (NCCI)
- American Medical Association (AMA) coding guidelines
- Centers for Medicare & Medicaid (CMS) guidelines
- Guidelines published by medical societies/associations such as the American Academy of Orthopedic Surgeons (AAOS) and American College of Obstetricians and Gynecologists (ACOG)
- Clinical rationale/expertise

BCBST code edit rules are also based on reimbursement policies such as, but not limited to, the following:

- Bundled Services regardless of the Location of Service
- Bundled Services when the Location of Service is the Practitioner's Office
- Durable Medical Equipment (Purchase and Rentals)
- Home Pulse Oximetry
- Screening Test for Visual Acuity
- Visual Function Screening
- Quarterly Reimbursement Changes

BCBST code edit rules will be applied during the claim payment process. BCBST's Provider Audit Department will continue the retrospective audit process, as a necessary and periodic onsite review.

Code edit rules reflect edits where a comprehensive and component code pair exists:

- Comprehensive (Column 1) code generally represents the major procedure or service when reported with another code.
- Component (Column 2) code generally represents the lesser procedure or service. Reimbursement for a component code is considered included in the reimbursement for the comprehensive code when the service is billed by the same Provider, for the same patient on the same date of service and is not made separately from the comprehensive code.

Code editing can occur on multiple levels depending on the combination of codes reported. For example, when multiple codes are billed for one date of service, two codes could bundle into one code. That one code could then bundle into another code.

Code pairs will be updated on a quarterly basis according to NCCI guidelines. Please refer to the CMS NCCI Policy Manual for updating rules or see other sections of the Manual for specific editing guidelines (e.g., Modifiers, RBRVS, etc.).

BCBST reserves the right to request supplemental information (e.g., anesthesia record, operative report, specific medical records) to determine appropriate application of its code bundling rules.

## 5. Modifiers

Modifiers should be reported in accordance with the governing coding organization.

Modifiers are two-digit indicators (alpha or numeric) that, when appended to a procedure code, indicate that a service or procedure has been altered by some specific circumstance, but not changed in its definition or code.

### a. Modifier 22 – Unusual Procedural Services

#### Description

Modifier 22 should be utilized to identify when services provided are greater than what is usually required for the listed procedure. The increment of work represented by affixing Modifier 22 should not be frequently encountered when performing the base procedure, nor should it be reportable with another code.

#### Guidelines

Documentation should exist that reflects justification of unusual and extraordinary complex work levels far more extensive than is usually necessary for the listed procedure. Documentation should clearly describe the difficult and complex nature of the procedure and support the difficulty of the case. It would be expected that several complicating factors prove an extremely hard case.

Examples/language which may indicate services may be greater than what would ordinarily be required are:

- Difficulty obtaining desired outcomes- due to anomalies, extenuating circumstances, etc.;
- Increased risk due to extenuating circumstances/conditions of patient;
- Extended time to accomplish end results (must be significant and demonstrate why);
- Excessive blood loss/hemorrhage (must note amount of (estimated) blood loss);
- Trauma extensive enough to complicate procedures- ensure that the complication is not billed with additional procedure codes;
- Pathologies, tumors, anomalies, or malformations that directly interfere with the base procedure, but not reported with other procedures;
- Extensive adhesions must be more than routine lysis performed to achieve end results and well documented with time involved, etc. and not separately reported;
- Complications, medical emergencies can warrant reporting with Modifier 22 when resulting in more work by physician than what would normally be required; or
- Clearly more extensive service, based on qualifying factors and/or judgment of reviewer.

Documentation supporting the unusual procedural service such as descriptive statements identifying the unusual circumstances, operative report, pathology report, progress notes, and/or office notes must be submitted by the Provider in order to determine if the service is eligible for additional reimbursement. Services billed with CPT® modifier 22 without the required supplemental documentation will not be considered for additional reimbursement.

If the documentation supports additional reimbursement for the unusual procedural service, reimbursement for eligible services will be based on the lesser of total covered charges or up to 130 percent (130%) of the base maximum fee schedule allowable.

This policy applies to unusual procedural services billed with CPT® modifier 22 on a Professional claim form.

Specialty designation of Provider type would not automatically qualify service for Modifier 22 eligibility.



**b. Modifier 25**

**Description**

Significant, separately identifiable evaluation and management service by the same Physician on the same day of the procedure or other service. Under certain circumstances, the Physician may need to indicate that a significant and separately identifiable evaluation and management (E&M) service was performed beyond the usual pre-procedure, intra-procedure, and post-procedure physician work; or beyond the normal components of another E&M service (e. g., preventive medicine service, anticoagulation management service, osteopathic manipulative treatment, chiropractic manipulative treatment, ophthalmological evaluation service) requiring significant additional work. The E&M service may or may not require a different diagnosis.

**Guidelines**

Modifier 25 will only be recognized as valid to bypass edits when:

- There is documentation of a significant, separately identifiable E&M service which must contain the required number of key elements (history, examination, & medical decision making) for the E&M service reported;
- The E&M service is provided beyond usual preoperative, intraoperative, or postoperative care associated with a procedure performed on the same day;
- A symptom or procedure presents that prompts the E/M service (may not require a separate diagnosis);
- An initial hospital visit, an initial inpatient consultation, and a hospital discharge service is billed for the same date of service as an inpatient dialysis service;
- Critical care codes are billed within a global surgical period; or
- A Medically Necessary visit is performed on the same day as routine foot care.

Modifier 25 will not be recognized for (including but not limited to the following):

- E&M service that resulted in decision for surgery
- Ventilation management in addition to E&M service
- Use on surgical codes
- Use on same day of minor procedure
- Use within global surgical period (pre- or postoperative care)

Use of Modifier 25 merely to bypass a bundling edit is inappropriate and will result in recoupment of erroneous reimbursement. Documentation for the evaluation and management service must be able to stand alone.

**c. Modifier 57**

**Description**

Decision for surgery

Under certain circumstances, an evaluation and management (E&M) service that resulted in the decision to perform the surgery may be identified by adding the Modifier 57 to the appropriate E&M service code. When the Modifier 57 is used appropriately, the E&M service should be separately reimbursed.

**Guidelines**

Guidelines related to the appropriate reporting of the Modifier 57 include, but are not limited to the following:

- Use of Modifier 57 may not be valid when the E&M service is associated with a minor surgical procedure. Because the decision to perform a minor procedure is typically

done immediately before the service, it is considered a routine preoperative service and therefore not separately reimbursable.

- Modifier 57 may be recognized as valid when used appropriately and there is documentation that the E&M service resulted in the initial decision to perform the service.
- Modifier 57 will not be recognized when the decision to perform the surgery was made in advance of the E&M visit.
- Modifier 57 is not appropriate when reported with non E&M codes.
- Modifier 57 is not appropriate to report with the E&M service when performed for the preoperative evaluation.
- Use of Modifier 57 merely to bypass a bundling edit is inappropriate and will result in recoupment of erroneous reimbursement.

**d. Modifier 59 and Other Specific Modifiers for Distinct Procedural Services**

As consistent with the initiatives of the Office of Inspector General (OIG), BCBST reserves the right to evaluate, audit and/or recoup any and all payments resulting from erroneous reporting of the Modifier 59. (OIG Workplan, FY 2005)

As of 1/1/2015, modifiers XE, XS, XP and XU will be included in the scope of the review.

**Description**

Distinct procedural service: Under certain circumstances, the Physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedure(s)/service(s) that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same Physician.

**59 – Distinct Procedural Service**

**XE Separate Encounter** - A Service That Is Distinct Because It Occurred During A Separate Encounter

**XS Separate Structure** - A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure

**XP Separate Practitioner** - A Service That Is Distinct Because It Was Performed By A Different Practitioner

**XU Unusual Non-Overlapping Service** - The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

**Guidelines**

Modifier 59, XE, XS, SP and XU will only be recognized as valid to bypass edits when:

- Combination of procedure codes represent procedures that would not normally be performed at the same time (e.g. procedure on head and procedure on feet; craniotomy and setting of compound fracture);
- Different session or patient encounter is documented in patient's medical record;
- Surgical procedures performed are not through the same incisional site (Note: doesn't matter if instrumentation changes if incision or presentation is the same);
- Surgical knee procedures involving multiple compartments of the same knee; or
- Another modifier is not more appropriate (e.g., Modifier 51).

Use of Modifier 59, XE, XS, SP and XU merely to bypass a bundling edit is inappropriate and will result in non-payment or recoupment of erroneous reimbursement.

Modifier 59, XE, XS, SP and XU should never be appended to an Evaluation & Management service, as this is inappropriate coding convention.

Refer to the resources/tools section on the BCBST website, [www.bcbst.com](http://www.bcbst.com) for the **National Correct Coding Initiative Superscript Designations – NCCI Indicators**.

**e. Modifier 63 – Reimbursement Guidelines for Procedures Performed on Infants Less than 4kg**

Procedures on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work. According to the Current Procedural Terminology, CPT® Manual, this modifier may only be appended to procedures/services listed in the 20005 through 69990 code series.

According to presentations made by representatives of the American Pediatric Surgical Association (APSA), there are many definite exclusions of CPT® codes within the Surgical series of CPT® codes.

The APSA consistent with CPT® guidelines, note the following exclusions, whereas Modifier 63 should **not** be appended to any CPT® codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections and any of the codes listed in the Summary of Codes Exempt from Modifier 63. These codes will be in an Appendix and have instructions listed below the code “(Do not report modifier 63 in conjunction with...)”.

If the documentation supports additional reimbursement for the indication of procedure performed on an infant less than 4 kg representing physician work and complexity over and above the services included in the standard base code, then reimbursement for eligible services will be based on the lesser of total covered charges or up to 130 percent (130%) of the contracted rate for that procedure. Documentation should include the procedure code, weight of the neonate or infant, time required to perform the procedure, anesthesia flow sheet/record, and any unusual condition/outcome for that particular procedure (complexity). Services billed with Modifier 63 without the required supplemental documentation will not be considered for additional reimbursement.

This policy applies to those appropriate CPT® codes with a Modifier 63 billed on a CMS-1500/ANSI-837P for all BCBST business.

**f. Modifier KX**

Regulations implementing Section 1557 of the Affordable Care Act prohibit covered entities from denying professional claims for Covered Services ordinarily appropriate for individuals of one sex that are provided to transgender, intersex or ambiguous-gender individuals based on their recorded gender.

**Description**

The KX modifier is a multipurpose modifier for professional claims and can be used to identify gender-specific services provided to transgender, intersex, or ambiguous-gender individuals. Requirements specified in the medical policy should have been met.

**Guidelines**

The KX modifier should be billed on the detail line, when appropriate, with procedure code(s) that are gender-specific. Using it also lets us know you performed a service for a Member for whom gender-specific editing may apply, and the service should be allowed to continue with normal processing. All benefit/authorization type requirements still apply.

## **6. Network M<sup>SM</sup> – Effective January 1, 2014**

Network M was created to be used with the clinical management services and shared savings arrangement provided to self-funded employers by our partner, MissionPoint Health Partners (MPHP). MPHP has negotiated the rates with participating Providers and holds the contracts with those Providers. The rates and pricing methodologies contracted by MPHP may be different from those used by BCBST.

Some Members have access to more than one BCBST Network, which will be indicated on the Member's ID card. In the event that a Provider treats a Member who has access to more than one Network in which the Provider participates, BCBST will reimburse the Provider in accordance with the terms of the Network listed first on the Member's ID card.

## **7. Qualitative Drug Screen Testing**

BCBST adopted the CMS recommendation to use 2015 G-codes for all drug testing – both screening and confirmatory tests (i.e. 80xxx) – for all lines of business. The G-codes help address overutilization of drug testing, offer established rates and ensure a more efficient and streamlined claims payment process.

Starting April 1, 2015, BCBST payment systems will automatically deny claims using 2015 CPT® codes for drug screenings and confirmatory tests.

For more information and a list of the G-codes, please refer to the CMS documentation "Clinical Laboratory Fee Schedule (CLFS)" located on its website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2017-CLFS-Codes-Final-Determinations.pdf>

## **8. Reimbursement Policy for Serious Reportable Adverse Events (Never Events)**

This policy applies to reimbursement for Serious Reportable Adverse Events (commonly referred to as "Never Events") billed on a Professional or Institutional claim form for all BCBST lines of business.

According to the National Quality Forum (NQF), Serious Reportable Adverse Events, (commonly referred to as "never events") are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility. Therefore, in an effort to reduce or eliminate the occurrence of "never events", BCBST will not provide reimbursement or allow hospitals to retain reimbursement for any care directly related to the never event. BCBST has adopted the list of serious adverse events in accordance with CMS as well as any additional events assigned by the BlueCross and BlueShield Association (BCBSA). The list of Serious Reportable Adverse Events can be located at CMS website, [www.cms.gov](http://www.cms.gov).

BCBST will require all participating Providers to report Serious Adverse Events by populating Present on Admission (POA) indicators on all acute care inpatient hospital claims. Otherwise, BCBST will follow CMS guidelines for the billing of Never Events. In the instance that the "Never Event" has not been reported, BCBST will use any means available to determine if any charges filed with BCBST meet the criteria, as outlined by the NQF and adopted by CMS, as a Serious Reportable Adverse Event. In the circumstance that a payment has been made for a

Serious Reportable Adverse Event, BCBST reserves the right to re-coup the reimbursement as necessary. BCBST will require all participating acute care hospitals to hold Members harmless for any services related to Never Events in any clinical setting.

## 9. Final Reimbursement

Presence of a fee on the Maximum Allowable Fee Schedule is not a guarantee the procedure, service or item will be eligible for reimbursement. Final reimbursement determinations are based on several factors, including but not limited to, Member eligibility on the date of service, Medical Appropriateness, code edits, applicable Member co-payments, coinsurance, deductibles, benefit plan exclusions/limitations, authorization/referral requirements and BCBST Medical Policy/coverage decisions.

When considering final reimbursement for services, procedures and items, BCBST considers several factors including:

- Member eligibility on the date of service
- Medical Necessity and Medical Appropriateness
- Code edits
- Applicable Member copayments, coinsurance and deductible
- Member's health care benefits plan exclusions/limitations
- Authorization/Referral requirements
- BCBST Medical Policy<sup>†</sup>

<sup>†</sup>Providers may view the BCBST Medical Policy Manual on the company website at <http://www.bcbst.com/providers/mpm.shtml>.

## 10. Policy for Quarterly Reimbursement Changes

This policy will be applicable when referenced in the Provider Agreement or BCBST Reimbursement Policy. Reimbursement changes\* applicable to this policy will be made according to the following schedule:

| Date Reimbursement Data is Published by Source | Date Change Will Be Applied by BlueCross Blue Shield of Tennessee |
|--|---|
| January 1 to March 31                          | July 1  |
| April 1 to June 30                             | October 1   |
| July 1 to September 30                         | January 1   |
| October 1 to December 31                       | April 1   |

Fee schedules incorporating these reimbursement changes will be published no later than the first of the month following the date the change is applied by BCBST, according to the above schedule. Updates or changes to codes that are made after publication may not be available on a published schedule until the next publication date.

\*Codes with revisions may be added when appropriate, same as new codes, at any quarter with BCBST Coding and Reimbursement staff's recommendation and appropriate approvals.

### Note:

- 1) This Quarterly Reimbursement Change Policy will not apply to Providers contracted for the Resourced Based Relative Value Scale (RBRVS) Reimbursement Methodology Amendment on or after July 23, 2011. The reimbursement changes applicable to this amendment will be updated per policy RBRVS Reimbursement Methodology Amendment Updates.
- 2) The Banded RBRVS Reimbursement Methodology Amendment for Providers contracted on or after November 1, 2014, will be updated per guidelines in Provider's Contract as indicated below:
  - For those procedure codes that fall into bands with a fee source of 2013 CMS RBRVS, the established fee will be calculated based on the Relative Value Units

(RVUs), conversion factors and Geographic Practice Cost Indices (GPCIs) in effect as of October 31, 2013. No updates will be made to these fee components, except with regard to any new procedure code added after October 31, 2013.

- For those procedure codes that fall into bands with a fee source of 2017 CMS RBRVS, the established fee will be calculated based on the Relative Value Units (RVUs), conversion factors and Geographic Practice Cost Indices (GPCIs) in effect as of October 31, 2017. No updates will be made to these fee components, except: (1) any new procedure code added after October 31, 2017, will be added as noted above; or (2) in the event that the AMA modifies the code description, the underlying use of the code or the components that make up the code, BCBST will treat the code as a new code in order to remain consistent with recognized coding guidelines.
- Other fee components, which are listed in the Guidelines for RBRVS Reimbursement Methodology in this Manual, may be updated to ensure that reimbursement is consistent with current usage of the code. Updates to these components may result in increases or decreases to the established fee at the individual code level.

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## C. Professional Claim Billing and Reimbursement Guidelines

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### 1. Lesser Of Calculation

The line item level Lesser Of methodology is utilized for professional services and is indicated on the Physician's contract in effect on the date the services are rendered.

### 2. Guidelines for Resource Based Relative Value Scale (RBRVS) Reimbursement Methodology

This policy only applies when specifically referenced in the Provider's Agreement.

RBRVS is a reimbursement methodology, which values services according to the relative costs required to provide them.

RBRVS reimbursement methodology applies to most surgery, radiology, non-clinical laboratory, evaluation and management services, and diagnostic/therapeutic procedures.

RBRVS reimbursement methodology does not apply to anesthesia administration, clinical laboratory, immune globulins, vaccines, toxoids, injectable drugs, radiopharmaceuticals, medical supplies, durable medical equipment, orthotics, prosthetics, vision products (e.g. frames, lens, contact lens), or hearing products (e.g., hearing aids).

RBRVS is comprised of the following components used to determine the base maximum allowable for a service:

- **Relative Value Units (RVUs)**

RVUs are expressed in numeric units that represent the units of measure of cost for Physician services. Services that are more complex, more time consuming will have higher unit values than services that are less complex, less time consuming.

There are three (3) types of RVUs including:

- **Physician Work RVUs** – reflects the cost of the Physician's time and skill related to each service provided.

- **Practice Expense RVUs** (facility and non-facility) – represents the Physician's direct and indirect costs related to each service provided.

Direct expenses include non-physician labor, medical equipment and medical supplies.

Indirect expenses include the cost of general office supplies, rent, utilities and other office overhead that cannot be directly tied to a specific procedure.

When a procedure is performed in a facility setting, the expenses related to non-physician labor, medical equipment, and medical supplies are incurred and billed by the facility. As a result, the physician's cost related to a procedure performed in a facility is less than the Physician's cost related to a procedure performed in a non-facility.

The facility practice expense RVUs apply when the location of service is inpatient hospital (place of service 21), on-campus outpatient hospital (place of service 22), off-campus outpatient hospital (place of service 19), emergency room-hospital (place of service 23), ambulatory surgery center (place of service 24), or skilled nursing facility (place of service 31).

The non-facility practice RVUs apply to all other locations of service.

- **Malpractice RVUs** – the relative value units assigned to the malpractice insurance component for a procedure.

The source for the physician work, practice expense (facility and non-facility) and malpractice RVUs is the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals published by Medicare. These documents can be located at [www.cms.gov](http://www.cms.gov).

**Note:** Updates to the RVUs are made in accordance with the BCBST Policy for Quarterly Reimbursement Changes with **some exceptions** as previously stated in the Policy for Quarterly Reimbursement Changes.

➤ **Geographic Practice Cost Indices (GPCIs)**

GPCIs are used to adjust the relative value units to reflect cost differences among geographic areas.

There are three 3) types of GPCIs including:

- Physician Work GPCI
- Practice Expense GPCI
- Malpractice GPCI

The source for GPCIs is the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals published by Medicare. These documents can be found on CMS website, [www.cms.gov](http://www.cms.gov).

BCBST uses the GPCIs assigned to Tennessee regardless of the geographic location in which the services are provided.

**Note:** Updates to the GPCIs are made in accordance with the BCBST Policy for Quarterly Reimbursement Changes with **some exceptions** as previously stated in the Policy for Quarterly Reimbursement Changes.

➤ **Conversion Factor**

The conversion factor represents the dollar value of each relative value unit.

When the conversion factor is multiplied by the geographically adjusted relative value units it will yield the maximum allowable for the specific service.

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Network conversion factors are determined by the Provider Contract.

The following are formulas used to calculate the base professional maximum allowable for procedures applicable under RBRVS reimbursement methodology:

### **Non-facility Professional Maximum Allowable**

$((\text{Physician Work RVU} \times \text{Physician Work GPCI}) + (\text{Non-Facility Practice Expense RVU} \times \text{Practice Expense GPCI}) + (\text{Malpractice RVU} \times \text{Malpractice GPCI})) \times \text{Conversion Factor}$

### **Facility Professional Maximum Allowable**

$((\text{Physician Work RVU} \times \text{Physician Work GPCI}) + (\text{Facility Practice Expense RVU} \times \text{Practice Expense GPCI}) + (\text{Malpractice RVU} \times \text{Malpractice GPCI})) \times \text{Conversion Factor}$

**Note:** *The sum of the Physician Work, Practice Expense, and Malpractice components of the RBRVS formula will be rounded to the nearest thousandth (i.e., to the 3rd decimal place, x.xxx) before the conversion factor is applied.*

**The following are examples only and may not reflect current percentages or rates**

#### **Example 1**

Maximum Allowable =  $[(1.27 \times 0.8994 \times 1.000) + (2.20 \times .900) + (.08 \times .612)] \times \text{Conversion Factor}$

Maximum Allowable = 3.17119 x Conversion Factor

Maximum Allowable = 3.171 x Conversion Factor

In this example 3.17119 is rounded to 3.171 before the conversion factor is applied.

#### **Example 2**

Maximum Allowable =  $[(1.19 \times 0.8994 \times 1.000) + (4.73 \times .900) + (.29 \times .612)] \times \text{Conversion Factor}$

Maximum Allowable = 5.50476 x Conversion Factor

Maximum Allowable = 5.505 x Conversion Factor

In this example 5.50476 is rounded to 5.505 before the conversion factor is applied.

#### **Example 3**

Maximum Allowable =  $[(2.30 \times 0.8994 \times 1.000) + (.55 \times .900) + (.21 \times .612)] \times \text{Conversion Factor}$

Maximum Allowable = 2.69214 x Conversion Factor

Maximum Allowable = 2.692 x Conversion Factor

In this example 2.69214 is rounded to 2.692 before the conversion factor is applied.

The following are other major components that may have an impact on the base maximum allowable under RBRVS reimbursement methodology:

- Reimbursement Policy for Bilateral Procedures
- Reimbursement Policy for Bundled Services Regardless of the Location of Service
- Reimbursement Policy for Bundled Services When the Location of Service is the Practitioner's Office
- Reimbursement Policy for Global Periods
- Reimbursement Policy for Multiple Procedures
- Reimbursement Policy for Preoperative Management Only, Surgical Care Only, and Postoperative Management Only
- Policy for Quarterly Reimbursement Changes



### 3. Anesthesia Billing and Reimbursement Guidelines

**Note:** *Anesthesia services provided by an anesthesiologist or CRNA should be billed on a Professional claim form.*

#### a. Administration of Anesthesia

##### **Paper Claim Form - Block 24D (CPT®/HCPCS)**

Administration of anesthesia must be billed using the most appropriate CPT® code 00100-01995 or 01999 in effect for the date of service.

The anesthesia administration code includes the following:

- The usual preoperative and postoperative visits
- The administration of fluids and/or blood products incident to the anesthesia care
- Interpretation of non-invasive monitoring (EKG, EEG, ECG, temperature, blood pressure, oximetry, capnography, and mass spectrometry).

**Note:** *Services for the administration of anesthesia will be rejected or returned if billed using a CPT® code in the range 10021-69979.*

When multiple surgical procedures are performed during a single anesthetic administration, only the procedure with the highest Basic Value should be reported. Refer to the American Society of Anesthesiologist Relative Value Guide in effect for the date of service to determine the procedure with the highest Basic Value. This applies to vaginal deliveries and Cesarean Sections followed immediately by a hysterectomy.

Billing more than one anesthesia administration code for a single anesthetic administration may result in delay in reimbursement, rejection of charge(s) or return of claim.

When multiple surgical procedures are performed during a single anesthetic administration, only the procedure with the highest Basic Value should be reported. Refer to the American Society of Anesthesiologist Relative Value Guide in effect for the date of service to determine the procedure with the highest Basic Value. This applies to vaginal deliveries and Cesarean Sections followed immediately by a hysterectomy.

Billing more than one anesthesia administration code for a single anesthetic administration may result in delay in reimbursement, rejection of charge(s) or return of claim.

##### **Paper Claim Form - Block 24D (First Modifier)**

Anesthesia services must be billed using the most appropriate anesthesia modifier.

Acceptable anesthesia modifiers are as follows:

| <u>Modifier</u> | <u>Description</u>  |
|-----------------|---|
| AA              | Anesthesia service performed personally by anesthesiologist                                     |
| AD              | Medical supervision by a physician: more than 4 concurrent procedures                           |
| QK              | Medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individuals |
| QX              | CRNA service: with medical direction by a physician   |
| QY              | Anesthesiologist medically directs one CRNA   |
| QZ              | CRNA service: without medical direction by a Practitioner                                       |

Anesthesia administration services billed without an acceptable anesthesia modifier will be rejected or returned.

It is not appropriate to bill modifier 47 (Anesthesia by Surgeon) with CPT® codes 00100-01995 or 01999.

**Paper Claim Form - Block 24D (Second Modifier)**

A physical status modifier may be billed in the second modifier field. Acceptable physical status modifiers are as follows:

| <u>Modifier</u> | <u>Description</u>  |
|-----------------|---|
| P1              | A normal healthy patient  |
| P2              | A patient with mild systemic disease  |
| P3              | A patient with severe systemic disease  |
| P4              | A patient with severe systemic disease that is a constant threat to life        |
| P5              | A moribund patient who is not expected to survive without the operation         |
| P6              | A declared brain-dead patient whose organs are being removed for donor purposes |

**Paper Claim Form - Block 24G (Days or Units)**

Anesthesia time begins when the anesthesiologist or CRNA begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ends when the anesthesiologist or CRNA is no longer in personal attendance, that is, when the patient may be safely placed under post-anesthesia supervision.

In cases where there is a break in anesthesia (e.g., due to technique used, delay of surgeon, relief, multiple start and stop times, etc.) time should be reported by summing up the blocks of time around a break in continuous anesthesia care.

Anesthesia time begins when the anesthesiologist or CRNA begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ends when the anesthesiologist or CRNA is no longer in personal attendance, that is, when the patient may be safely placed under post-anesthesia supervision.

In cases where there is a break in anesthesia (e.g., due to technique used, delay of surgeon, relief, multiple start and stop times, etc.) time should be reported by summing up the blocks of time around a break in continuous anesthesia care.

**Note:** *Anesthesia time must be reported in minutes. Anesthesia time must not be converted to units. Conversion to units will result in an incorrect payment.*

If anesthesia time exceeds 0999 minutes, it is recommended a paper claim be submitted with the supplemental information such as the anesthesia flow sheet to ensure correct reimbursement.

**b. Reimbursement Guidelines for Administration of Anesthesia**

Maximum allowables for administration of anesthesia performed by an anesthesiologist or certified registered nurse anesthetist (CRNA) are based on the lesser of total covered charges or the following formula:

$$\text{Maximum Allowable} = (\text{Basic Value} + \text{Time Unit} + \text{Physical Status Unit Value}) \times \text{Conversion Factor} \times \text{Percentage}$$

**1. Basic Values**

Basic Values are based on the American Society of Anesthesiologist (ASA) Relative Value Guide in effect for the date of service.

Updates to the Basic Values will be made in accordance with the BCBST Policy for Quarterly Reimbursement Changes.

Updates to the Basic Values may result in increases and decreases in maximum allowable.

**2. Time**

Anesthesia time begins when the anesthesiologist or CRNA begins to prepare the patient for anesthesia care in the operating room or in an equivalent area and ends when the anesthesiologist or CRNA is no longer in personal attendance, that is, when the patient may be safely placed under post-anesthesia supervision. In cases where there is a break in anesthesia (e.g. due to technique used, delay of surgeon, relief, multiple start and stop times, etc.), time should be reported by summing up the blocks of time around a break in continuous anesthesia care.

Anesthesia time in minutes will be converted to time units by BCBST as indicated below:

- Fractional time units will be rounded up to the next whole unit (i.e., 1.1 units will be rounded to 2 units, 1.4 units will be rounded to 2 units, 1.5 units will be rounded to 2 units, 1.6 units will be rounded to 2 units, 1.9 units will be rounded to 2 units). **Anesthesia time does not apply to Daily Hospital Management Services.**

**3. Physical Status Unit Values**

Additional base units for physical status will be allowed as follows:

| Modifier | Description   | Unit Value |
|----------|---|------------|
| P1       | A normal healthy patient  | 0          |
| P2       | A patient with mild systemic disease  | 0          |
| P3       | A patient with severe systemic disease  | 1          |
| P4       | A patient with severe systemic disease that is a constant threat to life        | 2          |
| P5       | A moribund patient who is not expected to survive without the operation         | 3          |
| P6       | A declared brain-dead patient whose organs are being removed for donor purposes | 0          |

**4. Time Units, Conversion Factors and Percentages**

Conversion Factors and Percentages are as follows:

| Modifier | Description   | Time Unit | Conversion Factor | Percentage |
|----------|---|-----------|-------------------|------------|
| AA       | Anesthesia service performed personally by anesthesiologist                                     | 15        | Refer to contract | 100%       |
| AD       | Medical supervision by a physician: more than 4 concurrent procedures                           | 15        |                   | 100%       |
| QK       | Medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individuals | 15        |                   | 50%        |
| QX       | CRNA service: with medical direction by a physician   | 15        |                   | 50%        |
| QY       | Medical direction of one certified registered nurse anesthetist (CRNA) by an anesthesiologist   | 15        |                   | 50%        |
| QZ       | CRNA service: without medical direction by a physician  | 15        |                   | 100%       |

**5. Medical Supervision of Anesthesia Services**

Reimbursement for medical supervision of anesthesia services, e.g. anesthesia modifier AD, will be limited to three (3) Basic Values, one (1) unit of time, and 100% of the conversion factor for the anesthesiologist.

**c. Qualifying Circumstances****Paper Claim Form - Block 24 D (CPT®/HCPCS)**

Qualifying circumstances for anesthesia may be billed with the following CPT® codes as applicable:

| Code  | Description  |
|-------|--|
| 99100 | Anesthesia for patient of extreme age, under one year and over seventy |
| 99116 | Anesthesia complicated by utilization of total body hypothermia        |
| 99135 | Anesthesia complicated by utilization of controlled hypotension        |
| 99140 | Anesthesia complicated by emergency condition                          |

An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part.

**Paper Claim Form - Block 24D Modifiers**

Do not bill qualifying circumstances with an anesthesia modifier (e.g. AA, AD, QK, QX, QY, or QZ) or a physical status modifier (e.g. P1, P2, P3, P4, P5 or P6) as this may result in delay in reimbursement, rejection of charge(s) or return of claim.

**Paper Claim Form - Block 24G (Days or Units)**

Qualifying circumstances should be billed with one number of service.

Do not bill anesthesia minutes in this field.

**d. Reimbursement Guidelines for Qualifying Circumstances for Anesthesia**

Maximum allowable for qualifying circumstances for anesthesia performed by an Anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) are based on the lesser of total covered charges or the following formula:

Maximum Allowable = Unit Value x Conversion Factor

The following are the Unit Values for qualifying circumstances for anesthesia:

| Code  | Description  | Unit Value | Conversion Factor |
|-------|--|------------|-------------------|
| 99100 | Anesthesia for patient of extreme age, under one year and over seventy | 1          | Refer to contract |
| 99116 | Anesthesia complicated by utilization of total body hypothermia        | 5          |                   |
| 99135 | Anesthesia complicated by utilization of controlled hypotension        | 5          |                   |
| 99140 | Anesthesia complicated by emergency condition                          | 2          |                   |

An emergency is defined as existing when delay in treatment of the patient would lead to a significant increase in the threat to life or body part.

**e. Unusual Forms of Monitoring**

**Paper Claim Form - Block 24 D (CPT® /HCPCS)**

Unusual forms of monitoring may be billed using the most appropriate CPT® or HCPCS code.

**Paper Claim Form - Block 24D Modifiers**

Do not bill unusual forms of monitoring with a (AA, AD, QK, QX, QY, or QZ) modifier or a physical status modifier (e.g. P1, P2, P3, P4, P5 or P6) as this may result in delay in reimbursement, rejection of charge(s) or return of claim.

**Paper Claim Form - Block 24G (Days or Units)**

Unusual forms of monitoring should be billed using the appropriate number(s) of service. Do not bill anesthesia minutes in this field.

**f. Reimbursement Guidelines for Unusual Forms of Monitoring of Anesthesia**

Maximum allowable for unusual forms of monitoring such as intra-arterial, central venous, Swan-Ganz, and transesophageal echocardiography (TEE) provided in conjunction with anesthesia administration will be based on the lesser of total covered charges or the Professional Maximum Allowable Fee Schedule.

**g. Postoperative Pain Management-Placement of Epidural**

If operative procedure was performed or ends under general anesthesia and epidural is placed for postoperative pain management purposes, placement of the epidural may be billed as follows:

**Paper Claim Form - Block 24 D (CPT® /HCPCS)**

Postoperative pain management-placement of epidural should be billed using the most appropriate CPT® code. Refer to the CPT® book in effect for the date of service for the most appropriate CPT® code.

**Paper Claim Form - Block 24D Modifiers**

Do not bill postoperative pain management-placement of epidural with a (AA, AD, QK, QX, QY, or QZ) modifier or a physical status modifier (e.g. P1, P2, P3, P4, P5 or P6) as this may result in delay in reimbursement, rejection of charge(s) or return of claim.

**Paper Claim Form - Block 24G (Days or Units)**

Postoperative pain management-placement of epidural should be billed using the appropriate number(s) of service.

Do not bill anesthesia minutes in this field.

**h. Reimbursement Guidelines for Postoperative Pain Management-Placement of Epidural**

Maximum allowable for placement of epidural for postoperative pain management services performed by an Anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) are based on the lesser of total covered charges or the Professional Maximum Allowable Fee Schedule.

**i. Postoperative Pain Management-Daily Hospital Management of Epidural (continuous) or subarachnoid (continuous) Drug Administration**

Postoperative pain management-daily hospital management should only be billed for postoperative days. Postoperative pain management-daily hospital management should not be billed on the same day as the operative procedure.

Billing of postoperative pain management-daily hospital management billed on the same day as the operative procedure may result in delay in reimbursement, rejection of charge or return of claim.

Postoperative pain management-daily hospital management should be billed as follows:

**Paper Claim Form - Block 24 D (CPT® /HCPCS)**

Postoperative pain management-daily hospital management should be billed using the most appropriate CPT® code. Refer to the CPT® book in effect for the date of service for the most appropriate CPT® code.

**Paper Claim Form - Block 24D Modifiers**

Do not bill postoperative pain management-daily hospital management with a (AA, AD, QK, QX, QY, or QZ) modifier or a physical status modifier (e.g. P1, P2, P3, P4, P5 or P6) as this may result in delay in reimbursement, rejection of charge(s) or return of claim.

**Paper Claim Form - Block 24G (Days or Units)**

Postoperative pain management-daily hospital management should be billed using one number of service for each day of postoperative management.

Do not bill anesthesia minutes in this field.

**j. Reimbursement Guidelines for Postoperative Pain Management-Daily Hospital Management of Epidural (continuous) or subarachnoid (continuous) Drug Administration**

The maximum allowable for postoperative pain management daily management of epidural (continuous) or subarachnoid (continuous) drug administration performed by an Anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) is based on the lesser of total covered charges or the following formula:

Maximum Allowable = Unit Value x Conversion Factor

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The following is the Unit Value for postoperative pain management daily management of epidural (continuous) or subarachnoid (continuous) drug administration:

| Code  | Description  | Unit Value | Conversion Factor |
|-------|--|------------|-------------------|
| 01996 | Daily Management of epidural or subarachnoid drug administration | 3          | Refer to contract |

Reimbursement is limited to no more than three postoperative days of daily hospital management of epidural (continuous) or subarachnoid (continuous) drug administration.

### 4. Obstetric Anesthesia

Obstetric anesthesia for a planned vaginal delivery (01967) that ends in a C-Section delivery (01968) is to be billed on a single claim form using the date of delivery as the date of service. Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code on a separate claim. Add-on codes submitted with no primary code or a different date of service result in rejection and non-payment of the add-on code.

Obstetric anesthesia services involving more than one Provider (e.g. two physicians or two CRNA's) for the same episode are to be submitted on a single claim with the date of delivery as the date of service.

### 5. Reimbursement Guidelines for Administration of Regional or General Anesthesia Provided by a Surgeon

Administration of regional or general anesthesia provided by a surgeon may be reported by appending Modifier 47 (Anesthesia by Surgeon) to the appropriate procedure code in accordance with CPT® guidelines.

Reimbursement for administration of regional or general anesthesia provided by a surgeon is included in the reimbursement for the surgical or other procedure and is not separately reimbursed.

Reimbursement for the surgical or other procedure is based on the lesser of total covered charges or the professional maximum allowable fee schedule.

Modifier 47 has no effect on the maximum allowable.

### 6. Reimbursement Policy for Moderate Conscious Sedation

Moderate (conscious) sedation provided by the same Physician performing the diagnostic or therapeutic service that the sedation supports.

Moderate (conscious) sedation provided by a Physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports.

#### **For Dates of Service (DOS) prior to 12/31/16:**

Moderate Conscious Sedation codes are identified in the CPT® codebook with a special symbol for Moderate Conscious Sedation.

#### **For DOS beginning 01/01/17:**

Reimbursement details for Moderate (Conscious) Sedation and related services can be found on the company website at [www.bcbst.com/sedationcode](http://www.bcbst.com/sedationcode).

## **7. Reimbursement Guidelines for Bundled Services Regardless of the Location of Service**

Under RBRVS methodology, Medicare considers reimbursement for certain codes bundled regardless of the location of service. Medicare considers these codes as an integral part of or incident to some other service even if billed alone. These codes are published by Medicare in the National Physician Fee Schedule Relative Value File and/or Program Memorandums/Transmittals with a Status Code “B”. These documents can be found online at [www.cms.gov](http://www.cms.gov).

Unless specified otherwise in this policy, BCBST considers codes published by Medicare with a Status Code “B” as bundled regardless of the location of service. The maximum allowable for these codes is \$0.00 even when billed alone.

Updates resulting from changes by Medicare for codes with a Status Code “B” will be made in accordance with the BCBST Policy for Quarterly Reimbursement Changes.

## **8. Reimbursement Guidelines for Bundled Services when the Location of Service is the Practitioner’s Office**

Under RBRVS methodology, Medicare considers reimbursement for certain codes bundled when the location of service is the Practitioner’s office. Medicare considers these codes as an integral part of or incident to some other service even if billed alone. These codes are published by Medicare in the National Physician Fee Schedule Relative Value File and/or Program Memorandums/Transmittals with a Status Code “P”. These documents can be found online at [www.cms.gov](http://www.cms.gov).

Unless specified otherwise in the policy, BCBST considers codes published by Medicare with a Status Code “P” as bundled when the location of service is the Practitioner’s office. The maximum allowable for these codes is \$0.00 even when billed alone.

Updates resulting from changes by Medicare for codes with a Status Code “P” will be made in accordance with the BCBST Policy for Quarterly Reimbursement Changes.

This policy applies to services billed on a Professional claim form.

### **Exception:**

When the location of service is the Practitioner’s office (place of service 11), HCPCS code V2520 is eligible for reimbursement.

## **9. Reimbursement Guidelines for Global Periods**

The concept of the “Global Period” includes the routine preoperative history and physical including the hospital admission, the operative procedure, and all care related to the surgical procedure. The CMS established global periods for certain surgical procedures. These assigned periods can be 0 days, 10 days, or 90 days.

Global periods are determined based on the guidelines published by Medicare in the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals. These documents can be found online at [www.cms.gov](http://www.cms.gov).

If Medicare has not assigned a global period for certain procedures, BCBST reserves the right to assign a global period based on a similar service.

## **10. Assistant-at-Surgery**

BCBST adopted CMS as the primary source for medical appropriateness for assistant-at-surgery services for Blue Networks M, P, and S.

CMS denotes whether a procedure is eligible for assistant-at-surgery services by assigning an indicator to each procedure code.

***The following guidelines apply:***

**Assistant-at-Surgery Services Provided by a Physician**

Assistant-at-surgery services provided by a Physician should be reported by appending the Level I HCPCS – CPT® modifier 80 (Assistant Surgeon), 81 (Minimum Assistant Surgeon) or 82 (Assistant Surgeon when qualified resident surgeon not available) to the procedure code.

The 80, 81 or 82 modifier should **not** be used to report assistant-at-surgery services provided by a Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist.

BCBST will reimburse eligible assistant-at-surgery services provided by a Physician based on the lesser of total covered charges or sixteen percent (16%) of the maximum allowable fee schedule amount for all BCBST networks.

**Assistant-at-Surgery Services Provided by a Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist**

Assistant-at-surgery services provided by a Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist should be reported by appending the Level II HCPCS modifier AS (Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist services for assistant-at-surgery).

Assistant-at-surgery services provided by a Nurse Practitioner or Clinical Nurse Specialist is considered ancillary support. Reimbursement for assistant-at-surgery services provided by a Nurse Practitioner or Clinical Nurse Specialist is included in the reimbursement to the licensed

Practitioner for services provided in the Physician's office or in the reimbursement to the facility for services provided in an inpatient or outpatient setting. The maximum allowable for assistant-at-surgery services provided by a Nurse Practitioner or Clinical Nurse Specialist will be \$0.00. Participating and non-participating Providers will not be permitted to bill the Member for the difference between the charge and the BCBST maximum allowable for the AS modifier as the Nurse Practitioner or Clinical Nurse Specialist should be compensated directly by the supervising Physician or facility.

Eligible assistant-at-surgery services provided by a Physician Assistant credentialed as an assistant-at-surgery will be based on the lesser of total covered charges or 13.6% (i.e. 85% of 16%) of the maximum allowable fee schedule amount. The maximum allowable for assistant-at-surgery services provided by a Physician Assistant who is not credentialed as an assistant-at-surgery will be \$0.00.

**Note:** *Physician Assistants must bill assistant-at-surgery services using the unique Provider number and/or NPI assigned for this purpose. **Assistant-at-surgery charges will only be reimbursed if filed with the appropriate taxonomy code.***

## **11. Global, Professional and Technical Components for Radiology, Laboratory and Other Diagnostic Procedures**

Per the BCBST Reimbursement Policy for Professional and Technical Components for Radiology, Laboratory, and Other Diagnostic Procedures, reimbursement will be limited to procedures where a 26-professional component or TC-technical component modifier is appropriate per the Medicare Physician Fee Schedule Data Base, Federal Register or National Physician Fee Schedule Relative Value File and/or Program Memorandums/Transmittals in effect for the date of service. These documents can be found online at [www.cms.gov](http://www.cms.gov).

Reimbursement will be based on the lesser of total covered charges or the maximum allowable fee schedule allowance for the procedure.



**Note:** For these certain Laboratory CPT® Codes: 81000, 85025, 87804, and 87880, please refer to your Contract for reimbursement and effective date of change.

- If the code is eligible to be billed with modifier TC per the BCBST's Reimbursement Policy for Technical and Professional Components for Radiology, Laboratory, and Other Diagnostic Procedures, **only** the technical component for a radiology, laboratory, or other diagnostic procedure, the Provider should append modifier TC to the CPT® or HCPCS code.
- If the code is eligible to be billed with modifier 26 per the BCBST's Reimbursement Policy for Technical and Professional Components for Radiology, Laboratory, and Other Diagnostic Procedures, **only** the professional component for a radiology, laboratory, or other diagnostic procedure, the Provider should append modifier 26 to the CPT® or HCPCS code.
- If **both** the technical and professional components for radiology, laboratory, or other diagnostic procedures are performed, it is appropriate to bill the service as a global procedure (i.e. without a 26 or TC modifier appended to the CPT® or HCPCS code).

**The following Note on this payment policy is suspended for Commercial claims with dates of service on and after January 1, 2018, through December 31, 2018. Effective for claims with dates of service on and After January 1, 2019, the following Note on this payment policy will apply. Please contact your BCBST Network Manager with questions.**

**Note: Regarding Technical Component for Professional Services Performed in a Facility:**

Commercial DRG and outpatient case rates paid to a facility are all-inclusive of any Technical component for professional services provided while a patient is in a facility setting. The facility must bill for the technical component of the services, even if these services are provided under arrangements with or subcontracted out to another entity such as a laboratory, pathologist, or other Provider. Payment is not made under the Physician fee schedule for technical components services furnished to patients in institutional settings. MedAdvantage claims should continue to be billed consistent with CMS guidelines.

## **12. Reimbursement Guidelines for Bilateral Procedures**

This policy applies to bilateral procedures billed for the same patient on the same date of service by the same Provider on a Professional claim form for all BCBST commercial business.

The maximum allowable for eligible bilateral procedures billed for the same patient on the same date of service by the same Provider will be based on the bilateral procedure indicator published by Medicare in the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals. These documents can be found online at [www.cms.gov](http://www.cms.gov).

Refer to Exhibit A for a summary of the percentages of the base allowable that will be applied for each bilateral procedure indicator.

Per HIPAA guidelines, bilateral procedures must be billed as a single line item using the most appropriate CPT® code with modifier 50. One (1) unit should be reported.

However, in certain situations, Modifier 50 should not be added to a procedure code. Some examples, but not limited to, are when:

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- a bilateral procedure is performed on different areas of the right and left sides of the body (e.g. reduction of fracture, left and right arm;
- the procedure code description specifically includes the word “bilateral”; and/or
- the procedure code description specifically indicates the words “one or both”.

Therefore, sometimes it is appropriate to bill a bilateral procedure with:

- a single line with no modifier and 1 unit;
- a single line with modifier 50 and 1 unit; and/or
- two lines with modifier LT and 1 unit on one line and modifier RT and 1 unit on another line.

**Note:** Refer to CMS website link below for specific Reimbursement Guidelines for All Bilateral Procedures:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html>

### 13. Reimbursement Guidelines for Multiple Procedures

This policy applies to multiple procedures billed for the same patient on the same date of service by the same Provider on a Professional claim form for all BCBST commercial business. The maximum allowable for eligible multiple procedures billed for the same patient on the same date of service by the same Provider will be based on the multiple procedure indicator published by Medicare in the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals. These documents can be found online at [www.cms.gov](http://www.cms.gov).

Codes published by Medicare National Physician Relative Value Fee Schedule with a multiple procedure indicator “3” will be administered by BCBST based on the guidelines for multiple procedure indicator “2”.

Updates resulting from changes to the multiple procedure indicators published by Medicare will be made in accordance with the BCBST Policy for Quarterly Reimbursement Changes.

Refer to Exhibit for a summary of percentages of the base allowable that will be applied for each multiple procedure indicator and procedure code rank.

The determination of the primary procedure when multiple procedures are billed for the same patient on the same date of service by the same Provider will be based on the procedure with the highest allowed amount according to the appropriate base fee schedule. All base allowables will be evaluated for each line billed. The procedure with the highest dollar amount according to the fee schedule will be considered as the primary procedure.

See following grid for Reimbursement Guidelines for All Multiple Procedures:

#### Exhibit A – Reimbursement Guidelines for All Multiple Procedures

| MPFSRVF Indicator | Procedure Rank | Percentage | Explanation   |
|-------------------|----------------|------------|---|
| 0                 | 1st            | 100%       | No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base the payment on the lower of (a) the actual charge, or (b) the maximum allowable amount of the fee schedule for the procedure.  |
| 0                 | 2nd +          | 100%       |   |
| 2                 | 1st            | 100%       | Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 2, or 3, rank the procedures by the maximum allowable amount of the fee schedule and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the maximum allowable amount of the fee schedule reduced by the appropriate percentage, regardless of the amount billed. |
| 2                 | 2nd            | 50%        |   |
| 2                 | 3rd            | 50%        |   |
| 2                 | 4th            | 50%        |   |
| 2                 | 5th            | 50%        |   |
| 2                 | 6th +          | IC         |   |

| MPFSRVF Indicator | Procedure Rank | Percentage | Explanation  |
|-------------------|----------------|------------|--|
| 3                 | 1st            | 100%       | Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 2, or 3, rank the procedures by fee schedule amount and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the maximum allowable amount of the fee schedule reduced by the appropriate percentage, regardless of the amount billed. |
| 3                 | 2nd            | 50%        |  |
| 3                 | 3rd            | 50%        |  |
| 3                 | 4th            | 50%        |  |
| 3                 | 5th            | 50%        |  |
| 3                 | 6th +          | IC         |  |
| 9                 | 1st            | 100%       | Concept does not apply.  |
| 9                 | 2nd+           | 100%       | Concept does not apply.  |

#### 14. Reimbursement Guidelines for Preoperative Management Only, Surgical Care Only, and Postoperative Management Only Services

This policy applies to the following services billed on a Professional claim form for all BCBST commercial business:

- Preoperative Management Only Services billed with CPT® modifier 56;
- Surgical Care Only Services billed with CPT® modifier 54; and
- Postoperative Management Only Services billed with CPT® modifier 55.

##### **Preoperative Management Only Services**

When one Physician performs the preoperative care and evaluation and another Practitioner performs the surgical procedure, the preoperative component should be reported with CPT® modifier 56 appended to the appropriate procedure code.

##### **Surgical Care Only Services**

When one Physician performs a surgical procedure and another Physician provides preoperative and/or postoperative management, the surgical services should be reported with CPT® modifier 54 appended to the appropriate procedure code.

##### **Postoperative Management Only Services**

When one Physician performs the postoperative management and another Physician performs the surgical procedure, the postoperative component should be reported with CPT® modifier 55 appended to the appropriate procedure code.

Eligible preoperative management only, surgical care only, and postoperative management only services will be reimbursed based on the lesser of total covered charges or a percentage of the base maximum allowable for the procedure code as published by Medicare in the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals. These documents can be found online at [www.cms.gov](http://www.cms.gov).

Updates resulting from changes to the percentages published by Medicare will be made in accordance with the BCBST Policy for Quarterly Reimbursement Changes.

#### 15. Reimbursement Guidelines for Procedures Performed by Two Surgeons

BCBST adopted Medicare as the primary source for medical appropriateness for procedures performed by two surgeons for Blue Networks M, P, and S. BCBST follows Medicare's guidelines by assigning an indicator to each procedure code to denote whether the procedure is Medically Appropriate for co-surgery services.

Reimbursement for eligible procedures performed by two surgeons based on the lesser of total covered charges or 62.5% of the base maximum allowable fee schedule amount for the

procedure for each surgeon (or a total of 125% of the base maximum allowable fee schedule amount for the procedure for both surgeons) when billed by the Provider in accordance with standard coding and billing guidelines.

Each co-surgeon from a different specialty performs a distinct portion of the complete procedure and reports the exact same surgical procedure code with the 62 modifier. Each surgeon must dictate his/her own operative report. BCBST uses the payment policy indicators on the Medicare Physician Fee Schedule Database (MPFSDB) to determine if co-surgeon services are reasonable and necessary for a specific HCPCS/CPT® code.

## **16. Reimbursement Guidelines for Screening Test for Visual Acuity**

According to Current Procedural Terminology (CPT®), a “screening test of visual acuity must employ graduated visual acuity stimuli that allow a quantitative estimate of visual acuity (e.g. Snellen chart). Other identifiable services unrelated to this screening test provided at the same time may be reported separately (e.g. preventive medicine services). When acuity is measured as part of a general ophthalmological service or of an evaluation and management service of the eye, it is a diagnostic examination and not a screening test.”

The American Medical Association created code 99173 (Screening test of visual acuity, quantitative, bilateral) at the request of the American Academy of Ophthalmology in association with the American Academy of Pediatrics to enable pediatricians to bill for performing a visual screening test to ascertain whether future referral for visual care is needed. The code was also developed to electronically track visual screenings for pediatric patients to support proposed Utilization Review Accreditation Commission (URAC) and Healthcare Effectiveness Data and Information Set (HEDIS) efforts.

According to the American Academy of Pediatrics, a screening test of visual acuity is typically provided in conjunction with a preventive medicine service, which includes external inspection of eyes, tests for ocular muscle motility and eye muscle imbalance, and ophthalmoscopic examination. Since a screening test of visual acuity would not be provided as an independent/standalone service and the service involves minimal labor on part of the health care professional as does the external inspection of eyes, tests for ocular muscle motility and eye muscle imbalance, and ophthalmoscopic examination, reimbursement for code 99173 will be considered bundled with the service to which it is incident such as the preventive medicine service.

The maximum allowable for visual acuity will be \$0.00 even when billed alone.

## **17. Reimbursement Guidelines for Visual Function Screening**

According to Current Procedural Terminology (CPT®), code 99172 may be used to report visual function screening which includes automated or semi-automated bilateral quantitative determination of visual acuity, ocular alignment, color vision by pseudoisochromatic plates, and field of vision. Code 99172 may also include all or some screening of the determination(s) for contrast sensitivity vision under glare. This service must employ graduated visual acuity stimuli that allow a quantitative determination of visual acuity (e.g. Snellen chart).

Code 99172 is intended for use by Practitioners who provide occupational health services, usually involving the specialties of occupational medicine, internal medicine, family practice and emergency Practitioners.

Code 99172 was created to facilitate reporting of federally mandated visual function screening services for certain workers in an occupational field where optimal vision is crucial and safety standards for vision exist (e.g. firefighter, heavy equipment controller, nuclear power plant operators). Since a visual function screening would not be provided as an independent/standalone service and the service involves minimal labor on part of the health care professional as does the external inspection of eyes, tests for ocular muscle motility and eye muscle

imbalance, and ophthalmoscopic examination, reimbursement for code 99172 will be considered bundled with the service to which it is incident.

## **18. OB/GYN Services**

Bill in accordance with CPT<sup>®</sup> and American College of Obstetricians and Gynecologist (ACOG) coding guidelines in effect for the date of service. Providers can write to the ACOG at 409 12th Street, SW, Washington, D.C., 20024-2188 to obtain a copy of ACOG's CPT<sup>®</sup> Coding in Obstetrics & Gynecology guidebook.

## **19. Reimbursement Guidelines for Independent Lab Services**

Reimbursement for Independent Lab services billed on a Professional claim form will be based on the lesser of total covered charges or at the contracted allowed amount of the published Current Medicare fee schedule for Tennessee, and the provisions, as outlined below for all BCBST commercial lines of business.

Services classified by Medicare as clinical laboratory services will be reimbursed by BCBST based on the published Current Clinical Lab, Non-Clinical Lab, and Pathology maximum allowable fee schedule. Updates for existing codes will be based on BCBST "Quarterly Reimbursement Changes" standard.

Services reimbursed by Medicare based on RBRVS methodology such as pathology and non-clinical laboratory, will be reimbursed by BCBST based on RVUs and GPCIs for Tennessee as published in the Federal Register-Department of Health and Human Services, Health Care Financing Administration (Final Rules). Updates for existing codes will be based on BCBST "Quarterly Reimbursement Changes" standard. Fees for Independent Lab services not published by Medicare will be reimbursed based on a reasonable allowable as determined by BCBST. Methods used by BCBST include, but are not limited to the following:

- BCBST Reimbursement Policies and Procedures
- OPTUM (or it's successors) RBRVS
- Based on fees for similar procedures in terms of time, skill, supplies, equipment, etc.

Updates to the Independent Lab Maximum Allowable Fee Schedule may result in increases and decreases in fees.

Independent Lab agrees to provide laboratory results to BCBST electronically, in accordance with the HL7 data format standards provided to Lab by BCBST, which may be updated from time to time. BCBST shall make updated standards available to Lab, either through providing Lab with a physical copy of updated standards or through publishing standards on [www.bcbst.com](http://www.bcbst.com), and shall use reasonable efforts to provide Lab with no less than ninety (90) days' notice to eliminating a previously acceptable standard.

## **20. Reimbursement Guidelines for Measurement Reporting Codes**

The purpose of measurement codes is to aid performance measurement by easing quality-of-care data collection. These codes generally describe either common components of Evaluation & Management services or test results that are part of a laboratory procedure. Each code is linked to a particular "performance measure set".

BCBST considers measurement-reporting codes bundled to the service to which they are incident. The maximum allowable for measurement reporting codes is \$0.00 even when billed alone with the exception of when the service is approved through an eligible BCBST initiative.

Examples of codes classified as measurement reporting codes:

- CPT® Category II codes (i.e., xxxxF codes)
- Other CPT® or HCPCS codes assigned a Status Code “M” (Measurement code, used for reporting purposes only) published on the Medicare Physician Fee Schedule Relative Value File

## **21. Reimbursement Guidelines for STAT Services**

STAT services reported to denote procedures processed as done immediately, as soon as possible, and/or processed with priority.

Reimbursement by BCBST for STAT services will be considered bundled with the service to which it is incident (e.g. specific laboratory, pathology etc. codes) regardless of the location of service.

The maximum allowable fee schedule amount for STAT services is \$0.00 even when billed alone with the exception of when the service is approved through an eligible BCBST initiative.

## **22. Reimbursement Guidelines for Online Evaluation and Management (E&M) Services**

The American Medical Association established the CPT® codes 99444 and 98969 to report an online E&M service, per encounter, provided by a Physician (99444), or qualified non-Physician health care professional (98969), using the Internet or similar electronic communications network, in response to a patient's request; established patient.

According to the American Medical Association, an online medical evaluation is a type of E&M service provided by a Physician or qualified healthcare professional, to a patient using Internet resources, in response to the patient's online inquiry. Reportable services involve the Physician's personal timely response to the patient's inquiry and must involve permanent storage (electronic or hardcopy) of the encounter. This service should not be reported for patient contacts (e.g. Telephone calls) considered to be pre-service or post-service work for other E&M or non-E&M services. A reportable service would encompass the sum of communication (e.g. Related telephone calls, prescription provision, laboratory orders) pertaining to the online patient encounter or problem(s).

The maximum allowable fee schedule amount for online E&M services will be \$0.00 even when billed alone with the exception of when the service is approved through an eligible BCBST initiative (e.g., Telehealth, Telemedicine, etc.).

This policy applies to services billed on a Professional claim form for all BCBST commercial business.

## **23. Guidelines for Evaluation and Management (E&M) New or Established Patient Determinations**

For the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by a Physician and reported by specific CPT® code(s).

A new patient is one who has not received any professional services (i.e., E&M or other face-to-face services) from the Physician, or another Physician of the same specialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services (i.e., E&M or other face-to-face services) from the Physician or another Physician of the same specialty who belongs to the same group practice, within the past three years.

Audits will be performed to identify if a new patient E&M code is filed on a patient who has had a new patient E&M code filed by the Physician or another Physician of the same specialty who belongs to the same group within the past three (3) years. For occurrences identified, we will replace the new patient E&M code with an established patient E&M code as supported by CPT® to the most appropriate code.

CPT® codes and CPT® coding resources can be obtained from the American Medical Association. CPT® code updates may also be located on the American Medical Association website, [www.ama-assn.org](http://www.ama-assn.org).

## **24. Billing Guidelines and Documentation Requirements for CPT® Code 99211**

The American Medical Association established the Evaluation and Management (E&M) CPT® code 99211 to report an office or other outpatient visit for the E&M of an established patient that may not require the presence of a Physician. Usually, the presenting problem(s) are minimal. Typically, five (5) minutes are spent performing or supervising these services. According to the American Medical Association, medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history. The medical record facilitates the ability of the Physician and other health care professionals to evaluate and plan the patient's immediate treatment and to monitor his/her health care over time.

There should be documentation in the medical record such as the patient/clinician face-to-face encounter exchanging significant and necessary information. There should be some type of limited physical assessment or patient review. The encounter must be for a problem stated by the patient and not involve solely the performance of tests or services ordered at prior encounters where E&M services were provided. There should be documentation in the medical record of management of the patient's care via medical decision-making and the medical record should provide evidence that E&M services (consistent with the above) were provided. Basic Guidelines for billing CPT® code 99211:

- The patient must be an established patient
- The patient/clinician encounter must be face-to-face
- Some degree of an evaluation and management service must be provided
- Pertinent documentation in the medical record of the encounter is required and documented
- Patient must state a present problem

This policy applies to services billed on a Professional claim form for all BCBST commercial business.

## **25. Genetic Counseling Services Billing Guidelines**

Per Section 2713 of the Affordable Care Act (which is also 42 U.S.C. §300gg-13), BCBST will cover lactation training, with no cost-sharing requirement, women's preventive care and screening that is included in guidelines covered by HRSA. HRSA includes lactation training and support in its guidelines, which are found online at <http://www.hrsa.gov/womensguidelines/>.

All Genetic Counseling services should be billed on a Professional claim form for any place of service (e.g. office, emergency room, outpatient or inpatient). When submitting ANSI-837 electronic claims, the Professional format must be used.

These guidelines apply to Genetic Counseling Specialty Contracted Providers only for services billed on a Professional claim form using the following HCPCS/CPT® codes:

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| Type of Service    | Description  | HCPSC/CPT® Code | Procedure Code | Billing Unit       |
|--------------------|--|-----------------|----------------|--------------------|
| Genetic Counseling | Genetic counseling, under physician supervision, each 15 minutes   | S0265           | required       | 1 unit 15 min.     |
|                    | Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family   | 96040           | required       | 1 unit per 30 min. |
|                    | Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient each 30 minutes                         | 98961           | required       | 1 unit per 30 min. |
|                    | Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient each 30 minutes; 2-4 patients           | 98962           | required       | 1 unit per 30 min. |
|                    | Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by non-physician qualified health care professional | 99366           | required       | 1 unit per 30 min. |

Genetic Counseling services not billed with the indicated HCPSC/CPT® codes will be rejected or denied.

To facilitate claims administration, a separate line item must be billed for each date of service and for each service previously indicated.

Allowable reimbursement will be per fee schedule indicated in Provider's contract. Non-contracted Providers claims will be rejected or denied as non-contracted without Member liability.

Out-of-Network Provider's claims will be rejected or denied as non-contracted as Member liability.

Code updates published by AMA/Medicare will be made in accordance with the BCBST Policy, "Quarterly Reimbursement Changes."

## 26. Chiropractor Billing and Reimbursement Guidelines (Does not apply to MedAdvantage or the Federal Employees Program (FEP))

Effective 10/1/16 the following Chiropractor Guidelines apply:

- Applicable office Evaluation & Management (excluding Preventive Medicine), Manipulative, Modality/Therapeutic or Radiology CPT® codes as indicated in table below must be billed in order to trigger payment. Reimbursement hierarchy order will be as follows:
  - 1) Manipulative
  - 2) Modality/Therapeutic
  - 3) Evaluation & Management
  - 4) Radiology
- The Billing Policy stipulates services must be rendered within the Chiropractic scope of practice.



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- Please refer to Provider agreement for reimbursement amounts.
- Current Member benefit limits apply, (for example, 20 visits max per year).
- For proper adjudication and to help ensure no delay in processing, please file one (1) visit per claim.
- For certain employer groups who cover acupuncture services, BCBST will reimburse \$37.88 per service.
- All services rendered during a chiropractic episode of care are to be submitted by the participating chiropractor on the same claim. Split billing of services for the same date of service or episode of care will be subject to review and potential recoupment.

The following CPT® codes apply:

|       |       |       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|-------|-------|
| 70120 | 72050 | 72202 | 73501 | 73660 | 97028 | 97542 | 99214 |
| 70140 | 72052 | 72220 | 73502 | 76120 | 97032 | 97750 | 99215 |
| 70220 | 72070 | 73000 | 73521 | 76125 | 97036 | 97799 | 99241 |
| 70250 | 72072 | 73020 | 73551 | 76140 | 97039 | 98940 | 99242 |
| 70260 | 72074 | 73030 | 73552 | 76499 | 97110 | 98941 | 99243 |
| 71045 | 72080 | 73050 | 73560 | 77071 | 97112 | 98942 | 99244 |
| 71046 | 72081 | 73060 | 73562 | 77072 | 97113 | 98943 | 99245 |
| 71100 | 72082 | 73070 | 73564 | 97010 | 97116 | 99201 |       |
| 71101 | 72100 | 73080 | 73565 | 97012 | 97124 | 99202 |       |
| 71110 | 72110 | 73090 | 73590 | 97014 | 97139 | 99203 |       |
| 71111 | 72114 | 73100 | 73600 | 97016 | 97140 | 99204 |       |
| 71120 | 72120 | 73110 | 73610 | 97018 | 97150 | 99205 |       |
| 71130 | 72170 | 73120 | 73620 | 97022 | 97530 | 99211 |       |
| 72020 | 72190 | 73130 | 73630 | 97024 | 97535 | 99212 |       |
| 72040 | 72200 | 73140 | 73650 | 97026 | 97537 | 99213 |       |

## 27. Injections and Immunizations

### a. Reimbursement Guidelines for Vaccines and Toxoids

BCBST shall reimburse Providers for eligible vaccines and toxoids based on a percentage of Average Wholesale Price (AWP), or Wholesale Acquisition Cost (WAC), if there is no published AWP, using one of the following methods:

#### Method 1

1. The AWP/WAC based on the National Drug Code (NDC) for the specific product billed.

#### Method 2

1. For a single-source product, the AWP/WAC equals the AWP/WAC of the single product.

2. For a multi-source product, the AWP/WAC is equal to the lesser of the median AWP/WAC of all of the generic forms of the product or the lowest brand name product AWP/WAC.

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BCBST reserves the right to select the method used to calculate AWP/WAC and the source for AWP/WAC for vaccines and toxoids.

To determine eligibility and reimbursement for a vaccine or toxoid for items billed with a miscellaneous, unlisted, or not otherwise classified CPT® or HCPCS code. BCBST reserves the right to request the name of the product, National Drug Code (NDC), specific dosage administered and number of units, based on packaging.

Reimbursement for vaccines and toxoids will be 100% of AWP or a comparable percentage of WAC.

Reimbursement for the administration of vaccines and toxoids will be made when appropriately billed and submitted on the same claim form with the product administered.

### **b. Reimbursement and Billing Guidelines for Infusion Therapy, Immunosuppressive, Immune Globulin, Nebulizer, Chemotherapy and Other Injectable Drugs**

#### **Reimbursement Guidelines**

The maximum allowable for eligible infusion therapy, immunosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs for professional and home infusion therapy Providers is based on a percentage of Average Sale Price (ASP) or Wholesale Acquisition Cost (WAC)/Average Wholesale Price (AWP) if there is no published ASP, or as indicated in the Provider Agreement and one of the below listed sources.

BCBST shall update maximum allowables for infusion therapy, immunosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs in accordance with the BCBST Policy for Quarterly Reimbursement Changes.

#### **Source A**

ASP as defined and published by the CMS for Medicare Part B - Tennessee.

#### **Source B**

The WAC/AWP based on the National Drug Code (NDC) for the specific drug billed per First Data/Medispan.

Maximum allowables for infusion therapy, immunosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs not published by Medicare Part B - Tennessee will be calculated based on a percentage of WAC/AWP according to one of the following methods:

#### **Method 1**

1. The WAC/AWP based on the National Drug Code (NDC) for the specific drug billed.

#### **Method 2**

1. For a single-source drug, the WAC/AWP equals the WAC/AWP of the single product.
2. For a multi-source drug, the WAC/AWP is equal to the lesser of the median WAC/AWP of all the generic forms of the drug or the lowest brand name product WAC/AWP.

BCBST reserves the right to select the method used to calculate ASP/WAC/AWP and the source for ASP/WAC/AWP for infusion therapy, immunosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs not published by Medicare Part B – Tennessee. Examples of sources for WAC/AWP include, but are not limited to First Data /Medispan, Redbook, and information provided by the drug manufacturer.

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To determine eligibility and reimbursement for an injectable drug, BCBST reserves the right to request the name of the drug, National Drug Code (NDC), specific dosage administered and number of units, based on specific code description. For items billed with an unlisted, miscellaneous, not otherwise classified HCPCS code, specific dosage administered should be reported in appropriate form and number of units.

Refer to Provider Contract Agreements for network percentages and specific sources for facilities, professional Providers, and Home Infusion Therapy Providers.

### **Billing Guidelines**

#### **General**

- When billing specific codes for drugs, the number of units billed should be based on the code description rather than the manufacturer's packaging.
- Place of service should indicate where the medication is administered or instilled into external/implanted pump rather than where it is dispensed.
- Separate line items should not be billed for the HCPCS when the same therapeutic agent is administered on the same date of service. If different packages of the same therapeutic agent, with different national Drug Codes (NDCs), must be utilized to obtain the order dosage. Block 19 – Reserved For Local Use, section of the CMS-1500 or its equivalent should be utilized to report additional NDCs required.
- Saline and heparin, utilized for flushing and maintenance of infusion devices, are considered supplies included in professional services and home infusion therapy (HIT) per diems. These supplies are not eligible for separate reimbursement.
- Basic pre-packaged intravenous fluids utilized for IV hydration administered in the Practitioner's office and fluids (e.g., partial-fills, 50 /100 / 250 ml bottles/bags) utilized to mix or facilitate administration of therapeutic agents in all places of service are considered supplies and are not eligible for separate reimbursement.
- Medications billed with unlisted, miscellaneous, non-specific and Not Otherwise Classified (NOC) codes should be billed with a unit of one (1) and require submission of drug name, National Drug Code (NDC), and dosage administered in appropriate form as ordered by Practitioner. Failure to submit this information may result in delay of reimbursement.

#### **Compounds**

- Only off-the-shelf medications packaged as manufactured from a pharmaceutical company should be coded utilizing specific HCPCS Level II codes with the exception of some inhalation mixtures having assigned specific codes.
- Refer to Compound Drugs in this Manual section for guidelines on medications compounded from bulk powder or altered from the manufacturers' packaging.

#### **Medication Wastage**

- When necessary to discard a portion of a single dose vial (SDV), documentation of time, date, drug name, dosage administered, amount wasted and route of administration in the medical record is expected.
- Provider is responsible for using the most economical packaging of medication to achieve the required dosage with the least amount of medication wastage necessary.
- Wastage is not to be billed for medications available in multi-dose vials (MDV) and is not reimbursable.
- The NDC of the SDV requiring wastage should be submitted in Block 24 – Supplemental Information, section of the CMS-1500 or its electronic equivalent.
- Instances of medication wastage from a SDV should be submitted on a single line item with the –JW modifier appended to the appropriate HCPCS Level II code. See General Guidelines section for reporting units of therapeutic agents with specific codes and for therapeutic agents billed with unlisted, miscellaneous, non-specific and Not Otherwise Classified (NOC) codes.

- The number of units billed for the SDV with specific HCPCS codes with the – JW modifier is inclusive of both the administered + discarded amounts.
- The number of units should be reported as one (1) for unlisted, miscellaneous, non-specific and Not Otherwise Classified (NOC) codes billed with the JW modifier appended. The “dosage administered” amount reported in Block 24 – Supplemental Information section of the CMS-1500 or its electronic equivalent should be inclusive of both the administered plus discarded amounts. The specific amounts administered and discarded should be reported in Block 19 - Reserved For Local Use section of the CMS-1500 or its electronic equivalent.

**c. Preventive Vaccines Administered by a Pharmacist**

**Claim Form**

Preventive vaccines administered by a Licensed Pharmacist and covered under the Member’s medical plan must be billed on a Professional claim form. Only those vaccines actually administered by the Pharmacist are to be billed. Vaccines administered in the pharmacy quick care clinic or by a subcontracted health care Provider (i.e. “flu clinics”) are not to be billed under these provisions.

**Block 24b - Place of Service**

The place of service (POS) should represent where the service is provided.

**Block 24a - From and To Date(s) of Service**

Enter the month, day and year for each vaccine and administration service provided.

**Block 24d - Codes and Modifiers**

Vaccines must be billed using the most appropriate CPT®/HCPCS code in effect for the date of service.

**Block 24g – Days or Units**

To report units for medications, the units must be billed in accordance with the CPT®/HCPCS definition in effect for the date of service and the Practitioner’s order.

**General Billing Guidelines**

- BCBST reserves the right to request the name of the drug, National Drug Code (NDC), dosage per the Practitioner’s order and quantity.
- Updates to the maximum allowable for existing codes will be made in accordance with the BCBST Reimbursement Policy for Immune Globulins, Vaccines and Toxoids.
- Due to frequent changes in AWP, BCBST reserves the right to update the maximum allowable amount without prior notification.
- Updates to the maximum allowable may result in increases and decreases in fees.
- Refer to Section XIX. Pharmacy in this Manual for additional guidelines.

**d. Specialty Pharmacy Medications**

**Claim Form**

Specialty pharmacy medications covered under the Member’s medical plan must be billed on a Professional claim form. Self-administered specialty pharmacy medications must be billed through the Member’s pharmacy benefits manager.

**Block 24b - Place of Service**

The place of service (POS) should represent where the service is provided.

**Block 24a - From and To Date(s) of Service**

Enter the month, day and year for each medication provided.

**Block 24d - Codes and Modifiers**

Medications must be billed using the most appropriate HCPCS code in effect for the date of service.

In the event there is not a specific HCPCS code for the medication, the most appropriate unlisted code (e.g., J3490, J7599, J9999) in effect for the date of service may be used.

Unlisted, miscellaneous, non-specific and Not Otherwise Classified (NOC) codes should only be used when a more specific CPT® or HCPCS code is not available or appropriate.

Medications billed with unlisted, miscellaneous, non-specific and Not Otherwise Classified (NOC) codes must be billed with the name of the drug, National Drug Code (NDC), dosage per the Practitioner's order and quantity.

**Block 24g – Days or Units**

To report units for medications, the units must be billed in accordance with the HCPCS definition in effect for the date of service and the Practitioner's order.

**General Billing Guidelines**

- BCBST reserves the right to request the name of the drug, National Drug Code (NDC), dosage per the Practitioner's order and quantity.
- Updates to the maximum allowables for existing codes will be made in accordance with the BCBST Reimbursement Policy for Infusion Therapy, Immunosuppressive, Nebulizer, Chemotherapy and Other Injectable Drugs.
- Due to frequent changes in ASP/WAC/AWP, BCBST reserves the right to update the maximum allowable amount without prior notification.
- Updates to the maximum allowables may result in increases and decreases in fees.
- Reimbursement for medications is limited to that amount actually prescribed and administered to the Member.
- Provider is responsible for using the most economical packaging of medication to achieve the required dosage for the Member with the least amount of medication wastage.
- Refer to Section XIX. Pharmacy in this Manual for self-administered specialty pharmacy medications as defined by BCBST covered under the Member's medical benefits plan.

**e. Compound Drugs**

Eligible compound drugs must be billed with the most appropriate HCPCS Level II code for compound drugs and contain at least one legend drug with a valid National Drug Code (NDC) and billed on a Professional claim form.

BCBST maximum allowable is \$0.00 for the following:

- Non-legend drugs
- Compounding and/or dispensing fees (May be considered for some lines of business – see following related Compound Services Policy)
- Diluents, solvents, or other ingredients utilized to mix, combine, or alter legend drug component(s)

The maximum allowable for compound drugs is determined from individual claim review and may vary by claim based on supplemental information provided with the claim or related claims. Supplemental information includes, but is not limited to:

- The name(s) of the drug component(s), NDC of legend drug component(s), and specific dosage of legend component(s) administered, instilled, inserted, or implanted.

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The maximum allowable for eligible compound drugs for professional Providers is based on a percentage of Wholesale Acquisition Cost (WAC) or Average Wholesale Price (AWP) based on the Provider Agreement according to one of the following methods:

### **Method 1**

1. The WAC/AWP based on the National Drug Code (NDC) for the specific drug billed.

### **Method 2**

1. For a single-source drug, the WAC/AWP equals the WAC/AWP of the single product.
2. For a multi-source drug, the WAC/AWP is equal to the lesser of the median WAC/AWP of all of the generic forms of the drug or the lowest brand name product WAC/AWP.

BCBST reserves the right to select the method used to calculate WAC/AWP and the source for WAC/AWP. Examples of sources for WAC/AWP include, but are not limited to First Data/Medispan, Redbook, and information provided by the drug manufacturer.

#### **f. Compounding Services**

Eligible compounding services must be billed with the most appropriate HCPCS Level II code for consideration of reimbursement to Providers when eligible compound drugs are administered under the "incident to" provision and/or considered as eligible medical benefits. These services must be billed on a Professional claim form for BCBST commercial and MedAdvantage lines of business.

A reasonable compounding allowance will be reimbursed, if applicable, for each intravitreal injection of compounded agent or each date of service compound drugs are administered, instilled, inserted, or implanted. In order to be considered for reimbursement, a separate line item must be included for these compounding services. This service must be billed with the appropriate HCPCS code for Pharmacy compounding and dispensing services.

#### **g. Reimbursement and Billing Guidelines for Radiopharmaceuticals and Contrast Materials**

This policy applies to all eligible drugs filed on a Professional claim form for all BCBST business.

The maximum allowable for eligible radiopharmaceuticals and contrast materials is based on the lesser of total covered charges or a percentage of Average Sales Price (ASP) or Wholesale Acquisition Cost (WAC)/Average Wholesale Price (AWP) if there is no published ASP, or as indicated in the Provider Agreement and one of the following sources:

##### **Source A**

ASP as defined and published by the CMS on the "Medicare Part B Drugs Average Sales Price" file.

Updates to maximum allowables for radiopharmaceuticals and contrast materials published by CMS will be made in accordance with the BCBST Policy Quarterly Reimbursement Changes.

##### **Source B**

The WAC/AWP based on the National Drug Code (NDC) for the specific radiopharmaceutical or contrast material billed per First Data/Medispan.

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Maximum allowables for radiopharmaceuticals and contrast materials not published by CMS will be calculated based on the lesser of total covered charges or a percentage of WAC/AWP according to one of the following methods:

### **Method 1**

1. The WAC/AWP based on the National Drug Code (NDC) for the specific radiopharmaceutical or contrast material billed.

### **Method 2**

1. For a single-source radiopharmaceutical or contrast material, the WAC/AWP equals the WAC/AWP of the single product.
2. For a multi-source radiopharmaceutical or contrast material, the WAC/AWP is equal to the lesser of the median WAC/AWP of all the generic forms of the radiopharmaceutical or contrast material or the lowest brand name product WAC/AWP.

BCBST reserves the right to select the method used to calculate WAC/AWP and the source for WAC/AWP for radiopharmaceuticals and contrast materials without an ASP published by CMS. Examples of sources for WAC/AWP include, but are not limited to First Data/Medispan, Redbook, and information provided by the radiopharmaceutical or contrast material manufacturer.

For codes where it is not feasible to establish a maximum allowable for a radiopharmaceutical or contrast material (e.g. when the radiopharmaceutical or contrast material does not have a NDC, when the dosage depends on the weight of the patient), the maximum allowable will be based on a reasonable allowable as determined by BCBST.

In order to determine a reasonable allowable, BCBST reserves the right to request one of the following:

- The name of the radiopharmaceutical or contrast material, NDC, dosage, and quantity;
- The manufacturer/supplier's invoice. When a manufacturer / supplier's invoice is requested, the name of the patient, name of the specific radiopharmaceutical or contrast material, dosage, and number of units must be provided. If multiple patients are listed on the manufacturer/supplier's invoice, the radiopharmaceutical or contrast material, dosage and number of units for the patient being billed should be clearly indicated.

Radiopharmaceuticals and contrast materials provided in a facility setting are not billable to or reimbursable by BCBST on a Professional claim form. Radiopharmaceuticals and contrast materials provided in a facility setting are considered facility services and must be billed by the facility.

- Reimbursement for medications is limited to that amount actually prescribed and administered to the Member.
- If the Radiopharmaceuticals and Contrast Materials are used in conjunction with a radiological procedure/service that is determined to be ineligible, the Radiopharmaceutical and Contrast Material will not be reimbursed.
- Provider is responsible for using the most economical packaging of medication to achieve the required dosage for the Member with the least amount of medication wastage.
- In order to be considered for reimbursement, Radiopharmaceuticals and Contrast Materials must be billed on the same claim as the related radiological procedure/service.

- Refer to Section XIX. Pharmacy in this Manual for self-administered specialty pharmacy medications as defined by BCBST covered under the Member's medical benefits plan.

**h. Reimbursement Guidelines for Non-Injectable Medications when the Location of Service is the Practitioner's Office**

Reimbursement by BCBST for prescription medications other than injectables when the location of service is the Practitioner's office will not be allowed. Exceptions to this policy include, but are not limited to nebulized inhalation drugs and other prescription drugs addressed under Reimbursement Policy for Immune Globulins, Infusion Therapy, Immunosuppressive, Nebulizer, Chemotherapy and Other Injectable Drugs.

The maximum allowable fee schedule amount for non-injectable medications when the location of service is the Practitioner's office is \$0.00 unless otherwise specified in the Member's medical benefit plan. This policy applies to services billed on a Professional claim form.

**i. Reimbursement Guidelines for Self-Administered Prescription Medications Dispensed and Submitted by a Licensed Pharmacist**

Whenever a Licensed Pharmacist submits a claim for reimbursement for self-administered medications to BCBST, the claim must either be submitted electronically or on a paper claim form through the appropriate Pharmacy Network. This will ensure that possible duplication of payment is avoided, that only costs for those prescription medications included on the appropriate contract formularies are reimbursed, that those medications requiring prior authorization are appropriately reviewed, and that all pertinent pharmacy discounts and copays apply. If a pharmacy claim is submitted paper to BCBST, that hardcopy will be routed to the appropriate pharmacy network for processing.

Self-administered prescription drugs submitted by a licensed pharmacist on a Professional or Institutional claim form will not be priced by BCBST as a medical benefit unless otherwise specified by the Member's medical benefit plan.

**j. Reimbursement Guidelines Any Prescription Medications Dispensed by a Provider Other Than a Licensed Pharmacist when the Location of Service is Not the Practitioner's Office**

Reimbursement by BCBST for any prescription medication dispensed by a Provider other than a licensed pharmacist when the medication is not administered in the Practitioner's office will not be allowed. This will ensure that only those professionals who are properly trained will administer these services at the contracted rates as stipulated in the Member's prescription drug benefit plan.

The maximum allowable fee schedule amount for prescription medications dispensed by a Provider other than a licensed pharmacist when the medication is not administered in the practitioner's office is \$0.00.

This policy applies to prescription medications dispensed by a Provider other than a licensed pharmacist when the location of service is not 11 when billed on a Professional claim form for all BCBST business.



**k. Reimbursement Guidelines for Medications Not Requiring a Prescription from a Licensed Pharmacist Regardless of the Location of Service**

Reimbursement by BCBST for medications that do not require a prescription from a licensed physician regardless of the location of service will be considered non-covered.

The maximum allowable for medications that do not require a prescription from a licensed Physician as defined by this policy will be \$0.00.

This policy applies to medications that do not require a prescription from a licensed Physician (e.g. over the counter drugs) regardless of the location of service billed on a Professional or Institutional claim form for all BCBST business.

## **28. Home Infusion Therapy (HIT)**

### **Definitions:**

**Home Infusion Therapy** is the continuous slow introduction of therapeutic agents—analgesics, chemotherapy, prostaglandins, tocolytics, hydration solutions, antibiotics, parenteral nutrition into the body on an intermittent basis, to achieve practitioner defined beneficial outcomes for the condition being treated in the Member's private residence.

- Therapeutic agents instilled into an implanted or ambulatory pump in the Practitioner's office are **not** considered HIT.
- Medications delivered to the Practitioner's office for infusion/instillation in the office setting are **not** billable or reimbursable as HIT.
- Infusion therapy provided in a location other than a Member's private residence is **not** billable or reimbursable as HIT.
- Field-based nursing services for drug infusions, PICC insertion, Midline insertion or accessing implanted pumps are considered home health agency/private duty nursing services and are not billable by the home infusion therapy Provider.

**Per Diems** are a payment for each day maintenance is performed or a therapeutic agent is actually infused or instilled into the body, in the Member's private residence, as prescribed by the Practitioner.

- A single per diem is reimbursable on the day therapeutic agent(s) is/are instilled into an implanted infusion device in the Member's private residence.

**Maintenance** is care of single or multiple lumen infusion catheters or implanted access devices, including dressing changes and flushes necessary to maintain patency between ordered episodes of care with therapeutic agents. (e.g. Monthly flushes of implanted access devices when no active HIT therapy is in progress, IV access flushes and dressing changes during week(s) between chemotherapy episodes or "rounds" of antibiotic therapy while awaiting laboratory results and new orders.)

- Maintenance per diem is only separately billable when this maintenance service is the only service provided on that date of service (DOS) and catheter care is actually administered.
- Maintenance services provided on the same DOS as HIT with therapeutic agents are included in the per diem for that infusion therapy and not separately billable.

**Multiple Infusion Therapies** are defined as more than one class of service (i.e. pain management, chemotherapy, Epoprostenol, Tocolytic, Hydration, Total Parenteral Nutrition (TPN), anti-infective and miscellaneous) provided concurrently on the same date of service.

**Adjunctive medications** are additional therapeutic agents, administered parenterally, that are included in a concurrent Practitioner ordered HIT regimen (e.g. IVP anti-emetic administered PRN for nausea related to chemotherapy or IV H<sub>2</sub> receptor antagonist administered concurrently with TPN.)

**Flushes** for catheter maintenance are **not** considered adjunctive therapeutic agents and are not separately billable or reimbursable. These supplies (e.g. heparin, sterile saline, sterile water, ethanol lock solution, etc.) are included in the per diem reimbursement. (See **Per Diems** section below.)

**Fluids** utilized as diluents or vehicles for administration of other therapeutic agents are **not** considered adjunctive therapeutic agents and are not separately billable or reimbursable. These supplies are included in the per diem reimbursement. (See **Per Diems** section below.)

**Intravenous push (IVP)** is an injection/infusion of a therapeutic agent requiring the continuous presence of the health care professional during administration into a vein or an intravenous injection infusion of a therapeutic agent over 15 minutes or less.

- Therapeutic medication(s) administered by IVP, dispensed as adjunctive to HIT, may be billed with the appropriate HCPCS code for that ordered medication, but a separate per diem is **not** billable or reimbursable.
- Length of infusion is determined based on administration recommendations from recognized sources (e.g. drug handbooks, PDR, and drug package inserts).
- IVP medication(s) dispensed as the sole agent(s), not included in a concurrent Practitioner ordered HIT regimen, for a DOS or span date are **not** billable or reimbursable as part of HIT.

**Other parenteral medications** are those therapeutic agents administered by intramuscular (IM) injection or subcutaneous (SQ) injection.

- Other therapeutic parenteral medication(s), dispensed as adjunctive to HIT and not self-administered, may be billed with the appropriate HCPCS code, but a separate per diem is **not** billable or reimbursable.
- Other parenteral medication(s) dispensed as the sole agent(s), not included in a concurrent Practitioner ordered HIT regimen, for a DOS or span date are **not** billable or reimbursable as part of HIT.

**Self-administered medications** are defined as Oral, Topical, or self-administered injectable medications, including those indicated as Self-Administered Specialty Pharmacy Products. (Refer to the Specialty Pharmacy Program in Section XIX of this Manual.)

- These are considered a pharmacy benefit and are **not** billable or reimbursable as HIT.

### **Claim Form**

Home Infusion Therapy must be billed on a Professional claim form as follows:

### **Block 19 – Reserved for Local Use**

Utilize this section for additional information. (See Additional Information section below).

- Additional NDC information when varying packaged products must be utilized to obtain the most economical packaging to achieve the Practitioner ordered dosage for the Member.
- Practitioner's order for therapeutic agent(s) including dosage, route, frequency and duration of therapy.

**Block 24a – From and To Date(s) of Service (DOS)**

Enter the month, day and year for each per diem and therapeutic agent as follows:

- Therapeutic agents billed with a specifically assigned HCPCS code, whose description includes a set amount per unit of the code, may be billed with “span dates” if additional information is submitted to indicate the Practitioner order for the daily dosage amount. (See example in Additional Information section below.)
- Therapeutic agents billed with unlisted, miscellaneous, non-specific, or Not Otherwise Classified (NOC) codes must be billed on a separate line item for each DOS (no span dates) along with additional information including NDC, daily dosage, and drug name. Submitting NOC codes with span dates may result in errors and/or delayed reimbursement. (See example in Additional Information section below.)
- Per Diem codes must be billed on a separate line item for each DOS (no span dates). Submitting per diem codes with span dates may result in errors and/or delays in reimbursement.

**Block 24b – Place of Service**

The place of service (POS) should indicate where the therapeutic agent is administered/instilled rather than where it is dispensed.

**Block 24d – Codes, Modifiers and Additional Information (shaded area)**

- Additional information should be submitted in the following format:  
National Drug Code (NDC) preceded by the N4 qualifier, dosage administered per day preceded by appropriate “basis of measurement qualifier” (i.e. GM, ME, ML, etc., as ordered by Practitioner) and name of drug preceded by narrative description modifier, ZZ. (See examples in Additional Information section below.)
- All per diems codes and related therapeutic agent codes for the same DOS or span date must be billed on the same claim submission. Splitting these services into multiple claims may result in errors and/or delays in reimbursement. (See specific guidelines in Therapeutic agents, Per Diems and Modifiers for Multiple Therapies sections below.)
- More than one medication may be associated with a single per diem (e.g., adjunctive therapeutic agents administered as part of the primary therapy ordered by the Physician). Therapeutic agents billed without an associated per diem are considered a pharmacy benefit and should be billed to the Member’s Pharmacy Benefits Manager (PBM).

**Block 24g – Days or Units**

Enter the number of units for each per diem and therapeutic agent as follows:

- Units for therapeutic agents, billed with specific HCPCS codes containing a defined “unit” amount, must be reported in accordance with code definition in effect for the DOS and the Practitioner’s orders.
- Units for therapeutic agents, billed with NOC codes or codes without a defined “unit” amount, must be reported with a unit of (1) per line item / DOS. Reporting multiple units may result in errors and/or delayed reimbursement.
- Units for per diem codes must be reported with a unit of (1) per line item / DOS.

**Additional Information**

- Additional NDC information related to varying packaged products assigned to the same CPT® or HCPCS code should be indicated in Block 19 (Reserved for Local Use), its electronic equivalent, or submitted as an attachment.

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Example for varying packaged products assigned the same CPT<sup>®</sup> or HCPCS code:  
Practitioner order of Octagam 500 mg/kg IV in divided doses over 2 days @ 0.5 mg/kg/min q3wks.

|   |    |    |    |    |    |    |  |       |  |   |      |       |
|---|----|----|----|----|----|----|--|-------|--|---|------|-------|
| 19. RESERVED FOR LOCAL USE                              |    |    |    |    |    |    |  |       |  |   |      |       |
| N468209084301 Octagam 500 mg/kg IV divided Wt. 150 lbs. |    |    |    |    |    |    |  |       |  |   |      |       |
| N468209084304 GM17 ZZOctagam                            |    |    |    |    |    |    |  |       |  |   |      |       |
| 12  | 01 | XX | 12 | 02 | XX | 12 |  | J1568 |  | A | XXXX | xx 68 |
|   |    |    |    |    |    |    |  |       |  |   |      |       |
| 12  | 01 | XX | 12 | 01 | XX | 12 |  | S9379 |  | A | XX   | xx 1  |
|   |    |    |    |    |    |    |  |       |  |   |      |       |
| 12  | 02 | XX | 12 | 02 | XX | 12 |  | S9379 |  | A | XX   | xx 1  |

The Practitioner's order for therapeutic agent(s) including dosage, route, frequency and duration should be indicated in Block 19, its electronic equivalent, or submitted as an attachment.

Example for specific HCPCS code billed with span dates:  
Practitioner order of Rocephin 1 Gm IV q12h x 5 days is started at 8:00 p.m. on 12/01/XX.

|                              |    |    |    |    |    |    |  |       |  |   |     |       |
|------------------------------|----|----|----|----|----|----|--|-------|--|---|-----|-------|
| 19. RESERVED FOR LOCAL USE   |    |    |    |    |    |    |  |       |  |   |     |       |
| Rocephin 1 Gm IV q12h x5d    |    |    |    |    |    |    |  |       |  |   |     |       |
| N4xxxxxxxxxxx GM2 ZZRocephin |    |    |    |    |    |    |  |       |  |   |     |       |
| 12                           | 01 | XX | 12 | 06 | XX | 12 |  | J0696 |  | A | XXX | xx 40 |
|                              |    |    |    |    |    |    |  |       |  |   |     |       |
| 12                           | 01 | XX | 12 | 01 | XX | 12 |  | S9501 |  | A | XX  | xx 1  |
|                              |    |    |    |    |    |    |  |       |  |   |     |       |
| 12                           | 02 | XX | 12 | 02 | XX | 12 |  | S9501 |  | A | XX  | xx 1  |
|                              |    |    |    |    |    |    |  |       |  |   |     |       |
| 12                           | 03 | XX | 12 | 03 | XX | 12 |  | S9501 |  | A | XX  | xx 1  |
|                              |    |    |    |    |    |    |  |       |  |   |     |       |
| 12                           | 04 | XX | 12 | 04 | XX | 12 |  | S9501 |  | A | XX  | xx 1  |
|                              |    |    |    |    |    |    |  |       |  |   |     |       |
| 12                           | 05 | XX | 12 | 05 | XX | 12 |  | S9501 |  | A | XX  | xx 1  |
|                              |    |    |    |    |    |    |  |       |  |   |     |       |
| 12                           | 06 | XX | 12 | 06 | XX | 12 |  | S9501 |  | A | XX  | xx 1  |

Example for NOC code:  
Practitioner order of Abcxyz 400 mg IV q8h x 3 days is started at 4:00 p.m. on 12/01/XX.

|                               |    |    |    |    |    |    |  |       |  |   |     |      |
|-------------------------------|----|----|----|----|----|----|--|-------|--|---|-----|------|
| 19. RESERVED FOR LOCAL USE    |    |    |    |    |    |    |  |       |  |   |     |      |
| Abcxyz 400 mg IV q8h x3d      |    |    |    |    |    |    |  |       |  |   |     |      |
| N4xxxxxxxxxxx ME400 ZZAAbcxyz |    |    |    |    |    |    |  |       |  |   |     |      |
| 12                            | 01 | XX | 12 | 01 | XX | 12 |  | J3490 |  | A | XXX | xx 1 |
|                               |    |    |    |    |    |    |  |       |  |   |     |      |
| N4xxxxxxxxxxx GM1.2 ZZAAbcxyz |    |    |    |    |    |    |  |       |  |   |     |      |
| 12                            | 02 | XX | 12 | 02 | XX | 12 |  | J3490 |  | A | XXX | xx 1 |
|                               |    |    |    |    |    |    |  |       |  |   |     |      |
| N4xxxxxxxxxxx GM1.2 ZZAAbcxyz |    |    |    |    |    |    |  |       |  |   |     |      |
| 12                            | 03 | XX | 12 | 03 | XX | 12 |  | J3490 |  | A | XXX | xx 1 |
|                               |    |    |    |    |    |    |  |       |  |   |     |      |
| N4xxxxxxxxxxx ME800 ZZAAbcxyz |    |    |    |    |    |    |  |       |  |   |     |      |
| 12                            | 04 | XX | 12 | 04 | XX | 12 |  | J3490 |  | A | XXX | xx 1 |

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Per Diem (S9502) should be submitted as indicated in examples above for each of the dates of service therapeutic agent is administered.

### Therapeutic agents

- Each therapeutic agent must be billed using the most specific CPT®/HCPCS code in effect for the DOS and the NDC. If these codes are billed with span dates, additional information indicating the Practitioner ordered daily dosage amount must be submitted. (See Additional Information section.)
- In the event there is not a specific CPT®/HCPCS code for a therapeutic agent ordered, the most appropriate unlisted code (e.g. J3490, J3590, J9999) in effect for the DOS may be used.
- Unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) codes should only be used when a more specific CPT®/HCPCS code is not available or appropriate. Submitting a NOC code when a more specific code is more appropriate may result in errors and/or delay in reimbursement.
- Therapeutic agents billed with an unlisted miscellaneous, non-specific, and Not Otherwise Classified (NOC) code must be accompanied by additional information as noted in the "Additional Information" section above. Failure to submit this information may result in reimbursement errors and/or delay of reimbursement.
- Reimbursement for therapeutic agent(s) is limited to that amount actually prescribed and administered to the Member.
- HIT Provider is responsible for using the most economical packaging of therapeutic agent(s) to achieve the required dosage for the Member with the least amount of wastage.
- BCBST reserves the right to request submission of a copy of the original Practitioner orders for home infusion therapy, if determined necessary for clarification.

### Per Diems

Maintenance or Home Infusion Therapy per diems **must** be billed using the most appropriate maintenance or "class of service" HCPCS code from one of the following tables:

#### MAINTENANCE

Maintenance per diems may only be billed, as a "stand alone service", on days when catheter care is actually administered and these maintenance services are not part of the per diem of another class of service code.

Maintenance per diems are **not** billable or reimbursable as secondary, tertiary or concurrent therapy.

| Code  | Type of Service         | Description   |
|-------|-------------------------|---|
| S5498 | Single Lumen            | Home infusion therapy, catheter care/maintenance, simple (single lumen), includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem  |
| S5501 | Multiple Lumens         | Home infusion therapy, catheter care/maintenance, complex (more than one lumen), includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem  |
| S5502 | Implanted Access Device | Home infusion therapy, catheter care/maintenance, implanted access device, includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (use this code for interim maintenance of vascular access not currently in use) |

**PAIN MANAGEMENT**

Only one of these class of service codes may be billed per day.

| <b>Code</b> | <b>Type of Service</b>      | <b>Description</b>  |
|-------------|-----------------------------|---|
| S9326       | Continuous Infusion         | Home infusion therapy, continuous (24 hours or more) pain management infusion; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem      |
| S9327       | Intermittent Infusion       | Home infusion therapy, intermittent (less than 24 hours) pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem |
| S9328       | Implanted Pump Instillation | Home infusion therapy, implanted pump pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem                    |

**CHEMOTHERAPY**

Only one of these class of service codes may be billed per day.

| <b>Code</b> | <b>Type of Service</b> | <b>Description</b>   |
|-------------|------------------------|--|
| S9330       | Continuous Infusion    | Home infusion therapy, continuous (24 hours or more) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem     |
| S9331       | Intermittent Infusion  | Home infusion therapy, intermittent (less than 24 hours) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem |

**EPOPROSTENOL**

| <b>Code</b> | <b>Type of Service</b> | <b>Description</b>   |
|-------------|------------------------|--|
| S9347       | Uninterrupted Infusion | Home infusion therapy, uninterrupted, long-term, controlled rate intravenous or subcutaneous infusion therapy (e.g., epoprostenol); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem |

**TOCOLYTIC**

| <b>Code</b> | <b>Type of Service</b> | <b>Description</b>  |
|-------------|------------------------|---|
| S9349       | Infusion Therapy       | Home infusion therapy, tocolytic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem |

**HYDRATION**

IV fluids utilized as a diluent or vehicles for administration of other therapeutic agents are **not** hydration services. Hydration per diems apply only when services are for the infusion of IV fluids in 1-liter increments solely for the therapeutic treatment of dehydration or other volume related conditions. Only one of these class of service codes may be billed per day.

| Code  | Type of Service | Description  |
|-------|-----------------|--|
| S9374 | 1 Liter         | Home infusion therapy, hydration therapy; 1 liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem                                      |
| S9375 | 2 Liters        | Home infusion therapy, hydration therapy; more than 1 liter but no more than 2 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem  |
| S9376 | 3 Liters        | Home infusion therapy, hydration therapy; more than 2 liters but no more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem |

**TOTAL PARENTERAL NUTRITION**

| Code  | Type of Service     | Description   |
|-------|---------------------|---|
| S9379 | TPN and / or lipids | Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem |

**ANTI-INFECTIVE**

Only one of these class of service codes may be billed per day.

| Code  | Type of Service | Description  |
|-------|-----------------|--|
| S9500 | Q 24 hours      | Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 24 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem |
| S9501 | Q 12 hours      | Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem |
| S9502 | Q 8 hours       | Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 8 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem  |
| S9503 | Q 6 hours       | Home infusion therapy, antibiotic, antiviral, or antifungal; once every 6 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem          |
| S9504 | Q 4 hours       | Home infusion therapy, antibiotic, antiviral, or antifungal; once every 4 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem          |

**MISCELLANEOUS**

| Code  | Type of Service  | Description   |
|-------|------------------|---|
| S9379 | Infusion Therapy | Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem |

- Per Diem(s) for class(es) of service not indicated in the above tables must be billed with the “miscellaneous” per diem code.
- The reimbursement allowed for the above noted per diem codes includes all necessary supplies and equipment, including but not limited to the following. These items should not be separately billed.
  - IV Start Kits and sterile site dressing materials (e.g. angio-caths, tape, antimicrobial ointments/pads, alcohol pads, betadine swabs, transparent film dressings, gauze dressings, etc.)
  - IV fluids utilized as vehicles for administration of other therapeutic agents (e.g. keep-vein-open (KVO) solutions, partial-fills, etc.)
  - Sterile saline or water utilized as a diluent for other therapeutic agents.
  - Flush solutions (e.g. heparin, sterile saline, sterile water, ethanol lock solution, etc.)
  - Tubing, filters, needles and syringes (e.g. pump cassettes with tubing, extension tubing, secondary sets, injection caps, in-line filters, etc.)
  - Disposable drug delivery systems (e.g. elastomeric technology based devices).
  - Daily rental of ambulatory infusion pumps.
  - Anaphylactic agents (e.g. EpiPen, etc.)
- Per Diems for multiple drugs administered in a single class of service (e.g. three antibiotics) will be reimbursed as a single per diem based on the highest administration frequency.

**Modifiers for Multiple Therapies**

- The primary class of service per diem must be billed using the most appropriate HCPCS code from the tables above without a modifier.
- The secondary class of service per diem must be billed using the appropriate HCPCS code from the tables above with the “SH” modifier in the 1<sup>st</sup> modifier field to indicate the second concurrently administered class of service on the same DOS.
- The tertiary or concurrent class of service per diems must be billed using the appropriate HCPCS code from the tables above with the “SJ” modifier in the 1st modifier field to indicate the third or more concurrently administered class of service on the same DOS.

**General Billing Guidelines**

- **For Members with primary Medicare coverage:**
  - Supplies, drugs and equipment utilized in conjunction with HIT must be filed to the appropriate Medicare carrier prior to filing to BCBST for secondary payment.
  - Secondary claims for HIT services must be filed with the appropriate Medicare Part B and D electronic remittance advices indicating payment or denial of the services.
  - If Part D covers the drug, Providers should submit a \$0.00 charge for the drug to BCBST. The \$0.00 charge indicates that Part D covered the drug and no additional payment is expected.
  - Additional information on billing HIT services can be found on the CGS Administrators, LLC website at <http://www.cgsmedicare.com/>.



## 29. Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)

**Note:** Effective 4/1/16 dates of service and after, reimbursement for DME Providers to include: DME, Medical supplies, Orthotic & Prosthetics, and Specialty DME providers will be locked at 2015 CMS (Medicare Region C DMEPOS Fee Schedule for Tennessee published as of January 1st). There will be NO Annual updates to the maximum allowable for existing codes since these schedules will be locked at 2015 CMS rates. Updates to these fee schedules for new codes are indicated below, as stated in provider's contract.

**New codes added to the DMEPOS fee schedule on or after Jan. 1, 2016, will be locked at:**

- **If CMS establishes a non-competitive bid payment amount for a new code:** the highest CMS rate for Tennessee will be added and locked based on the contract percentage and the first published Medicare fee.
- **If CMS establishes a Competitive Bid Program (CBP) single payment amount for a new code:** the new code will be added with the rate locked at 100% of the first published Medicare fee.

### a. Durable Medical Equipment (DME) and Medical Supplies

Durable Medical Equipment (DME) is any equipment that provides therapeutic benefits or enables the beneficiary to perform certain tasks that he or she is unable to undertake otherwise due to certain medical conditions and/or illnesses. DME is considered to be equipment, which can withstand repeated use and is primarily and customarily used to serve a medical purpose. It is generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home. There are items, although durable in nature, which may fall into other coverage categories such as braces, prosthetic devices, artificial arms, legs and eyes.

CMS defines customized Durable Medical Equipment (DME) as being items of DME which have been uniquely constructed or substantially modified for a specific beneficiary according to the description and orders of the beneficiary's treating Physician.

Source: <https://www.cms.gov>

**Medical Supplies** are items for health use other than drugs, prosthetic or orthotic appliances, or durable medical equipment that have been ordered by a qualified Practitioner in the treatment of a specific medical condition and that are: consumable, non-reusable, disposable, for a specific rather than incidental purpose and generally have no salvageable value.

#### **Claim Form**

Durable medical equipment and medical supplies must be billed on a Professional claim form.

#### **Block 24b – Place of Service**

The place of service (POS) should represent where the item is being used, not where it is dispensed.

#### **Block 24a – From and To Date(s) of Service**

Enter the month, day and year for each procedure, service or supply.

The following items require the use of span dates (i.e. a span of time between the "from and to" dates of service). Failure to use span dates will result in incorrect payment for the following items:

- Enteral Feeding Supply kits
- Continuous passive motion device
- Enteral Formulae
- Food Thickener
- External Insulin Pump Supplies

**EX:** Code A4224 also includes all cannulas, needles, dressings and infusion supplies (excluding insulin reservoir A4225, (Supplies for external insulin infusion pump, syringe type cartridge, sterile each) related to continuous subcutaneous insulin infusion via external insulin infusion pump (E0784). Billing for more than one (1) unit of service per week is incorrect use of the code and will be denied accordingly.

Source: <http://www.cgsmedicare.com>.

Suppliers who elect to bill for partial months should enter the date of service the rental period begins in the "From" field and the ending rental date of service in the "To" field of the CMS-1500/ ANSI-837P for each partial month of billing. In this case, the HCPCS code should be billed with the RR modifier in the first modifier field and the KR modifier in the second modifier field.

**DO NOT SPAN DATES FOR ITEMS OTHER THAN THOSE LISTED.**

All DME monthly rentals must not be billed with a DOS span and must bill only one (1) unit per month.

**Block 24d - Codes and Modifiers**

Durable medical equipment must be billed using the most appropriate HCPCS code and applicable modifiers in effect for the date of service. Pricing modifiers published on the Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) Fee Schedule are required for correct claim adjudication. In some cases, more than one pricing modifier is required. This document is located on the CGS Administrators, LLC website at <http://www.cgsmedicare.com>.

Claims billed with an inappropriate code and modifier combination will be returned to the Provider for submission of corrected claim and result in delay in reimbursement.

- Unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) codes (e.g., E1399) should only be used when a more specific CPT® or HCPCS code is not available or appropriate. Components of the primary equipment should be billed with the most specific CPT® or HCPCS code or the most specific Unlisted, Miscellaneous code.
- Durable medical equipment billed with an unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) codes must be billed with the name of the manufacturer, product name, product number, and quantity provided.

Pricing modifiers are always appended first in the modifier fields. These will always impact the reimbursement. Informational/descriptive modifiers are used in the subsequent modifier fields. These modifiers are informational or utilized for benefit management by Medicare but do not impact reimbursement amounts.

The following is a partial list of common pricing HCPCS modifiers reported with HCPCS durable medical equipment codes:

| Modifier | Description  |
|----------|--|
| AU       | Item furnished in conjunction with a urological, ostomy, or tracheostomy supply                          |
| AV       | Item furnished in conjunction with a prosthetic device, prosthetic or orthotic                           |
| AW       | Item furnished in conjunction with surgical dressing   |
| KF       | Item designated by FDA as class III device   |
| KR       | Rental item, billing for partial month   |
| NU       | New equipment  |
| RR       | Rental (use the 'RR' modifier when DME is to be rented)  |
| UE       | Used durable medical equipment   |
| KL       | DMEPOS item delivered by mail  |
| KE       | Bid under round one of DMEPOS competitive bidding program for use with noncompetitive bid base equipment |

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Labor for DME repairs to Member-owned equipment is to be billed using the most appropriate 5-digit HCPCS code. A modifier will not be required with the labor codes.

### **Codes and modifiers must be billed in accordance with the following:**

- Durable Medical Equipment Medicare Administrative Contractor (DME MAC\*) for Jurisdiction C guidelines which include, but are not limited to the following:
  - DMEPOS Supplier Manual and Revisions
  - DME MAC Jurisdiction C Fee Schedule
  - Pricing, Data Analysis and Coding Contractor (PDAC\*\*) Product Classification Lists
  - Pricing, Data Analysis and Coding Contractor (PDAC\*\*) Coding Bulletins

\*This document is located on the CGS Administrators, LLC website at <http://www.cgsmedicare.com>.

\*\*This document is located on the Noridian Administrative Services, LLC (NAS) Web site at <http://www.dmepdac.com>.

### **Block 24g - Days or Units**

For monthly rentals, one unit should be billed for each month the item is rented as the maximum allowable for the rental is for a whole month.

For partial month rentals, one unit should be billed for each month the item is rented. BCBST reserves the right to prorate the maximum allowable to reflect the partial month rental.

For rentals with DME codes and supply kits requiring span dates, one unit should be billed for each day the item is rented or supplied as the maximum allowable is for one day. For enterals, food thickener and external insulin supplies requiring span dates, the units are to be billed in accordance with the unit defined in the code description.

### **General Billing Guidelines**

- The maximum allowable for durable medical equipment constitutes full reimbursement for the item including all labor charges involved in the assembly and support services such as emergency services, delivery, set-up, education, and on-going assistance with the item. These services including mileage are not separately billable.
- Warranties-Supplier must honor all product warranties, express and implied, under applicable state law.
- Maintenance and/or service charges for durable medical equipment covered under a manufacturer or supplier's warranty are not billable unless such charges are excluded from the warranty.
- Supplies and accessories related to DME must be billed in accordance with DME MAC for Jurisdiction C guidelines and be on the same claim form as the rented DME.
- There must be a valid detailed order on file prior to submitting claims for supplies.
- Regular submission of claims for supplies that exceed the usual utilization may prompt a request for medical records to support the need for additional supplies.
- Additional supplies must be requested by a Member or caregiver before being dispensed. Supplies are not to be automatically dispensed on a predetermined regular basis.
- Codes without a published Medicare fee - BCBST reserves the right to request the name of the manufacturer, product name, product number, and quantity provided.
- Leased DME should be billed in accordance with guidelines for rented DME. Reimbursement for leased DME will be based on the reimbursement provisions for rented DME.

### **NOTE: Ventricular Assist Device (VAD) Supply or Accessory**

Effective Dec. 1, 2017, supplemental information will no longer be required when filing medical CMS-1500/ANSI-837P claims with HCPCS Codes Q0508 and Q0509 (Miscellaneous supply or accessory for use with an implanted ventricular assist device) unless specifically requested as indicated below.

The most appropriate codes to use for these dressing supplies are HCPCS codes Q0508 or Q0509. The prepackaged supplies typically contain various items including but not limited to gloves, gauze, tape, anchoring device, bouffant cap, local antiseptic (betadine/dynadex/chloraprep), and facemask. If there is a specific code for an associated supply or accessory, that specific code should be billed for the item. When billing for a miscellaneous supply or accessory for use with a VAD, (Q0508 or Q0509), the following documentation should be on file and available upon request:

- Physician's order for supply/accessory listing frequency and duration of its use
- Invoice for supply/accessory provided
- List of supply/accessory provided whether individually or in a kit
- Office/progress notes for the Member documenting the presence of a LVAD device

Q0508 or Q0509 will be reimbursed as 1 unit per month and shall include all supplies necessary to treat Members' VAD dressing changes.

### **Aerosol Therapy**

- Equipment used in conjunction with aerosol therapy must be billed by a durable medical equipment Provider.
- Supplies used in conjunction with aerosol therapy must be billed by a durable medical equipment Provider or medical supplier.
- Inhalation medication used in conjunction with aerosol therapy must be billed through Member's pharmacy program.

### **Enteral Therapy**

- Equipment used with enteral therapy must be billed by a durable medical equipment Provider.
- Supply kits, pumps and formulae used with enteral therapy must be billed by a durable medical equipment Provider or medical supplier. These items must be billed with the most appropriate HCPCS code and modifier, if applicable. DME used for enteral feedings should be billed as follows:

- **Supply Kits** – The appropriate "B" HCPCS code should be billed with span dates using one unit for each day a kit is used. These are disposable supply items and no modifier is required to indicate a purchase. A span date indicates the time period services were provided; i.e., 01012015 to 01152015. Because of the use of span dates, a separate line item is not required for each day.

The codes for enteral feeding supplies include all supplies, other than the feeding tube itself, required for the administration of enteral nutrients to the beneficiary for one day. These supply kit codes describe a daily supply fee rather than a specifically defined "kit". Some items are changed daily; others may be used for multiple days. Items included in these codes are not limited to pre-packaged "kits" bundled by manufacturers or distributors. These supplies include, but are not limited to, feeding bag/container, flushing solution bag/container, administration set tubing, extension tubing, feeding/flushing syringes, gastrostomy tube holder, dressings (any type) used for gastrostomy tube site, tape (to secure tube or dressings), Y connector, adapter, gastric pressure relief valve, declogging device, etc. These items must not be separately billed using the miscellaneous code (B9998) or using specific codes for dressings or tape. The use of individual items may differ from beneficiary to beneficiary and from day to day. Only one unit of service may be billed for any one day. Units of service in excess of one per day will be rejected as incorrect coding.

Source: <http://www.cgsmedicare.com/>

- **Pump** (if used) – Pumps are considered as monthly rentals. The “from” and “to” dates on the claim should indicate the month, day and year for the rental; i.e., 01012015 to 01012015. One unit should be used for each month the pump is rented.
- **Formulae** – Span dates should be used to indicate the period formulae were provided. Formulae are billed with one unit for 100 calories. If formulae has not been assigned a specific HCPCS code by Pricing, Data Analysis and Coding Contractor (PDAC), bill formulae using B9998 with one unit for each 100 calories. BCBST requires the complete brand name and NDC for formulae billed with this miscellaneous code to determine appropriate reimbursement.
- **Food Thickener** - Span dates should be used to indicate the period thickener was provided. Food thickener is billed with one unit for each ounce of product. All brands of commercially manufactured food thickener, used as an additive, should be billed with the specific HCPCS code assigned Pricing, Data Analysis and Coding Contractor (PDAC). Bill pre-thickened foods, juices and other liquids using B9998 with one unit for each bottle, box, or container. BCBST requires the complete brand name, volume of container supplied, manufacturer's name, and product number for pre-thickened foods billed with this miscellaneous code to determine appropriate reimbursement.

**Note:** *Claims for orally administered nutrition must include the appropriate HCPCS code and BO modifier or they will be considered an enteral tube feeding.*

#### **DME Repairs, Adjustments, and Replacements**

- If the item is rented, the repair, adjustment or replacement of the equipment and its components are included in the maximum allowable for the rental for the equipment and are not separately billable.
- Reimbursement for reasonable and necessary parts and labor to Member-owned equipment which are not covered under any manufacturer or supplier warranty, may be allowed. Parts should be billed using the most appropriate HCPCS code with the appropriate new or used purchase modifier in the modifier 1 field. Labor should be billed using the most appropriate HCPCS code. A modifier will not be required with the labor codes.
- Repairs to Member-owned durable medical equipment are billable when necessary to make the item functional. If the expense for repairs exceeds the estimated expense of purchasing another entire item, no payments can be made for the amount of the excess.
- Billable parts and labor must be billed on the same claim form.
- Mileage is not separately reimbursed or billable.
- Temporary replacement for Member-owned equipment while being repaired billed a K0462 require a description and procedure code of the Member-owned equipment being repaired.
- Thirty (30) days is allowed for rental or loaner equipment when Member-owned equipment is being repaired.

#### **Guidelines for Wheelchairs**

- All accessories related to the purchase of a wheelchair base must be billed on the same claim form as the wheelchair base itself.
- If multiple accessories are provided using the miscellaneous code K0108, each should be billed on a separate claim line.

- Code E1028 is appropriate for swingaway, removable or retractable hardware (e.g., joystick, headrest or laterals). E1028 is inappropriate for screws, bolts or any fixed hardware (e.g., hardware for seat, back or tray).
- A separate claim line is required for each item billed with code E1028. Submission of multiple units of E1028 on a single claim line may result in delayed claim adjudication.

For information on items appropriately billed with code E1028, refer to DME Product Classification List located on the Noridian Administrative Services, LLC (NAS) website at <http://www.dmepdac.com>.

**b. Reimbursement Guidelines for Durable Medical Equipment (DME) Purchase and Rentals**

This policy applies to durable medical equipment purchases and rentals billed on a Professional claim form for Blue Networks M, P, and S.

The maximum allowable for durable medical equipment classified as Capped Rental, Inexpensive/Routinely Purchased, TENS, and enteral nutrition infusion pumps (i.e. purchases and rentals) will be the lesser of total Covered charges or the contracted network percentage of the DME MAC for Jurisdiction C DMEPOS Fee Schedule for Tennessee.

Durable medical equipment will be considered purchased after the equipment has been rented for a period of 10 months.

The published Medicare fees for durable medical equipment classified as Capped Rentals are based on a 13-month rental period where the Medicare allowable for the first 3 months is at 100 percent and the Medicare allowable for the remaining 10 months is at 75 percent. Since BCBST considers durable medical equipment purchased after the equipment has been rented for a period of 10 months, the published Medicare fees for durable medical equipment classified as Capped Rentals (except Power-Driven wheelchairs) will be adjusted as follows:

$$\begin{aligned} & \text{Published Medicare Fee for Capped Rental} \times 3 \text{ months} \times 100\% \\ + & \text{Published Medicare Fee for Capped Rental} \times 10 \text{ months} \times 75\% \\ = & \text{Medicare Purchase Fee} \end{aligned}$$

$$\text{BCBST Purchase Allowable} = \text{Medicare Purchase Fee} \times \text{Contracted Network \%}$$

$$\text{BCBST Rental Allowable} = \text{BCBST Purchase Allowable} / 10 \text{ months}$$

**Capped Rental for Power-Driven Wheelchairs:**

Since BCBST considers durable medical equipment purchased after the equipment has been rented for a period of 10 months, the published Medicare fees for durable medical equipment classified as **Capped Rentals for Power Driven Wheelchairs** will be adjusted as follows:

$$\begin{aligned} & \text{Published Medicare Fee for Capped Rental} \times 3 \text{ months} \times 150\% \\ + & \text{Published Medicare Fee for Capped Rental} \times 10 \text{ months} \times 60\% \\ = & \text{Medicare Purchase Fee} \end{aligned}$$

$$\text{BCBST Purchase Allowable} = \text{Medicare Purchase Fee} \times \text{Contracted Network \%}$$

$$\text{BCBST Rental Allowable} = \text{BCBST Purchase Allowable} / 10 \text{ months}$$

If the Member changes to different but similar equipment (e.g. from a non-heated humidifier to a heated humidifier) when the equipment is medically needed (i.e. the Member's medical needs have substantially changed and the new equipment is necessary), a new 10-month rental period begins with the new equipment. Otherwise, BCBST will reimburse the least expensive piece of equipment (continuing to count against the current 10-month period). If the 10-month rental period has already expired, then no additional rental payments can be made.

Reimbursement for supplies used in conjunction with durable medical equipment rentals will be determined by the DME MAC for Jurisdiction C guidelines.

Rental rates include reimbursement for repair, adjustment, maintenance and replacement of equipment and its components related to normal wear and tear, defects, or obsolescence or aging.

The maximum allowable for durable medical equipment constitutes full reimbursement for the item including all labor charges involved in the assembly and support services such as emergency services, delivery, set-up, education, and on-going assistance with the item.

All maximum allowables for rentals are monthly rates unless specified otherwise on the Maximum Allowable Detail Report.

BCBST reserves the right to pro-rate the maximum allowable for partial month rentals.

Providers are contractually obligated to provide services at the agreed upon rates, regardless of patient acuity or nursing skill level. DME Providers must follow the DME Quality Standards set forth by CMS, which include:

- Assistive Technology certification for custom wheelchair suppliers;
- Certified Respiratory Therapists on staff when respiratory equipment supplied; and
- Accreditation as verified by the BCBST Credentialing Department.

**c. Oxygen, Oxygen Contents, Oxygen Supplies**

This policy for Oxygen systems, supplies, and contents billed on a Professional claim form applies for all BCBST lines of business.

BCBST reserves the right to pay the rental of oxygen systems to include oxygen contents, oxygen supplies and accessories for as long as the patient's need continues.

Reimbursement for rental of oxygen, contents, supplies and accessories will be based on the lesser of total covered charges or the BCBST contracted percentage of the Medicare Region C DMEPOS Fee Schedule for Tennessee as stipulated in the Provider Agreement.

Reimbursement for rental of oxygen systems, contents, supplies and accessories for all BCBST networks including BlueCare and Corporate Medicare will be limited to services eligible for separate reimbursement per the *Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for Jurisdiction C Durable Medical Equipment, Prosthetics, Orthotics and Supplies Supplier Manual (DMEPOS)* in effect for date of service prior to 1/1/2006.

The maximum allowable for durable medical equipment constitutes full reimbursement for the item including all labor charges involved in the assembly and support services such as emergency services, delivery, set-up education, and on-going assistance with the item.

All maximum allowables for reimbursement rentals are monthly rates unless specified otherwise.

To be considered for reimbursement, oxygen systems, contents, supplies and accessories for eligible services must be billed in accordance with standard coding and billing guidelines.

Rental rates include reimbursement for repair, adjustment, maintenance and replacement of equipment and its components related to normal wear and tear, defects, or obsolescence or aging.



**d. Reimbursement Guidelines for Home Pulse Oximetry**

**Spot Home Pulse Oximetry**

A spot home pulse oximetry check is a single measurement of oxygen saturation that may provide adjunctive information for the clinician. It is no different than any other routine vital sign (e.g. blood pressure) obtained as part of a general patient assessment. Reimbursement for home pulse oximetry is included in the reimbursement for the rental of oxygen equipment or home health service when used as a spot oxygen saturation check. When used as a spot oxygen saturation check, home pulse oximetry should not be billed separately from the rental of oxygen equipment or the home health visit.

**Continuous Home Pulse Oximetry**

Reimbursement for Medically Appropriate continuous home pulse oximetry will be limited to the rental of the pulse oximetry equipment. Medically appropriate home pulse oximetry equipment will be considered purchased when the rental payments have reached the network cap limitation.

This policy applies to home pulse oximetry services billed with HCPCS code E0445 on a Professional claim form for all BCBST business.

**e. Prosthetics and Orthotics – Blue Networks M, P, and S**

**Qualified Providers** - Providers billing prosthetic and orthotic equipment must meet credentialing requirements outlined in Section XIV. Credentialing, in this Manual.

Prosthetic devices (other than dental) are devices that replace all or part of an Internal or external body organ or replace all or part of the function of a permanently inoperative or malfunctioning internal or external body organ. **Source:** <https://www.cms.gov>.

Orthotics are rigid or semi-rigid devices, often called braces, which are applied to the outside of the body as a means used either to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. A prefabricated or custom-fitted orthosis is one, which is manufactured in quantity without a specific beneficiary in mind. A prefabricated orthosis may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific beneficiary (i.e., custom fitted). An orthosis that is assembled from prefabricated components is considered prefabricated. Any orthosis that does not meet the definition of a custom-fabricated orthosis is considered prefabricated.

**Custom fitted orthotics are:**

- Devices that are prefabricated.
- They may or may not be supplied as a kit that requires some assembly. Assembly of the item and/or installation of add-on components and/or the use of some basic materials in preparation of the item does not change classification from OTS to custom fitted.
- Classification as custom fitted requires substantial modification for fitting at the time of delivery in order to provide an individualized fit, i.e., the item must be trimmed, bent, molded (with or without heat), or otherwise modified resulting in alterations beyond minimal self-adjustment.
- This fitting at delivery does require expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthosis to fit the item to the individual beneficiary.

**Off-the-shelf (OTS) orthotics are:**

- Items that are prefabricated.
- They may or may not be supplied as a kit that requires some assembly. Assembly of the item and/or installation of add-on components and/or the use of some basic materials in preparation of the item does not change classification from OTS to custom fitted.
- OTS items require minimal self-adjustment for fitting at the time of delivery for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit an individual.



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- This fitting does not require expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthoses to fit the item to the individual beneficiary. It is inherent in the definition of “prefabricated” that a particular item is complete. Custom-fabricated additions are appropriate only for custom-fabricated base orthotics and will be denied as not reasonable and necessary if billed with prefabricated base orthotics.

**Source:** <https://www.cms.gov>

### **Claim Form**

Prosthetics and orthotics must be billed on a Professional claim form.

### **Block 24b - Place of Service**

The place of service (POS) should represent where the item is being used, not where it is dispensed.

### **Block 24a - From and To Date(s) of Service**

Enter the month, day and year for each procedure, service or supply.

### **Block 24d - Codes and Modifiers**

Prosthetics and orthotics must be billed using the most appropriate HCPCS code and applicable modifiers in effect for the date of service.

Claims billed with inappropriate code and modifier combinations will be returned to the Provider for submission of corrected claim and result in delay in reimbursement.

- Unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) codes (e.g. L0999, L1499, L2999, L3649, L3999, L5999, L7499, L8039, L8499, L8699, L9900) should only be used when a more specific CPT® or HCPCS code is not available or appropriate.
- Failure to submit the most specific CPT® or HCPCS code or the omission of modifiers will result in denial and return of claim to Provider for most appropriate coding.
- Prosthetics or orthotics billed with an unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) codes must be billed with the name of the manufacturer, product name, product number, and quantity provided.
- Codes without a published Medicare fee - BCBST reserves the right to request the name of the manufacturer, product name, product number, and quantity provided

To facilitate claim adjudication claims for bilateral orthotics coded with a single code and provided on the same DOS are to be submitted as a single claim line using the LTRT modifiers and 2 units of service.

### **Codes and modifiers must be billed in accordance with the following:**

- Durable Medical Equipment Medicare Administrative Contractor (DME MAC\*) for Jurisdiction C guidelines which includes, but are not limited to the following:
  - DMEPOS Supplier Manual and Revisions
  - DME MAC for Jurisdiction C Fee Schedule
  - Pricing, Data Analysis and Coding Contractor (PDAC\*\*) Product Classification Lists
  - Pricing, Data Analysis and Coding Contractor (PDAC\*\*) Coding Bulletins

\*This document is located on the CGS Administrators, LLC website at <http://www.cgsmedicare.com>.

\*\*This document is located on the Noridian Administrative Services, LLC (NAS) website at <http://www.dmepdac.com>.

### Prosthetics

- Repairs, Adjustments, and Replacements
  - An adjustment is any modification to the prosthesis due to change in the patient's condition or to improve the function of the prosthesis.
  - A repair is a restoration of the prosthesis to correct problems due to wear or damage.
  - A replacement is the removal and substitution of a component of a prosthesis that has a HCPCS definition.
- The following items are included in the reimbursement for a prosthesis and, therefore, are not separately billable:
  - Evaluation of the residual limb and gait
  - Fitting of the prosthesis
  - Cost of base component parts and labor contained in HCPCS base codes
  - Repairs due to normal wear or tear within 90 days of delivery
  - Adjustments of the prosthesis or the prosthetic component made when fitting the prosthesis or component and for 90 days from the date of delivery when the adjustments are not necessitated by changes in the residual limb or the patient's functional abilities
- Routine periodic servicing, such as testing, cleaning, and checking of the prosthesis is not separately billable.
- Repairs to prosthesis are billable when necessary to make the prosthesis functional. If the expense for repairs exceeds the estimated expense of purchasing another entire prosthesis, no payment can be made for the amount of the excess. Maintenance, which may be necessitated by manufacturer's recommendations or the construction of the prosthesis and must be performed by the prosthetist, is billable as a repair.
- Reimbursement for reasonable and necessary parts and labor, which are not covered under any manufacturer or supplier warranty, may be allowed. Parts should be billed using the most appropriate HCPCS code. Labor should be billed using the most appropriate HCPCS code (e.g. L7500, L7520).

Billable parts and labor must be billed on the same claim form.

### Orthotics

- Evaluation of the patient, measurement and/or casting, and fitting of the orthosis are included in the allowance for the orthosis and are not separately billable. There is no separate payment for these services.
- Repairs to an orthotic due to wear or to accidental damage are billable when they are necessary to make the orthosis functional. The reason for the repair must be documented in the supplier's record. If the expense for the repairs exceeds the estimated expense of providing another entire orthosis, no payment will be made for the amount in excess.
- Replacement of a complete orthotic or component of an orthotic due to loss, significant change in the Member's condition, irreparable wear, or irreparable accidental damage is billable if the device is still Medically Necessary. The reason for the replacement must be documented in the supplier's record.
- The allowance for the labor involved in replacing an orthotic component that is coded with a specific L code is included in the allowance for that component and is not separately billable.
- The allowance for the labor involved in replacing an orthotic component that is coded with the miscellaneous code L4210 is separately billable in addition to the allowance for that component.

Billable orthotic components and labor must be billed on the same claim form.

**f. Reimbursement and Billing Guidelines for Hearing Services/Equipment**

BCBST reimbursement and billing guidelines for hearing-related services and equipment are as follows:

- Hearing examinations, screenings, assessments and conformity evaluations will be reimbursed based on the lesser of total covered charges or the network maximum allowable fee schedule. These services should be billed using the most appropriate CPT® or HCPCS code.
- Hearing aids, hearing aid batteries, hearing aid accessories, assisted listening devices, and dispensing fees will be reimbursed based on total covered charges, except when the Member's benefit has no dollar limit for hearing aids. When there is no dollar limit, a manufacturer's invoice will be required. These items should be billed using the most appropriate "V" HCPCS code and number of units as defined by HCPCS.
- Reimbursement for the dispensing fee includes reimbursement for fabrication and fitting of the ear mold, fitting tubing to ear mold, hearing aid orientation and instruction, shipping/handling, and sales tax.
- Covered as DME benefit.

**Note:** In order to process claims, Providers must include the right side or left side (RT or LT) modifier with the appropriate HCPCS code for the hearing aid device. The claim must have the hearing aid device and appropriate modifier for the left or right side submitted as the first line item on the claim. Claims for hearing aid devices and accessories filed without the appropriate right side or left side modifiers will be denied. No modifier is required for codes identifying bilateral procedures, devices or accessories.

These guidelines apply to services billed on a Professional claim form for all BCBST commercial business.

**g. Reimbursement Guidelines for Codes Classified as Durable Medical Equipment, Medical Supplies, Orthotics and Prosthetics without an Established Maximum Allowable**

Codes classified as durable medical equipment, medical supplies, orthotics, and prosthetics without an established maximum allowable may require submission of the manufacturer name, product name, product number, and quantity.

The maximum allowable for these services will be based **on the lesser of** total covered charges or the following percentages of the manufacturer's published list price as determined **by BCBST**:

|      |                           |
|------|---------------------------|
| 100% | Medical Supplies          |
| 100% | Durable Medical Equipment |
| 100% | Orthotics                 |
| 100% | Prosthetics               |

BCBST reserves the exclusive right to determine the manufacturer's published list price. Sources used by BCBST to determine the manufacturer's published list price include, but are not limited to:

- ✎ Information provided to BCBST by the manufacturer and/or Provider (e.g. product catalogs, product price listings, direct inquiries to manufacturers, manufacturer order forms and Provider-submitted manufacturer invoices ,that have not been altered in any way by the Provider, with list price).

In the event BCBST is unable to determine the acquisition cost using one of the aforementioned sources, BCBST reserves the right to request submission of an unaltered manufacturer/supplier's

invoice indicating the product acquisition cost after all discounts and rebates. The maximum allowable for these items will be the lesser of total covered charges or 120 percent of the acquisition cost after all discounts and rebates per the manufacturer/supplier's invoice.

This policy applies to:

- ↳ durable medical equipment, medical supplies, orthotics, and prosthetics billed on the Professional claim form; and
- ↳ medical supplies on the BCBST Home Health Non-routine Supply List billed by a home health agency on the Institutional claim form.

Reimbursement for codes classified as durable medical equipment, medical supplies, orthotics, and prosthetics without an established maximum allowable is subject to the Medicare Administrative Contractor for Jurisdiction C (DME MAC) guidelines, BCBST reimbursement guidelines and BCBST billing guidelines.

### 30. Billing Telehealth Originating Site Fees

BCBST reimburses for services rendered via Telehealth in accordance with Tennessee Telehealth mandate (TCA 56-7-10) effective Jan. 1, 2015. Qualifying codes for BlueCross Commercial and BlueAdvantage lines of business are consistent with the Centers for Medicare & Medicaid Services (CMS). By filing claims for encounters rendered via Telehealth, Providers are attesting that said claims are rendered according to these rules and guidelines. This reimbursement may not apply to certain self-funded groups if Telehealth is listed as a coverage exclusion in their contract. BlueAdvantage will follow all CMS guidelines regarding billing and reimbursement.

Effective for dates of service 3/1/17 and after, Commercial and BlueAdvantage Originating Site Providers may bill and receive a flat fee payment for Q3014 when the Originating Site Provider is not affiliated with the Distant Site Practitioner. For the Originating Site, code Q3014 is allowed for each qualifying unit of service received via Telehealth for all appropriate Provider type claims.

For Distant Site Practitioners, per CMS guidelines, the qualifying encounter code should include a GT modifier to indicate the service was delivered via Telehealth.

**Effective for dates of service 1/1/17 and after**, the American Medical Association (AMA) has created two (2) new codes that are considered eligible to be filed by the Distant Site Practitioner as a Telehealth qualifying encounter and must be billed with a 95 modifier. These CPT<sup>®</sup> codes are 90863 and 96040.

All Telehealth related services should be filed with Place of Service code "02" for both the originating and distant site Providers.

In the event that CMS designates a replacement code for Q3014 or the fee for Q3014 or its replacement code, BlueCross will utilize the new code reimbursement to replace the current flat fee.

**While it is acceptable to render services via Telehealth from satellite to satellite as a convenience for multi-site Providers (as indicated by a GT or 95 modifier), it is not appropriate to bill Q3014 under these circumstances.**

Q3014 billing will be audited in dollars recouped for billing outside policy and/or billing when no corresponding GT or 95 modifier encounter is on file for the same date of service.

Medicare guidance can be found at the following websites:

- [www.cms.gov/Medicare/Medicare-General-Information/Telehealth](http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth)
- <http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsh.pdf>

Final HIPAA Privacy Rules, including a section on "How might HIPAA affect Telemedicine Providers?" can be found at <http://www.hrsa.gov/telehealth>.

**Note:** On March 27, 2017, per State Legislative Law: SB 0195/HB 0338: Coverage for Telehealth Services Provided in Schools, the following applies to the Telehealth mandate provision for contracted Providers in addition to standard CMS requirements as an originating site Provider. The new law amends the definition of “qualified site” to include a public elementary or secondary school staffed by a health care services Provider (licensed in TN) where previously it only referenced a “school clinic.”

### 31. Air Ambulance Services

Effective 1/1/2018, this policy applies to Rotary Wing Service HCPCS codes A0431 and A0436 filed on a Professional CMS-1500/ANSI-837P claim form. Any other service codes filed for Air Ambulance transports will not receive reimbursement.

| Code  | Code Description          |
|-------|---------------------------|
| A0431 | Rotary wing air ambulance |
| A0436 | Air mileage - Rotary wing |

**Emergency Transports** are transport from scene of accidents, as indicated by appropriate origin & destination modifiers filed on claim. All other transports *may be* reviewed retrospectively for appropriateness as an Emergency Transport.

- Base Rate reimbursement should include all associated supplies and services other than separate reimbursement for mileage charges.
- Any service codes billed other than A0436 and A0431 will not be reimbursed.
- Claims filed to BCBST for ambulance services are to be billed with the appropriate origin and destination modifiers as outlined by national standards.
- Prior authorization is required for all **(Non-Emergent)** Transports.
- Rotary Transports will be capped at 250 miles.
- Provider must bill with appropriate taxonomy code, mileage, & pick-up/drop-off zip code for proper adjudication.

**Note** - For Air Ambulance services submitted on the CMS1500 claim form, the Pick-up Location Zip Code should be submitted in Block 23. Multiple Zip Codes should not be submitted in this Block. If the points of pick-up are located in different Zip Codes a separate claim form should be submitted for each trip. The correct ZIP Code is five numeric digits; if a nine-digit ZIP Code is submitted the last four digits are ignored. **If Pick-up Location Zip Code is missing, invalid, or submitted in an incorrect format the claim will be returned unprocessed.**

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## D. Institutional Claim Billing and Reimbursement Guidelines – Section 1

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### 1. Revenue Codes (CMS-1450)

BCBST will use the Uniform Billing Editor published by OPTUM, Appendix 3, “Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments”, or its successor, as a guide to determine appropriate billing services rendered. Otherwise, based on Institutional contract.

## 2. Split and Interim Billing

All services rendered must be reported on the claim. For example, an emergency room revenue code with the related CPT® code cannot be omitted, if in fact the patient received care or was admitted through the emergency room. Such omissions are recoverable by BCBST and if deemed to be intentional, the network contract is subject to cancellation. To correct a claim with a coding error the entire claim must be refiled.

A split bill is appropriate only when requested by BCBST. Split bills are used to reflect covered charges allocated for approved and denied days. Split bills that have not been requested by BCBST are subject to denial or recovery.

Interim bills are claims filed for a portion of a large inpatient hospital stay. All interim billing submitted by a facility is required in no less than (30) thirty-day increments, with the exception of final billing. Any interim bill, with the exception of that associated with final billing, which contains fewer than (30) thirty days is subject to denial or recovery.

Interim bills are identified by the last digit of the Type of Bill code found in field locator #4 on the Institutional claim form. When billing electronically, the ANSI-837I (Institutional) format must be used. See following example:

|                  |                              |            |
|------------------|------------------------------|------------|
| First Claim      | Type of Bill (last digit) =2 | 112 or 122 |
| Continuing Claim | Type of Bill (last digit) =3 | 113 or 123 |
| Last Claim       | Type of Bill (last digit) =4 | 114 or 124 |

## 3. Electronic Billing Instruction

For those facilities wishing to submit claims electronically, additional information may be obtained from BCBST e-Business Solutions. If desired, a copy of the Electronic Billing Format Specifications is available for download from the Provider page on our company website, [www.bcbst.com](http://www.bcbst.com). You may make additional electronic billing inquiries to:

BlueCross BlueShield of Tennessee, Inc.  
 Provider Network Services  
 1 Cameron Hill Circle, Ste 0007  
 Chattanooga, TN. 37402-0007

Or call, fax or e-mail:

Phone: 423-535-5775  
 Fax: 423-535-7523  
 e-mail: [eBusiness\\_Service@bcbst.com](mailto:eBusiness_Service@bcbst.com)

## 4. Explanation Codes

Explanation Codes are the processing codes found on the Member Explanation of Benefits (EOB) and Provider Remittance Advice. A list of these codes can be found on the BCBST website, [www.bcbst.com](http://www.bcbst.com).

## 5. Adjusted Claims

To adjust a claim previously filed with BCBST, a complete corrected claim must be resubmitted.

## 6. Late Charges

BCBST does not accept late charges. To receive consideration for late charges, a corrected claim should be resubmitted.

**Note:** Beginning August 1, 2015, Institutional claims (UB-04 and 837I) filed with Types of Bill ending in '5' will be returned with the following rejection:

➤ 150168 CLM FREQUENCY CODE 5 NOT ACCEPTED

**7. Member Liability**

Revenue codes considered Member liability and may be billed to BCBST Member follow:

| Member Liability Revenue Codes |   |
|--------------------------------|---|
| Revenue Code                   | Service   |
| 0624                           | FDA Investigational Devices (requires Member consent) |
| 0990                           | General - Patient Convenience Items                   |
| 0991                           | Cafeteria/Guest tray                                  |
| 0992                           | Private Linen Service                                 |
| 0993                           | Telephone/Telegraph                                   |
| 0994                           | TV/Radio  |
| 0995                           | Non patient Room Rentals                              |
| 0996                           | Late Discharge Charge                                 |
| 0997                           | Admission Kits  |
| 0998                           | Beauty Shop/Barber                                    |
| 0999                           | Other Patient Convenience Items                       |

**8. Lesser Of Calculation**

Effective for dates of service 1/1/2018, and after, Lesser Of is dependent on the facility's individual contract. Non-contracted and non-Covered Services are excluded from the Lesser Of calculation.

Prior to 1/1/2018, there were two methodologies for calculating Lesser Of, the line item level and the claim level. Both represent a Lesser Of calculation but incorporate a different methodology for calculating each. The Lesser Of methodology utilized in adjudicating the claim was dependent on the facility's contract in effect on the date the services were rendered. Claims processed under facility contracts containing claim level Lesser Of language were adjudicated using a claim level Lesser Of calculation. All other claims were adjudicated using a line item Lesser Of calculation.

**Note:** In accordance with Medicare anti-fraud statutes at 42 USC 1320 et seq, when Medicare is primary, Providers may not accept secondary payments above the Medicare allowed amounts. This rule overrides any Lesser Of contractual agreements allowing amounts greater than charges.

**Methodologies for calculating Lesser Of prior to 1/1/2018 follow:**

**a. Claim Level Lesser Of Calculation:**

Acute Care facilities holding contracts with Claim Level Lesser Of language will have claims with dates of services on or after the contract effective date processed according to the following methodology. Claim Level Lesser Of calculation compares the lesser of total covered charges for Covered Services against the contracted rates outlined in Schedules 1 and 2 of the Institution Contract. If the total covered charges filed on the claim are less than the amounts outlined in the contract, BCBST will allow the lesser of the total covered charges as submitted by the facility. Claims adjudicated using Claim Level Lesser Of Calculation are dependent upon the date of service and the contract in effect at the time of service.

***Items excluded from Claim Level Lesser Of Calculation***

When calculating the lesser of total covered charges for inpatient or outpatient services, there are three categories of services that are excluded. Examples of these exclusions are listed below:

- Services reimbursed based on a percentage of total covered charges, or discount off of charges.
- Services that are considered incidental, or part of the primary service.
- Services that are identified as non-covered under the Institution Contract, or the Member's health care plan.

**b. Line Item Lesser Of Calculation:**

- In the Line Item Lesser Of Calculation, the lesser of calculation for an inpatient claim is based on a per day methodology. The covered ancillary charges shown on each claim are totaled and divided by the number of total days shown on the claim to calculate an average covered ancillary charge per day. This average covered ancillary charge per day is then added to the actual room charge per day for each service category (defined by each facility's contract) to arrive at a total charge per day for that service category. The total covered charge per day applicable to each service category is multiplied by total days associated with same and a comparison of total covered charges by service category is made to that of negotiated payment per contract for that same category. The lower of these two amounts is the amount that will be paid on the claim for that service category.
- This same methodology is used for the outpatient lesser of calculation when it is applicable. Some outpatient services stand alone and do not receive allocations while others roll to a case or per procedure pricing method. If an outpatient claim has two or more of these cases or per procedure items then the appropriate ancillary lines will be allocated to each, based on a percentage of number of cases/procedures to total. Total covered charges for the case/procedure will then be compared to the negotiated rate for each and the lower of the two amounts is paid.

The following examples show two inpatient Per Diem contract scenarios, one is not impacted by lesser of while the other is:

**\*2 days @ \$900**

| Not Impacted by Lesser Of |                   |         |            |              |          |         |
|---------------------------|-------------------|---------|------------|--------------|----------|---------|
| Days                      | Type of Service   | Charges | Allocation | Re-allocated | Per Diem | Reimb.  |
| 2                         | Medical           | \$700   | \$1,533    | \$2,233      | *\$1800  | \$1800  |
| 1                         | ICU               | 500     | 767        | 1,267        | 1,200    | 1,200   |
|                           | Ancillary Charges | 2,300   |            |              |          |         |
|                           | Total             | \$3,500 | \$2,300    | \$3,500      | \$3,000  | \$3,000 |

**\*\*3 days @ \$900**

| Impacted by Lesser Of |                   |         |            |              |           |         |
|-----------------------|-------------------|---------|------------|--------------|-----------|---------|
| Days                  | Type of Service   | Charges | Allocation | Re-allocated | Per Diem  | Reimb.  |
| 3                     | Medical           | \$1,050 | \$1,875    | \$2,925      | **\$2,700 | \$2,700 |
| 1                     | ICU               | 500     | 625        | 1,125        | 1,200     | 1,125   |
|                       | Ancillary Charges | 2,500   |            |              |           |         |
|                       | Total             | \$4,050 | \$2,500    | \$4,050      | \$3,900   | \$3,825 |

**Note for Per Diem Contracts:** Only the Per Diem amount will be allowed for inpatient services. No reimbursement will be given for any other Revenue Code, unless specifically contracted.

## 9. Non-Standard Billing Requirement

BCBST makes every effort to structure its commercial Provider network contracts and specific billing guidelines to meet the reporting requirements imposed by federal and state agencies. However, due to contract terms in our commercial networks and other business requirements, it sometimes becomes necessary that we require a facility bill in a manner that does not conform to these reporting requirements.



Additionally, BCBST provides services to a diverse Member population whose benefits may or may not be provided by federal and state agencies and the billing guidelines required for these services may not always be conducive to the requirements of federal and state agencies.

In circumstances where BCBST's billing requirements are not consistent with federal and state agency reporting, Providers are still required to remain in compliance with all reporting requirements mandated by those agencies. The Provider's medical records, census documents and financial reporting should never change as a result of BCBST's billing requirements. BCBST recognizes this may cause a discrepancy between the Provider's reporting records and the actual billing documents; however the billing to BCBST is a contractual requirement for claim payment only and should never impact regulated reporting requirements.

The most common example of a non-standard billing requirement is billing for observation services when BCBST has only authorized outpatient observation services and the admitting physician has written an inpatient admission order. In this case, in order to receive payment for observation services, the Provider is required to bill BCBST as follows:

- Change the Type of Bill from inpatient to outpatient (13x)
- Convert the Room and Board revenue code to Observation (76x)

In this example the Provider should make no changes to its medical records, continue to report the days as inpatient on their census reports and reflect charges under the Room & Board revenue codes on their financial system. This will keep the Provider in compliance with Medicare reporting but will allow payment under contractual terms of their BCBST Provider Contract.

## 10. Acute Care Facilities – Inpatient

### a. Diagnosis Related Groups (DRG) Business Rules

The following guidelines apply to all hospitals having DRG contracts with BCBST that participate in Blue Networks M, S, and P.

#### 1. Grouper

BCBST will make DRG assignment via CMS Based Grouper as defined by Provider's contract purchased from Third Party Software Vendor.

#### 2. DRG Code Update

DRGs, which are deleted by CMS subsequent to the establishment of the schedule, will be removed. For new DRGs added by CMS after the establishment of the schedule, BCBST will utilize the initial CMS Relative Weight and ALOS published in the Federal Register.

#### 3. DRG Payment Application

The DRG assignment will be based on the principal diagnosis, up to twenty-four (24) other secondary diagnoses, additional associated present on admission codes, as well as age, sex, and discharge status of patient. If CMS changes the DRG assignment criteria, BCBST will remain on current grouper assignment until a time and in a manner mutually agreed upon by the parties to ensure revenue neutrality to both parties. Until such time that the parties mutually agree, the contracted DRGs will be utilized. In the event the parties cannot reach an agreement, the dispute shall be resolved by the Provider Dispute Resolution Procedure as described in this Manual. The base rate and relative weights in effect at the admission date are used to calculate the payment level.

- **Regular DRG Payment** The formula to calculate the Regular DRG Allowed follows:

Regular DRG Allowed = DRG Relative Weight X Institution Base Rate  
Total Payment = Regular DRG Allowed – Deductible and Coinsurance

➤ **Outlier Payments**

The formula for calculating the Total Allowed Amount for an inpatient stay qualifying as an Outlier Stay is as follows:

Total Allowed Amount = Regular DRG Payment + ((Regular DRG Payment/ALOS x 70%) x (Approved LOS – Outlier Day Threshold))

| Claim Assumptions  |               | Allowed Calculation |          |
|--------------------|---------------|---------------------|----------|
| Admit Date         | July 1, 2015  | <b>Normal DRG:</b>  |          |
| Discharge Date     | July 18, 2015 | Base Rate           | \$3,992  |
| Authorization Date | July 8, 2015  | Relative Weight     | 1.1120   |
| DRG                | 014           | Normal DRG Allowed  | \$4,439  |
| DRG (ALOS)         | 4             |                     |          |
| Relative Weight    | 1.1120        | <b>Outlier:</b>     |          |
| Outlier Threshold  | 12            | Total Outlier Days  | 5*       |
| Base Rate          | \$3,992       | Outlier Per Diem    | \$777    |
| Outlier Per Diem   | \$777         | Outlier Allowed     | \$3,885* |
| Length of Stay     | 17            | Total Claim Allowed | \$8,324* |

\*Outlier days will be reviewed for Medical Necessity.

**4. Exclusions from DRG Reimbursement**

The following conditions and/or treatments are specifically excluded under the DRG Network Attachment. Facilities intending to provide these services for BCBST Members must execute a separate Network Attachment covering the provision of these services.

- Mental Disease and Disorders (MDC 19\*)
- Alcohol and Drug Use (MDC 20\*)
- Transplants (Excluding Kidney)

\*For these services, in the event that a Member is admitted under a covered medical diagnosis, BCBST will allow reimbursement based on the Provider's contracted type of reimbursement methodology (e.g., CMS-DRG, MS-DRG, Per Diem).

**5. Ungroupable DRG(s)**

Claims that are linked to an ungroupable DRG will receive no reimbursement and require the institution to file a corrected claim for payment.

**b. Relative Weight Revisions**

Relative weights are updated according to one of two schedules for revisions. To determine which schedule you are on refer to your contract.

**c. Annual Base Rate Adjustments**

Base rates are updated annually on January 1 of each year in accordance with the contract.

**d. Private Room Differential**

The DRG payment is a total payment to include all room and board services provided during the inpatient stay. Private room differentials are considered part of the DRG and are not to be balance billed to any BCBST Member.

**e. Mother and Newborn**

A combined claim is required for both mother and newborns. A separate DRG payment will not be made for a Normal Newborn because payment for this claim is combined with the mother's DRG payment.

**f. Implants and Prosthetics**

Implants and prosthetics are not reimbursed separately. Reimbursement for these items is included in the base rate and relative weights that determine DRG payment.

**g. Kidney Transplants**

Kidney transplants are reimbursed under BCBST's DRG agreement.

Every participating hospital is contracted for both the DRG and the Organ Acquisition Cost. The Schedule of Payments in the contract contains the Relative Weight, Base Rate, and Outlier Per-Diem for the appropriate Kidney Transplant DRG. Organ Acquisition Cost has been included in the relative weight and is reimbursed through the DRG payment. Organ Acquisition Cost as defined below is the responsibility of the Transplant hospital.

➤ ***Administrative and Payment Policies in regards to Kidney Transplants are:***

- Requires prior authorization and must be within BCBST Utilization Management Guidelines.
- The claim should be filed in accordance with the Tennessee Uniform Billing Guidelines.
- Organ acquisition costs, which are billed by other Providers to and subsequently paid by BCBST will be accumulated by BCBST and deducted from the DRG payment to the transplant hospital via BCBST's retrospective audit process.
- Practitioner costs associated with organ acquisition cost are not included in the definition of organ acquisition cost and are to be billed separately to BCBST on a Professional claim form.
- The lesser of total covered charges or DRG allowed adjusted for deductible and coinsurance represents payment for the transplant including the organ acquisition cost.
- Hospitals not contracted under a DRG reimbursement methodology need to contact BCBST to negotiate a single patient agreement prior to providing services to a BCBST Member.
- Refer to "Tips for Completing CMS-1500, CMS-1450 and Electronic Claims Filing" section of this Manual for Donor/Recipient special billing instructions.

➤ ***Organ Acquisition Costs Include:***

***Living Donor:***

- Kidney recipient registration fees
- Laboratory test (including tissue typing of recipient and donor)
- Hospital services that are directly related to the excision of the kidney

***Cadaver Kidneys:***

- Operating room services
- Intensive care cost
- Preservation supplies (perfusion materials and equipment)
- Preservation technician's services
- Transportation cost
- Tissue typing of the cadaver organ

**h. Pre-Admission Services**

Pre-admission Diagnostic Services performed on an outpatient basis that are related to the Member's facility admission by the admitting hospital, or by an entity wholly owned or operated by the facility (or by another entity under arrangements with the facility) within three (3) days of an inpatient admission will be covered under the inlier portion of the DRG payment. No separate payment will be made for pre-admission diagnostic services within the three-day period.

Other Pre-admission Non-Diagnostic Services that are related to the Member's facility admission and performed by the admitting facility, or by an entity wholly owned or operated by the facility (or by another entity under arrangements with the facility) during the three days immediately preceding the date of admission will be covered under the inlier portion of the DRG payment for approved admissions. No separate payment will be

made for these services. All testing performed on the day of discharge or within one day following the discharge will also be covered under the inlier portion of the DRG payment. No separate payments will be made for outpatient testing within the one-day period.

**i. Transfer Payments**

BCBST allows a transfer per diem times the number of days not to exceed the amount allowed under the DRG to the transferring hospital. These claims are identified by the discharge status codes 02, 05, 70, or 82-95. The receiving hospital is reimbursed according to its acute care contract with BCBST.

**j. Readmissions (Does not apply to MedAdvantage)**

A readmission is defined as a preventable, unplanned admission occurring within fourteen (14) days after a hospital discharge to the same facility for a condition related to, or complication of the original hospital stay or admission resulting from a modifiable cause. The following conditions are eligible for 14-day readmission review: CHF, COPD, and Class I surgeries. (These are considered clean wounds, which show no signs of infection or inflammation. They often involve the eye, skin, or vascular system). Claims for patients at either a DRG or Per Diem facility that are re-admitted under these circumstances are not eligible for multiple payments. Only a single payment will be made by BCBST. These guidelines are subject to the Provider's contract.

In the instance where more than one payment has been made, BCBST reserves the right to re-coup the overpayment.

**Some examples of readmissions that MAY NOT be authorized:**

- respiratory admissions, e.g., COPD;
- complications from surgical procedures; or
- congestive heart failure (CHF).

**Some examples of readmissions that MAY be authorized are:**

- NICU admissions;
- planned admissions;
- cancer diagnoses for chemotherapy;
- complications of pregnancy;
- admissions for coronary artery bypass surgery following an admission for chest pain;
- children 18 years and under admitted to any facility; or
- admissions for complication due to rejection of transplant/implant surgery.

**Note:** The Member cannot be held liable for payment of services received when not authorized.

**k. Reimbursement Guidelines for Inpatient Services Based on Admission**

BCBST updated its reimbursement policy for inpatient facilities participating in Blue Networks M, P, and S. These facilities were transitioned to a reimbursement methodology based on the *earliest agreement date*.

For these Providers, reimbursement for inpatient services will be based on the contracted rates in effect at the time of admission. The contracted rates in effect on the admit date will be used in calculating payment for the entire stay. In some instances, a patient's admission date may span multiple Provider Agreements. In this situation, charges for all approved days will still be reimbursed based on the rates that were in effect on the date of admission and will remain in effect until the patient's discharged.

The following grid lists Provider types that may be affected by this methodology. Please refer to your specific contract in effect on the date of the patient's admission to determine applicable reimbursement rates:

| Provider's affected by Earliest Agreement Date |
|--|
| Acute Care Hospital                            |
| Freestanding Inpatient Rehabilitation Hospital |
| Skilled Nursing Facility                       |
| Hospice Facility                               |

**I. Policy for Present On Admission (POA) Indicators**

This policy applies to claims billed on an Institutional claim form for all BCBST lines of business.

For all inpatient admissions to general acute care hospitals, BCBST requires the Present on Admission code on primary and secondary diagnoses (Form Locator 67) for all discharges, by using National Coding Standard guidelines. This may impact reimbursement.

POA indicators are needed when Acute Inpatient Prospective Payment System (IPPS) Hospital Providers bill for selected Hospital Acquired Conditions (HACs), including some conditions on the National Quality Forum's (NQF) list of Serious Reportable Events (commonly referred to as "Never Events"), these certain conditions have been selected according to the criteria in section 5001(c) of the Deficit Reduction Act (DRA) of 2005 and are reportable by CMS POA Indicator Options:

**Note:** For all inpatient admissions to general acute care hospitals, based on National Coding Standard guidelines, the following POA Indicator Option "1" reporting guidelines apply.

***Present on Admission (POA) Indicator Options:***

|     |  |
|-----|--|
| Y=  | Diagnosis was present at time of inpatient admission.  |
| N = | Diagnosis was not present at time of inpatient admission.  |
| U = | Documentation insufficient to determine if the condition was present at the time of inpatient admission.   |
| W = | Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.               |
| 1 = | Unreported/Not used. Exempt from POA reporting on paper claims. A blank space is only valid when submitting this data via the ANSI 837 5010 version. |

**When filing electronic ANSI 837 Inpatient facility claims,** Providers should no longer enter Indicator Option "1" in the POA field when exempt POA reporting. The POA field should be left blank for EDI format 5010 claims.

**When filing paper CMS-1450 inpatient facility claims,** Providers should enter a "1" in the POA field when exempt from POA reporting.

**When any other POA Indicator Options apply,** they should be reported in the POA field on **both** electronic and paper claims.

***Claims will reject if:***

- POA "1" is submitted on an electronic "ANSI 837 inpatient claim; **or**
- POA is left blank on a paper CMS-1450 (UB04) inpatient claim; **or**
- POA is required, but not submitted.

The guidelines for reporting POA Indicators can be found on the CMS website at [www.cms.gov/HospitalAcqCond/](http://www.cms.gov/HospitalAcqCond/).

**m. Reimbursement Policy for Selected Hospital Acquired Conditions (HACS) Not Present On Admission (POA)**

This policy applies to claims billed on an Institutional claim form for all BCBST lines of business.

BCBST will use POA indicators to determine DRG assignment for selected HACs (a.k.a. avoidable hospital conditions) not present on admission as outlined by CMS National Reimbursement Policy.

POA adjustment reimbursement for Commercial lines of business will be based on individual Provider contracts. In addition to the Provider contracts, any reimbursement adjustments for Hospital Acquired Conditions (HACS) that are recognized as Serious Reportable Adverse Events will be made as defined by CMS guidelines.

BCBST began accepting POA Indicator codes on inpatient hospital claims effective January 1, 2008.

**Note:** *MedAdvantage lines of business will follow CMS guidelines regarding both reimbursement and reporting.*

**n. Billing and Reimbursement Guidelines for Durable Medical Equipment, Medical Supplies, Orthotics and Prosthetics (O&P) (DMEPOS) Dispensed by a Facility (Inpatient or Outpatient)**

When a facility partners with a durable medical equipment (DME) supplier for the provision of equipment, supplies, or O & P used in conjunction with surgical or other procedures, the facility is responsible for submitting all charges associated with the service. Separate claims submitted by the DME supplier for any unbundled charges related to the facility service will result in zero reimbursement. The Member cannot be held liable in these cases, as reimbursement for DME is part of the all-inclusive global payment for inpatient and/or outpatient surgeries to contracted facilities.

Should a facility choose to partner with a DME supplier for the provision of equipment associated with the facility services, the facility will be responsible for submitting all charges to BCBST as well as responsible for payment of the DME supplier.

Unbundling of charges is a violation of contract, National Coding Conventions, and legal requirements. Under certain situations, inappropriate bundling could be considered abusive or even possibly fraudulent.

These guidelines are in accordance with the BCBST Institution Agreement. Please contact your local Provider Relations Consultant for any questions concerning your Provider Contract.

**o. Reimbursement Policy and Billing Guidelines for Unclassified Infusion Therapy, Immunosuppressive, Immune Globulin, Nebulizer, Chemotherapy and Other Injectable Drugs Billed by an Acute Care Facility**

This policy applies to all eligible, infusion therapy, immunosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs filed on an Institutional claim form by a facility contracted for Commercial Acute Care Drug Schedule for the drugs considered unclassified drugs and exceed \$1,000 per line. If preceding qualifications are not met for institutional claims the reimbursement will be set at \$0.00. All other eligible infusion therapy, immunosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs filed on an Institutional claim form with the appropriate revenue code/CPT<sup>®</sup> code will be reimbursed at the Provider's contracted percentage.

**Reimbursement Guidelines**

The maximum allowable for eligible infusion therapy, immunosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs for Acute Care Facility Providers is based on a percentage of the published Medicare allowable. Maximum allowables not published by Medicare will be calculated based on a percentage of Average Wholesale Price (AWP) or Wholesale Acquisition Cost (WAC) if there is no published AWP, using one of the following methods:

**Method 1**

1. The AWP/WAC based on the National Drug Code (NDC) for the specific drug billed.

**Method 2**

1. For a single-source drug, the AWP/WAC equals the AWP/WAC of the single product.
2. For a multi-source drug, the AWP/WAC is equal to the lesser of the median AWP/WAC of all the generic forms of the drug or the lowest brand name product AWP/WAC.

BCBST reserves the right to select the method used to calculate AWP/WAC and the source for AWP/WAC for infusion therapy, immunosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs not published by Medicare. Examples of sources for AWP/WAC include, but are not limited to First Data /Medispan, Redbook, and information provided by the drug manufacturer.

To determine eligibility and reimbursement for an injectable drug, BCBST reserves the right to request the name of the drug, National Drug Code (NDC), dosage and number of units for items billed with an unlisted, miscellaneous, not otherwise classified HCPCS code or for HCPCS codes not published by Medicare.

**Source B**

The AWP/WAC based on the National Drug Code (NDC) for the specific drug billed per First Data/Medispan and Redbook.

Infusion therapy, immunosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs provided in a facility setting are not billable to or reimbursable by BCBST filed on a Professional claim form. These are considered facility services and must be billed by the facility.

**p. Reimbursement Policy and Billing Guidelines for Unclassified**

**Radiopharmaceuticals and Contrast Materials Billed by an Acute Care Facility**

This policy applies to all eligible Radiopharmaceuticals and Contrast Materials filed on an Institutional claim form by a facility contracted for the Commercial Acute Care Drug Schedule for the drugs that are considered unclassified drugs and exceed \$1,000 per line. If preceding qualifications are not met for institutional claims the reimbursement will be set at \$0.00. All other eligible radiopharmaceuticals and contrast materials filed on an Institutional claim form with the appropriate revenue code/CPT<sup>®</sup> code will be reimbursed at the Provider's contracted percentage.

The maximum allowable for eligible radiopharmaceuticals and contrast materials is based on a percentage of the published Medicare allowable.

Maximum allowables for eligible radiopharmaceuticals and contrast materials not published by Medicare will be calculated is based on a percentage of Average Wholesale Price (AWP), or Wholesale Acquisition Cost (WAC), if there is no published AWP, according to one of the following methods:

**Method 1**

1. The AWP/WAC based on the National Drug Code (NDC) for the specific radiopharmaceutical or contrast material billed per First Data/Medispan, Redbook, and information provided by the radiopharmaceutical or contrast material manufacturer.

**Method 2**

1. For a single-source radiopharmaceutical or contrast material, the AWP/WAC equals the AWP/WAC of the single product.
2. For a multi-source radiopharmaceutical or contrast material, the AWP/WAC is equal to The lesser of the median AWP/WAC of all the generic forms of the radiopharmaceutical or contrast material or the lowest brand name product AWP/WAC.

Updates to maximum allowables for radiopharmaceuticals and contrast materials published by CMS will be made in accordance with the BCBST Policy - Quarterly Reimbursement Changes.

BCBST reserves the right to select the method used to calculate AWP/WAC and the source for AWP/WAC for radiopharmaceuticals and contrast materials without an ASP published by CMS. Examples of sources for AWP/WAC include, but are not limited to First Data/Medispan, Redbook, and information provided by the radiopharmaceutical or contrast material manufacturer.

For codes where it is not feasible to establish a maximum allowable for a radiopharmaceutical or contrast material (e.g. when the radiopharmaceutical or contrast material does not have a NDC, when the dosage depends on the weight of the patient), the maximum allowable will be based on a reasonable allowable as determined by BCBST.

In order to determine a reasonable allowable, BCBST reserves the right to request one of the following:

- The name of the radiopharmaceutical or contrast material, NDC, dosage, and quantity
- The manufacturer/supplier's invoice. When a manufacturer/supplier's invoice is requested, the name of the patient, name of the specific radiopharmaceutical or contrast material, dosage, and number of units must be provided. If multiple patients are listed on the manufacturer/supplier's invoice, the radiopharmaceutical or contrast material, dosage and number of units for the patient being billed should be clearly indicated.

Radiopharmaceuticals and contrast materials provided in a facility setting are not billable to or reimbursable by BCBST on a CMS-1500/ANSI-837P. Radiopharmaceuticals and contrast materials provided in a facility setting are considered facility services and must be billed by the facility.

## **11. Acute Care Outpatient Services**

### **a. Outpatient Surgery**

Outpatient Surgery is reimbursed based on an All-Inclusive Rate. This All-Inclusive will fully compensate Facility for all related facility services and supplies provided in association with a particular surgical procedure. Pre-admission testing (PAT), which is provided by the facility or any facility wholly owned or operated by the facility at which the surgery is performed up to three (3) days prior to the surgery is included in the all-inclusive rate and must be filed on the same claim as the outpatient surgery. Services not related to PAT should be filed on a separate claim for appropriate reimbursement and will be subject to audit.



The maximum allowable for eligible multiple procedures billed on the same date of service by the same Provider will be based on the lesser of covered charges or 100 percent of the base maximum allowable for the primary procedure and the lesser of covered charges or 50 percent of the base maximum allowable for the secondary and each subsequent procedure. When a procedure is repeated on the same day, no additional amount will be allowed on the second procedure. The primary procedure will be determined by the code with the greatest base maximum allowable.

The aggregate maximum allowable for eligible bilateral procedures will be based on the lesser of covered charges or 150 percent of the base maximum allowable. When a bilateral procedure is performed in conjunction with other surgeries, the reimbursement for the bilateral procedure will be the lesser of covered charges or 75 percent of the fee schedule, when determined that the bilateral procedure is not the primary procedure.

Per HIPAA guidelines, Bilateral procedures filed on an Institutional claim /Transaction must be filed as a single item using the most appropriate CPT<sup>®</sup> code with modifier 50. One (1) unit should be reported. For BCBST, only **surgical** procedures filed on an Institutional claim form as indicated above will receive bilateral reimbursement.

However, in certain situations, Modifier 50 should not be added to a procedure code. Some examples, but not limited to, are when:

- a bilateral procedure is performed on different areas of the right and left sides of the body (e.g. reduction of fracture, left and right arm),
- the procedure code description specifically includes the word “bilateral”; and/or
- the procedure code description specifically indicates the words “one or both”

Therefore, sometimes it is appropriate to bill a bilateral procedure with:

- a single line with no modifier and 1 unit
- a single line with modifier 50 and 1 unit; and/or if procedure is “**other**” than surgical such as radiology CPT<sup>®</sup> codes then bill as:
- two lines with modifier LT and 1 unit on one line and modifier RT and 1 unit on another line.

All procedures performed in an Outpatient Surgery setting and not shown in the applicable Schedule of the provider’s contract will be reviewed and assigned to an Outpatient Surgery Grouping if appropriate for payment by BCBST. The outpatient surgery is considered to be an all-inclusive service. Re-bundling of charges will occur when appropriate.

**Grouped surgical procedures rendered in:** the radiology department due to stationary radiology equipment or imaging guidance, the Breast Center due to use of imaging guidance or the Cardiac Cath Lab in conjunction with Cardiac procedures. BCBST will accept and will reimburse based off of the Outpatient Surgical Grouping guidelines for the appropriate HCPCS code when filed with RC(s) 0360, 0490 or 0499. RC(s) 0360, 0490 or 0499 should not be filed if the procedure is not rendered in the operating room suite, radiology department, breast center, or Cardiac Cath Lab per situations as indicated above. BCBST reserves the right to Audit.

**b. Endoscopic Gastrointestinal Procedures**

Revenue Code 0750 indicates Endoscopic Gastrointestinal procedures that are performed in the GI Lab and not in an Operating Room. The Endoscopic Gastrointestinal procedure is considered an all-inclusive service when filed with a contracted surgical grouper CPT<sup>®</sup> Code. Rebundling of charges will occur when appropriate.

**Note:** For Donor Lymphocyte Infusion (DLI) – For commercial acute care facilities, any eligible outpatient surgical HCPCS/CPT<sup>®</sup> codes appropriately filed with Revenue Codes 0362, 0810, 0815 or 0819 that are NOT included within an all-inclusive transplant rate will be reimbursed according to the Outpatient Surgical Facility (OSF) guidelines, unless otherwise contracted. All surgical reimbursement policies will apply.

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**c. Minor Surgery**

Minor Surgery (Revenue Code 0361) Codes are outpatient surgery codes that according to BCBST's medical staff should be performed in a Physician office setting. These codes have been assigned to Group 0. The agreed upon Maximum Allowed between the Facility and BCBST is \$0.00. BCBST will not make any payment for the supplies or room charges when these procedures are performed in the facility.

If a minor surgery is performed in conjunction with an all-inclusive service, the minor surgery will bundle to the all-inclusive service. If an all-inclusive service is not billed on a claim then the line item will disallow.

**d. Observation Services Billing & Reimbursement Guidelines**

Observation Services include the use of a bed and periodic monitoring by a hospital's nursing staff, which are reasonable and necessary to evaluate a patient's condition.

BCBST will consider reimbursement for the following outpatient Observation Services:

- Observation Services for Members, who, after six hours of recovery for outpatient services, are not medically stable for discharge, provided an authorization is obtained.

BCBST will base the observation time on when the Member arrives in a designated observation bed and when he/she leaves observation, after the six (6)-hour recovery time, if applicable.

BCBST will not consider reimbursement for the following outpatient Observation Services:

- Observation Services the day before an elective inpatient surgery;
- Inpatient stays which are billed as Observation Services. Those Members who are inpatient must have an authorization within one business day from the date of admission;
- Charges for Observation Services in addition to payment for inpatient services;
- Charges for Observation Services following an outpatient surgical procedure unless authorization is given. On those authorized, Observation Services may not be billed until six (6) hours after surgery. Recovery times up to six (6) hours are included in the Outpatient Surgery All-Inclusive Rates.
- Observation Services billed for convenience such as holding a Member overnight in the hospital if his or her regular post-surgery recovery period ends late at night. Observation Services require prior authorization. BCBST does not reimburse Labor Room/Delivery services billed under Revenue Code 0721 "Labor Room/Delivery – Labor" or 0722 "Labor Room / Delivery – Delivery". These services should be billed under Revenue Code 0762 "Treatment or Observation Room – Observation Room" \*.

**\*Note:** *Fetal stress and fetal non-stress tests are considered Observation and are to be billed as Observation under revenue code 0762 with the number of hours as units. However, these fetal stress tests do not require prior authorization.*

Observation services billed with Revenue Code 0762 do not require a HCPCS/CPT® code in Form Locator 44 on an Institutional claim form unless the Provider is billing for fetal stress and non-stress tests. Adding an Evaluation and Management code with the Observation code may result in delayed or denied payment of the service.

BCBST will allow up to 23 hours for the Observation Services if Medically Necessary and Medically Appropriate. Hours billed in excess of 23 hours will not be allowed

| Revenue Code | Type of Service  | HCPCS/CPT® Code | Allowed   |
|--------------|------------------|-----------------|---|
| 0762         | Observation Room | N/A             | Allowed at an hourly rate per contract, not to exceed 23 hours. |

**How to calculate Observation Services**

| <b>Less than 23 Hour Stay</b>                      |             |
|--|-------------|
| Observation Service Charges Billed by Facility     | \$ 1,500.00 |
| Observation Services Maximum Allowed Charge        | \$ 900.00   |
| Hourly Rate (Indicated by Provider Contract)       | \$ 39.13    |
| Total Hours Billed by Facility (1-hour increments) | 3           |
| Total Allowed Amount for Revenue Code 762          | \$ 117.39   |

| <b>Greater than 23 Hour Stay</b>                   |             |
|--|-------------|
| Observation Service Charges Billed by Facility     | \$ 1,500.00 |
| Hourly Rate  | \$ 39.13    |
| Total Hours Billed by Facility (1-hour increments) | 30          |
| Total Hours Allowed by BCBST (1-hour increments)   | 23          |
| Total Allowed Amount for Revenue Code 762          | \$ 900.00   |

**e. Acute Care Emergency Room Services**

Emergency room services for an emergency condition do not require prior authorization. However, if the Member is admitted to the hospital as inpatient from the emergency room, the facility is required to obtain an authorization within 24 hours or the next business day of the date of admission. These claims will be reimbursed an all-inclusive negotiated case rate or total covered charges, subject to the lesser of provision found in the facility's contract. Only the contracted HCPCS Codes will be reimbursed when filed with Revenue Code 0450, 0451, and/or 0459. Any other HCPCS code filed with Revenue Code 0450, 0451 and/or 0459 will be reimbursed at zero.

**12. Acute Care All-Inclusive Rates****a. Cardiac Catheterization and Ablation Services**

Cardiac Catheterization and Ablation services are all-inclusive and reimbursement will fully compensate the facility for all Covered Services provided in connection with these services and the exceptions based on Provider's contract. Claims billed with multiple contracted codes for RCs 0480 and 0481 may be reviewed for rebundling.

**b. Angioplasty Services**

Angioplasty services, including stents, are all-inclusive and reimbursement will fully compensate the facility for all Covered Services provided in connection with these services with the exception of outpatient surgery, approved observation services, and the exceptions based on Provider's contract. Claims billed with multiple contracted codes for RCs 0480 and 0481 may be reviewed for rebundling.

**Note:** Due to significant HCPCS/CPT® code set changes where single codes were deleted and replaced with multiple codes, BCBST will only allow reimbursement for one cardiac ablation case rate per day, one cardiac catheterization case rate per day, and one angioplasty case rate per day. RCs 0480 and 0481 are interchangeable between these services.

**c. Lithotripsy Services**

Lithotripsy will reimburse the contracted rate when billed with RC 0790. Lithotripsy services are all-inclusive services.

**13. Acute Care Fee Schedules**

BCBST will update the BCBST Facility Fee schedule for quarterly additions and deletions to HCPCS/CPT® codes that are effective January 1, April 1, July 1, and October 1 of each year in accordance with the American Medical Association (AMA). For new HCPCS/CPT® codes, the allowable reimbursed by BCBST beginning with the effective date of the code from

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January 1 until March 31 will be considered an interim allowable based on the reimbursement pricing methodology below. Revisions for the existing HCPCS/CPT® codes allowable reimbursement will be updated effective April 1 of each year in accordance with the Provider's Contract.

### a. Laboratory Services

Laboratory Services will be allowed according to the contract unless performed with an all-inclusive service. When filed with an all-inclusive service, the Laboratory Services will be bundled with the all-inclusive service. The Fee Schedule will be allowed when filed separately. These Fee Schedules are priced at the current Medicare reimbursement rate and updated on April 1 of each year.

| Revenue Code | Type of Service             | HCPCS/CPT® Code                   | Allowed   |
|--------------|-----------------------------|-----------------------------------|---|
| 0300         | Laboratory                  | Requires a valid HCPCS/CPT® Code. | Reimbursement is based upon the contract. Refer to Laboratory Fee Schedule. |
| 0301         | Chemistry                   |                                   |   |
| 0302         | Immunology                  |                                   |   |
| 0304         | Non-Routine Dialysis        |                                   |   |
| 0305         | Hematology                  |                                   |   |
| 0306         | Bacteriology & Microbiology |                                   |   |
| 0307         | Urology                     |                                   |   |
| 0309         | Other Laboratory            |                                   |   |
| 0310         | General                     |                                   |   |
| 0311         | Cytology                    |                                   |   |
| 0312         | Histology                   |                                   |   |
| 0314         | Biopsy                      |                                   |   |
| 0319         | Other                       |                                   |   |

### Note: Regarding Technical Component for Professional Services Performed in a Facility:

Commercial DRG and outpatient case rates paid to a facility are all-inclusive of any Technical component for professional services provided while a patient is in a facility setting. The facility must bill for the technical component of the services, even if these services are provided under arrangements with or subcontracted out to another entity such as a laboratory, pathologist, or other Provider. Payment is not made under the Physician fee schedule for technical components services furnished to patients in institutional settings. MedAdvantage claims should continue to be billed consistent with CMS guidelines.

### b. Radiology Services

When filed with all-inclusive services, the radiology procedure will be bundled with the all-inclusive service. The Fee Schedule will be allowed when filed separately. These Fee Schedules are priced at the current Medicare reimbursement rate and updated on April 1 of each year.

| Revenue Code | Type of Service          | HCPCS/CPT® Code                   | Allowed  |
|--------------|--------------------------|-----------------------------------|--|
| 0320         | Radiology Diagnostic     | Requires a valid HCPCS/CPT® Code. | Reimbursement is based upon the contract. Refer to Radiology Fee Schedule. |
| 0321         | Angiocardiology          |                                   |  |
| 0322         | Arthrography             |                                   |  |
| 0323         | Arteriography            |                                   |  |
| 0324         | Chest X-ray              |                                   |  |
| 0329         | Other Radiology Services |                                   |  |
| 0330         | Radiology Therapeutic    |                                   |  |
| 0333         | Radiation Therapy        |                                   |  |
| 0340         | General Radiology        |                                   |  |

| Revenue Code | Type of Service                    | HCPSC/CPT <sup>®</sup> Code | Allowed |
|--------------|------------------------------------|-----------------------------|---------|
| 0341         | Diagnostic Procedures              |                             |         |
| 0342         | Therapeutic Procedures             |                             |         |
| 0349         | Other Radiology Services           |                             |         |
| 0400         | Other Imaging Services             |                             |         |
| 0401         | Diagnostic Mammography             |                             |         |
| 0402         | Ultrasound                         |                             |         |
| 0403         | Screening Mammography              |                             |         |
| 0404         | Positron Emission Tomography (PET) |                             |         |
| 0409         | Other imaging Services             |                             |         |

**c. MRI/MRA/CT Scan**

MRI/MRA/CT Scan reimbursement is allowed in addition to other all-inclusive rate(s). The reimbursement includes pharmacy, anesthesia, and/or supplies used in conjunction with these Radiology Services.

| Revenue Code | Type of Service   | HCPSC/CPT <sup>®</sup> Code                   | Allowed  |
|--------------|---|---|--|
| 0350         | General Scans   | Requires a valid HCPSC/CPT <sup>®</sup> Code. | Reimbursement is based upon the contract. Refer to MRI/MRA/CT Scan Fee Schedule. |
| 0351         | Head Scan   |   |  |
| 0352         | Body Scan   |   |  |
| 0359         | Other CT Scan   |   |  |
| 0610         | Magnetic Resonance Technology (MRT)<br>General MRI Technology |   |  |
| 0611         | MRI – Brain (including brainstem)                             |   |  |
| 0612         | MRI – Spinal Cord (including spine)                           |   |  |
| 0614         | MRI – Other   |   |  |
| 0615         | Magnetic Resonance Angiography – (MRA) Head and Neck          |   |  |
| 0616         | MRA – Lower Extremities                                       |   |  |
| 0618         | MRA - Other   |   |  |
| 0619         | MRT – Other   |   |  |

**Note:** Supplies incidental to radiology – RC 0621 and Supplies incidental to other diagnostic services – RC 0622 should be filed accordingly with the appropriate HCPSC/CPT<sup>®</sup> Code but will not be reimbursed in addition to the MRI/MRA/CT Scan as this is an all-inclusive service as indicated above.

**d. BCBST Facility Fee Schedule Reimbursement Methodology Policy**

This policy applies to claims filed on an Institutional claim form/transaction. It defines the reimbursement methodology used for all new codes and existing HCPSC/CPT<sup>®</sup> codes for BCBST lines of business on the BCBST Facility Fee Schedule. The purpose is to establish consistent method to add and update HCPSC/CPT<sup>®</sup> codes on the BCBST Facility Fee Schedule for all contracts.

BCBST will update the BCBST Facility Fee Schedule for quarterly additions and deletions to HCPSC/CPT<sup>®</sup> codes that are effective January 1, April 1, July 1, and October 1 of each year in accordance with the American Medical Association (AMA). For new HCPSC/CPT<sup>®</sup> codes, the allowable reimbursed by BCBST beginning with the effective date of the code from January 1 until March 31 will be considered an interim allowable based on the reimbursement pricing methodology below. Revisions for the existing HCPSC/CPT<sup>®</sup> codes allowable reimbursement will be updated effective April 1 of each year in accordance with the Provider's contract.

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To establish the codes that are added to the BCBST Facility Fee Schedule, BCBST will utilize Appendix 3, "Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments," of the *OPTUM Uniform Billing (UB) Editor* or its successor. These codes will be updated annually on July 1st from the *First Quarter OPTUM Uniform Billing (UB) Editor Updates*.

The reimbursement methodology within this policy does not apply to "C" codes such as drugs, biologicals, radiopharmaceuticals, and devices that have alternate reimbursement methodologies.

The established BCBST Facility allowable will be based on the published maximum allowable non-facility rate. BCBST will not establish an allowable for an unlisted code. Some exceptions may apply.

**To determine the allowable, BCBST will utilize the following reimbursement pricing methodology hierarchy excluding laboratory (see laboratory pricing grid):**

| Order | Description  |
|-------|--|
| 1st   | Current Year Medicare RBRVS fee schedule TC component (Calculated using the CMS formula) x contract multiplier %.  |
| 2nd   | Current Year Medicare RBRVS fee schedule *Global (Calculated using the CMS formula) x contract multiplier %.   |
| 3rd   | Current Year Palmetto GBA (or its successor) Complete RBRVS TC component x contract multiplier %.  |
| 4th   | Current Year Palmetto GBA (or its successor) Complete RBRVS *Global x contract multiplier %.   |
| 5th   | Current Year OPTUM (or its successor) Complete RBRVS TC component (Calculated using the CMS formula) x contract multiplier %.  |
| 6th   | Current Year OPTUM (or its successor) Complete RBRVS *Global (Calculated using the CMS formula) x contract multiplier %.   |
| 7th   | Current Year National Medicare APC Payment Rate x contract multiplier %.   |
| 8th   | Allowables that were not priced by any source mentioned above remain at zero dollars with "BR – By report" to be reviewed and priced by using a similar HCPCS/CPT® code. |

**To determine the allowable, BCBST will utilize the following reimbursement pricing methodology hierarchy for laboratory:**

| Order | Description  |
|-------|--|
| 1st   | Current Year Palmetto GBA (or its successor) Clinical Laboratory fee schedule x contract multiplier %.   |
| 2nd   | Current Year Medicare Physician fee schedule TC component (Calculated using the CMS formula) x contract multiplier %.  |
| 3rd   | Current Year Medicare Physician fee schedule *Global (Calculated using the CMS formula) x contract multiplier %.   |
| 4th   | Current Year Palmetto GBA (or its successor) Physician fee schedule TC component x contract multiplier %.  |
| 5th   | Current Year Palmetto GBA (or its successor) Physician fee schedule *Global x contract multiplier %.   |
| 6th   | Current Year OPTUM (or its successor) Complete RBRVS TC component (Calculated using the CMS formula) x contract multiplier %.  |
| 7th   | Current Year OPTUM (or its successor) Complete RBRVS *Global (Calculated using the CMS formula) x contract multiplier %.   |
| 8th   | Allowables that were not priced by any source mentioned above remain at zero dollars with "BR – By report" to be reviewed and priced by using a similar HCPCS/CPT® code. |

\* Global represents the 5-digit code on fee schedule with no modifiers.

**e. Reimbursement Policy and Billing Guidelines for the Commercial Acute Care Drug Schedule**

This policy is to establish the codes that are added to the Drug and Radiopharmaceutical Fee Schedule. BCBST will utilize Appendix 3, "Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments," of the *OPTUM Uniform Billing (UB) Editor* or its successor. CPT®/HCPCS codes that are appropriate to be billed under RC(s) 0250, General Drugs; 0343, Radiopharmaceuticals Diagnostic; 0344, Radiopharmaceuticals Therapeutic; and 0636, Drugs Requiring Detail Coding will be added to the fee schedule annually on July 1 from the *First Quarter OPTUM Uniform Billing (UB) Editor Updates*.

A drug or radiopharmaceutical that is not addressed by OPTUM may be added to the fee schedule at BCBST discretion in accordance with BCBST Policy, "Quarterly Reimbursement Changes," if it is appropriate to be reimbursed to an Acute Care Hospital under the CMS Hospital Outpatient Prospective Payment System (OPPS) methodology. OPTUM updates the UB-Editor periodically. In this instance, the Schedule may be adjusted if OPTUM addresses the code in a subsequent publication of the UB-Editor. These periodic updates to the Drug and Radiopharmaceutical Fee Schedule will be made in accordance with BCBST Policy, "Quarterly Reimbursement Changes."

The base allowed is the equivalent of the CMS National APC Payment Rate under the Medicare OPPS methodology. Drugs and radiopharmaceuticals not priced by CMS that are on the Fee Schedule are to be presented with a zero allowed indicating BCBST will not make payment. The BCBST allowed is a negotiated percentage of the base allowed that is defined in the hospital contract.

*Unclassified drugs or radiopharmaceuticals* must exceed \$1,000 per line to be considered for manual pricing, otherwise reimbursement will be set at \$0.00. Drugs will be priced in accordance with BCBST Policies for Vaccines, and Toxoids, or "Unclassified Infusion Therapy, Immunosuppressive, Immune Globulins, Nebulizer, Chemotherapy and Other Injectable Drugs Billed by Facility. Radiopharmaceuticals will be priced in accordance with BCBST Policy for "Unclassified Radiopharmaceuticals and Contrast Materials Billed by an Acute Care Facility." Drugs and radiopharmaceuticals billed without a valid CPT®/HCPCS code under RC(s) 0250, 0343, 0344, and 0636 will not be considered for payment.

The Drug and Radiopharmaceutical Fee Schedule is to be updated quarterly in conjunction with the CMS quarterly updates.

Only those CPT®/HCPCS codes on the fee schedule will be considered for reimbursement when filed with one of the RC(s) listed in the table below. Services billed outside of the Agreement are subject to recovery.

**Note:** BCBST will not make a payment to an Acute Care Facility for any CPT®/HCPCS code where the UB-Editor indicates it is not appropriate to reimburse for these codes in an Acute Care Hospital Outpatient setting. In the circumstance that an inappropriate payment has occurred, BCBST reserves the right to re-coup the reimbursement as necessary.

The appropriate CPT®/HCPCS code should be billed in conjunction with the corresponding RC according to the following chart:

| Revenue Code | Description                                 | CPT®/HCPCS Code |
|--------------|---|-----------------|
| 0250         | General Drugs                               | Required        |
| 0251         | Generic Drugs                               | Required        |
| 0252         | Non-generic Drugs                           | Required        |
| 0254         | Drugs Incident to Other Diagnostic Services | Required        |
| 0255         | Drugs Incident to Radiology                 | Required        |
| 0257         | Non-prescription                            | Required        |

| Revenue Code | Description                      | CPT®/HCPCS Code         |
|--------------|----------------------------------|-------------------------|
| 0258         | IV Solutions                     | Required                |
| 0259         | Other Pharmacy                   | Required                |
| 0343         | Radiopharmaceuticals Diagnostic  | Required, if applicable |
| 0344         | Radiopharmaceuticals Therapeutic | Required, if applicable |
| 0636         | Drugs Requiring Detail Coding    | Required, if applicable |

Providers filing electronic claims should refer to the Electronic Billing Instructions of this Manual.

**f. Reimbursement Policy and Billing Guidelines for the Facility Drug Schedule**

This policy is to establish the codes that are added to the BCBST Facility Drug Fee Schedule. BCBST will utilize Appendix 3, "Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments," of the *OPTUM Uniform Billing (UB) Editor* or its successor.

BCBST will identify the HCPCS codes that are appropriate to be billed under RC(s) 0250, General Drugs; 0251, Generic Drugs; 0252, Non-generic Drugs; 0254, Drugs Incident to Other Diagnostic Services; 0255, Drugs Incident to Radiology; 0257, Non-prescription; 0258, IV Solutions; 0259, Other Pharmacy; 0343, Radiopharmaceuticals Diagnostic; 0344, Radiopharmaceuticals Therapeutic; and 0636, Drugs Requiring Detail Coding, as indicated in the *OPTUM Uniform Billing (UB) Editor* or its successor and add these codes to the fee schedule.

Drug codes submitted for consideration, but not listed in the BCBST Facility Drug Fee Schedule are not eligible for reimbursement and will be denied as non-contracted. Effective 3/17/14, any of the above indicated RC(s) filed without a HCPCS/CPT® code will also be denied as non-contracted. Drug codes submitted that are on this schedule with a \$0.00 fee and no indicator in note to review for manual pricing will be denied – exceeds the scheduled rate. In the circumstance that an inappropriate payment has occurred, BCBST reserves the right to re-coup the reimbursement as necessary. BCBST shall reimburse acute care hospitals contracted for BCBST Facility Drug Fee Schedule for eligible outpatient drug codes based on a percentage of the Average Sales Price (ASP), or in the absence of a published ASP, Wholesale Acquisition Cost (WAC) or Average Wholesale Price (AWP). The table below indicates the Base Facility Drug Fee Schedule pricing for each of the above methodologies.

**BCBST Base Facility Drug Fee Schedule**

| Pricing Methodology              | Percentage of Base Allowed |
|----------------------------------|----------------------------|
| Average Sales Price (ASP)        | X %                        |
| Wholesale Acquisition Cost (WAC) | X %                        |
| Average Wholesale Price (AWP)    | X %                        |

Eligible outpatient drugs will be reimbursed in addition to other outpatient services filed on the CMS-1450 (UB-04 or successor) claim form, including but not limited to Outpatient Surgery, Emergency Room, Observation and Cardiac Care.

In the event a valid outpatient drug C code is considered to be a covered procedure and there is not an acceptable CPT® code that could be used, BCBST will reimburse the C code by using ASP multiplied by an indicated contract percentage. The source for this reimbursement is derived from the Medicare Hospital Outpatient Prospective Payment System (OPPS) methodology.

Any new eligible outpatient drug codes that apply to this schedule and do not have a fee will be added to schedule with \$0.00 allowable and "BR" indicator. These codes as well as Not Otherwise Classified (NOC) and Unlisted/Miscellaneous/Non-Specific HCPCS Codes



will be reviewed for manual pricing according to BCBST's policy for Unlisted, Miscellaneous, Non-specific, and Not Otherwise Classified Procedures/Services until a CMS fee has been established. In situations where fees may not be established for an eligible drug then invoice pricing may be utilized. These fees will be updated in accordance with BCBST's Policy "Quarterly Reimbursement Changes". Failure to submit the following information for these codes will result in delay of reimbursement.

**Not Otherwise Classified (NOC) and Unlisted/Miscellaneous/Non-Specific HCPCS Codes:**

- Must be billed with a unit of one (1); and
- Requires submission of drug name; National Drug Code (NDC) in field 43, "Revenue Description/ IDE/ Medicaid Drug Rebate", on the CMS-1450 claim form; and dosage administered

**Note:** Percentages and base allowables as set forth in the Base Facility Drug Fee Schedule are not eligible for an annual contract increase pursuant to the Outpatient language excluding services reimbursed at a percentage of Medicare or percent of Covered charges. Also, any items identified as over the counter or drugs not requiring a prescription, self-administered and oral medications and medications not reimbursed by Medicare have been excluded from this BCBST Facility Drug Fee Schedule.

**g. C Codes – Outpatient PPS**

In the event a valid C code is considered to be a covered procedure and there is not an acceptable CPT® code that could be used, BCBST will reimburse the C code based on the BCBST Facility Commercial Base Fee Schedule Reimbursement Update Policy (\*see below note for exception). Revisions to existing codes will be made effective January 1 of each year. The effective date of new and deleted codes will coincide with that of CMS. The replacement code(s) will be added according to the CMS reimbursement methodology - technical component if applicable - related to that code.

The reimbursement methodology within this policy does not apply to C codes such as drugs, biologicals, radiopharmaceuticals, and devices that have alternate reimbursement methodologies.

BCBST recognizes C Codes only on CMS-1450/ANSI-837I claims.

**\*Note** Valid drug C codes considered to be a covered procedure when there is not an acceptable CPT® code that could be used, will be reimbursed based on the BCBST Facility Drug Fee Schedule Policy, the Commercial Acute Care Drug Fee Schedule Policy, or the Separately Reimbursed Facility Drug Fee Schedule Policy when contracted by Provider.

**h. Ambulance Services**

Ambulance services shall be paid in accordance with the Institutional Ambulance Fee Schedule. The ambulance codes are based on those established by CMS codes. These codes are reimbursed based on Provider's contract and updated April 1 of each year.

**i. Implants and Pacemaker and Orthotic/Prosthetic Devices**

Facilities that bill BCBST in excess of the contracted amount are subject to recovery. Likewise, hospitals that cannot support a charge for an Implant or Pacemaker with a manufacturer's invoice, or other documentation, meeting BCBST satisfaction verifying the cost, **(that excludes shipping & handling and state sales tax)** and a medical record indicating that it was provided to a BCBST Member are subject to recovery.

Orthotic and Prosthetic (O & P) devices must be billed with an appropriate HCPCS code under RC 0274. The reimbursement for all these services is based on the Provider's contract. When not specifically contracted, the allowable will be zero.

BCBST requires Providers to file the most appropriate HCPCS codes in accordance with the National Uniform Billing Guidelines on an Institutional claim form for Implant RCs 0275, and 0278.

## 14. Other Acute Care Outpatient Services

### a. Clinic Visits

BCBST does not make payment for the clinic revenue codes. BCBST will allow other eligible services based on the contracted rate or total covered charges, whichever is less when filed in conjunction with clinic visits.

### b. Venipuncture

Venipuncture services will be allowed according to the contract unless performed with an all-inclusive service.

| Revenue Code | Type of Service | HCPCS/CPT <sup>®</sup> Code                  | Allowed                                   |
|--------------|-----------------|--|---|
| 0300         | Venipuncture    | Requires a valid HCPCS/CPT <sup>®</sup> Code | Reimbursement is based upon the contract. |

### c. Cardiac and Pulmonary Rehabilitation

Prior Authorization requirements for cardiac and pulmonary rehabilitation services will be driven by the Member's health care benefits plan.

To ensure appropriate payment is made for cardiac and pulmonary rehabilitation services, Providers are encouraged to verify available benefits and prior authorization requirements under the Member's health care benefits plan by calling the Provider Services line at 1-800-924-7141 or via *e-health Services*<sup>®</sup> located on Availity, our secure area on [www.bcbst.com](http://www.bcbst.com). For those health care benefits plans requiring prior authorization penalties will continue to apply for non-compliance.

### d. Wound Care

BCBST may reimburse Wound Care services if they have been contracted. Wound Care services **will not** be reimbursed if they have not been contracted.

Wound Care services must be performed by a certified wound care nurse or other qualified health care professional. The services must be considered Medically Necessary as determined by BCBST's clinical decision process.

At least one of the HCPCS codes listed in the contract must be billed in Form Locator 44 on the CMS-1450 claim form. HCPCS codes not listed should not be billed. All Wound Care services should be billed with Revenue Code 0519, Other Clinic, in Form Locator 42. Only Wound Care services should be billed under Revenue Code 0519. Any Non-Wound Care services billed with Revenue Code 0519 are subject to recovery by BCBST

### e. Sleep Study

Sleep studies must be performed in a certified place of service, as required by applicable state and federal regulations, and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and/or American Osteopathic Association (AOA) and/or the American Academy of Sleep Medicine. The evaluating physician and staff are required to have specialized training that meets the standards set forth by the American Academy of Sleep Medicine. To help ensure the most appropriate Member benefit is applied, Providers are reminded to submit claims with the most appropriate Revenue Code, Procedure Code and HCPCS code in effect on the date of service. The appropriate Revenue Code can be determined by utilizing the Uniform Billing Editor by *OPTUM* Appendix 3, "Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments", and/or the Revenue Codes indicated on the fee schedule in Provider's Contract.

**f. Other Diagnostic Services**

The Other Diagnostic Services will be allowed according to the contract unless performed with an all-inclusive service.

| Revenue Code | Type of Service           | HCPSCS/CPT® Code                   | Allowed   |
|--------------|---------------------------|------------------------------------|---|
| 0920         | Other Diagnostic Services | Requires a valid HCPSCS/CPT® Code. | Reimbursement is based upon the contract.             |
| 0921         | Peripheral Vascular Lab   |                                    | Also See All Other Outpatient Services, if contracted |
| 0922         | Electromyelogram          |                                    |   |
| 0923         | Pap Smear                 | Requires a valid HCPSCS/CPT® Code. | Reimbursement is based upon the contract.             |
| 0924         | Allergy Test              |                                    |   |
| 0925         | Pregnancy Test            |                                    |   |
| 0929         | Other Diagnostic Services |                                    |   |

**g. Other Therapeutic Services**

Other Therapeutic Services will be allowed according to the contract unless performed with an all-inclusive service.

| Revenue Code | Type of Service                       | HCPSCS/CPT® Code                   | Allowed                                   |
|--------------|---------------------------------------|------------------------------------|---|
| 0940         | Other Therapeutic Services            | Requires a valid HCPSCS/CPT® Code. | Reimbursement is based upon the contract. |
| 0941         | Recreational Therapy                  | Requires a valid HCPSCS/CPT® Code. | Reimbursement is based upon the contract  |
| 0944         | Drug Rehabilitation                   |                                    |   |
| 0945         | Alcohol Rehabilitation                |                                    |   |
| 0946         | Complex medical equipment - routine   |                                    |   |
| 0947         | Complex medical equipment - ancillary |                                    |   |
| 0948         | Pulmonary Rehabilitation              |                                    |   |
| 0949         | Other therapeutic services            |                                    |   |

**h. Acute Care Dialysis**

BCBST will allow an all-inclusive composite rate for qualified Acute Care Dialysis services as negotiated in the Provider's Contract. Except where specifically noted in the contract, the composite rate includes all services, drugs, and supplies associated with dialysis, dialysis training, or a combination of dialysis and training. The composite rate may only be billed to BCBST when an actual dialysis treatment has been performed within the acute care facility.

This standard applies to all BCBST commercial networks for Acute Care Facility agreements and reimbursement is based upon negotiated rates as established in Provider's Contract. This standard does not apply to inpatient services. In situations where Acute Care services have not been contracted, reimbursement will be set at zero.

To be considered for reimbursement, qualified dialysis services must be billed with Revenue Code (RC) 0829\* and one of the following diagnosis codes for Acute Renal Failure: 584.5, 584.6, 584.7, 584.8 or 584.9. These diagnosis codes were established and will be updated per CMS as outlined in ICD Code Manual.

**Effective 10/1/15**, for ICD-10 for ICD-10 conversion, the diagnosis codes for Acute Renal Failure as follows: N17.0, N17.1, N17.2, N17.8, or N17.9.

\*RC 0829 will be reimbursed in addition to primary outpatient services (e.g. Observation, Emergency Room, Outpatient Surgery, Case Rates, etc.). In the instance that an overpayment has been made, BCBST reserves the right to re-coup the reimbursement as necessary.

**i. Birthing Center Payment Reimbursement Policy**

This policy applies to charges billed on an Institutional claim form for all BCBST lines of business to establish a consistent reimbursement methodology for payment when the delivery is at the Birthing Center and Member transfers to an Acute Care Facility.

In the instance that a Member delivers the baby at the Birthing Center then has to be transferred to an Acute Care Facility for follow-up care related to the delivery or for other medical conditions, BCBST will allow the delivery rate, not the transfer rate.

The Birthing Center will receive the transfer rate when the Member is in labor but is transferred to an Acute Care Facility for delivery.

**15. All Other Outpatient Services**

All other Outpatient Services are defined as those services that cannot be appropriately categorized for reimbursement in other sections within the Outpatient Services in Schedule 2 of the applicable Schedule in the facility's contract and that are approved for reimbursement by BCBST.

The following RCs will be considered according to the All Other Outpatient Services section of the contract unless performed with an all-inclusive service. **If any of the following RCs are on any other fee schedules, these guidelines do not apply.**

**Note:** This is not an all-inclusive list of "All Other Outpatient Service" RCs:

| Revenue Code | Type of Service  | HCPCS/CPT® Code   | Allowed                                   |
|--------------|--|---|---|
| 0250         | Pharmacy   | HCPCS/CPT® Code does not affect reimbursement. Facility is required to file a valid HCPCS/CPT® Code when appropriate. | Reimbursement is based upon the contract. |
| 0251         | Generic Drugs  |   |   |
| 0252         | Non-Generic Drugs  |   |   |
| 0257         | Non-Prescription   |   |   |
| 0258         | IV Solutions   |   |   |
| 0263         | IV Therapy/Drug Supply Delivery                          |   |   |
| 0272         | Sterile Supply   |   |   |
| 0280         | Oncology   |   |   |
| 0289         | Other oncology   |   |   |
| 0331         | Radiology/Therapeutic and/or chemotherapy administration |   |   |
| 0332         | Radiology/Therapeutic/ chemotherapy - oral               |   |   |
| 0335         | Radiology/therapeutic chemotherapy - IV                  |   |   |
| 0370         | Anesthesia   |   |   |
| 0379         | Other Anesthesia   |   |   |
| 0380         | Blood  |   |   |
| 0381         | Blood - packed red cells                                 |   |   |
| 0382         | Blood - whole blood                                      |   |   |
| 0383         | Blood - plasma   |   |   |
| 0384         | Blood - platelets  |   |   |
| 0385         | Blood - leucocytes                                       |   |   |
| 0386         | Blood - other components                                 |   |   |
| 0387         | Blood - other derivatives (Cryoprecipitates)             |   |   |
| 0389         | Blood - other blood                                      |   |   |
| 0390         | Blood storage & processing                               |   |   |

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|--------------|--|---|---|
| 0391         | Blood storage & processing - blood administration                  |   |   |
| 0399         | Blood storage & processing - other blood storage & processing      |   |   |
| 0410         | Respiratory services   |   |   |
| 0412         | Respiratory services - inhalation services                         |   |   |
| 0413         | Respiratory services - Hyperbaric oxygen therapy                   | HCPCS/CPT® Code does not affect reimbursement. Facility is required to file a valid HCPCS/CPT® Code when appropriate.               | Reimbursement is based upon the contract. |
| 0419         | Respiratory services - other respiratory services                  |   |   |
| 0420         | Physical therapy   |   |   |
| 0421         | Physical therapy - visit charge                                    |   |   |
| 0422         | Physical therapy - hourly charge                                   |   |   |
| 0423         | Physical therapy - group rate                                      |   |   |
| 0424         | Physical therapy - evaluation or re-evaluation                     |   |   |
| 0429         | Physical therapy - other physical therapy                          |   |   |
| 0479         | Audiology - other Audiology  |   |   |
| 0482         | Cardiology - stress test   |   |   |
| 0483         | Cardiac Echocardiology   |   |   |
| 0489         | Cardiology – other cardiology                                      | HCPCS/CPT® Code does not affect reimbursement. Facility is required to file a valid HCPCS/CPT® Code when appropriate.               | Reimbursement is based upon the contract. |
| 0636         | Drugs Requiring Detailed Coding                                    |   |   |
| 0637         | Drugs Requiring Specific Identification – Self-Administrable Drugs |   |   |
| 0730         | EKG/ECG (Electrocardiogram)  |   |   |
| 0731         | EKG/ECG (Electrocardiogram) – Holter Monitor                       |   |   |
| 0732         | EKG/ECG (Electrocardiogram) - Telemetry                            |   |   |
| 0739         | EKG/ECG (Electrocardiogram) – Other EKG/ECG                        |   |   |
| 0740         | EEG (Electroencephalogram)   |   |   |
| 0749         | EEG (Electroencephalogram) – Other EEG                             |   |   |
| 0770         | Preventive Care Services   |   |   |
| 0771         | Vaccine Administration   |   |   |
| 0779         | Other Preventive Care Services                                     |   |   |
| 0921         | Peripheral Vascular lab  | HCPCS/CPT® Code does not affect reimbursement <sup>^</sup> . Facility is required to file a valid HCPCS/CPT® Code when appropriate. | Reimbursement is based upon the contract. |
| 0922         | Eletromylogram   |   |   |

## 16. Other Acute Care Exclusions

### a. Outpatient Revenue Code Treatment

BCBST has three categories of revenue codes that are not paid under the outpatient agreement. Outlined below is a brief description of those codes:

- **Incidental to Acute Service:** Services that are considered part of the contracted rate and not paid in addition to the rate. For example, Ancillary Services, inpatient or outpatient (e.g., Revenue Code 0220 or 0235, for Special Charges and Incremental Nursing Services) would not be paid in addition to a case rate or fee schedule.

- **Invalid/Excluded Revenue Codes:** Revenue codes associated with services not covered under the acute care contract, and those, which are invalid via the revenue, code description.
- **Revenue Codes that Require a More Detailed Revenue Code:** In some cases BCBST requires the detail revenue code in lieu of the general revenue code.

**b. Non-Contracted Services**

BCBST has contracted specific outpatient services for each facility network and line of business. In situations where services shown on these contracts have not been contracted, a rate must be negotiated prior to billing those services or reimbursement will be set at zero. In addition, services not included in the contract that would require a separate contract for payment of those services are listed in the following table:

For specific information regarding the services listed below or to discuss contracting those services not currently contracted, please call your Provider Relations Consultant.

**Non-Contracted Services**

|                             |                            |                           |
|-----------------------------|----------------------------|---------------------------|
| Retail Pharmacy             | Hospice                    | Durable Medical Equipment |
| Independent or Outreach Lab | Skilled Nursing Facilities | Sub Acute Care            |
| Clinic-Based Services       | Physician Services         | Wound Care                |
| Home Health                 | Dialysis                   | Sleep Study               |
| Home Infusion Therapy       |                            |                           |

## 17. Other Institutional Facility Types

**a. Ambulatory Surgery Centers**

Outpatient Surgery is reimbursed based on an All-Inclusive Rate. This All-Inclusive Rate will fully compensate Institution for all related facility services and supplies provided in association with a particular surgical procedure. Pre-admission testing which is provided by the facility or any facility wholly owned or operated by the facility at which the surgery is performed up to three (3) days prior to the surgery is included in the all-inclusive rate and must be filed on the same claim as the outpatient surgery.

Services paid at an All-Inclusive Rate are assigned to an Outpatient Surgery Group for payment by BCBST. Current Outpatient Surgery Group assignments are contained in Provider's contract. For services payable under this Section without an assigned Outpatient Surgery Group, assignment may be made in a method consistent with that used in previous Outpatient Surgery Group assignments.

When multiple outpatient procedures are performed on the same day, the rate for the second and subsequent procedures shall be fifty percent (50%) of the All-Inclusive Rate assigned to the Outpatient Surgery Group for the procedure, subject to the lesser of total covered charges. When a procedure is repeated on the same day, no additional amount will be paid for the second procedure.

For more detailed billing and reimbursement guidelines regarding bilateral and multiple surgery procedures, refer to Outpatient Surgery under Acute Care Outpatient Services section of this manual.

**b. Inpatient Rehabilitation**

- Inpatient Rehabilitation claims must be billed following the CMS-1450 format.
- Inpatient services must be billed with a Type of Bill 11X in Form Locator 4.

| Revenue Code | Description                               |
|--------------|---|
| 0118         | Private Room and Board                    |
| 0128         | Semi-Private Room and Board (2 Beds)      |
| 0138         | Semi-Private Room and Board (3 or 4 Beds) |
| 0148         | Private Deluxe Room and Board             |
| 0158         | Ward Room and Board                       |

When incidental revenue codes are filed, they will be included with the room and board charges and the appropriate per diem rate will be applied.

The appropriate admitting, principal, and subsequent diagnosis codes are to be filed in accordance to the current International Classification of Diseases Clinical Modification (ICD CM) according to the patient's date(s) of service. Form Locator 67 is reserved for the principal diagnosis code, whereas the subsequent diagnosis codes would be indicated in Form Locators 67 – A through Q. Form Locator 69 is to be used for the admitting diagnosis code.

Prior authorization is required for all inpatient admissions. When obtaining prior authorization for a patient on a ventilator, the Provider must specify authorization is for a vent patient in order to receive the vent per diem.

**c. Outpatient Rehabilitation – Not Applicable to Acute Care**

Units being billed should be appropriate for each code as described in the "Current Procedural Terminology" (CPT<sup>®</sup>) and/or in the HCPCS Level II codes for the current year codes.

Outpatient rehabilitation services should be billed with an appropriate Type of Bill in Form Locator 4 according to Type of Facility as indicated below:

| Type of Bill | Type of Facility   |
|--------------|--|
| 13X          | Freestanding Inpatient Rehabilitation Facilities Providing outpatient therapy services |
| 23X          | Skilled Nursing Facilities Providing outpatient therapy services                       |
| 74X or 75X   | Freestanding Outpatient Rehabilitation Facilities                                      |

**The appropriate RC should be billed according to the following:**

| Revenue Code | Description               |
|--------------|---------------------------|
| 0270         | General Supplies          |
| 0413         | Hyperbaric Oxygen Therapy |
| 042X         | Physical Therapy          |
| 043X         | Occupational Therapy      |
| 044X         | Speech Therapy            |
| 047X         | Audiology                 |
| 051X         | Clinic Visit              |
| 055X         | Skilled Nursing Visit     |
| 0623         | Surgical Dressings        |

- Only those CPT<sup>®</sup> and HCPCS codes that are appropriate to bill under the Revenue Codes listed in the previous table will be paid. Codes that are not appropriate to the Revenue Codes billed will be subject to recovery by audit.

- Revenue Code 0413, Hyperbaric Oxygen Therapy, can only be billed when Medically Necessary. Unit being billed under Revenue Code 0413 should be appropriate for each code as described in the *Current Procedural Terminology (CPT®)* and/or the *HCPCS Level II Codes* for the year of the codes.
- Evaluation and Management (E&M) codes are not reimbursed in addition to Rehabilitation Therapies.
- The following guidelines apply when billing G0128:
  - G0128 cannot be billed with any other codes other than supplies and 99211.
  - G0128 can be billed when a registered nurse provides direct (face to face with the patient) skilled nursing services in a comprehensive outpatient rehabilitation facility, each 10 minutes beyond the first 5 minutes. The first 5 minutes can be billed with CPT® code 99211.
  - G0128 and 99211 can be billed to BCBST only in conjunction with wound care services and must be provided by a certified wound care nurse. Practitioner cannot bill for these codes. All other evaluation and management (E&M) codes for Practitioner are not reimbursed unless wound care services are contracted.
  - G0128 cannot be billed when debridement services are performed.
- Visit/Unit/Service – Bill in increments of one (1) each time Visit/Unit/Service is performed.
- Modalities are limited to:
  - A limit of three charged modalities to one specific body area per treatment session should be used as a billing practice.
  - Any billing beyond three modalities per body part per treatment session will be subject to review of documentation by BCBST auditors for appropriate billing practice.
  - When billing multiple modalities, redundancies of the same CPT® code will also be subject to audit for appropriate billing practice.

**d. Skilled Nursing Facility**

Skilled Nursing Facility (SNF) claims must be billed on an Institutional claim form. Inpatient services billed on an Institutional claim form must be billed with a Type of Bill 21X or 22X in Form Locator 4. The related levels of care outlined in the Skilled Nursing Fee Schedule must be billed according to the table listed below. Reimbursement for SNF services will be based on the lesser of total covered charges or the listed per diem.

| Revenue Code | Description                   |
|--------------|-------------------------------|
| 0191         | Level I ~ Skilled Care        |
| 0192         | Level II ~ Comprehensive Care |
| 0193         | Level III ~ Complex Care      |

- Outpatient services must be billed with a Type of Bill of 23x in Form Locator 4.
- The revenue codes for eligible ancillaries will be combined with the appropriate per diem code. The revenue codes for non-Covered Services will be denied as Member liability.
- A participating DME Provider must submit charges/claims for customized wheelchairs.
- All other DME/supplies are to be submitted by the Skilled Nursing Facility.
- The per diems are all inclusive (excluding customized wheelchairs).



**e. Home Health and Private Duty Nursing**

In order to comply with NUBC guidelines, Providers should use TOB 032X for claims filed for home health services. All Home Health and Private Duty Nursing services should be billed on the Institutional claim form. When submitting electronic claims, the Institutional format must be used.

Home Health visits and Private Duty Nursing services should be billed using the following RCs and billing units:

| Type of Service           | Description                                    | Revenue Code | Procedure Code | Billing Unit     |
|---------------------------|--|--------------|----------------|------------------|
| Home Health Agency Visits | Home Health Agency Physical Therapy            | 0421         | Not required   | 1 unit per visit |
|                           | Home Health Agency Occupational Therapy        | 0431         | Not required   | 1 unit per visit |
|                           | Home Health Agency Speech Therapy              | 0441         | Not required   | 1 unit per visit |
|                           | Home Health Agency Skilled Nursing (RN or LPN) | 0551         | Not required   | 1 unit per visit |
|                           | Home Health Agency Medical Social Services     | 0561         | Not required   | 1 unit per visit |
|                           | Home Health Agency Home Health Aide            | 0571         | Not required   | 1 unit per visit |
| Private Duty Nursing      | Private Duty Nursing (RN or LPN)               | 0552         | Not required   | 1 unit per hour  |
|                           | Private Duty Nursing (Home Health Aide)        | 0572         | Not required   | 1 unit per hour  |

One unit per hour should be billed for Private Duty Nursing Services. Fractional hours should be rounded to the nearest whole hour (e.g., 1 hour 15 minutes should be rounded to 1 unit, 1 hour 29 minutes should be rounded to 1 unit, 1 hour 30 minutes should be rounded to 2 units, 1 hour 31 minutes should be rounded to 2 units, 1 hour 45 minutes should be rounded to 2 units).

Home Health visits and Private Duty Nursing services not billed with the indicated RCs will be rejected or denied. A procedure code may be billed to further identify the service provided, but is not required.

To facilitate claims administration, a separate line item must be billed for each date of service and for each service previously indicated.

Supplies on the BCBST Home Health Agency Non-Routine Supply List should be billed using the indicated RCs and HCPCS codes. Units should be billed based on the HCPCS code definition in effect for the date of service. HCPCS code definitions can be found in the Healthcare Common Procedure Coding System (HCPCS) Manual.

Supplies not billed with the indicated RCs and HCPCS codes will be rejected or denied.

Reimbursement for supplies not indicated on the BCBST Home Health Agency Non-Routine Supply List used in conjunction with the above services are included in the maximum allowable for the Home Health or Private Duty Nursing service and will not be reimbursed separately.

Billing of supplies including those provided by third party vendors such as medical supply companies that are used in conjunction with a Home Health visit or Private Duty Nursing service are the responsibility of the Home Health Agency.

Supplies not used in conjunction with a Home Health visit or Private Duty Nursing services are not billable by the Home Health Agency or Private Duty Nursing Provider.

The only supplies that may be billed in addition to the above services are those indicated on the following BCBST Home Health Agency Non-Routine Supply List.

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The following codes should be used when billing Home Health Agency Non-Routine Supplies with Revenue Code 0270:

|       |       |       |       |       |       |       |       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| A4212 | A4331 | A4357 | A4375 | A4390 | A4407 | A4422 | A4455 | A5056 | A5112 | A7504 | S8185 | T4533 |
| A4248 | A4333 | A4358 | A4376 | A4391 | A4408 | A4423 | A4456 | A5057 | A5113 | A7505 | S8210 | T4534 |
| A4310 | A4334 | A4360 | A4377 | A4392 | A4409 | A4424 | A4459 | A5061 | A5114 | A7506 | T4521 | T4535 |
| A4311 | A4338 | A4361 | A4378 | A4393 | A4410 | A4425 | A4461 | A5062 | A5121 | A7507 | T4522 | T4537 |
| A4312 | A4340 | A4362 | A4379 | A4394 | A4411 | A4426 | A4463 | A5063 | A5122 | A7508 | T4523 | T4540 |
| A4313 | A4344 | A4363 | A4380 | A4395 | A4412 | A4427 | A4481 | A5071 | A5126 | A7509 | T4524 | T4541 |
| A4314 | A4346 | A4364 | A4381 | A4396 | A4413 | A4428 | A4623 | A5072 | A5131 | A7520 | T4525 | T4542 |
| A4315 | A4349 | A4366 | A4382 | A4397 | A4414 | A4429 | A4625 | A5073 | A6413 | A7521 | T4526 | T4543 |
| A4316 | A4351 | A4367 | A4383 | A4398 | A4415 | A4430 | A4626 | A5081 | A6531 | A7522 | T4527 |       |
| A4320 | A4352 | A4368 | A4384 | A4399 | A4416 | A4431 | A5051 | A5082 | A6532 | A7523 | T4528 |       |
| A4321 | A4353 | A4369 | A4385 | A4400 | A4417 | A4432 | A5052 | A5083 | A7047 | A7045 | T4529 |       |
| A4326 | A4354 | A4371 | A4387 | A4404 | A4418 | A4433 | A5053 | A5093 | A7501 | A7524 | T4530 |       |
| A4328 | A4355 | A4372 | A4388 | A4405 | A4419 | A4434 | A5054 | A5102 | A7502 | A7526 | T4531 |       |
| A4330 | A4356 | A4373 | A4389 | A4406 | A4420 | A4435 | A5055 | A5105 | A7503 | A7527 | T4532 |       |

The following codes should be used when billing Home Health Agency Non-Routine supplies with Revenue Code 0623:

|       |       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|-------|
| A6010 | A6205 | A6221 | A6237 | A6252 | A6407 | A6450 |
| A6011 | A6206 | A6222 | A6238 | A6253 | A6410 | A6451 |
| A6021 | A6207 | A6223 | A6239 | A6254 | A6412 | A6452 |
| A6022 | A6208 | A6224 | A6240 | A6255 | A6413 | A6453 |
| A6023 | A6209 | A6228 | A6241 | A6256 | A6441 | A6454 |
| A6024 | A6210 | A6229 | A6242 | A6258 | A6442 | A6455 |
| A6154 | A6211 | A6230 | A6243 | A6259 | A6443 | A6456 |
| A6196 | A6212 | A6231 | A6244 | A6261 | A6444 | A6457 |
| A6197 | A6213 | A6232 | A6245 | A6262 | A6445 | A6545 |
| A6198 | A6214 | A6233 | A6246 | A6266 | A6446 | A7040 |
| A6199 | A6215 | A6234 | A6247 | A6402 | A6447 | A7041 |
| A6203 | A6219 | A6235 | A6248 | A6403 | A6448 | A7048 |
| A6204 | A6220 | A6236 | A6251 | A6404 | A6449 |       |

### f. Home Obstetrical Management

All Home Obstetrical Management services should be billed on the Institutional claim form using Type of Bill 33X. When submitting electronic claims, the Institutional format must be used.

Home Obstetrical Management services must be billed using the following RCs, procedure codes, and billing units:

| Description                                 | Revenue Code | Procedure Code | Billing Unit   |
|---|--------------|----------------|----------------|
| Home management of preterm labor            | 0559         | S9208          | 1 unit per day |
| Home management of gestational hypertension | 0559         | S9211          | 1 unit per day |
| Home management of preeclampsia             | 0559         | S9213          | 1 unit per day |
| Home management of gestational diabetes     | 0559         | S9214          | 1 unit per day |

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Home Obstetrical Management services not billed with the indicated RCs **and** procedure codes will be rejected or denied. To facilitate claims administration, a separate line item must be billed for each date of service for the above services.

The maximum allowable for Home Obstetrical Management services per diems constitutes full reimbursement for all administrative services, professional pharmacy services, care coordination, and all necessary supplies or equipment.

The per diem does not include home health agency skilled nursing (RN or LPN) visits. Home health agency skilled nursing (RN or LPN) visits should be billed in accordance with the BCBST Home Health Billing Guidelines.

### g. Dialysis Freestanding Facility

***The following Dialysis Billing and Reimbursement Guidelines were effective on 12/1/2013 for all participating Dialysis Providers based on the contract date.***

- **Treatment Rate** – The base composite rate is adjusted by the treatment multiplier to arrive at the Treatment Rate BCBST will allow for ESRD-related services. The adjusted Treatment Rate is considered to be an all-inclusive charge for services, teaching, supplies, lab and drugs. BCBST allows the lesser of total covered charges or the treatment rates negotiated in the contract.

The Treatment Rate should only be billed to BCBST when an actual dialysis treatment has been performed. Reimbursement for these services is an all-inclusive rate.

BCBST will not reimburse for services billed in addition to the Treatment Rate as indicated in following chart. Any “other” services billed without a treatment RC as “stand alone” will deny as “Not paid in addition to primary service”. The relevant CPT® or HCPCS code is required in FL 44 in conjunction with appropriate RC in FL 42 for proper reimbursement. Claims submitted without required coding will be returned to the Provider or denied per billing guidelines as “Non-contracted Service”. Codes not specifically listed in the contract are not allowed and may not be billed to a BCBST Member.

Form locators related to the composite rate should be completed on the Institutional claim form as described in the following table. Use the Institutional format when submitting electronic claims.

| Service Description                               | Revenue Code<br>FL 42 | CPT®<br>Code/Required<br>FL 44 | Unit/<br>Frequency<br>FL 46 | Treatment<br>Rate<br>FL 47 |
|---|-----------------------|--------------------------------|-----------------------------|----------------------------|
| Hemodialysis, in-center - Composite or Other Rate | 0821                  | 90999                          | Per Visit                   | Treatment Rate             |
| Hemodialysis, home - Composite or Other Rate      | 0821                  | 90989                          | Per Visit                   | Treatment Rate             |
| IPD, in-center - Composite or Other Rate          | 0831                  | 90999                          | Per Visit (Daily)           | Treatment Rate             |
| CAPD, treatment per day - Composite or Other Rate | 0841                  | 90945                          | Per Visit (Daily)           | Treatment Rate             |
| CAPD, training - Composite or Other Rate          | 0841                  | 90993                          | Per Visit (Daily)           | Treatment Rate             |
| CCPD, treatment per day - Composite or Other Rate | 0851                  | 90945                          | Per Visit (Daily)           | Treatment Rate             |
| CCPD, training - Composite or Other Rate          | 0851                  | 90993                          | Per Visit (Daily)           | Treatment Rate             |
| Ultrafiltration, in center                        | 0881                  | 90999                          | Per Visit (Daily)           | Treatment Rate             |

| Condition Code Descriptions                     | Condition Code | Informational Only/<br>Does not affect reimbursement<br>FL(s) 18 - 28 |
|---|----------------|---|
| Home – Self-Administered Anemia Management Drug | 70             | Required  |
| Full care in unit                               | 71             | Required  |
| Self care in unit                               | 72             | Required  |
| Self care training                              | 73             | Required  |
| Home  | 74             | Required  |
| Home – 100% reimbursement                       | 75             | Required  |
| Back-up in facility Dialysis                    | 76             | Required  |

- **No Shows** – If a facility sets up in preparation for a dialysis treatment, but the treatment is never started (the patient never arrives), no payment is made.
- **Non-Reimbursable Revenue Codes (RCs)** – Unless specifically indicated in the contract, BCBST will not reimburse for services billed in addition to the composite rate. In order to administer the contract, BCBST does not utilize the general RCs. Detail RCs and CPT® or HCPCS codes are required.

**h. Hospice (These guidelines do not apply to Medicare Advantage)**

Hospice services must be billed in accordance with BCBST Billing Guidelines:

- Hospice claims must be billed on an Institutional claim form.
- To facilitate claims administration, a separate line item must be billed for each date of service.
- Hospice Providers may bill with either Type of Bill (TOB) 081X or 082X in Form Locator 4 as long as the inpatient and outpatient services are on separate claims.
- TOB should determine Place of Service (POS). Only when a patient expires in a Hospice facility will the inpatient per diem be reimbursed. If a patient expires at home, the POS should be Home, NOT the Hospice facility.
- The Statement From/Thru Dates must also correspond with the total days billed on the inpatient care.
- Hospice discharge date is eligible for payment and will not be considered as an exclusion.
- Discharge status should reflect where the patient expired.
- Hospice claims should be billed with the Hospice Provider number and/or NPI referenced in the Network Attachment.
- Reimbursable allowable rate per unit will be rounded up to the second decimal amount (e.g., \$8.7110 would reimburse as \$8.72).

In all cases reimbursement for Hospice services is based on:

- Per diems allowed on a per day, not per visit;
- The lesser of total covered charges or maximum allowable Hospice Fee Schedule;

**Note:** Charges submitted for non-Covered Services are not eligible for meeting the per diem amount.

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The related levels of care outlined in the Hospice Fee Schedule should be billed according to the following table:

| Revenue Code | Description/Service  |
|--------------|--|
| 0651         | Routine Home Care (RHC) – less than 8 hours of care (1 day = 1 unit)   |
| 0652         | Continuous Home Care Full Rate - 24 hours of care based on an hourly rate. A separate line item must be billed for each date of service using the appropriate number of units in the unit field.(Billed in 15 minute increments) |
| 0653         | Invalid  |
| 0654         | Invalid  |
| 0655         | Inpatient Respite Care – Family member or other caregiver requiring a short relief period (limited to 5 consecutive days)  |
| 0656         | General Inpatient Care – Inpatient stays, which meet general inpatient care criteria.  |

**Note:** For Continuous Home Care (CHC), one unit will equal 15 minutes. Continuous Home Care will not be reimbursed when less than 8 hours (32 units) and will be capped at 24 hours (96 units) per calendar day. Continuous home care hours are defined as being between 8 and 24 cumulative hours within a 24-hour period, as defined by Medicare.

Providers are contractually obligated to provide service at the agreed upon rates regardless of patient acuity.

Allowed amounts are all-inclusive with the exception of Practitioner services not related to Hospice care. This includes but is not limited to Hospice Practitioner services, drugs, DME, medical supplies, etc. Practitioner services are excluded from the Hospice allowed amounts when not related to Hospice care and should be billed to BCBST on a Professional claim form.

When a Member is receiving care for Hospice services and is admitted as “Inpatient” for Hospice related care, the assigned Hospice Provider is to bill BCBST for the services and will receive the contracted rates for Covered Services. BCBST should not receive any claims from the “Admitting Facility”. It is the responsibility of the Hospice Provider to reimburse the “Admitting Facility”. BCBST reserves the right to audit. (See Section XXIII. Provider Audit Guidelines in this Manual.)

Prior authorization is required for these services for commercial fully insured products. Benefits should be verified prior to providing services for other commercial business.

Effective January 1, 2016, BCBST implemented the CMS rule that changes payment methodology for RHC (RC 0651). These changes are:

- **Day 1- 60:** Allow higher rate based on admission date.
- **Day 61- thereafter:** Allow lower rate based on admission date.
- **Service Intensity Add-on (SIA Payment):** SIA payment is equal to RC 0652 hourly rate for services billed by either RC 0561-Social Worker Services or RC 0551-Registered Nurse visits for a maximum of combined 4 hours per day with a minimum of one (1) unit to a maximum of sixteen (16) units billed. These services are only eligible when billed in conjunction with RHC services. To receive the SIA add-on payment, claims must include the appropriate discharge status code and only applies when these services are performed within the last seven (7) days of life.

**Note:** BCBST utilizes the Medicare Hospice rates for Continuous Home Care, Inpatient Respite Care and General Inpatient Care that reflect compliance with the quality reporting requirements.

## E. Institutional Claim Billing and Reimbursement Guidelines – Section 2

The following guidelines/policies apply to Ambulatory Surgical Facilities that have contracted for the new surgical groupers 0-10 and UL (Unlisted) and Acute Care Facilities that have contracted for the new surgical groupers 0-10 and UL with the BCBST Facility Base Fee Schedule version 6 or later. The guidelines/policies indicated below will apply. Otherwise, refer to applicable category in D. Institutional - Section 1.

### 1. Lesser Of Calculation

Effective for dates of service 1/1/2018 and after, Lesser Of is dependent on the facility's individual contract. Non-contracted and non-Covered Services are excluded from the Lesser Of calculation.

Prior to 1/1/2018, Acute Care facilities adjudicated contracts with Lesser Of calculation language. This language compared the lesser of total covered charges minus non-Covered Services against the contracted rates outlined in Schedules 1 and 2 of the Institution Contract. If the total covered charges filed on the claim were less than the amounts outlined in the contract, BCBST allowed the lesser of the total covered charges as submitted by the facility. Claims adjudicated using Lesser of Calculation are dependent upon the date of service and the contract in effect at the time of service.

#### *Items excluded from Lesser of Calculation*

When calculating the lesser of total covered charges for inpatient or outpatient services, there are three categories of services that are excluded. Examples of these exclusions are listed below:

- Services reimbursed based on a percentage of total covered charges, or discount off of charges.
- Services that are considered incidental, or part of the primary service.
- Services that are identified as non-covered under the Institution Contract, or the Member's health care plan.

**Note:** In accordance with Medicare anti-fraud statutes at 42 USC 1320 et seq, when Medicare is primary, Providers may not accept secondary payments above the Medicare allowed amounts. This rule overrides any Lesser Of contractual agreements allowing amounts greater than charges.

### 2. Acute Care Outpatient Surgery

BCBST has established new all-inclusive surgery groupers between 0 through 10 and UL. Providers must refer to their contract for applicable services. A published list of new surgery HCPCs codes and Revenue codes (RC) is provided when contracted. All services must be billed based on where services are rendered.

BCBST may revise the information in the outpatient surgery grouper listing based on newly published and/or deleted codes and updated outpatient surgery information developed by CMS, which may be modified by BCBST to include procedures that are not maintained by CMS but are considered for reimbursement. The Outpatient Surgery Groupers will be subject to annual updates and recalibration to occur on April 1.

### 3. Minor Surgery

As of January 1, 2018, CPT/HCPCS codes that are eligible for reimbursement and billed with Minor Surgery Revenue Code 0361 will automatically default to the Group 0 payment rate indicated in the provider's contract.

### 4. Acute Care Fee Schedules

There will be no revisions for the existing HCPCS/CPT® codes allowable reimbursement for the Acute Care Fee Schedules indicated below as they will remain static to January 1, 2014, CMS rates until contract renewal. Refer to D. Institutional - Section I for any new or deleted code updates. A published list of HCPCS Codes and Revenue Codes is provided when contracted.

BCBST Facility Fee Schedule Version 6 or later  
Laboratory  
MRI/MRA/CT Scan  
Radiology

### 5. Acute Care Emergency Room Services

Emergency room services for an emergency condition do not require prior authorization. However, if the Member is admitted to the hospital as inpatient from the emergency room, the facility is required to obtain an authorization within 24 hours or the next business day of the date of admission. These claims will be reimbursed an all-inclusive negotiated case rate or total covered charges, subject to the lesser of provision found in the facility's contract. Only the contracted HCPCS Codes will be reimbursed when filed with Revenue Code 0450, 0451, 0452, and/or 0459. Any other HCPCS code filed with Revenue Code 0450, 0451, 0452, and/or 0459 will be reimbursed at zero.

### 6. Reimbursement Policy and Billing Guidelines for the Separately Reimbursed Facility Drug Fee Schedule

This policy is to establish the codes that are added to the Separately Reimbursed Facility Drug Fee Schedule. BCBST will utilize Appendix 3, "Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments," of the *OPTUM Uniform Billing (UB) Editor* or its successor.

BCBST will identify the eligible outpatient drug HCPCS codes that are appropriate to be billed under RC(s) 0343, Radiopharmaceuticals Diagnostic; 0344, Radiopharmaceuticals Therapeutic; and 0636, Drugs Requiring Detail Coding, as indicated in the OPTUM Uniform Billing (UB) Editor or its successor and add these codes to the fee schedule.

Drug codes submitted for consideration, but not listed in the Separately Reimbursed Facility Drug Schedule that are not considered Not Otherwise Classified (NOC) and Unlisted/Miscellaneous/Non-Specific HCPCS Codes are not eligible for separate reimbursement. Any of the above indicated RC(s) filed without a HCPCS/ CPT® code will be denied as procedure code required for RC. Drug codes submitted that are on this schedule with a \$0.00 fee and no indicator in note to review for manual pricing are not eligible for separate reimbursement.

In the circumstance that an inappropriate payment has occurred, BCBST reserves the right to re-coup the reimbursement as necessary.

BCBST shall reimburse acute care hospitals contracted for the Separately Reimbursed Facility Drug Fee Schedule for eligible outpatient drug codes based on a percentage of the Average Sales Price (ASP), or in the absence of a published ASP, Wholesale Acquisition Cost (WAC) or Average Wholesale Price (AWP). The table below indicates the Base Facility Drug Fee Schedule pricing for each of the above methodologies.

**Base Facility Drug Fee Schedule**

| Pricing Methodology              | Percentage of Base Allowed |
|----------------------------------|----------------------------|
| Average Sales Price (ASP)        | 108%                       |
| Wholesale Acquisition Cost (WAC) | 100%                       |
| Average Wholesale Price (AWP)    | 84%                        |

If facility is contracted with this schedule, eligible outpatient drugs on the schedule will be reimbursed in addition to all other services filed on the CMS-1450 (UB-04 or successor) claim form. In the event a valid outpatient drug C code is considered to be a covered procedure and there is not an acceptable HCPCS/ CPT® code that could be used, BCBST will reimburse the C code by using ASP multiplied by an indicated contract percentage, where applicable. The source for this reimbursement is derived from the Medicare Hospital Outpatient Prospective Payment System (OPPS) methodology.

Any new eligible outpatient drug codes that apply to this schedule and do not have a fee will be added to schedule with a \$0.00 allowable and "BR" indicator. These codes as well as Not Otherwise Classified (NOC) and Unlisted/Miscellaneous/Non-Specific HCPCS Codes will be reviewed for manual pricing according to BCBST's policy for Unlisted, Miscellaneous, Non-specific, and Not Otherwise Classified Procedures/Services until a CMS fee has been established. In situations where fees may not be established for an eligible drug then invoice pricing may be utilized. These fees will be updated in accordance with BCBST's Policy "Quarterly Reimbursement Changes." Failure to submit the following information for these codes will result in delay of reimbursement.

**Not Otherwise Classified (NOC) and Unlisted/Miscellaneous/Non-Specific HCPCS Codes:**

- Must be billed with a unit of one (1); and
- Requires submission of drug name; National Drug Code (NDC) in field 43, "Revenue Description/ IDE/ Medicaid Drug Rebate", on the CMS-1450 Claim form; and dosage administered.

**Note:** Percentages and base allowables as set forth in the Separately Reimbursed Facility Drug Fee Schedule are not eligible for an annual contract increase pursuant to the Outpatient language excluding services reimbursed at a percentage of Medicare or percent of covered charges. Also, any items identified as over the counter or drugs not requiring a prescription, self-administered or oral medications, and medications not reimbursed separately by Medicare based on status indicator have been excluded from this Facility Drug Fee Schedule. Updates to this schedule may occur annually on April 1 for existing codes that no longer meet the above descriptive or revenue code criteria.

**7. All Other Outpatient Services:**

BCBST has established a new All Other class for services that are not categorized for reimbursement within other sections of the Acute Care Outpatient Schedule 2 facility contract. The following RCs will be considered according to the new All Other Outpatient Services section of the contract unless performed with an all-inclusive service. **If any of the following**

**RCs are on any other fee schedules, these guidelines do not apply.**

| Revenue Code | Type of Service                        |
|--------------|--|
| 0240         | All -Inclusive Ancillary-General       |
| 0241         | All -Inclusive Ancillary-Basic         |
| 0242         | All -Inclusive Ancillary-Comprehensive |
| 0243         | All -Inclusive Ancillary-Specialty     |
| 0249         | All -Inclusive Ancillary-Other         |
| 0623         | Surgical dressings                     |
| 0770         | Preventive care services               |



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## **VII. PRIMARY CARE PRACTITIONER (PCP) POINT-OF-SERVICE (POS) BENEFIT PLANS**

Information in this section has been removed. Effective January 1, 2004, BlueCross BlueShield of Tennessee no longer requires Blue Network S Point-of-Service (POS) members to:

- choose a Primary Care Practitioner; **or**
- obtain a referral when seeking in-network or out-of-network specialist care.

However, to receive maximum benefits, POS members should continue to seek health care services from Providers that participate in Blue Network S. When Members utilize Providers outside their network, benefits are substantially reduced.

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## VIII. UTILIZATION MANAGEMENT PROGRAM

### A. Program Overview

BlueCross BlueShield of Tennessee's Utilization Management Program (UM) is committed to providing quality and cost effective health care services to its Members. The UM program is designed to manage, evaluate and improve the quality, appropriateness and accessibility of health care services while achieving Member and Provider satisfaction.

The UM Program monitors compliance with the National Committee for Quality Assurance (NCQA) standards in order to maintain accreditation. BlueCross BlueShield of Tennessee's UM decision-making is based only on appropriateness of care and service and existence of coverage. The Organization does not specifically reward Practitioners or other individuals for issuing denials of coverage or care and financial incentives for UM decision-makers do not encourage decisions that result in underutilization.

The program is directed, guided and monitored by our Medical Director who actively seeks input from network-participating Practitioners and other regulatory agencies. The Medical Director is ultimately responsible for facilitating medical management in the following UM areas:

- Prior Authorization Review
- Provider Appeals
- Medical Quality Management
- Specialty Services
- Concurrent Review
- Medical Policy
- Retrospective Review
- Delegate Oversight
- Disease Management
- Technology Assessment
- Transition of Care/Discharge Planning

#### Evaluation of the UM Program

- The UM Program is formally evaluated on an annual basis and revised as needed. Designated staff evaluate the consistency with which health care professionals involved in the UM process apply criteria in decision making through Physician and non-Physician inter-rater Reliability (IRR). The program is reviewed to add or modify activities necessitating the quality improvement of effective and efficient service to BlueCross BlueShield of Tennessee Members.
- Marketing, Customer Services and UM departments provide Member satisfaction data which are reviewed to add or modify activities necessitating the quality improvement of effective and efficient service to BlueCross BlueShield of Tennessee Members.
- UM nurses coordinate referrals to the Clinical Risk Management Department and the Medical Director. Trend reports are utilized to determine areas of need for corrective action, as well as areas that show improvement.

**Note:** The term "Provider" may include "Practitioner", "Facility", or "Other Licensed Professional".

### B. Medical Review

Medical reviews are prospective, concurrent, or retrospective of selected interventions and are performed where evidence suggests safe, effective alternatives exist or because of mandates from oversight agencies. Prior authorization review results in efficient use of covered health care services and helps to ensure Members receive the appropriate level of care in the appropriate setting.

**Note:** *BlueCross BlueShield of Tennessee administers both insured and self-funded arrangements. Because of differences in relationships, some prior authorization requirements may differ. Benefits are always subject to verification of eligibility and coverage at the time services are rendered.*

If the Provider chooses to render services that have not received prior authorization, or that do not meet Medical Necessity criteria according to BlueCross BlueShield of Tennessee's Clinical Decision Process, the Member is not financially liable for the charges.

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However, if the Provider obtains a *BlueCross Acknowledgement of Financial Responsibility for the Cost of Services Form* for the **specific** procedure, and any related services prior to the services being rendered, the Member may be held liable. This form cannot be utilized to waive the Provider's prior authorization requirements. Members obtaining services out of network or outside the State of Tennessee from a non-BlueCard PPO Provider, the Member may be responsible for all or a substantial share of the charges.

Review is required for all hospital admissions (excluding deliveries), observation admissions (see Observation Stay), select procedures and skilled nursing facility/restorative care unit admissions. Based on the line of business, home health services, e.g., skilled nursing visits, private duty nursing, home infusion therapy, certain outpatient or office procedures or tests, and hospice may require prior authorization. Some health care benefit plans also require review for speech therapy, occupational therapy, physical therapy, pulmonary rehabilitation (if applicable), durable medical equipment, (if applicable), cardiac rehabilitation (if applicable), and non-emergent air ambulance transportation.

To promote consistent utilization management across all product lines, BlueCross uses the following clinical decision process, 1) Member's Benefit Plan, 2) BlueCross BlueShield of Tennessee Medical Policy, 3) Utilization Management Guidelines and MCG Care Guidelines to make utilization management decisions. MCG Care Guidelines are nationally recognized guidelines that are updated annually by a panel of consultants including, but not limited to Practitioners and registered nurses. A MCG Care Guideline used in a specific medical decision can be obtained by submitting a written request to the UM Department or by calling 1-800-924-7141. BlueCross BlueShield of Tennessee will supply, at no charge, up to three MCG Care Guidelines as they pertain to a specific medical decision.

### BCBST Utilization Management Guidelines

BlueCross BlueShield of Tennessee uses MCG Care Guidelines to assist in its clinical decision-making processes. There are times when BlueCross BlueShield of Tennessee must modify, supplement, or customize certain MCG criteria to meet practice patterns in Tennessee (i.e., a guideline does not exist, the length of stay needs to be customized, or the decision criteria needs to be modified). MCG criteria that have been modified and/or customized by BlueCross BlueShield of Tennessee are published on the company website, [www.bcbst.com](http://www.bcbst.com). This allows Providers the opportunity to review and be aware of any changes or variances made to MCG criteria by BlueCross BlueShield of Tennessee. Providers are notified through *BlueAlert*, BlueCross BlueShield of Tennessee's monthly Provider newsletter, 30 days in advance of subsequent changes to these guidelines. Providers may appeal BlueCross BlueShield of Tennessee Utilization Management Guidelines (UMGs) by following the *Utilization Management Guideline Appeals Process* available in the Utilization Management section on the Provider Page of the company website, [www.bcbst.com](http://www.bcbst.com).

### Prior Authorization Reviews

Prior authorization reviews can be initiated by the Member, designated Member advocate, Practitioner, or facility. **However, it is ultimately the facility and Practitioner's responsibility to contact BlueCross BlueShield of Tennessee to request an authorization and to provide the clinical and demographic information that is required to complete the authorization.** Scheduled admissions/services must be authorized at least 24 hours prior to admission. Emergent inpatient admissions/services must be authorized within 24 hours or next business day following an admission.

When a request for an authorization of a procedure, an admission/service or a concurrent review of the days is denied, the penalty for not meeting authorization guidelines will apply to both the facility and the Practitioner rendering care for the day(s) or service(s) that have been denied. BlueCross BlueShield of Tennessee's non-payment is applicable to both facility and Practitioner rendering care. The Member is held harmless if the Member is eligible at the time services are rendered and the Covered Services are received from a network Provider.

Nurse reviewers receive requests for prior authorization, including necessary medical information. The nurse reviews the medical information, applying benefits, medical policies, BlueCross Utilization

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Management Guidelines and/or MCG criteria, to render decisions. Nurses have the authority to approve all situations that meet those guidelines, e.g., approve admissions, assign lengths of stay, and number of services.

For **Urgent Care**, the decision must be completed as soon as possible based on the clinical situation, but no later than 24-72 hours of the receipt of the request for a UM determination. For **Non-urgent Care**, the decision must be made within 15 calendar days.

The Practitioner and/or the facility are notified via telephone and/or electronically of the determination. In the event of an adverse determination, written confirmation to the Practitioner, facility and Member follows. Timeframes begin with receipt of the UM requests and include the issuance of the initial notification and/or confirmation of the decision.

Nurse reviewers refer potential denials or questionable cases to a Medical Director for review. Additional information may be submitted via the regular authorization process when an adverse determination is issued by BlueCross BlueShield of Tennessee. This information may be submitted to BlueCross BlueShield of Tennessee from the Provider or Provider representative. If a BlueCross BlueShield of Tennessee Medical Director denies a request for prior authorization, the Provider or Member may appeal the decision. (See Provider Appeals Process at the end of this section.)

Concurrent/extended stay reviews are performed for inpatient admissions and concurrent/extended service reviews are performed for ancillary services. Approval of the admission or an initial length of stay is assigned upon admission to a facility and an initial length of service is assigned upon onset of ancillary service. However, to receive payment beyond the initial length of stay or length of service, additional medical information, which meets criteria and/or demonstrates Medical Necessity, must be submitted by the facility/Practitioner contacting the Utilization Management Department either by telephone, fax or electronically with the additional information to support the request.

BlueCross Providers can submit authorization requests for inpatient and 23-hour observation via telephone, facsimile or *e-Health Services*® via *Availity*, the secure area on the company website, [www.bcbst.com](http://www.bcbst.com). Facsimile transmissions will be received Monday through Thursday, 24-hours-a-day, and Friday until 4 p.m., ET. The facsimile will be turned off from 4 p.m. Friday until 6 a.m. Monday, and will be turned off on holidays until the next business day at 6 a.m. Otherwise, the requests should be received via telephone, facsimile or *e-Health Services*® on the **next business day**. To access *e-Health Services*®, enter your ID number and password in the *Availity* secure login box or for first-time users, go to <http://www.Availity.com> and click on "Register" in the upper right corner of the home page, select "Let's get started" and follow the instructions in the Availity registration wizard. If you have an urgent case in need of an urgent response, you must telephone the request to the Utilization Management Department at 1-800-924-7141. A voicemail line will be available after business hours and on weekends/holidays for Providers to contact BlueCross BlueShield of Tennessee regarding **concurrent or urgent** information. These calls will be returned the next business day. Providers submitting requests via facsimile should utilize the authorization request form located on the company website at [http://www.bcbst.com/providers/forms/Commercial\\_Auth\\_Fax\\_Form.pdf](http://www.bcbst.com/providers/forms/Commercial_Auth_Fax_Form.pdf).

The form must be completed in its entirety; any authorization requests received that are not on this form will be returned.

Prior authorization requests for Inpatient, Outpatient Procedures and 23-hour Observation can receive online approval. Simply select the option to apply MCG criteria and answer a few clinical questions. If the authorization meets specific criteria you will receive online approval and a reference number. Your request will be recorded in our computer system real time as it is received. This service is available 24-hours-a-day, 7-days-a-week for all registered BlueCross BlueShield of Tennessee Providers.

#### DRG Inpatient Stays

- Contact the BlueCross BlueShield of Tennessee UM Department on the date specified with current clinical information.
- Clinical information is needed in order to implement and to discuss discharge planning efforts. Date of update will be determined at the time of call from Provider.
- DRG admissions will be assigned a length of stay. Date of update will be determined at the time of call from Provider.
- All claims submitted for DRG reimbursement with outlier days will be reviewed for Medical Necessity.

#### Per Diem Admissions Needing Extensions

- Contact the BlueCross UM Department with the required clinical information on the originally scheduled day of discharge when a Member's condition indicates a need for additional days. Extension requests can also be arranged via telephone, facsimile, or eHealth Services® via Availity, the secure area on BlueCross' website, [www.bcbst.com](http://www.bcbst.com).

#### Discharge Dates

- Discharge information should be sent daily to BCBST to help ensure appropriate Member follow up and coordination of care. Discharge dates may be entered via the web, e-mailed to [dccdates@bcbst.com](mailto:dccdates@bcbst.com), faxed to (423)591-9501, or toll-free to 1-855-339-9781 for all lines of business. If faxing or e-mailing, Providers may submit one list with all Member names as long as the appropriate line of business to which the Member belongs is indicated. Provider cover sheets should include the facility name and NPI number to help ensure appropriate and efficient processing.

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## C. Medical Review Requirements

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Types of reviews required are subject to change. Providers will be notified of any changes in review requirements through quarterly updates to this Manual, *BlueAlert* monthly provider newsletter, and other BlueCross communications, including the BlueCross company website, [www.bcbst.com](http://www.bcbst.com). All information is subject to verification by review of the medical record and other sources. (See *Medical record submission guidelines* later under "Provider Appeal Process".)

When prior authorization\* is required, Providers must obtain authorization prior to scheduled services or within 24 hours/the next business day of emergent services. Failure to comply within specified authorization timeframes will result in a denial or reduced benefits due to non-compliance, and **BlueCross participating Providers will not be allowed to bill Members for Covered Services rendered, except for any applicable copayment/deductible and coinsurance amounts.** Prior authorization requests may be requested via e-Health Services® via Availity, the secure area on the company website, [www.bcbst.com](http://www.bcbst.com), called in to 1-800-924-7141 or faxed to 1-866-558-0789 using the appropriate BlueCross fax form located at <http://www.bcbst.com/providers/forms/>.

Requests for tests, procedures, or services requiring prior authorization must contain adequate information for review. Requests for authorization where additional information is requested but not received by the end of the next calendar day will be denied for lack of information. Covered Services that have not been authorized may **not** be billed to the Member. The Practitioner may appeal a denial due to lack of information to BlueCross within 180 days of notification of denial.

*\*BlueCross administers both insured and self-funded arrangements. Because of differences in relationships, some prior authorization requirements as well as benefit coverages may differ. Benefits are always subject to verification of eligibility and coverage at the time services are rendered.*

The following describes specific medical review guidelines:

## 1. Inpatient Admission

### a. Acute Care Facility

All inpatient stays require prior authorization. Authorization will be issued when care and treatment are determined to be Medically Necessary and Appropriate in an inpatient setting. Scheduled inpatient stays require admission the morning of a procedure in nearly all instances.

***Basic information needed for processing a prior authorization request:***

- Member's identification number and name;
- Patient's name and date of birth;
- Practitioner's name, provider number and/or National Provider Identifier (NPI), address, telephone number and caller's name;
- Hospital/Facility's name, provider number and/or NPI, address, telephone number, caller's name.

***Clinical information required for prior authorization:***

- Procedure/Operation to be performed, if applicable;
- Diagnosis with supporting signs/symptoms;
- Vital signs and abnormal lab results;
- Elimination status;
- Ambulatory status;
- Hydration status;
- Co-morbidities that impact patient's condition;
- Complications;
- Prognosis or expected length of stay;
- Current medications.

### b. Skilled Nursing Facility (SNF)

All inpatient stays require prior authorization. Authorization will be issued when care and treatment are determined to be Medically Necessary and Medically Appropriate in an inpatient setting. Skilled services are services requiring the skills of qualified technical or professional health personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, and/or audiologists. Skilled services must be provided directly by or under the general supervision of technical or professional health care personnel.

***Basic information needed for processing a prior authorization request:***

- Member's identification number and name;
- Patient's name and date of birth;
- Practitioner's name, provider number and/or NPI, address, telephone number and caller's name;
- Hospital/Facility's name, provider number and/or NPI, address, telephone number, caller's name;
- Initial review, concurrent review or reconsideration request with admission date, admitting diagnosis, symptoms, treatment; and
- Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care that would influence the Medical Necessity determination.

If a covered benefit, SNF admission may be approved for Members with **all** the following:

- A condition requiring skilled nursing services or skilled rehabilitation services on an inpatient basis at least daily;



- A Practitioner's order for skilled services;
- Ability and willingness to participate in ordered therapy;
- Medical Necessity for the treatment of illness or injury (this includes the treatment being consistent with the nature and severity of the illness or injury and consistent with accepted standards of medical practice); and
- Expectation for significant reportable improvement within a predictable amount of time.

### **Evaluation and Plan of Care**

- Evaluation of the Member must be submitted including the following as appropriate:

- |  |   |
|--|---|
| • Primary diagnosis                            | • Circulation and sensation                 |
| • Ordering Practitioner and date of last visit | • Gait analysis                             |
| • Date of diagnosis onset                      | • Cooperation and comprehension             |
| • Baseline status                              | • Developmental delays (pediatric patients) |
| • Current functional abilities                 | • Other therapies or treatments             |
| • Functional potential                         | • Patient's goals                           |
| • Strength                                     | • Medical compliance                        |
| • Range of Motion                              | • Support system                            |

- Plan of care must be submitted including the following as appropriate:

- |                              |  |
|------------------------------|--|
| • Short- and Long-term goals | • Proposed admission date                |
| • Discharge goals            | • Frequency of treatment                 |
| • Measurable objectives      | • Specific modalities, therapy, exercise |
| • Functional objectives      | • Safety and preventive education        |
| • Home program               | • Community resources                    |

### **Therapy Services**

Therapy services appropriate for skilled nursing facilities include occupational therapy, physical therapy and speech therapy not possible on an outpatient basis. Specific therapy services that may be appropriate for a SNF include, but are not limited to the following:

- Complex wound care requiring hydrotherapy; and
- Gait evaluation and training to restore function in a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality.

### **Nursing Services**

Nursing services appropriate for skilled nursing facilities include skilled nursing services not possible on an outpatient basis. Specific nursing services that may be appropriate for a SNF include, but are not limited to the following:

- Intramuscular injections or intravenous injections or infusions;
- Initiation of and training for care of newly placed
  - Tracheostomy
  - Pain Management
  - In-dwelling catheter with sterile irrigation and replacement
  - Colostomy
  - Gastrostomy tube and feedings
- Complex wound care involving medication application and sterile technique
- Ulcer treatment with any Stage 3 or 4 pressure ulcer or 2 or more ulcers

### Nursing and Therapy Services Not Requiring SNF Placement

Skilled nursing facility placement is not necessary for the services listed below. This list is **not** all-inclusive.

- Administration of routine oral, intradermal or transdermal medications, eye drops, and ointments;
- Custodial services, e.g., non-infected postoperative or chronic conditions;
- Activities or programs primarily social or diversional in nature;
- General supervision of exercises in paralyzed extremities, not related to a specific loss of function;
- Routine care of colostomy or ileostomy;
- Routine services to maintain functioning of in-dwelling catheters;
- Routine care of incontinent patients;
- Routine care in connection with braces and similar devices;
- Prophylactic and palliative skin care (i.e., bathing, application of creams, or treatment of minor skin problems);
- Duplicative services - Physical therapy services that are duplicative of Occupational Therapy services being provided or vice versa;
- Invasive procedures (i.e., iontophoresis involving needle);
- General supervision of aquatic exercise or water-based ambulation;
- Heat modalities (hot packs, diathermy or ultrasound) for pulmonary conditions or wound treatment, or as a palliative or comfort measure only (whirlpool and hydrocollator);
- Hot and cold packs applied in the absence of associated modalities;
- Diagnostic procedures performed by a Physical Therapist (i.e., nerve conduction studies); and
- Electrical stimulation for strokes when there is no potential for restoration of functional improvement. *Nerve supply to the muscle must be intact.*

### Extension of Services

Extension of services requires the following documentation:

- Clinical progress in meeting goals
- Updated goals
- Compliance & participation with any ordered therapy
- Discharge plans & target date

### c. Rehabilitation Facility

All inpatient stays require prior authorization. Authorization will be issued when care and treatment are determined to be Medically Necessary and Medically Appropriate in an inpatient setting. Inpatient Rehabilitation provides multidisciplinary, structured, intensive therapy for Members both requiring and able to participate in a **minimum of 3 hours of daily therapy for 5 days**. Rehabilitation goals are to prevent further disability, to maintain existing ability, and to restore maximum levels of functioning within the limits of the Member's impairment.

Potential inpatient rehabilitation admissions include Members with recent CVA, head trauma, multiple trauma, or spinal cord injury.

### ***Basic information needed for processing a prior authorization request:***

- Member's identification number and name;
- Patient's name and date of birth;
- Practitioner's name, provider number and/or NPI, address, telephone number and caller's name;
- Hospital/Facility's name, provider number and/or NPI, address, telephone number, caller's name;

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- Initial review, concurrent review or reconsideration request with admission date, admitting diagnosis, symptoms, treatment, frequency of therapies, Member's ability to participate in treatment;
- Member is ventilator dependent or not; and
- Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care that would influence the Medical Necessity determination.

If a Covered Service, inpatient rehabilitation admission may be approved for Members with **all** the following:

- Rehabilitative potential, to include assessment and/or Functional Independence Measure Score (FIMS) of impairment from illness or injury and premorbid condition;
- Ability and willingness to actively participate in a minimum of 3 hours of daily therapy, 5-days-per-week;
- A condition requiring 24-hour rehabilitation nursing and 24-hour availability of a Practitioner with special training in the field of rehabilitation;
- A requirement for at least 2 therapies and a multidisciplinary team approach;
- Medical Necessity for the treatment of illness or injury (this includes the treatment being consistent with the nature and severity of the illness or injury, and consistent with accepted standards of medical practice);
- Acute medical condition stabilized;
- Reasonable and reportable goals in a written plan of care submitted with the request for admission; and
- Documented family commitment to the rehabilitation program (where family involvement will eventually be required).

In addition, a request for an additional inpatient rehabilitation admission for a Member previously admitted to inpatient rehabilitation for essentially the same condition needs to be carefully assessed. The date and length of previous rehabilitation, along with the improvement attained, need to be carefully considered. Alternatives in these cases may be outpatient rehabilitation, home therapy or therapies, or skilled nursing facility (SNF) placement.

### Evaluation and Plan of Care

➤ Evaluation of the Member must be submitted including the following as appropriate:

- |  |   |
|--|---|
| • Ordering Practitioner and date of last visit | • Gait analysis                             |
| • Primary diagnosis                            | • Circulation and sensation                 |
| • Date of diagnosis onset                      | • Cooperation and comprehension             |
| • Baseline status                              | • Developmental delays (pediatric patients) |
| • Current functional abilities                 | • Other therapies or treatments             |
| • Functional potential                         | • Patient's goals                           |
| • Strength                                     | • Medical compliance                        |
| • Range of Motion                              | • Support system                            |

➤ Plan of care must be submitted including the following as appropriate:

- |                              |  |
|------------------------------|--|
| • Short- and Long-term goals | • Proposed admission date                |
| • Discharge goals            | • Frequency of treatment                 |
| • Measurable objectives      | • Specific modalities, therapy, exercise |
| • Functional objectives      | • Safety and preventive education        |
| • Home program               | • Community resources                    |

### Extension of Services

Extension of services requires the following documentation:

- Clinical progress in meeting goals
- Updated goals
- Compliance & participation with therapy
- Discharge plans & target date
- Team conference reports (at least every two weeks or with any significant change in the Member's condition)

**Note:** A sample copy of the Skilled Nursing Facility/Inpatient Rehabilitation form is available on the BlueCross Provider page on the company website, [www.bcbst.com](http://www.bcbst.com).

## 2. Emergency Admission

In-network Providers are responsible for contacting BlueCross BlueShield of Tennessee within 24 hours or the next business day of the inpatient admission. Although emergency procedures do not require prior authorization, benefits are subject to verification for Medical Necessity and Medical Appropriateness and eligibility of coverage.

In the event that an emergency hospital admission or emergency outpatient service occurs after normal office hours, you may submit the information via our website, [www.bcbst.com](http://www.bcbst.com), for registered users, or contact the Utilization Management Department within 24 hours or the next business day. If the Member is still admitted at that time, an admission review will be initiated. If the Member has been admitted and discharged, or has already received an emergency outpatient service, a retrospective review will be completed.

## 3. Observation Stays

Prior authorization for 23-hour observation stays **through the emergency room** is not required for commercial Members. Observation for elective services, direct admissions from the Physician's office, or a transfer from another facility require prior authorization.

The goal of observation stays is to either complete treatment, e.g., hydration, or rule out need for inpatient stays; (e.g., chest pain is not caused by an acute myocardial infarction). Members in this status may advance to admission status if the clinical situation warrants. Admissions need to be reported to the Utilization Management Department before a scheduled admission, or, within the next business day for emergency admissions to determine Medical Necessity and Medical Appropriateness.

### ***23-Hour Observation Room Services Policy***

The medical record must support the need for observation and a specific Practitioner's order for observation must be documented. The record must also show the time and date of arrival and discharge from the facility.

## 4. Non-Compliance

Services requiring prior authorization rendered without obtaining approval are considered "non-compliant." Emergency admissions require authorization within **24 hours or one (1) business day after services have started or within 24 hours or one (1) business day after conversion from observation to inpatient status**. When prior authorization is required, Provider must obtain authorization prior to scheduled services. Non-compliance applies to initial as well as concurrent review for ongoing services beyond dates previously approved.

Failure to comply within specified authorization timeframes will result in a denial or reduced benefits due to non-compliance. BlueCross BlueShield of Tennessee Providers cannot bill Members for Covered Services denied due to non-compliance by the Provider.

If a Member does not inform the Provider that he/she has BlueCross BlueShield of Tennessee coverage and the Provider discovers that the Member **does have** BlueCross BlueShield of Tennessee coverage,

the Provider should send a copy of the medical record relevant to the admission or services, along with the face sheet, including the reason the authorization was not obtained. The medical records will be reviewed only when a valid reason for not obtaining a prior authorization is provided with the request. Providers should follow the Provider appeal process within sixty (60) days of the initial denial.

An appeal will only be overturned if Medical Necessity is determined and there is clear evidence that the facility was not aware that the Member had BlueCross BlueShield of Tennessee coverage at the time services were rendered.

## **5. Maternity, Labor and Delivery, Newborn**

Normal deliveries do not require notification or authorization. Complication of pregnancy continues to require authorization. Direct admissions to 23-hour observation will follow observation guidelines and will require prior authorization.

### **Newborns require notification/prior authorization if:**

- continued hospitalization is required after the mother has been discharged; or
- admitted to any level other than well-baby nursery; or
- transferred to another facility due to their fragile condition.

## **6. Home Health Services/Skilled Nursing Visits**

Home health services may require prior authorization. Home health services are hands-on, skilled care/services, by or under the supervision of a registered nurse that are needed to maintain the Member's health or to facilitate treatment of the Member's illness or injury. In order for the services to be covered under BlueCross BlueShield of Tennessee, the Member must have a medical condition that makes him/her unable to perform personal care and meet Medical Necessity and Medical appropriateness criteria. Documentation must support the Member's limitations, homebound status, and the availability of a caregiver/family and degree of caregiver/families' participation/ability in Member's care.

### **Home Health Services normally covered include, but are not limited to:**

- Part-time intermittent Skilled Nursing Services
- Medical Social Service
- Home Infusion Therapy
- Dietary guidance
- Rehabilitative Therapies such as physical therapy, occupational therapy, etc.

### **Home Health Services not normally covered include, but are not limited to:**

- |                                      |                        |
|--------------------------------------|------------------------|
| • Non-treatment services             | • Social casework      |
| • Routine transportation             | • Meal delivery        |
| • Homemaker or housekeeping services | • Personal hygiene     |
| • Behavioral counseling              | • Convenience items    |
| • Supportive environmental equipment | • Home Health Aides    |
| • Maintenance or custodial care      | • Private Duty Nursing |

### **In order for an approval of Skilled Nursing/Home Health Visit services to be issued, the following criteria must be met:**

- The Member requires the skills of a nurse on an intermittent basis;
- The Member has a condition that requires active skilled care;
- The services must be reasonable and necessary to the care of the condition; and
- The Member must be determined by BlueCross BlueShield of Tennessee to be homebound during the episode of care.

**Documentation for prior authorization:**

- Practitioner's verbal or signed medical orders and plan of care for dates of service;
- Number of services requesting;
- Nurse's visit and progress notes;
- Therapist's visit and progress notes, if applicable;
- Availability of a caregiver; and
- Homebound status.

Home health visits should be for skilled nursing services. Visits for assessment and teaching should be for services beyond those one would expect to be taught in the Practitioner's office and the request must include the frequency and duration of services, and must specify what services are to be provided. An insulin-dependent diabetic may have up to three skilled nursing visits to teach diabetic care. However, these visits should be lengthy, comprehensive and show evidence that clinical problem solving is actively used.

## **7. Transitional Care/Discharge Planning**

BlueCross BlueShield of Tennessee acknowledges a vested interest in assuring patient care is provided in the most appropriate setting and will continue to assist Providers with discharge planning for its patients who are BlueCross BlueShield of Tennessee Members. Discharge planning should begin upon admission. BlueCross BlueShield of Tennessee transition of care/discharge planning nurses will assist Providers and Members upon admission, during the prior authorization process, or prior to admission if a scheduled admission. Authorization for the following services should be completed and Providers notified of the determination **prior** to the anticipated discharge and service date:

- Hospital admissions, select procedures;
- Skilled nursing facility/restorative care unit admissions;
- Inpatient rehabilitation admission;
- Home health services (skilled nursing visits and home infusion therapy);
- Certain durable medical equipment;
- Speech therapy, occupational therapy, physical therapy;

## **8. Cosmetic Surgery**

Cosmetic surgery is not a Covered Service. However, breast reconstructive and symmetry surgery following a mastectomy is a Covered Service.

- Reconstructive breast surgery, in all stages, on the diseased breast as a result of a mastectomy (not including a lumpectomy) is considered Medically Necessary.

## **9. Out-of-Network Services**

Benefits may be limited, reduced or not be available in accordance with the terms of the Member's health care benefits plan even if required prior authorization is obtained.

Emergency out-of-network services (based on admitting and discharge diagnosis filed on claim) are covered, but must be reported to BlueCross BlueShield of Tennessee within 24 hours or the next business day. BlueCross BlueShield of Tennessee may need to assist the Provider in returning the Member to the network when it is medically safe.

## **10. Transplant Services**

Please see Section X. Case Management for transplant specifics.

## **11. Hospice Services**

Hospice services are for terminally ill Members where life expectancy is six (6) months or less and may require prior authorization.

**Hospice services normally covered include, but are not limited to:**

- Part-time intermittent nursing care
- Bereavement counseling
- Home health aide services
- Medical social services
- Medications for control or palliation of the illness
- Physical or respiratory therapy for symptom control

**Hospice services not normally covered include, but are not limited to:**

- Homemaker or housekeeping services
- Meals
- Supportive environmental equipment
- Private Duty Nursing
- Routine transportation
- Funeral or financial counseling
- Practitioner visits
- Inpatient and outpatient care
- Ambulance
- Chemotherapy
- Radiation therapy
- Enteral and parenteral feeding
- Home hemodialysis
- Psychiatric care
- Convenience or comfort items not related to the illness

## **12. Ambulatory Surgeries (Appropriateness Review), Diagnostic & Other Procedures**

Some outpatient surgical/diagnostic procedures may require prior authorization. These procedures may be performed in outpatient surgical facilities, hospital outpatient departments, outpatient diagnostic centers, and in Practitioners' offices. Providers may call Customer Service at the phone number listed on the Member's ID card to determine prior authorization requirements. Some procedures do not require prior authorization if performed on an outpatient basis; however, if performed as 23-hour observation or on an inpatient basis, a prior authorization is required for the hospitalization. Non-emergency elective procedures should be submitted up to thirty (30) days, but not less than 24 hours prior to the scheduled procedure. Failure to obtain prior authorization will result in denial of payment for Covered Services.

Prior authorization is required for the following procedures performed in an inpatient or outpatient setting:

- Blepharoplasty (if Covered)
- Vein ligation
- Bariatric procedures (if Covered)
- Hysterectomy
- Breast Augmentation/Reduction
- Panniculectomy
- Endometrial Ablation
- Hyperbaric Treatments
- Occipital Nerve Neurostimulator Implantation
- Neurostimulator Implantation for Fecal and Urinary Incontinence
- 72-hour Glucose Monitoring
- Gender Reassignment Surgery (if Covered)
- Molecular Markers in Fine Needle Aspiration of the Thyroid

Covered Services that have not been authorized may **not** be billed to the Member if rendered by a BlueCross BlueShield of Tennessee network Provider. Denials for failure to request an authorization must be appealed within sixty (60) days of notification of denial. This does not preclude Provider responsibility for claims timely filing requirements. The Practitioner may appeal a Medical Necessity denial to BCBST within 180 days of notification of denial.

**Note:** *Select outpatient procedures are subject to focused retrospective review.*

Providers should call the BlueCross Provider Service line, 1-800-924-7141, or visit e-Health Services® at [www.bcbst.com](http://www.bcbst.com) to determine prior authorization requirements.

### 13. Specialty Pharmacy Medications

Certain high-risk/high-cost specialty pharmacy medications administered in any setting other than inpatient hospital requires prior authorization for all lines of business. This authorization requirement applies to all Provider types including home infusion therapy Providers, specialty pharmacies, hospitals providing outpatient infusions, and injections.

A complete listing of Provider-Administered Specialty Pharmacy drugs can be found at <https://www.bcbst.com/docs/pharmacy/provider-administered-specialty-pharmacy-list.pdf>. Those requiring prior authorization under the Member's medical benefits plan are identified by "PA". Drugs that do not require a prior authorization will require adherence to BCBST Medical Policy.

Practitioners may contact one of our Specialty Pharmacy Network vendors to obtain a specialty drug. The specialty pharmacy will obtain the necessary information and will request prior authorization. The pharmacy will ship the drug to either the Provider's office (for Provider-Administered drugs) or directly to the Member (for Self-Administered drugs). The specialty pharmacy will bill BlueCross for the drugs and collect any necessary copays or coinsurance from the Member. A complete listing of BlueCross Specialty Pharmacy vendors are located online <https://www.bcbst.com/docs/pharmacy/specialty-pharmacy-network.pdf>.

If the Provider is supplying a Provider-Administered drug that requires prior authorization, they must call BlueCross Utilization Management department at 1-800-924-7141 and choose the "Specialty Pharmacy" authorization option or submit the request via Availity, BCBST's secure portal on bcbst.com. This will route to Magellan RX Management, our Specialty Pharmacy Network vendor, who may request additional information if required to complete the review process.

In addition to the Member information, the following is required when requesting prior authorization for Provider-Administered specialty drugs:

- Provider NPI Number (more than one of your subsidiaries may share the same number)
- Tax ID Number (more than one of your subsidiaries may share the same number)
- Appropriate Taxonomy Code in Block 33b (taxonomy code should be specific for specialty pharmacy, HIT, etc.)
- HCPCS Code (J, Q or S code)
- Drug Name
- Strength of Drug
- National Drug Code (NDC)
- Number of Units being billed
- Frequency of Dosing
- Dosage
- Days' Supply if billing an "ambulatory" drug on a medical claim (for example, when accepting Assignment of Benefits for Members who have to pay 100 percent up front)
- Clinical Information to support the request (Reference the BlueCross Medical Policy Manual)

**Note:** *New drugs may be periodically added to the specialty pharmacy list and those products requiring authorization are subject to change. Changes will be communicated via BlueAlert newsletter or updates to this Manual.*

The specialty medication section of the *BlueCross BlueShield of Tennessee Medical Policy Manual* includes decision support trees for Provider-Administered drugs to assist Providers considering use of these medications. Providers can select the appropriate drug from the manual at <http://www.bcbst.com/mpmanual/!SSL!/WebHelp/mpmprov.htm> and connect to the decision support tree in the policy.



If you are not satisfied with the decision by Magellan RX Management, you may file a Provider appeal by sending a written request, along with the supporting documentation, a copy of the denial notice and any pertinent medical information to:

Magellan RX Management  
Attn: Appeals Department  
PO Box 1459  
Maryland Heights, MO 63043  
Phone: 1-800-424-8240  
Fax: 1-888-656-6805

Self-Administered Specialty Pharmacy drugs are found in the Preferred Formulary guidebook and are marked with a "PA" indicator to reflect which drugs require prior authorization. For Self-Administered drugs requiring prior authorization, and NOT supplied by a Specialty Pharmacy Network vendor, the Provider may call 1-877-916-2271.

For additional information on Specialty Pharmacy Medications, see Section XIX. Pharmacy, in this Manual.

## **14. Home Infusion Therapy**

Home Infusion Therapy (HIT) is the administration of medications, nutrients or other solutions intravenously, subcutaneously, epidurally, intramuscularly or via implanted reservoir while in the Member's **private residence**. A request for HIT originates with prescription from a qualified Practitioner to achieve defined therapeutic results. HIT must be provided by a licensed pharmacy. Home nursing for patient education, medication administration, training, and monitoring are handled directly by a qualified home health agency.

A complete listing of Provider-Administered Specialty Pharmacy drugs can be found at <https://www.bcbst.com/docs/pharmacy/provider-administered-specialty-pharmacy-list.pdf>. Those requiring prior authorization under the Member's medical benefits plan are identified by "PA".

Authorization listings are subject to change; Changes will be communicated via *BlueAlert* newsletter or updates to this Manual. Case Management may assist the Practitioner in arranging HIT for extraordinary cases and when Medical Necessity and Medical Appropriateness warrant close attention.

When an authorization is needed, specific information is required. Authorizations are valid for the dates approved; any break in service requires a new authorization. HIT Providers requesting approval of HIT services should submit the following information to Magellan RX Management:

- Member name, address, date of birth, sex, ID number;
- Practitioner name, address, phone number;
- HIT agency name, address, phone number, HIT-related provider number and/or National Provider Number (NPI) and a contact person;
- Type of request: initial prior authorization, extension of services or change of services;
- Type of therapy (e.g., palliative, long-term therapy, short-term antibiotic therapy) should include dosage, frequency, date and length of service, including NDC number, HCPCS code and grams of protein for TPN;
- Primary and HIT diagnosis;
- Clinical documentation (e.g., lab values, cultures, X-rays) to support reason and need for HIT services; and
- A Practitioner's verbal or signed medical order.

The administration of intramuscular (IM) drugs (Rocephin, Phenergan, Procrit, etc.) is not considered HIT and therefore, should not receive HIT benefits. If nursing is required to administer the drug and/or

conduct teaching for the Member, these services may require prior authorization under Home Health guidelines. If the HIT Provider is dispensing the drug, they are required to follow the Pharmacy Benefits Manager (PBM) requirements for prior authorization. All self-administered drugs must be authorized and billed through the Member's appropriate PBM. (See Section XIX. Pharmacy in this Manual.)

Authorization decisions will be phoned, faxed, sent electronically, or mailed to the HIT Provider, the prescribing Practitioner and Member. Adverse decisions are rendered if Medical Necessity and Medical Appropriateness are not shown.

If you are not satisfied with the decision by Magellan RX Management, you may file a Provider appeal by sending a written request, along with the supporting documentation, a copy of the denial notice and any pertinent medical information to:

Magellan RX Management  
Attn: Appeals Department  
PO Box 1459  
Maryland Heights, MO 63043  
Phone: 1-800-424-8240  
Fax: 1-888-656-6805

#### **Extension of Services**

When prior authorization is required and services are needed beyond the number of days authorized by BlueCross BlueShield of Tennessee, the HIT supplier must have the additional services authorized.

#### **Changes/Termination in Services**

When prior authorization is required, the HIT Provider must notify Magellan RX Management of any changes in therapies/medication, dosages, and/or an order for discontinuation by the ordering Practitioner, during the time frame authorized.

## **15. Rehabilitation Therapy Outpatient Services**

Therapies/Rehabilitative services must be Medically Necessary and Medically Appropriate therapeutic and rehabilitative services intended to restore or improve bodily function lost as a result of illness or injury.

Prior authorization requirements for Cardiac Rehabilitation services are driven by the Member's health care benefit plan. BlueCross BlueShield of Tennessee administers both insured and self-funded arrangements and because of differences in relationships, some prior authorization requirements may differ.

To ensure appropriate payment is made for Cardiac and Pulmonary Rehabilitation services, Providers are encouraged to verify the Member's health care benefit plan's prior authorization requirements by calling the Provider Services line, 1-800-924-7141 or via e-Health Services® at [www.bcbst.com](http://www.bcbst.com). For those health care benefit plans requiring prior authorization, penalties will continue to apply for non-compliance.

#### **Therapy services normally covered include:**

- Outpatient, home health or office therapeutic and rehabilitative services, which are expected to result in significant and measurable improvement in the Member's condition resulting from an acute disease or injury. The services must be performed by, or under the direct supervision of a licensed therapist. (See medical policy regarding "Staff Supervision Requirement for Delegated Services" and "Staff Practitioner to Whom Services may be Delegated" in the BlueCross BlueShield of Tennessee Medical Policy Manual at <http://www.bcbst.com/providers/mpm.shtml>);
- Services must be performed in a Practitioner's office, outpatient facility or home health setting;

**Therapy services normally covered include (cont'd):**

- Physical Therapy;
- Speech Therapy (limited to coverage for disorders of articulation and swallowing, following an Acute illness);
- Occupational Therapy;
- Manipulative Therapy; and
- Cardiac and Pulmonary Rehabilitative services.

**Therapy services normally not covered include, but are not limited to:**

- Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care;
- Enhancement therapy which is designed to improve the Member's physical status beyond their pre-injury or pre-illness state;
- Complementary and alternative therapeutic services, which include, but are not limited to:
  - Massage therapy
  - Acupuncture
  - Craniosacral Therapy
  - Neuromuscular Reeducation
  - Vision Exercise Therapy
  - Cognitive Therapy
- Modalities that do not require the attendance of a licensed therapist:
  - Activities which are primarily social or recreational in nature
  - Simple exercise programs
  - Hot and cold packs applied in the absence of associated therapy modalities
  - Repetitive exercises or tasks which can be performed by the Member without a therapist, in a home setting
  - Routine dressing changes
  - Custodial services that can ordinarily be taught to a caregiver or the Member themselves.
  - Behavioral therapy
  - Play therapy,
  - Communication therapy
  - Therapy for self correcting language dysfunctions
  - Duplicate therapy (therapies should provide different treatments and not duplicate the same treatment).

**a. Speech Therapy Services (provided in a non-acute setting)**

In order for Speech Therapy services to be considered for benefits, the services must be Medically Necessary and Medically Appropriate to the treatment of the Member's illness or injury. Unskilled services are not eligible for coverage.

***The following information must be included when authorization request is submitted:***

- Date of last visit
- Primary diagnosis
- Date of diagnosis onset
- Baseline status/current abilities
- Functional potential
- Prior level of functioning
- Diagnostic and assessment services used to ascertain the type, causal factors, and severity of speech and language disorders
- Support system
- Developmental delays
- Other therapies or treatments
- Patient's goals
- Therapy compliance
- Prior speech therapy received and outcome

**Treatment Plan**

- Long and short-term goals
- Discharge goals
- Measurable objectives
- Functional objectives
- Home program, if applicable
- Duration of therapy
- Frequency of therapy
- Date therapy is to begin
- Specific therapy techniques

**Note:** *BlueCross BlueShield of Tennessee utilizes MCG criteria when reviewing requests for speech therapy services provided in a non-acute setting.*

**b. Occupational Therapy Services (provided in a non-acute setting)**

In order for occupational therapy services to be considered for benefits, the services must be Medically Necessary and Medically Appropriate to the treatment of the Member's illness or injury. Unskilled services are not eligible for coverage.

***The following information must be included when authorization request is submitted:***

- Date of last visit
- Primary diagnosis
- Date of diagnosis onset
- Baseline status/current abilities
- Functional potential
- Prior level of functioning
- Diagnostic and assessment services used to ascertain the type, causal factors, and severity of dysfunction or disorders
- Support system
- Developmental delays
- Other therapies or treatments
- Patient's goals
- Medical compliance
- Prior occupational therapy received and outcome

**Treatment Plan**

- Long and short-term goals
- Discharge goals
- Measurable objectives
- Functional objectives
- Home program
- Duration of therapy
- Frequency of therapy
- Dates of service
- Specific modalities and therapy

**Note:** *BlueCross BlueShield of Tennessee utilizes MCG criteria when reviewing requests for occupational therapy services provided in a non-acute setting.*

**c. Physical Therapy Services (provided in a non-acute setting)**

In order for physical therapy services to be considered for benefits, the services must be Medically Necessary and Medically Appropriate to the treatment of the Member's illness or injury. A prior authorization may be required for physical therapy based on the Member's benefit coverage. Unskilled services are not eligible for coverage.

***The following information must be included when authorization request is submitted:***

- Date of last visit
- Primary diagnosis
- Baseline status
- Functional potential
- Current functional abilities
- Strength
- ROM
- Circulation and sensation
- Cooperation and comprehension
- Support system
- Developmental delays/pediatrics
- Other therapies, treatments, chiropractic
- Patient's goals
- Medical compliance
- Homebound status

**Treatment Plan**

- Short- and Long-term goals
- Discharge goals
- Measurable objectives
- Functional objectives
- Home exercise program
- Time frame (frequency and duration)
- Date therapy is to begin
- Frequency of treatment
- Specific modalities, therapy, exercise
- Safety and preventive education
- Community resources

BlueCross BlueShield of Tennessee utilizes MCG criteria when reviewing requests for physical therapy services provided in a non-acute setting.

**16. Medical Supplies (Outpatient Rehabilitation Services)**

The following coverage criteria apply to medical supplies billed to BlueCross BlueShield of Tennessee:

- Records must clearly support that supplies were used during the Member's treatment.
- Must be prescribed by the Member's Practitioner.
- Must be Medically Necessary and Medically Appropriate for treating illness or injury.
- Generally recognized as therapeutically effective and primarily medical in nature.
- Must be at the level and quality required (not "luxury" in nature).
- Cannot be for environmental control, personal hygiene, comfort, or convenience.
- Cannot be reusable.
- Supplies required for use with rental items are included in the rental fee.

**17. Durable Medical Equipment**

Durable Medical Equipment (DME) purchases, rentals, or repairs require prior authorization for most lines of business. DME may be subject to retrospective review for Medical Necessity.

DME may be covered if it is determined to be Medically Necessary and Medically Appropriate for the Member's condition. The following guidelines and documentation requirements apply to DME whether equipment is purchased or rented:

- The Member's diagnosis should substantiate the need and use of the equipment in the medical record.
- Documentation of the Member's capability to be trained in the appropriate use of the equipment.
- Rental equipment is generally considered equipment that requires frequent and substantial servicing and maintenance and/or estimated period of use is finite.
- Certain rented DME is purchased after the equipment has been rented for a total of ten (10) months.
- Documentation for customized equipment should specify the need for the custom equipment versus standard equipment.
- Reimbursement may be determined for a more cost-effective alternative if medical necessity and appropriateness for the equipment is not demonstrated in the documentation submitted for review.

**Information that needs to be submitted with the claim and/or prior authorization (when applicable) request:**

- Practitioner's order (if not submitted with the claim, it may be requested at any time and payment recouped if unavailable);
- Member's diagnosis and expected prognosis;
- Estimated duration of use;
- Limitations and capability of the Member to use the equipment;
- Itemization of the equipment components, if applicable;
- Appropriate HCPCS codes for equipment being requested; and
- The Member's weight and/or dimensions (needed to determine coverage of manual or power wheelchairs), if available.

**The following guidelines apply to reimbursement for repair of DME equipment:**

- Equipment less than one (1) year old requires documentation related to the warranty coverage. Repairs that are covered by the warranty will not be reimbursed by BlueCross BlueShield of Tennessee;
- Documentation supporting need for services and/or items being billed; initial purchase date of equipment should be included, if available; and
- Prior authorization may be required for DME repairs for some BlueCross BlueShield of Tennessee lines of business.

BlueCross BlueShield of Tennessee will **only** provide benefits for Medically Necessary and Medically Appropriate Equipment. Requests for extraordinary items require justification.

BlueCross BlueShield of Tennessee will **not** provide benefits for Investigational Durable Medical Equipment.

## **18. Advanced Imaging/High Tech Imaging**

Prior authorization\* is required for select advanced imaging radiology procedures performed in an outpatient setting. Prior authorization reviews for these cases are processed by our High Tech Imaging vendor on behalf of BCBST. Prior authorization is **not** required for imaging procedures performed during an inpatient admission or emergency room visit.

Procedures requiring prior authorization include, but are not limited to:

- Computed tomography (CT)
- Computed tomography angiography (CTA)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Positron emission tomography (PET)
- Magnetic resonance spectroscopy (MRS)
- Nuclear cardiology

\* Applies to Fully Insured Members. This program is an optional add-on for Administrative Services Only (ASO) Members.

To request prior authorization for any of the previously listed radiology procedures, call our High Tech Imaging vendor at 1-888-693-3211.

## **19. Musculoskeletal (MSK) Management**

The Musculoskeletal Management Program applies to Fully Insured Members. This program is an optional add-on for Administrative Services Only (ASO) Members. Prior authorization is required for select musculoskeletal services and procedures performed in an outpatient or pre-scheduled inpatient setting. Prior authorization is **not** required by the MSK vendor for musculoskeletal procedures performed during an unplanned admission or emergency room visit.

Procedures requiring prior authorization include, but are not limited to:

- Pain Management
- Spinal Surgeries
- Joint Surgeries (Hip, Knee and/or Shoulder)

To request prior authorization for any of the above listed musculoskeletal procedures or services, submit information via the company website, [www.bcbst.com](http://www.bcbst.com), fax to 1-866-747-0587, or call 1-866-747-0586. If questions, call the MSK vendor at 1-866-747-0586.

Note: Medical Records required for **initial** authorization review.

Concurrent review requests beyond the initial authorization will require review through BlueCross BlueShield of TN's normal process (via phone, fax, or Web).

## **20. NICU/SCN through First Year Care Management**

Prior authorization is required for newborns admitted to the Neonatal Intensive Care Unit or Special Care Nursery. Prior authorization reviews for these cases are processed by the NICU vendor on behalf of BCBST, and are reviewed for Medical Necessity throughout the hospitalization. The date of the next clinical review will be determined with each review. The NICU vendor will review:

- Birth inpatient admission to NICU or SCN
- All subsequent inpatient and outpatient admissions through Member's first birthday
- Ancillary services including DME and Home Health through Member's first birthday

To contact the NICU vendor, call 1-888-832-2006.

## **21. Performance Evaluations of Delegate Vendors and Providers**

The BlueCross BlueShield of Tennessee Delegate Oversight Program provides an organized and systematic approach to help ensure oversight of delegated administrative functions, which include Utilization Management, Quality Improvement, Credentialing, Independent Record Review, Case Management, Claims, Customer Service, Complaints, Grievance and/or Appeals, Transportation, EPSDT, and Medical Records Review.

BlueCross BlueShield of Tennessee will, at a minimum, complete an annual assessment of reports and annual performance evaluations of vendors/Providers to whom activities have been delegated. The purpose of a performance evaluation is to ensure compliance with standards of all of the applicable state and federal laws and regulations, as well as those of all applicable accrediting and regulatory review agencies, including but not limited to URAC, Tennessee Department of Commerce and Insurance (TDCI), and BlueCross BlueShield of Tennessee policies and procedures.

The performance evaluation includes, but is not limited to, the following:

- Desktop and /or onsite evaluation of the vendor's/Provider's compliance with all applicable standards
- Documentation and file review to determine the compatibility of the organization's goals and objectives with BlueCross BlueShield of Tennessee goals and objectives
- Criteria, methods, and process for determining Medical Necessity and Medical Appropriateness of care
- Written evaluation of the vendor's/Provider's capabilities to perform delegated functions, staffing capabilities, and performance record

The delegate vendor/Provider will support BlueCross BlueShield of Tennessee in meeting its requirements of annual and periodic performance evaluations by providing access to all records, policies, procedures, reports, and other documents as necessary to demonstrate compliance with the delegate program.

## **22. Second Surgical Opinion**

BlueCross BlueShield of Tennessee will pay for any second surgical opinion requested by a Member. This includes not only major surgery, but also other procedures (e.g., pacemakers, ambulatory surgery procedures, etc.).

The following guidelines apply to Second Surgical Opinions:

- A surgeon (one who is not in the same group or practice as the Practitioner who rendered the first opinion) must render the second opinion.
- The Practitioner rendering the second surgical opinion must be in a BlueCross BlueShield of Tennessee network and proper referrals must be in place, if applicable.

## **23. Non-Emergent Air Ambulance Transportation**

- Prior authorization is required for non-emergent air ambulance transportation.
- Prior authorization is NOT required for emergency air ambulance transportation (e.g., from the scene of an accident when ground transport is not appropriate or would pose a threat to the Member).

To request prior authorization for non-emergent air transportation for a BCBST Member with commercial benefits, call 1-800-515-2121 (extension 6900) from 8 a.m. to 6 p.m. (ET).

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## **D. Emergency Services**

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Emergency Room services for an emergency condition do not require prior authorization. BlueCross BlueShield of Tennessee communicates to its Members to go to the nearest emergency room if they are suffering from an emergency condition.

An emergency is defined as a sudden and unexpected medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect to result in: serious impairment of bodily functions; serious dysfunction of any bodily organ or part; or placing the prudent layperson's health in serious jeopardy. These services may be provided by facility-based providers. It is understood that in those instances where a Physician makes emergency care determinations, the Physician shall use the skill and judgment of a reasonable Physician in making such determinations.

**Note:** *Prior authorization is not required for emergency room visits.*



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## E. Investigational Services

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Investigational services are those services that do not meet BlueCross BlueShield of Tennessee's definition of Medical Necessity. New and established technologies are researched and evaluated by BlueCross BlueShield of Tennessee's Medical Policy Research & Development Department and are assessed using sources that rely upon evidence based studies. Input is also sought from our network Providers.

The definition of "Investigational" is based on the BlueCross BlueShield of Tennessee's technology evaluation criteria. Any technology that fails to meet **ALL** of the following four (4) criteria is considered to be Investigational.

1. The technology must have final approval from the appropriate governmental regulatory bodies, as demonstrated by:
  - This criterion applies to drugs, biological products, devices and any other product or procedure that must have final approval to market from the U.S. Food and Drug Administration or any other federal governmental body with authority to regulate the use of the technology.
  - Any approval that is granted as an interim step in the U.S. Food and Drug Administration's or any other federal governmental body's regulatory process is not sufficient.
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes, as demonstrated by:
  - The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.
  - The evidence should demonstrate that the technology could measure or alter the physiological changes related to a disease, injury, illness, or condition. In addition, there should be evidence or a convincing argument based on established medical facts that such measurement or alteration affects health outcomes.
3. The technology must improve the net health outcome, as demonstrated by:
  - The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
4. The improvement must be attainable outside the Investigational settings, as demonstrated by:
  - In reviewing the criteria above, the Medical Policy Panel will consider Physician specialty society recommendations, the view of prudent medical Practitioners practicing in relevant clinical areas and any other relevant factors.

The Medical Director, in accordance with applicable ERISA standards, shall have discretionary authority to make a determination concerning whether a service or supply is an Investigational Service. If the Medical Director does not authorize the provision of a service or supply, it will not be a Covered Service. In making such determinations, the Medical Director shall rely upon any or all of the following, at his or her discretion:

1. Your medical records, or
2. The protocol(s) under which proposed service or supply is to be delivered, or
3. Any consent document that You have executed or will be asked to execute, in order to received the proposed service or supply, or
4. The published authoritative medical or scientific literature regarding the proposed service or supply in connection with the treatment of injuries or illnesses such as those experienced by You, or

5. Regulations or other official publications issued by the FDA and HHS, or
6. The opinions of any entities that contract with the Plan to assess and coordinate the treatment of Members requiring non-experimental or Investigational Services, or
7. The findings of the BlueCross BlueShield Association Technology Evaluation Center or other similar qualified evaluation entities.

These criteria are used in making such determinations as whether a service is considered to be Investigational or Medically Necessary. Providers have access to these policies via the Medical Policy Manual in the Provider section on the company website, [www.bcbst.com](http://www.bcbst.com) and are also informed of determinations via our monthly *BlueAlert* Newsletter.

If a BlueCross BlueShield of Tennessee Network Provider renders services that are Investigational or do not meet Medically Necessary and Appropriate criteria, the Provider must obtain a written statement from the Member, **prior** to the service(s) being rendered, acknowledging that the Member understands he/she will be responsible for the cost of the specific service(s). It is essential the signed statement be kept on file. It may be necessary to provide a copy of the written statement to BlueCross BlueShield of Tennessee if the Member questions the Member Liability amount reflected on his/her Explanation of Benefits (EOB). Once BlueCross BlueShield of Tennessee contacts the Provider, he/she will be asked to provide a copy of the signed written statement within two (2) business days. If the Provider is not able to supply the written statement, the claim will be adjusted to reflect Provider liability and the Member will not be responsible for those charges.

To help assist in this process, BlueCross BlueShield of Tennessee developed the *Acknowledgement of Financial Responsibility for the Cost of Services* form for Provider use. A sample copy of this form is located in Section V. Member Policy, in this Manual. Providers are encouraged to use this form. The form can also be found in the Provider section of the company website, [www.bcbst.com](http://www.bcbst.com). This form meets the contractual obligations of BlueCross BlueShield of Tennessee Provider Agreements. However, it does not waive Prior Authorization requirements.

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## **F. Medically Necessary and Medically Appropriate Policy**

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BlueCross BlueShield of Tennessee covers Medically Necessary and Medically Appropriate health care services not otherwise excluded under BlueCross BlueShield of Tennessee health care benefits plans.

### **Medically Necessary or Medical Necessity**

“Medically Necessary” refers to procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical Practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient’s illness, injury or disease; and
- not primarily for the convenience of the patient, Physician or other health care Provider; and
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician specialty society recommendations, and the views of medical Practitioners practicing in relevant clinical areas and any other relevant factors.

### Medically Appropriate

“Medically Appropriate” refers to services, which have been determined by BlueCross BlueShield of Tennessee in its discretion to be of value in the care of a specific Member. To be Medically Appropriate, a service must meet all of the following:

1. Be Medically Necessary.
2. Be consistent with generally accepted standards of medical practice for the Member’s medical condition.
3. Be provided in the most appropriate site and at the most appropriate level of service for the Member’s medical condition.
4. Not be provided solely to improve a Member’s condition beyond normal variation in individual development, appearance and aging.
5. Not be for the sole convenience of the Provider, Member or Member’s family.

BlueCross BlueShield of Tennessee may request medical records when the complexity of a case requires a review of the medical records in order to determine if a service is Medically Necessary and Medically Appropriate.

**Note:** *According To Contract, BlueCross BlueShield of Tennessee Will Not Reimburse For Photocopying Expenses.*

BlueCross BlueShield of Tennessee encourages open Practitioner/patient communication regarding appropriate treatment alternatives.

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## G. Prospective and Retrospective Review

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These reviews are conducted based on MCG criteria (if applicable), BlueCross BlueShield of Tennessee adopted utilization management guidelines, BlueCross BlueShield of Tennessee Medical Policy, *Physician’s CPT®*, *CMS Common Procedure Coding System* and the Member’s health care benefits plan. The following listed services are not all-inclusive and may be subject to prospective or retrospective review:

- Possible cosmetic services;
- Potential Investigational services;
- Skilled nursing facility confinements;
- Chiropractic services;
- Outpatient therapies;
- Durable Medical Equipment (when prior authorization is not required);
- Prosthetics, orthotics, and supplies;
- Practitioner office services;
- Dental, accident related, and temporomandibular joint dysfunction;
- Pain management;
- Unbundled codes and/or code combinations; and
- Non-participating provider or no prior authorization obtained.

Types of reviews may change based on policy or guideline changes, identification of the need for focused reviews, etc.

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## H. Provider Appeal Process

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It is the policy of BlueCross BlueShield of Tennessee to make available to treating Practitioners a peer-to-peer review to discuss, by telephone, determinations based on Medical Appropriateness. These reviews can be requested in the following situations:

1. Anytime during the hospital stay;
2. Within twenty-four (24) hours of notification of decision if already discharged; and
3. For elective services, prior to services being rendered or filing an appeal.

Providers can reach a dedicated voicemail system by calling the Provider Service line, 1-800-924-7141, Monday through Thursday, 8 a.m. to 6 p.m. (ET); Friday, 9 a.m. to 6 p.m. (ET). All messages left before 3 p.m. (ET) will be returned the same day. Messages left after 3 p.m. (ET) will be returned the next business day. The voicemail system requires two (2) specific dates and times to schedule the Physician-to-Physician review as well as other Member demographics indicated by the voicemail prompts. If the Provider is still not satisfied following a peer-to-peer discussion, the Provider should proceed to the next level of appeal (i.e., Provider Dispute Resolution).

### Utilization Management Appeals

#### Reconsideration Prior to Service

Additional information may be submitted via the regular authorization process when an adverse determination is issued by BlueCross BlueShield of Tennessee. This information may also be submitted to BlueCross BlueShield of Tennessee from the Provider or Provider representative.

Provider office staff should only initiate a Physician-to-Physician discussion with one of our medical directors when the attending or ordering Physician requests, and is aware of the discussion.

#### Expedited Appeal

- The request for an expedited appeal must be initiated by phone and should include a request for expedited appeal along with any pertinent information not originally submitted.
- An expedited appeal may or may not require a peer-to-peer conversation.
- An expedited appeal can be requested when the Provider believes that the adverse determination:
  1. could seriously jeopardize the life or health of the Member and the ability of the Member to regain maximum function, and/or
  2. in the opinion of the Practitioner with knowledge of the Member's medical condition would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case.

An expedited appeal will be completed and notification issued to the Member and Provider no later than seventy-two (72) hours after initial request of the appeal, however, the clinical circumstances will help determine the speed of the response.

Expedited appeals may be requested by calling the appropriate prior authorization number. You should verbally request the review to be labeled as an expedited appeal in order for BlueCross to assure the review is completed within the timeframe. (Refer to Section II. Quick Reference Telephone Guide in this Manual.)

#### Non-Compliance Denial Appeal

There is no reconsideration of a non-compliance denial. If a party is dissatisfied with a non-compliance denial, they may appeal the denial. Appeals of non-compliance denials must be submitted within sixty (60) days of the initial denial. The request should include a copy of any pertinent clinical information, face sheet, if applicable, and a statement from the Practitioner/Facility indicating the reason(s) for the appeal

and a copy of the denial letter. A determination will be sent to the Practitioner/Facility and/or Member within thirty (30) days of the receipt of the request for appeal. If the party is still dissatisfied with the decision, he/she may proceed to Arbitration pursuant to Section II C. of the PDRP.

### **Standard Appeal**

The standard appeal process can be used if reconsideration resulted in an adverse determination. Requests for standard appeal for Medical Necessity denials **must** be received in writing by the Utilization Management department within 180 days of the date of the initial denial notification. This does not preclude timely filing requirements.

Exhausting the above noted process satisfies Section II. A. and B. of the Provider Dispute Resolution Procedure (PDRP) outlined in Section XIII in this Manual. If the party is still dissatisfied, he/she may appeal the adverse decision pursuant to Section II. C. of the PDRP.

### **Medical record submission guidelines**

Occasionally, medical records are received at BlueCross BlueShield of Tennessee without a clear indication of who requested the information, what is being requested or complete Member identification. Medical records may be submitted via hardcopy, fax or CD-ROM.

When submitting medical records for appeal:

1. Submit any request or notification letter from us as the **first** page of your medical record or the UM appeals form located at <http://www.bcbst.com/providers/forms/Utilization-Management-Appeal-Form.pdf>. **Failure to do so may result in a delayed response to your request or your request being returned until appropriate documentation is supplied.**
2. If submitting multiple records for a single patient or multiple records for multiple Members, ensure the individual records are secured with a clip or other indicator if mailed in the same envelope.
3. Medical records may be submitted through certified mail.
4. Medical records must be legible with all appropriate information pertinent to the presenting case.
5. Include all Member information in a clear, legible format. We must be able to identify the Member and the relationship to BlueCross BlueShield of Tennessee.
6. Claims must be attached **behind** the medical record. If attached to the front, it will be mistaken for a claim needing adjudication rather than a medical record needing review.

Fax Appeal (preferred method) to: (423) 591-9451

Or

Mail Appeal to:

BlueCross BlueShield of Tennessee  
Commercial Appeals/Retrospective Claims Review  
1 Cameron Hill Circle, Suite 0017  
Chattanooga, TN 37402-0017

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## **I. Medical Policy Manual**

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The Medical Policy Manual contains medical policies and Administrative Services policies approved by BlueCross BlueShield of Tennessee. **Medical policies** address specific new medical technologies or pharmaceutical agents.

Medical policies are based upon evidence-based research using published studies and/or prevailing Tennessee practice. Determinations with respect to technologies are made using criteria developed by the BlueCross BlueShield Association's Technology Evaluation Center. The criteria are as follows:

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1. The technology must have final approval from the appropriate governmental regulatory bodies.
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
3. The technology must improve the net health outcome.
4. The technology must be as beneficial as any established alternatives.
5. The improvement must be attainable outside the investigational settings.

The medical policies specifically state whether a technology is considered Medically Necessary, Not Medically Necessary, Investigational, or Cosmetic. Definitions of these terms are found within the Medical Policy Manual Glossary. Providers may view the BlueCross BlueShield of Tennessee Medical Policy Manual in its entirety on the company website at <http://www.bcbst.com/providers/mpm.shtml>.

Many policies also contain a Medical Appropriateness section. This section contains the criteria used in determining whether a particular technology is appropriate in a particular case (i.e., for a specific individual).

### Medical Policy Appeals

BlueCross BlueShield of Tennessee network Providers may appeal a draft or active medical policy. A medical policy appeal is a formal notice from a network Provider stating dissatisfaction with any medical policy determination. The dissatisfaction could be questioning the Investigational status of a medical policy or the Medical Appropriateness criteria contained in a medical policy. Published, peer-reviewed studies supporting the appealing Providers position must be submitted with each medical policy appeal.

#### ***The medical policy appeal process follows:***

- Provider submits a written request for appeal of a medical policy, along with full-text copies of supporting documentation to the Provider Appeals Department.
- Provider Appeals Coordinator sends the request to the division representative for the Medical Policy Research & Development Department.
- Medical Policy Research & Development Department reviews the appeal and supporting documentation.
- The appeal decision is returned to the Provider Appeals Department with a detailed response for the Provider.
- A written response is sent via registered mail to the network Provider.

Network Providers may submit a written medical policy appeal along with supporting documentation to:

Provider Appeals Coordinator  
Provider Network Management  
BlueCross BlueShield of Tennessee  
1 Cameron Hill Circle, Ste 0039  
Chattanooga, TN 37402, 0039

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## J. Directing Members to Participating Providers in Members' Network

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When a Member needs additional care outside your practice, you can assist them by directing them to participating Providers in the Member's network. Members seeking care outside their network will have significant reductions in benefits or no benefits. An illustration of the increased Member liability for out-of-network utilization follows:

**Example:**

Physician charges = \$300.00

BlueCross BlueShield of Tennessee maximum allowed = \$180.00

***Utilizing an in-network Provider***

Provider network Physician discount = \$120.00

BlueCross BlueShield of Tennessee payment = \$150.00 (or 80% of \$180 maximum allowed)

Member payment = \$30.00

***Utilizing an out-of-network Provider***

Provider network Physician discount = \$0

BlueCross BlueShield of Tennessee payment = \$108.00 (or 60% of \$180 maximum allowed)

Member payment = \$192.00

By helping your patients utilize **in-network** Providers, you can help ensure they receive the highest level of benefits. An online directory of participating Providers by network-type is available on the company website, [www.bcbst.com](http://www.bcbst.com). Both Members and Providers may access the Provider directories from any page of our site by selecting "Find a Doctor!" located on the right-hand side of the screen.

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## K. Utilization Management Resources

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The following tools are utilized in the clinical decision process:

***First Tool- Member's contract***

The Member's contract is the first tool in the clinical decision process. If the service is provided within the contract, then it may require evaluation of Medical Appropriateness.

***Second Tool-Medical Policy***

The Medical Policy is the second tool in the clinical decision process. The Medical Policy Manual will provide policy statements and Medical Appropriateness criteria to determine Medical Necessity.

***Third Tool-Clinical Guidelines***

The Utilization Management criteria are the third tool in the clinical decision process. Clinical guidelines include MCG, and BCBST Utilization Management Guidelines. If the contract addresses the service, but Medical Policy does not, the Clinical Guidelines should be applied to the request for services.

## IX. REFERRAL PROCESS

Information in this section has been removed. Effective January 1, 2004, BlueCross BlueShield of Tennessee no longer requires Blue Network S Point-of-Service (POS) members to:

- choose a Primary Care Practitioner; or
- obtain a referral when seeking in-network or out-of-network specialist care.

However, to receive maximum benefits, POS members should continue to seek health care services from providers that participate in Blue Network S. When Members utilize providers outside their network, benefits are substantially reduced.



## VIII. UTILIZATION MANAGEMENT PROGRAM

### A. Program Overview

BlueCross BlueShield of Tennessee's Utilization Management Program (UM) is committed to providing quality and cost effective health care services to its Members. The UM program is designed to manage, evaluate and improve the quality, appropriateness and accessibility of health care services while achieving Member and Provider satisfaction.

The UM Program monitors compliance with the National Committee for Quality Assurance (NCQA) standards in order to maintain accreditation. BlueCross BlueShield of Tennessee's UM decision-making is based only on appropriateness of care and service and existence of coverage. The Organization does not specifically reward Practitioners or other individuals for issuing denials of coverage or care and financial incentives for UM decision-makers do not encourage decisions that result in underutilization.

The program is directed, guided and monitored by our Medical Director who actively seeks input from network-participating Practitioners and other regulatory agencies. The Medical Director is ultimately responsible for facilitating medical management in the following UM areas:

- Prior Authorization Review
- Provider Appeals
- Medical Quality Management
- Specialty Services
- Concurrent Review
- Medical Policy
- Retrospective Review
- Delegate Oversight
- Disease Management
- Technology Assessment
- Transition of Care/Discharge Planning

#### Evaluation of the UM Program

- The UM Program is formally evaluated on an annual basis and revised as needed. Designated staff evaluate the consistency with which health care professionals involved in the UM process apply criteria in decision making through Physician and non-Physician inter-rater Reliability (IRR). The program is reviewed to add or modify activities necessitating the quality improvement of effective and efficient service to BlueCross BlueShield of Tennessee Members.
- Marketing, Customer Services and UM departments provide Member satisfaction data which are reviewed to add or modify activities necessitating the quality improvement of effective and efficient service to BlueCross BlueShield of Tennessee Members.
- UM nurses coordinate referrals to the Clinical Risk Management Department and the Medical Director. Trend reports are utilized to determine areas of need for corrective action, as well as areas that show improvement.

**Note:** The term "Provider" may include "Practitioner", "Facility", or "Other Licensed Professional".

### B. Medical Review

Medical reviews are prospective, concurrent, or retrospective of selected interventions and are performed where evidence suggests safe, effective alternatives exist or because of mandates from oversight agencies. Prior authorization review results in efficient use of covered health care services and helps to ensure Members receive the appropriate level of care in the appropriate setting.

**Note:** BlueCross BlueShield of Tennessee administers both insured and self-funded arrangements. Because of differences in relationships, some prior authorization requirements may differ. Benefits are always subject to verification of eligibility and coverage at the time services are rendered.

If the Provider chooses to render services that have not received prior authorization, or that do not meet Medical Necessity criteria according to BlueCross BlueShield of Tennessee's Clinical Decision Process, the Member is not financially liable for the charges.

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However, if the Provider obtains a *BlueCross Acknowledgement of Financial Responsibility for the Cost of Services Form* for the **specific** procedure, and any related services prior to the services being rendered, the Member may be held liable. This form cannot be utilized to waive the Provider's prior authorization requirements. Members obtaining services out of network or outside the State of Tennessee from a non-BlueCard PPO Provider, the Member may be responsible for all or a substantial share of the charges.

Review is required for all hospital admissions (excluding deliveries), observation admissions (see Observation Stay), select procedures and skilled nursing facility/restorative care unit admissions. Based on the line of business, home health services, e.g., skilled nursing visits, private duty nursing, home infusion therapy, certain outpatient or office procedures or tests, and hospice may require prior authorization. Some health care benefit plans also require review for speech therapy, occupational therapy, physical therapy, pulmonary rehabilitation (if applicable), durable medical equipment, (if applicable), cardiac rehabilitation (if applicable), and non-emergent air ambulance transportation.

To promote consistent utilization management across all product lines, BlueCross uses the following clinical decision process, 1) Member's Benefit Plan, 2) BlueCross BlueShield of Tennessee Medical Policy, 3) Utilization Management Guidelines and MCG Care Guidelines to make utilization management decisions. MCG Care Guidelines are nationally recognized guidelines that are updated annually by a panel of consultants including, but not limited to Practitioners and registered nurses. A MCG Care Guideline used in a specific medical decision can be obtained by submitting a written request to the UM Department or by calling 1-800-924-7141. BlueCross BlueShield of Tennessee will supply, at no charge, up to three MCG Care Guidelines as they pertain to a specific medical decision.

### BCBST Utilization Management Guidelines

BlueCross BlueShield of Tennessee uses MCG Care Guidelines to assist in its clinical decision-making processes. There are times when BlueCross BlueShield of Tennessee must modify, supplement, or customize certain MCG criteria to meet practice patterns in Tennessee (i.e., a guideline does not exist, the length of stay needs to be customized, or the decision criteria needs to be modified). MCG criteria that have been modified and/or customized by BlueCross BlueShield of Tennessee are published on the company website, [www.bcbst.com](http://www.bcbst.com). This allows Providers the opportunity to review and be aware of any changes or variances made to MCG criteria by BlueCross BlueShield of Tennessee. Providers are notified through *BlueAlert*, BlueCross BlueShield of Tennessee's monthly Provider newsletter, 30 days in advance of subsequent changes to these guidelines. Providers may appeal BlueCross BlueShield of Tennessee Utilization Management Guidelines (UMGs) by following the *Utilization Management Guideline Appeals Process* available in the Utilization Management section on the Provider Page of the company website, [www.bcbst.com](http://www.bcbst.com).

### Prior Authorization Reviews

Prior authorization reviews can be initiated by the Member, designated Member advocate, Practitioner, or facility. **However, it is ultimately the facility and Practitioner's responsibility to contact BlueCross BlueShield of Tennessee to request an authorization and to provide the clinical and demographic information that is required to complete the authorization.** Scheduled admissions/services must be authorized at least 24 hours prior to admission. Emergent inpatient admissions/services must be authorized within 24 hours or next business day following an admission.

When a request for an authorization of a procedure, an admission/service or a concurrent review of the days is denied, the penalty for not meeting authorization guidelines will apply to both the facility and the Practitioner rendering care for the day(s) or service(s) that have been denied. BlueCross BlueShield of Tennessee's non-payment is applicable to both facility and Practitioner rendering care. The Member is held harmless if the Member is eligible at the time services are rendered and the Covered Services are received from a network Provider.

Nurse reviewers receive requests for prior authorization, including necessary medical information. The nurse reviews the medical information, applying benefits, medical policies, BlueCross Utilization

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Management Guidelines and/or MCG criteria, to render decisions. Nurses have the authority to approve all situations that meet those guidelines, e.g., approve admissions, assign lengths of stay, and number of services.

For **Urgent Care**, the decision must be completed as soon as possible based on the clinical situation, but no later than 24-72 hours of the receipt of the request for a UM determination. For **Non-urgent Care**, the decision must be made within 15 calendar days.

The Practitioner and/or the facility are notified via telephone and/or electronically of the determination. In the event of an adverse determination, written confirmation to the Practitioner, facility and Member follows. Timeframes begin with receipt of the UM requests and include the issuance of the initial notification and/or confirmation of the decision.

Nurse reviewers refer potential denials or questionable cases to a Medical Director for review. Additional information may be submitted via the regular authorization process when an adverse determination is issued by BlueCross BlueShield of Tennessee. This information may be submitted to BlueCross BlueShield of Tennessee from the Provider or Provider representative. If a BlueCross BlueShield of Tennessee Medical Director denies a request for prior authorization, the Provider or Member may appeal the decision. (See Provider Appeals Process at the end of this section.)

Concurrent/extended stay reviews are performed for inpatient admissions and concurrent/extended service reviews are performed for ancillary services. Approval of the admission or an initial length of stay is assigned upon admission to a facility and an initial length of service is assigned upon onset of ancillary service. However, to receive payment beyond the initial length of stay or length of service, additional medical information, which meets criteria and/or demonstrates Medical Necessity, must be submitted by the facility/Practitioner contacting the Utilization Management Department either by telephone, fax or electronically with the additional information to support the request.

BlueCross Providers can submit authorization requests for inpatient and 23-hour observation via telephone, facsimile or *e-Health Services*® via *BlueAccess*, the secure area on the company website, [www.bcbst.com](http://www.bcbst.com). Facsimile transmissions will be received Monday through Thursday, 24-hours-a-day, and Friday until 4 p.m., ET. The facsimile will be turned off from 4 p.m. Friday until 6 a.m. Monday, and will be turned off on holidays until the next business day at 6 a.m. Otherwise, the requests should be received via telephone, facsimile or *e-Health Services*® on the **next business day**. To access *e-Health Services*®, enter your ID number and password in the *BlueAccess* secure login box or for first-time users, click on the “register now” tab. If you have an urgent case in need of an urgent response, you must telephone the request to the Utilization Management Department at 1-800-924-7141. A voicemail line will be available after business hours and on weekends/holidays for Providers to contact BlueCross BlueShield of Tennessee regarding **concurrent or urgent** information. These calls will be returned the next business day. Providers submitting requests via facsimile should utilize the authorization request form located on the company website at [http://www.bcbst.com/providers/forms/Commercial\\_Auth\\_Fax\\_Form.pdf](http://www.bcbst.com/providers/forms/Commercial_Auth_Fax_Form.pdf).

The form must be completed in its entirety; any authorization requests received that are not on this form will be returned.

Prior authorization requests for Inpatient, Outpatient Procedures and 23-hour Observation can receive online approval. Simply select the option to apply MCG criteria and answer a few clinical questions. If the authorization meets specific criteria you will receive online approval and a reference number. Your request will be recorded in our computer system real time as it is received. This service is available 24-hours-a-day, 7-days-a-week for all registered BlueCross BlueShield of Tennessee Providers.

### DRG Inpatient Stays

- Contact the BlueCross BlueShield of Tennessee UM Department on the date specified with current clinical information.
- Clinical information is needed in order to implement and to discuss discharge planning efforts. Date of update will be determined at the time of call from Provider.

- DRG admissions will be assigned a length of stay. Date of update will be determined at the time of call from Provider.
- All claims submitted for DRG reimbursement with outlier days will be reviewed for Medical Necessity.

#### Per Diem Admissions Needing Extensions

- Contact the BlueCross UM Department with the required clinical information on the originally scheduled day of discharge when a Member's condition indicates a need for additional days. Extension requests can also be arranged via telephone, facsimile, or eHealth Services® via BlueAccess, the secure area on BlueCross' website, [www.bcbst.com](http://www.bcbst.com).

#### Discharge Dates

- Discharge information should be sent daily to BCBST to help ensure appropriate Member follow up and coordination of care. Discharge dates may be entered via the web, e-mailed to [dcdates@bcbst.com](mailto:dcdates@bcbst.com), faxed to (423)591-9501, or toll-free to 1-855-339-9781 for all lines of business. If faxing or e-mailing, Providers may submit one list with all Member names as long as the appropriate line of business to which the Member belongs is indicated. Provider cover sheets should include the facility name and NPI number to help ensure appropriate and efficient processing.

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## C. Medical Review Requirements

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Types of reviews required are subject to change. Providers will be notified of any changes in review requirements through quarterly updates to this Manual, *BlueAlert* monthly provider newsletter, and other BlueCross communications, including the BlueCross company website, [www.bcbst.com](http://www.bcbst.com). All information is subject to verification by review of the medical record and other sources. (See *Medical record submission guidelines* later under "Provider Appeal Process".)

When prior authorization\* is required, Providers must obtain authorization prior to scheduled services or within 24 hours/the next business day of emergent services. Failure to comply within specified authorization timeframes will result in a denial or reduced benefits due to non-compliance, and **BlueCross participating Providers will not be allowed to bill Members for Covered Services rendered, except for any applicable copayment/deductible and coinsurance amounts.** Prior authorization requests may be requested via e-Health Services® via BlueAccess, the secure area on the company website, [www.bcbst.com](http://www.bcbst.com), called in to 1-800-924-7141 or faxed to 1-866-558-0789 using the appropriate BlueCross fax form located at <http://www.bcbst.com/providers/forms/>.

Requests for tests, procedures, or services requiring prior authorization must contain adequate information for review. Requests for authorization where additional information is requested but not received by the end of the next calendar day will be denied for lack of information. Covered Services that have not been authorized may **not** be billed to the Member. The Practitioner may appeal a denial due to lack of information to BlueCross within 180 days of notification of denial.

*\*BlueCross administers both insured and self-funded arrangements. Because of differences in relationships, some prior authorization requirements as well as benefit coverages may differ. Benefits are always subject to verification of eligibility and coverage at the time services are rendered.*

**The following describes specific medical review guidelines:**

### 1. Inpatient Admission

#### a. Acute Care Facility

All inpatient stays require prior authorization. Authorization will be issued when care and treatment are determined to be Medically Necessary and Appropriate in an inpatient setting. Scheduled inpatient stays require admission the morning of a procedure in nearly all instances.

***Basic information needed for processing a prior authorization request:***

- Member's identification number and name;
- Patient's name and date of birth;
- Practitioner's name, provider number and/or National Provider Identifier (NPI), address, telephone number and caller's name;
- Hospital/Facility's name, provider number and/or NPI, address, telephone number, caller's name.

***Clinical information required for prior authorization:***

- Procedure/Operation to be performed, if applicable;
- Diagnosis with supporting signs/symptoms;
- Vital signs and abnormal lab results;
- Elimination status;
- Ambulatory status;
- Hydration status;
- Co-morbidities that impact patient's condition;
- Complications;
- Prognosis or expected length of stay;
- Current medications.

**b. Skilled Nursing Facility (SNF)**

All inpatient stays require prior authorization. Authorization will be issued when care and treatment are determined to be Medically Necessary and Medically Appropriate in an inpatient setting. Skilled services are services requiring the skills of qualified technical or professional health personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, and/or audiologists. Skilled services must be provided directly by or under the general supervision of technical or professional health care personnel.

***Basic information needed for processing a prior authorization request:***

- Member's identification number and name;
- Patient's name and date of birth;
- Practitioner's name, provider number and/or NPI, address, telephone number and caller's name;
- Hospital/Facility's name, provider number and/or NPI, address, telephone number, caller's name;
- Initial review, concurrent review or reconsideration request with admission date, admitting diagnosis, symptoms, treatment; and
- Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care that would influence the Medical Necessity determination.

If a covered benefit, SNF admission may be approved for Members with **all** the following:

- A condition requiring skilled nursing services or skilled rehabilitation services on an inpatient basis at least daily;
- A Practitioner's order for skilled services;
- Ability and willingness to participate in ordered therapy;
- Medical Necessity for the treatment of illness or injury (this includes the treatment being consistent with the nature and severity of the illness or injury and consistent with accepted standards of medical practice); and
- Expectation for significant reportable improvement within a predictable amount of time.

### Evaluation and Plan of Care

- Evaluation of the Member must be submitted including the following as appropriate:

- Primary diagnosis
- Ordering Practitioner and date of last visit
- Date of diagnosis onset
- Baseline status
- Current functional abilities
- Functional potential
- Strength
- Range of Motion
- Circulation and sensation
- Gait analysis
- Cooperation and comprehension
- Developmental delays (pediatric patients)
- Other therapies or treatments
- Patient's goals
- Medical compliance
- Support system

- Plan of care must be submitted including the following as appropriate:

- Short- and Long-term goals
- Discharge goals
- Measurable objectives
- Functional objectives
- Home program
- Proposed admission date
- Frequency of treatment
- Specific modalities, therapy, exercise
- Safety and preventive education
- Community resources

### Therapy Services

Therapy services appropriate for skilled nursing facilities include occupational therapy, physical therapy and speech therapy not possible on an outpatient basis. Specific therapy services that may be appropriate for a SNF include, but are not limited to the following:

- Complex wound care requiring hydrotherapy; and
- Gait evaluation and training to restore function in a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality.

### Nursing Services

Nursing services appropriate for skilled nursing facilities include skilled nursing services not possible on an outpatient basis. Specific nursing services that may be appropriate for a SNF include, but are not limited to the following:

- Intramuscular injections or intravenous injections or infusions;
- Initiation of and training for care of newly placed
  - Tracheostomy
  - Pain Management
  - In-dwelling catheter with sterile irrigation and replacement
  - Colostomy
  - Gastrostomy tube and feedings
- Complex wound care involving medication application and sterile technique
- Ulcer treatment with any Stage 3 or 4 pressure ulcer or 2 or more ulcers

### Nursing and Therapy Services Not Requiring SNF Placement

Skilled nursing facility placement is not necessary for the services listed below. This list is **not** all-inclusive.

- Administration of routine oral, intradermal or transdermal medications, eye drops, and ointments;
- Custodial services, e.g., non-infected postoperative or chronic conditions;
- Activities or programs primarily social or diversional in nature;
- General supervision of exercises in paralyzed extremities, not related to a specific loss of function;
- Routine care of colostomy or ileostomy;

- Routine services to maintain functioning of in-dwelling catheters;
- Routine care of incontinent patients;
- Routine care in connection with braces and similar devices;
- Prophylactic and palliative skin care (i.e., bathing, application of creams, or treatment of minor skin problems);
- Duplicative services - Physical therapy services that are duplicative of Occupational Therapy services being provided or vice versa;
- Invasive procedures (i.e., iontophoresis involving needle);
- General supervision of aquatic exercise or water-based ambulation;
- Heat modalities (hot packs, diathermy or ultrasound) for pulmonary conditions or wound treatment, or as a palliative or comfort measure only (whirlpool and hydrocollator);
- Hot and cold packs applied in the absence of associated modalities;
- Diagnostic procedures performed by a Physical Therapist (i.e., nerve conduction studies); and
- Electrical stimulation for strokes when there is no potential for restoration of functional improvement. *Nerve supply to the muscle must be intact.*

#### **Extension of Services**

Extension of services requires the following documentation:

- Clinical progress in meeting goals
- Updated goals
- Compliance & participation with any ordered therapy
- Discharge plans & target date

#### **c. Rehabilitation Facility**

All inpatient stays require prior authorization. Authorization will be issued when care and treatment are determined to be Medically Necessary and Medically Appropriate in an inpatient setting. Inpatient Rehabilitation provides multidisciplinary, structured, intensive therapy for Members both requiring and able to participate in a **minimum of 3 hours of daily therapy for 5 days**. Rehabilitation goals are to prevent further disability, to maintain existing ability, and to restore maximum levels of functioning within the limits of the Member's impairment.

Potential inpatient rehabilitation admissions include Members with recent CVA, head trauma, multiple trauma, or spinal cord injury.

#### ***Basic information needed for processing a prior authorization request:***

- Member's identification number and name;
- Patient's name and date of birth;
- Practitioner's name, provider number and/or NPI, address, telephone number and caller's name;
- Hospital/Facility's name, provider number and/or NPI, address, telephone number, caller's name;
- Initial review, concurrent review or reconsideration request with admission date, admitting diagnosis, symptoms, treatment, frequency of therapies, Member's ability to participate in treatment;
- Member is ventilator dependent or not; and
- Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care that would influence the Medical Necessity determination.

If a Covered Service, inpatient rehabilitation admission may be approved for Members with **all** the following:

- Rehabilitative potential, to include assessment and/or Functional Independence Measure Score (FIMS) of impairment from illness or injury and premorbid condition;
- Ability and willingness to actively participate in a minimum of 3 hours of daily therapy, 5-days-per-week;
- A condition requiring 24-hour rehabilitation nursing and 24-hour availability of a Practitioner with special training in the field of rehabilitation;
- A requirement for at least 2 therapies and a multidisciplinary team approach;
- Medical Necessity for the treatment of illness or injury (this includes the treatment being consistent with the nature and severity of the illness or injury, and consistent with accepted standards of medical practice);
- Acute medical condition stabilized;
- Reasonable and reportable goals in a written plan of care submitted with the request for admission; and
- Documented family commitment to the rehabilitation program (where family involvement will eventually be required).

In addition, a request for an additional inpatient rehabilitation admission for a Member previously admitted to inpatient rehabilitation for essentially the same condition needs to be carefully assessed. The date and length of previous rehabilitation, along with the improvement attained, need to be carefully considered. Alternatives in these cases may be outpatient rehabilitation, home therapy or therapies, or skilled nursing facility (SNF) placement.

### **Evaluation and Plan of Care**

➤ Evaluation of the Member must be submitted including the following as appropriate:

- |  |   |
|--|---|
| • Ordering Practitioner and date of last visit | • Gait analysis                             |
| • Primary diagnosis                            | • Circulation and sensation                 |
| • Date of diagnosis onset                      | • Cooperation and comprehension             |
| • Baseline status                              | • Developmental delays (pediatric patients) |
| • Current functional abilities                 | • Other therapies or treatments             |
| • Functional potential                         | • Patient's goals                           |
| • Strength                                     | • Medical compliance                        |
| • Range of Motion                              | • Support system                            |

➤ Plan of care must be submitted including the following as appropriate:

- |                              |  |
|------------------------------|--|
| • Short- and Long-term goals | • Proposed admission date                |
| • Discharge goals            | • Frequency of treatment                 |
| • Measurable objectives      | • Specific modalities, therapy, exercise |
| • Functional objectives      | • Safety and preventive education        |
| • Home program               | • Community resources                    |

### **Extension of Services**

Extension of services requires the following documentation:

- Clinical progress in meeting goals
- Updated goals
- Compliance & participation with therapy
- Discharge plans & target date
- Team conference reports (at least every two weeks or with any significant change in the Member's condition)

**Note:** A sample copy of the Skilled Nursing Facility/Inpatient Rehabilitation form is available on the BlueCross Provider page on the company website, [www.bcbst.com](http://www.bcbst.com).



## 2. Emergency Admission

In-network Providers are responsible for contacting BlueCross BlueShield of Tennessee within 24 hours or the next business day of the inpatient admission. Although emergency procedures do not require prior authorization, benefits are subject to verification for Medical Necessity and Medical Appropriateness and eligibility of coverage.

In the event that an emergency hospital admission or emergency outpatient service occurs after normal office hours, you may submit the information via our website, [www.bcbst.com](http://www.bcbst.com), for registered users, or contact the Utilization Management Department within 24 hours or the next business day. If the Member is still admitted at that time, an admission review will be initiated. If the Member has been admitted and discharged, or has already received an emergency outpatient service, a retrospective review will be completed.

## 3. Observation Stays

Prior authorization for 23-hour observation stays **through the emergency room** is not required for commercial Members. Observation for elective services, direct admissions from the Physician's office, or a transfer from another facility require prior authorization.

The goal of observation stays is to either complete treatment, e.g., hydration, or rule out need for inpatient stays; (e.g., chest pain is not caused by an acute myocardial infarction). Members in this status may advance to admission status if the clinical situation warrants. Admissions need to be reported to the Utilization Management Department before a scheduled admission, or, within the next business day for emergency admissions to determine Medical Necessity and Medical Appropriateness.

### ***23-Hour Observation Room Services Policy***

The medical record must support the need for observation and a specific Practitioner's order for observation must be documented. The record must also show the time and date of arrival and discharge from the facility.

## 4. Non-Compliance

Services requiring prior authorization rendered without obtaining approval are considered "non-compliant." Emergency admissions require authorization within **24 hours or one (1) business day after services have started or within 24 hours or one (1) business day after conversion from observation to inpatient status**. When prior authorization is required, Provider must obtain authorization prior to scheduled services. Non-compliance applies to initial as well as concurrent review for ongoing services beyond dates previously approved.

Failure to comply within specified authorization timeframes will result in a denial or reduced benefits due to non-compliance. BlueCross BlueShield of Tennessee Providers cannot bill Members for Covered Services denied due to non-compliance by the Provider.

If a Member does not inform the Provider that he/she has BlueCross BlueShield of Tennessee coverage and the Provider discovers that the Member **does have** BlueCross BlueShield of Tennessee coverage, the Provider should send a copy of the medical record relevant to the admission or services, along with the face sheet, including the reason the authorization was not obtained. The medical records will be reviewed only when a valid reason for not obtaining a prior authorization is provided with the request. Providers should follow the Provider appeal process within sixty (60) days of the initial denial.

An appeal will only be overturned if Medical Necessity is determined and there is clear evidence that the facility was not aware that the Member had BlueCross BlueShield of Tennessee coverage at the time services were rendered.

## 5. Maternity, Labor and Delivery, Newborn

Normal deliveries do not require notification or authorization. Complication of pregnancy continues to require authorization. Direct admissions to 23-hour observation will follow observation guidelines and will require prior authorization.

**Newborns require notification/prior authorization if:**

- continued hospitalization is required after the mother has been discharged; or
- admitted to any level other than well-baby nursery; or
- transferred to another facility due to their fragile condition.

**6. Home Health Services/Skilled Nursing Visits**

Home health services may require prior authorization. Home health services are hands-on, skilled care/services, by or under the supervision of a registered nurse that are needed to maintain the Member's health or to facilitate treatment of the Member's illness or injury. In order for the services to be covered under BlueCross BlueShield of Tennessee, the Member must have a medical condition that makes him/her unable to perform personal care and meet Medical Necessity and Medical appropriateness criteria. Documentation must support the Member's limitations, homebound status, and the availability of a caregiver/family and degree of caregiver/families' participation/ability in Member's care.

**Home Health Services normally covered include, but are not limited to:**

- Part-time intermittent Skilled Nursing Services
- Medical Social Service
- Home Infusion Therapy
- Dietary guidance
- Rehabilitative Therapies such as physical therapy, occupational therapy, etc.

**Home Health Services not normally covered include, but are not limited to:**

- |                                      |                        |
|--------------------------------------|------------------------|
| • Non-treatment services             | • Social casework      |
| • Routine transportation             | • Meal delivery        |
| • Homemaker or housekeeping services | • Personal hygiene     |
| • Behavioral counseling              | • Convenience items    |
| • Supportive environmental equipment | • Home Health Aides    |
| • Maintenance or custodial care      | • Private Duty Nursing |

**In order for an approval of Skilled Nursing/Home Health Visit services to be issued, the following criteria must be met:**

- The Member requires the skills of a nurse on an intermittent basis;
- The Member has a condition that requires active skilled care;
- The services must be reasonable and necessary to the care of the condition; and
- The Member must be determined by BlueCross BlueShield of Tennessee to be homebound during the episode of care.

**Documentation for prior authorization:**

- Practitioner's verbal or signed medical orders and plan of care for dates of service;
- Number of services requesting;
- Nurse's visit and progress notes;
- Therapist's visit and progress notes, if applicable;
- Availability of a caregiver; and
- Homebound status.

Home health visits should be for skilled nursing services. Visits for assessment and teaching should be for services beyond those one would expect to be taught in the Practitioner's office and the request must include the frequency and duration of services, and must specify what services are to be provided. An insulin-dependent diabetic may have up to three skilled nursing visits to teach diabetic care. However, these visits should be lengthy, comprehensive and show evidence that clinical problem solving is actively used.

## 7. Transitional Care/Discharge Planning

BlueCross BlueShield of Tennessee acknowledges a vested interest in assuring patient care is provided in the most appropriate setting and will continue to assist Providers with discharge planning for its patients who are BlueCross BlueShield of Tennessee Members. Discharge planning should begin upon admission. BlueCross BlueShield of Tennessee transition of care/discharge planning nurses will assist Providers and Members upon admission, during the prior authorization process, or prior to admission if a scheduled admission. Authorization for the following services should be completed and Providers notified of the determination **prior** to the anticipated discharge and service date:

- Hospital admissions, select procedures;
- Skilled nursing facility/restorative care unit admissions;
- Inpatient rehabilitation admission;
- Home health services (skilled nursing visits and home infusion therapy);
- Certain durable medical equipment;
- Speech therapy, occupational therapy, physical therapy;

## 8. Cosmetic Surgery

Cosmetic surgery is not a Covered Service. However, breast reconstructive and symmetry surgery following a mastectomy is a Covered Service.

- Reconstructive breast surgery, in all stages, on the diseased breast as a result of a mastectomy (not including a lumpectomy) is considered Medically Necessary.

## 9. Out-of-Network Services

Benefits may be limited, reduced or not be available in accordance with the terms of the Member's health care benefits plan even if required prior authorization is obtained.

Emergency out-of-network services (based on admitting and discharge diagnosis filed on claim) are covered, but must be reported to BlueCross BlueShield of Tennessee within 24 hours or the next business day. BlueCross BlueShield of Tennessee may need to assist the Provider in returning the Member to the network when it is medically safe.

## 10. Transplant Services

Please see Section X. Case Management for transplant specifics.

## 11. Hospice Services

Hospice services are for terminally ill Members where life expectancy is six (6) months or less and may require prior authorization.

**Hospice services normally covered include, but are not limited to:**

- |                                       |  |
|---------------------------------------|--|
| • Part-time intermittent nursing care | • Medical social services                              |
| • Bereavement counseling              | • Medications for control or palliation of the illness |
| • Home health aide services           | • Physical or respiratory therapy for symptom control  |

**Hospice services not normally covered include, but are not limited to:**

- |                                      |   |
|--------------------------------------|---|
| • Homemaker or housekeeping services | • Inpatient and outpatient care                           |
| • Meals                              | • Ambulance   |
| • Supportive environmental equipment | • Chemotherapy  |
| • Private Duty Nursing               | • Radiation therapy                                       |
| • Routine transportation             | • Enteral and parenteral feeding                          |
| • Funeral or financial counseling    | • Home hemodialysis                                       |
| • Practitioner visits                | • Psychiatric care  |
|                                      | • Convenience or comfort items not related to the illness |

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## 12. Ambulatory Surgeries (Appropriateness Review), Diagnostic & Other Procedures

Some outpatient surgical/diagnostic procedures may require prior authorization. These procedures may be performed in outpatient surgical facilities, hospital outpatient departments, outpatient diagnostic centers, and in Practitioners' offices. Providers may call Customer Service at the phone number listed on the Member's ID card to determine prior authorization requirements. Some procedures do not require prior authorization if performed on an outpatient basis; however, if performed as 23-hour observation or on an inpatient basis, a prior authorization is required for the hospitalization. Non-emergency elective procedures should be submitted up to thirty (30) days, but not less than 24 hours prior to the scheduled procedure. Failure to obtain prior authorization will result in denial of payment for Covered Services.

Prior authorization is required for the following procedures performed in an inpatient or outpatient setting:

- Blepharoplasty (if Covered)
- Vein ligation
- Bariatric procedures (if Covered)
- Hysterectomy
- Breast Augmentation/Reduction
- Panniculectomy
- Endometrial Ablation
- Hyperbaric Treatments
- Occipital Nerve Neurostimulator Implantation
- Neurostimulator Implantation for Fecal and Urinary Incontinence
- 72-hour Glucose Monitoring
- Gender Reassignment Surgery (if Covered)
- Molecular Markers in Fine Needle Aspiration of the Thyroid

Covered Services that have not been authorized may **not** be billed to the Member if rendered by a BlueCross BlueShield of Tennessee network Provider. Denials for failure to request an authorization must be appealed within sixty (60) days of notification of denial. This does not preclude Provider responsibility for claims timely filing requirements. The Practitioner may appeal a Medical Necessity denial to BCBST within 180 days of notification of denial.

**Note:** *Select outpatient procedures are subject to focused retrospective review.*

Providers should call the BlueCross Provider Service line, 1-800-924-7141, or visit e-Health Services® at [www.bcbst.com](http://www.bcbst.com) to determine prior authorization requirements.

## 13. Specialty Pharmacy Medications

Certain high-risk/high-cost specialty pharmacy medications administered in any setting other than inpatient hospital requires prior authorization for all lines of business. This authorization requirement applies to all Provider types including home infusion therapy Providers, specialty pharmacies, hospitals providing outpatient infusions, and injections.

A complete listing of Provider-Administered Specialty Pharmacy drugs can be found at <http://www.bcbst.com/docs/pharmacy/2017-Provider-Administered-Specialty-Pharmacy-List.pdf>. Those requiring prior authorization under the Member's medical benefits plan are identified by "PA". Drugs that do not require a prior authorization will require adherence to BCBST Medical Policy.

Practitioners may contact one of our Specialty Pharmacy Network vendors to obtain a specialty drug. The specialty pharmacy will obtain the necessary information and will request prior authorization. The pharmacy will ship the drug to either the Provider's office (for Provider-Administered drugs) or directly to the Member (for Self-Administered drugs). The specialty pharmacy will bill BlueCross for the drugs and collect any necessary copays or coinsurance from the Member. A complete listing of BlueCross Specialty Pharmacy vendors are located online <http://www.bcbst.com/providers/pharmacy/specialty-pharmacy.page>.

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If the Provider is supplying a Provider-Administered drug that requires prior authorization, they must call BlueCross Utilization Management department at 1-800-924-7141 and choose the “Specialty Pharmacy” authorization option or submit the request via BlueAccess<sup>SM</sup>, BCBST’s secure portal on bcbst.com. This will route to Magellan RX Management, our Specialty Pharmacy Network vendor, who may request additional information if required to complete the review process.

In addition to the Member information, the following is required when requesting prior authorization for Provider-Administered specialty drugs:

- Provider NPI Number (more than one of your subsidiaries may share the same number)
- Tax ID Number (more than one of your subsidiaries may share the same number)
- Appropriate Taxonomy Code in Block 33b (taxonomy code should be specific for specialty pharmacy, HIT, etc.)
- HCPCS Code (J, Q or S code)
- Drug Name
- Strength of Drug
- National Drug Code (NDC)
- Number of Units being billed
- Frequency of Dosing
- Dosage
- Days’ Supply if billing an “ambulatory” drug on a medical claim (for example, when accepting Assignment of Benefits for Members who have to pay 100 percent up front)
- Clinical Information to support the request (Reference the BlueCross Medical Policy Manual)

**Note:** *New drugs may be periodically added to the specialty pharmacy list and those products requiring authorization are subject to change. Changes will be communicated via BlueAlert newsletter or updates to this Manual.*

The specialty medication section of the *BlueCross BlueShield of Tennessee Medical Policy Manual* includes decision support trees for Provider-Administered drugs to assist Providers considering use of these medications. Providers can select the appropriate drug from the manual at <http://www.bcbst.com/mpmanual/!SSL!WebHelp/mpmprov.htm> and connect to the decision support tree in the policy.

If you are not satisfied with the decision by Magellan RX Management, you may file a Provider appeal by sending a written request, along with the supporting documentation, a copy of the denial notice and any pertinent medical information to:

Magellan RX Management  
Attn: Appeals Department  
PO Box 1459  
Maryland Heights, MO 63043  
Phone: 1-800-424-8240  
Fax: 1-888-656-6805

Self-Administered Specialty Pharmacy drugs are found in the Preferred Formulary guidebook and are marked with a “PA” indicator to reflect which drugs require prior authorization. For Self-Administered drugs requiring prior authorization, and NOT supplied by a Specialty Pharmacy Network vendor, the Provider may call 1-877-916-2271.

For additional information on Specialty Pharmacy Medications, see Section XIX. Pharmacy, in this Manual.

## 14. Home Infusion Therapy

Home Infusion Therapy (HIT) is the administration of medications, nutrients or other solutions intravenously, subcutaneously, epidurally, intramuscularly or via implanted reservoir while in the Member's **private residence**. A request for HIT originates with prescription from a qualified Practitioner to achieve defined therapeutic results. HIT must be provided by a licensed pharmacy. Home nursing for patient education, medication administration, training, and monitoring are handled directly by a qualified home health agency.

A complete listing of Provider-Administered Specialty Pharmacy drugs can be found at <http://www.bcbst.com/docs/pharmacy/2017-Provider-Administered-Specialty-Pharmacy-List.pdf>. Those requiring prior authorization under the Member's medical benefits plan are identified by "PA".

Authorization listings are subject to change; Changes will be communicated via *BlueAlert* newsletter or updates to this Manual. Case Management may assist the Practitioner in arranging HIT for extraordinary cases and when Medical Necessity and Medical Appropriateness warrant close attention.

When an authorization is needed, specific information is required. Authorizations are valid for the dates approved; any break in service requires a new authorization. HIT Providers requesting approval of HIT services should submit the following information to Magellan RX Management:

- Member name, address, date of birth, sex, ID number;
- Practitioner name, address, phone number;
- HIT agency name, address, phone number, HIT-related provider number and/or National Provider Number (NPI) and a contact person;
- Type of request: initial prior authorization, extension of services or change of services;
- Type of therapy (e.g., palliative, long-term therapy, short-term antibiotic therapy) should include dosage, frequency, date and length of service, including NDC number, HCPCS code and grams of protein for TPN;
- Primary and HIT diagnosis;
- Clinical documentation (e.g., lab values, cultures, X-rays) to support reason and need for HIT services; and
- A Practitioner's verbal or signed medical order.

The administration of intramuscular (IM) drugs (Rocephin, Phenergan, Procrit, etc.) is not considered HIT and therefore, should not receive HIT benefits. If nursing is required to administer the drug and/or conduct teaching for the Member, these services may require prior authorization under Home Health guidelines. If the HIT Provider is dispensing the drug, they are required to follow the Pharmacy Benefits Manager (PBM) requirements for prior authorization. All self-administered drugs must be authorized and billed through the Member's appropriate PBM. (See Section XIX. Pharmacy in this Manual.)

Authorization decisions will be phoned, faxed, sent electronically, or mailed to the HIT Provider, the prescribing Practitioner and Member. Adverse decisions are rendered if Medical Necessity and Medical Appropriateness are not shown.

If you are not satisfied with the decision by Magellan RX Management, you may file a Provider appeal by sending a written request, along with the supporting documentation, a copy of the denial notice and any pertinent medical information to:

Magellan RX Management  
Attn: Appeals Department  
PO Box 1459  
Maryland Heights, MO 63043  
Phone: 1-800-424-8240  
Fax: 1-888-656-6805

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**Extension of Services**

When prior authorization is required and services are needed beyond the number of days authorized by BlueCross BlueShield of Tennessee, the HIT supplier must have the additional services authorized.

**Changes/Termination in Services**

When prior authorization is required, the HIT Provider must notify Magellan RX Management of any changes in therapies/medication, dosages, and/or an order for discontinuation by the ordering Practitioner, during the time frame authorized.

**15. Rehabilitation Therapy Outpatient Services**

Therapies/Rehabilitative services must be Medically Necessary and Medically Appropriate therapeutic and rehabilitative services intended to restore or improve bodily function lost as a result of illness or injury.

Prior authorization requirements for Cardiac Rehabilitation services are driven by the Member's health care benefit plan. BlueCross BlueShield of Tennessee administers both insured and self-funded arrangements and because of differences in relationships, some prior authorization requirements may differ.

To ensure appropriate payment is made for Cardiac and Pulmonary Rehabilitation services, Providers are encouraged to verify the Member's health care benefit plan's prior authorization requirements by calling the Provider Services line, 1-800-924-7141 or via e-Health Services® at [www.bcbst.com](http://www.bcbst.com). For those health care benefit plans requiring prior authorization, penalties will continue to apply for non-compliance.

**Therapy services normally covered include:**

- Outpatient, home health or office therapeutic and rehabilitative services, which are expected to result in significant and measurable improvement in the Member's condition resulting from an acute disease or injury. The services must be performed by, or under the direct supervision of a licensed therapist. (See medical policy regarding "Staff Supervision Requirement for Delegated Services" and "Staff Practitioner to Whom Services may be Delegated" in the BlueCross BlueShield of Tennessee Medical Policy Manual at <http://www.bcbst.com/providers/mpm.shtml>);
- Services must be performed in a Practitioner's office, outpatient facility or home health setting;
- Physical Therapy;
- Speech Therapy (limited to coverage for disorders of articulation and swallowing, following an Acute illness);
- Occupational Therapy;
- Manipulative Therapy; and
- Cardiac and Pulmonary Rehabilitative services.

**Therapy services normally not covered include, but are not limited to:**

- Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care;
- Enhancement therapy which is designed to improve the Member's physical status beyond their pre-injury or pre-illness state;
- Complementary and alternative therapeutic services, which include, but are not limited to:
  - Massage therapy
  - Acupuncture
  - Craniosacral Therapy
  - Neuromuscular Reeducation
  - Vision Exercise Therapy
  - Cognitive Therapy
- Modalities that do not require the attendance of a licensed therapist:
  - Activities which are primarily social or recreational in nature
  - Simple exercise programs
  - Hot and cold packs applied in the absence of associated therapy modalities

- Repetitive exercises or tasks which can be performed by the Member without a therapist, in a home setting
- Routine dressing changes
- Custodial services that can ordinarily be taught to a caregiver or the Member themselves.
- Behavioral therapy
- Play therapy,
- Communication therapy
- Therapy for self correcting language dysfunctions
- Duplicate therapy (therapies should provide different treatments and not duplicate the same treatment).

**a. Speech Therapy Services (provided in a non-acute setting)**

In order for Speech Therapy services to be considered for benefits, the services must be Medically Necessary and Medically Appropriate to the treatment of the Member's illness or injury. Unskilled services are not eligible for coverage.

***The following information must be included when authorization request is submitted:***

- Date of last visit
- Primary diagnosis
- Date of diagnosis onset
- Baseline status/current abilities
- Functional potential
- Prior level of functioning
- Diagnostic and assessment services used to ascertain the type, causal factors, and severity of speech and language disorders
- Support system
- Developmental delays
- Other therapies or treatments
- Patient's goals
- Therapy compliance
- Prior speech therapy received and outcome

**Treatment Plan**

- Long and short-term goals
- Discharge goals
- Measurable objectives
- Functional objectives
- Home program, if applicable
- Duration of therapy
- Frequency of therapy
- Date therapy is to begin
- Specific therapy techniques

**Note:** *BlueCross BlueShield of Tennessee utilizes MCG criteria when reviewing requests for speech therapy services provided in a non-acute setting.*

**b. Occupational Therapy Services (provided in a non-acute setting)**

In order for occupational therapy services to be considered for benefits, the services must be Medically Necessary and Medically Appropriate to the treatment of the Member's illness or injury. Unskilled services are not eligible for coverage.

***The following information must be included when authorization request is submitted:***

- Date of last visit
- Primary diagnosis
- Date of diagnosis onset
- Baseline status/current abilities



- Functional potential
- Prior level of functioning
- Diagnostic and assessment services used to ascertain the type, causal factors, and severity of dysfunction or disorders
- Support system
- Developmental delays
- Other therapies or treatments
- Patient's goals
- Medical compliance
- Prior occupational therapy received and outcome

**Treatment Plan**

- Long and short-term goals
- Discharge goals
- Measurable objectives
- Functional objectives
- Home program
- Duration of therapy
- Frequency of therapy
- Dates of service
- Specific modalities and therapy

**Note:** *BlueCross BlueShield of Tennessee utilizes MCG criteria when reviewing requests for occupational therapy services provided in a non-acute setting.*

**c. Physical Therapy Services (provided in a non-acute setting)**

In order for physical therapy services to be considered for benefits, the services must be Medically Necessary and Medically Appropriate to the treatment of the Member's illness or injury. A prior authorization may be required for physical therapy based on the Member's benefit coverage. Unskilled services are not eligible for coverage.

***The following information must be included when authorization request is submitted:***

- Date of last visit
- Primary diagnosis
- Baseline status
- Functional potential
- Current functional abilities
- Strength
- ROM
- Circulation and sensation
- Cooperation and comprehension
- Support system
- Developmental delays/pediatrics
- Other therapies, treatments, chiropractic
- Patient's goals
- Medical compliance
- Homebound status

**Treatment Plan**

- Short- and Long-term goals
- Discharge goals
- Measurable objectives
- Functional objectives

- Home exercise program
- Time frame (frequency and duration)
- Date therapy is to begin
- Frequency of treatment
- Specific modalities, therapy, exercise
- Safety and preventive education
- Community resources

BlueCross BlueShield of Tennessee utilizes MCG criteria when reviewing requests for physical therapy services provided in a non-acute setting.

## **16. Medical Supplies (Outpatient Rehabilitation Services)**

The following coverage criteria apply to medical supplies billed to BlueCross BlueShield of Tennessee:

- Records must clearly support that supplies were used during the Member's treatment.
- Must be prescribed by the Member's Practitioner.
- Must be Medically Necessary and Medically Appropriate for treating illness or injury.
- Generally recognized as therapeutically effective and primarily medical in nature.
- Must be at the level and quality required (not "luxury" in nature).
- Cannot be for environmental control, personal hygiene, comfort, or convenience.
- Cannot be reusable.
- Supplies required for use with rental items are included in the rental fee.

## **17. Durable Medical Equipment**

Durable Medical Equipment (DME) purchases, rentals, or repairs require prior authorization for most lines of business. DME may be subject to retrospective review for Medical Necessity.

DME may be covered if it is determined to be Medically Necessary and Medically Appropriate for the Member's condition. The following guidelines and documentation requirements apply to DME whether equipment is purchased or rented:

- The Member's diagnosis should substantiate the need and use of the equipment in the medical record.
- Documentation of the Member's capability to be trained in the appropriate use of the equipment.
- Rental equipment is generally considered equipment that requires frequent and substantial servicing and maintenance and/or estimated period of use is finite.
- Certain rented DME is purchased after the equipment has been rented for a total of ten (10) months.
- Documentation for customized equipment should specify the need for the custom equipment versus standard equipment.
- Reimbursement may be determined for a more cost-effective alternative if medical necessity and appropriateness for the equipment is not demonstrated in the documentation submitted for review.

**Information that needs to be submitted with the claim and/or prior authorization (when applicable) request:**

- Practitioner's order (if not submitted with the claim, it may be requested at any time and payment recouped if unavailable);
- Member's diagnosis and expected prognosis;
- Estimated duration of use;
- Limitations and capability of the Member to use the equipment;

- Itemization of the equipment components, if applicable;
- Appropriate HCPCS codes for equipment being requested; and
- The Member's weight and/or dimensions (needed to determine coverage of manual or power wheelchairs), if available.

**The following guidelines apply to reimbursement for repair of DME equipment:**

- Equipment less than one (1) year old requires documentation related to the warranty coverage. Repairs that are covered by the warranty will not be reimbursed by BlueCross BlueShield of Tennessee;
- Documentation supporting need for services and/or items being billed; initial purchase date of equipment should be included, if available; and
- Prior authorization may be required for DME repairs for some BlueCross BlueShield of Tennessee lines of business.

BlueCross BlueShield of Tennessee will **only** provide benefits for Medically Necessary and Medically Appropriate Equipment. Requests for extraordinary items require justification.

BlueCross BlueShield of Tennessee will **not** provide benefits for Investigational Durable Medical Equipment.

## **18. Advanced Imaging/High Tech Imaging**

Prior authorization\* is required for select advanced imaging radiology procedures performed in an outpatient setting. Prior authorization reviews for these cases are processed by our High Tech Imaging vendor on behalf of BCBST. Prior authorization is **not** required for imaging procedures performed during an inpatient admission or emergency room visit.

Procedures requiring prior authorization include, but are not limited to:

- |   |   |
|---|---|
| ➤ Computed tomography (CT)              | ➤ Magnetic resonance angiography (MRA)  |
| ➤ Computed tomography angiography (CTA) | ➤ Positron emission tomography (PET)    |
| ➤ Magnetic resonance imaging (MRI)      | ➤ Magnetic resonance spectroscopy (MRS) |
|   | ➤ Nuclear cardiology                    |

\* Applies to Fully Insured Members. This program is an optional add-on for Administrative Services Only (ASO) Members.

To request prior authorization for any of the previously listed radiology procedures, call our High Tech Imaging vendor at 1-888-693-3211.

## **19. Musculoskeletal (MSK) Management**

The Musculoskeletal Management Program applies to Fully Insured Members. This program is an optional add-on for Administrative Services Only (ASO) Members. Prior authorization is required for select musculoskeletal services and procedures performed in an outpatient or pre-scheduled inpatient setting. Prior authorization is **not** required by the MSK vendor for musculoskeletal procedures performed during an unplanned admission or emergency room visit.

Procedures requiring prior authorization include, but are not limited to:

- Pain Management
- Spinal Surgeries
- Joint Surgeries (Hip, Knee and/or Shoulder)

To request prior authorization for any of the above listed musculoskeletal procedures or services, submit information via the company website, [www.bcbst.com](http://www.bcbst.com), fax to 1-866-747-0587, or call 1-866-747-0586. If questions, call the MSK vendor at 1-866-747-0586.

Note: Medical Records required for **initial** authorization review.

Concurrent review requests beyond the initial authorization will require review through BlueCross BlueShield of TN's normal process (via phone, fax, or Web).

## **20. NICU/SCN through First Year Care Management**

Prior authorization is required for newborns admitted to the Neonatal Intensive Care Unit or Special Care Nursery. Prior authorization reviews for these cases are processed by the NICU vendor on behalf of BCBST, and are reviewed for Medical Necessity throughout the hospitalization. The date of the next clinical review will be determined with each review. The NICU vendor will review:

- Birth inpatient admission to NICU or SCN
- All subsequent inpatient and outpatient admissions through Member's first birthday
- Ancillary services including DME and Home Health through Member's first birthday

To contact the NICU vendor, call 1-888-832-2006.

## **21. Performance Evaluations of Delegate Vendors and Providers**

The BlueCross BlueShield of Tennessee Delegate Oversight Program provides an organized and systematic approach to help ensure oversight of delegated administrative functions, which include Utilization Management, Quality Improvement, Credentialing, Independent Record Review, Case Management, Claims, Customer Service, Complaints, Grievance and/or Appeals, Transportation, EPSDT, and Medical Records Review.

BlueCross BlueShield of Tennessee will, at a minimum, complete an annual assessment of reports and annual performance evaluations of vendors/Providers to whom activities have been delegated. The purpose of a performance evaluation is to ensure compliance with standards of all of the applicable state and federal laws and regulations, as well as those of all applicable accrediting and regulatory review agencies, including but not limited to URAC, Tennessee Department of Commerce and Insurance (TDCI), and BlueCross BlueShield of Tennessee policies and procedures.

The performance evaluation includes, but is not limited to, the following:

- Desktop and /or onsite evaluation of the vendor's/Provider's compliance with all applicable standards
- Documentation and file review to determine the compatibility of the organization's goals and objectives with BlueCross BlueShield of Tennessee goals and objectives
- Criteria, methods, and process for determining Medical Necessity and Medical Appropriateness of care
- Written evaluation of the vendor's/Provider's capabilities to perform delegated functions, staffing capabilities, and performance record

The delegate vendor/Provider will support BlueCross BlueShield of Tennessee in meeting its requirements of annual and periodic performance evaluations by providing access to all records, policies, procedures, reports, and other documents as necessary to demonstrate compliance with the delegate program.

## **22. Second Surgical Opinion**

BlueCross BlueShield of Tennessee will pay for any second surgical opinion requested by a Member. This includes not only major surgery, but also other procedures (e.g., pacemakers, ambulatory surgery procedures, etc.).

The following guidelines apply to Second Surgical Opinions:

- A surgeon (one who is not in the same group or practice as the Practitioner who rendered the first opinion) must render the second opinion.
- The Practitioner rendering the second surgical opinion must be in a BlueCross BlueShield of Tennessee network and proper referrals must be in place, if applicable.

### 23. Non-Emergent Air Ambulance Transportation

- Prior authorization is required for non-emergent air ambulance transportation.
- Prior authorization is NOT required for emergency air ambulance transportation (e.g., from the scene of an accident when ground transport is not appropriate or would pose a threat to the Member).

To request prior authorization for non-emergent air transportation for a BCBST Member with commercial benefits, call 1-800-515-2121 (extension 6900) from 8 a.m. to 6 p.m. (ET).

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## D. Emergency Services

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Emergency Room services for an emergency condition do not require prior authorization. BlueCross BlueShield of Tennessee communicates to its Members to go to the nearest emergency room if they are suffering from an emergency condition.

An emergency is defined as a sudden and unexpected medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect to result in: serious impairment of bodily functions; serious dysfunction of any bodily organ or part; or placing the prudent layperson's health in serious jeopardy. These services may be provided by facility-based providers. It is understood that in those instances where a Physician makes emergency care determinations, the Physician shall use the skill and judgment of a reasonable Physician in making such determinations.

**Note:** *Prior authorization is not required for emergency room visits.*

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## E. Investigational Services

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Investigational services are those services that do not meet BlueCross BlueShield of Tennessee's definition of Medical Necessity. New and established technologies are researched and evaluated by BlueCross BlueShield of Tennessee's Medical Policy Research & Development Department and are assessed using sources that rely upon evidence based studies. Input is also sought from our network Providers.

The definition of "Investigational" is based on the BlueCross BlueShield of Tennessee's technology evaluation criteria. Any technology that fails to meet **ALL** of the following four (4) criteria is considered to be Investigational.

1. The technology must have final approval from the appropriate governmental regulatory bodies, as demonstrated by:
  - This criterion applies to drugs, biological products, devices and any other product or procedure that must have final approval to market from the U.S. Food and Drug Administration or any other federal governmental body with authority to regulate the use of the technology.
  - Any approval that is granted as an interim step in the U.S. Food and Drug Administration's or any other federal governmental body's regulatory process is not sufficient.

## BlueCross BlueShield of Tennessee Commercial Provider Administration Manual

2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes, as demonstrated by:
  - The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.
  - The evidence should demonstrate that the technology could measure or alter the physiological changes related to a disease, injury, illness, or condition. In addition, there should be evidence or a convincing argument based on established medical facts that such measurement or alteration affects health outcomes.
3. The technology must improve the net health outcome, as demonstrated by:
  - The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
4. The improvement must be attainable outside the Investigational settings, as demonstrated by:
  - In reviewing the criteria above, the Medical Policy Panel will consider Physician specialty society recommendations, the view of prudent medical Practitioners practicing in relevant clinical areas and any other relevant factors.

The Medical Director, in accordance with applicable ERISA standards, shall have discretionary authority to make a determination concerning whether a service or supply is an Investigational Service. If the Medical Director does not authorize the provision of a service or supply, it will not be a Covered Service. In making such determinations, the Medical Director shall rely upon any or all of the following, at his or her discretion:

1. Your medical records, or
2. The protocol(s) under which proposed service or supply is to be delivered, or
3. Any consent document that You have executed or will be asked to execute, in order to received the proposed service or supply, or
4. The published authoritative medical or scientific literature regarding the proposed service or supply in connection with the treatment of injuries or illnesses such as those experienced by You, or
5. Regulations or other official publications issued by the FDA and HHS, or
6. The opinions of any entities that contract with the Plan to assess and coordinate the treatment of Members requiring non-experimental or Investigational Services, or
7. The findings of the BlueCross BlueShield Association Technology Evaluation Center or other similar qualified evaluation entities.

These criteria are used in making such determinations as whether a service is considered to be Investigational or Medically Necessary. Providers have access to these policies via the Medical Policy Manual in the Provider section on the company website, [www.bcbst.com](http://www.bcbst.com) and are also informed of determinations via our monthly *BlueAlert* Newsletter.

If a BlueCross BlueShield of Tennessee Network Provider renders services that are Investigational or do not meet Medically Necessary and Appropriate criteria, the Provider must obtain a written statement from the Member, **prior** to the service(s) being rendered, acknowledging that the Member understands he/she will be responsible for the cost of the specific service(s). It is essential the signed statement be kept on file. It may be necessary to provide a copy of the written statement to BlueCross BlueShield of Tennessee if the Member questions the Member Liability amount reflected on his/her Explanation of Benefits (EOB). Once BlueCross BlueShield of Tennessee contacts the Provider, he/she will be asked to provide a copy of the signed written statement within two (2) business days. If the Provider is not able to supply the written statement, the claim will be adjusted to reflect Provider liability and the Member will not be responsible for those charges.

To help assist in this process, BlueCross BlueShield of Tennessee developed the *Acknowledgement of Financial Responsibility for the Cost of Services* form for Provider use. A sample copy of this form is located in Section V. Member Policy, in this Manual. Providers are encouraged to use this form. The

form can also be found in the Provider section of the company website, [www.bcbst.com](http://www.bcbst.com). This form meets the contractual obligations of BlueCross BlueShield of Tennessee Provider Agreements. However, it does not waive Prior Authorization requirements.

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## F. Medically Necessary and Medically Appropriate Policy

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BlueCross BlueShield of Tennessee covers Medically Necessary and Medically Appropriate health care services not otherwise excluded under BlueCross BlueShield of Tennessee health care benefits plans.

### **Medically Necessary or Medical Necessity**

“Medically Necessary” refers to procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical Practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient’s illness, injury or disease; and
- not primarily for the convenience of the patient, Physician or other health care Provider; and
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician specialty society recommendations, and the views of medical Practitioners practicing in relevant clinical areas and any other relevant factors.

### **Medically Appropriate**

“Medically Appropriate” refers to services, which have been determined by BlueCross BlueShield of Tennessee in its discretion to be of value in the care of a specific Member. To be Medically Appropriate, a service must meet all of the following:

1. Be Medically Necessary.
2. Be consistent with generally accepted standards of medical practice for the Member’s medical condition.
3. Be provided in the most appropriate site and at the most appropriate level of service for the Member’s medical condition.
4. Not be provided solely to improve a Member’s condition beyond normal variation in individual development, appearance and aging.
5. Not be for the sole convenience of the Provider, Member or Member’s family.

BlueCross BlueShield of Tennessee may request medical records when the complexity of a case requires a review of the medical records in order to determine if a service is Medically Necessary and Medically Appropriate.

**Note:** *According To Contract, BlueCross BlueShield of Tennessee Will Not Reimburse For Photocopying Expenses.*

BlueCross BlueShield of Tennessee encourages open Practitioner/patient communication regarding appropriate treatment alternatives.

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## G. Prospective and Retrospective Review

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These reviews are conducted based on MCG criteria (if applicable), BlueCross BlueShield of Tennessee adopted utilization management guidelines, BlueCross BlueShield of Tennessee Medical Policy, *Physician's CPT®*, *CMS Common Procedure Coding System* and the Member's health care benefits plan. The following listed services are not all-inclusive and may be subject to prospective or retrospective review:

- Possible cosmetic services;
- Potential Investigational services;
- Skilled nursing facility confinements;
- Chiropractic services;
- Outpatient therapies;
- Durable Medical Equipment (when prior authorization is not required);
- Prosthetics, orthotics, and supplies;
- Practitioner office services;
- Dental, accident related, and temporomandibular joint dysfunction;
- Pain management;
- Unbundled codes and/or code combinations; and
- Non-participating provider or no prior authorization obtained.

Types of reviews may change based on policy or guideline changes, identification of the need for focused reviews, etc.

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## H. Provider Appeal Process

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It is the policy of BlueCross BlueShield of Tennessee to make available to treating Practitioners a peer-to-peer review to discuss, by telephone, determinations based on Medical Appropriateness. These reviews can be requested in the following situations:

1. Anytime during the hospital stay;
2. Within twenty-four (24) hours of notification of decision if already discharged; and
3. For elective services, prior to services being rendered or filing an appeal.

Providers can reach a dedicated voicemail system by calling the Provider Service line, 1-800-924-7141, Monday through Thursday, 8 a.m. to 6 p.m. (ET); Friday, 9 a.m. to 6 p.m. (ET). All messages left before 3 p.m. (ET) will be returned the same day. Messages left after 3 p.m. (ET) will be returned the next business day. The voicemail system requires two (2) specific dates and times to schedule the Physician-to-Physician review as well as other Member demographics indicated by the voicemail prompts. If the Provider is still not satisfied following a peer-to-peer discussion, the Provider should proceed to the next level of appeal (i.e., Provider Dispute Resolution).

### Utilization Management Appeals

#### Reconsideration Prior to Service

Additional information may be submitted via the regular authorization process when an adverse determination is issued by BlueCross BlueShield of Tennessee. This information may also be submitted to BlueCross BlueShield of Tennessee from the Provider or Provider representative.

Provider office staff should only initiate a Physician-to-Physician discussion with one of our medical directors when the attending or ordering Physician requests, and is aware of the discussion.



### **Expedited Appeal**

- The request for an expedited appeal must be initiated by phone and should include a request for expedited appeal along with any pertinent information not originally submitted.
- An expedited appeal may or may not require a peer-to-peer conversation.
- An expedited appeal can be requested when the Provider believes that the adverse determination:
  1. could seriously jeopardize the life or health of the Member and the ability of the Member to regain maximum function, and/or
  2. in the opinion of the Practitioner with knowledge of the Member's medical condition would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case.

An expedited appeal will be completed and notification issued to the Member and Provider no later than seventy-two (72) hours after initial request of the appeal, however, the clinical circumstances will help determine the speed of the response.

Expedited appeals may be requested by calling the appropriate prior authorization number. You should verbally request the review to be labeled as an expedited appeal in order for BlueCross to assure the review is completed within the timeframe. (Refer to Section II. Quick Reference Telephone Guide in this Manual.)

### **Non-Compliance Denial Appeal**

There is no reconsideration of a non-compliance denial. If a party is dissatisfied with a non-compliance denial, they may appeal the denial. Appeals of non-compliance denials must be submitted within sixty (60) days of the initial denial. The request should include a copy of any pertinent clinical information, face sheet, if applicable, and a statement from the Practitioner/Facility indicating the reason(s) for the appeal and a copy of the denial letter. A determination will be sent to the Practitioner/Facility and/or Member within thirty (30) days of the receipt of the request for appeal. If the party is still dissatisfied with the decision, he/she may proceed to Arbitration pursuant to Section II C. of the PDRP.

### **Standard Appeal**

The standard appeal process can be used if reconsideration resulted in an adverse determination. Requests for standard appeal for Medical Necessity denials **must** be received in writing by the Utilization Management department within 180 days of the date of the initial denial notification. This does not preclude timely filing requirements.

Exhausting the above noted process satisfies Section II. A. and B. of the Provider Dispute Resolution Procedure (PDRP) outlined in Section XIII in this Manual. If the party is still dissatisfied, he/she may appeal the adverse decision pursuant to Section II. C. of the PDRP.

### ***Medical record submission guidelines***

Occasionally, medical records are received at BlueCross BlueShield of Tennessee without a clear indication of who requested the information, what is being requested or complete Member identification. Medical records may be submitted via hardcopy, fax or CD-ROM.

When submitting medical records for appeal:

1. Submit any request or notification letter from us as the **first** page of your medical record or the UM appeals form located at <http://www.bcbst.com/providers/forms/Utilization-Management-Appeal-Form.pdf>. **Failure to do so may result in a delayed response to your request or your request being returned until appropriate documentation is supplied.**
2. If submitting multiple records for a single patient or multiple records for multiple Members, ensure the individual records are secured with a clip or other indicator if mailed in the same envelope.
3. Medical records may be submitted through certified mail.
4. Medical records must be legible with all appropriate information pertinent to the presenting case.

5. Include all Member information in a clear, legible format. We must be able to identify the Member and the relationship to BlueCross BlueShield of Tennessee.
6. Claims must be attached **behind** the medical record. If attached to the front, it will be mistaken for a claim needing adjudication rather than a medical record needing review.

Fax Appeal (preferred method) to: (423) 591-9451

Or

Mail Appeal to:

BlueCross BlueShield of Tennessee  
Commercial Appeals/Retrospective Claims Review  
1 Cameron Hill Circle, Suite 0017  
Chattanooga, TN 37402-0017

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## **I. Medical Policy Manual**

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The Medical Policy Manual contains medical policies and general policies approved by BlueCross BlueShield of Tennessee. **Medical policies** address specific new medical technologies or pharmaceutical agents.

Medical policies are based upon evidence-based research using published studies and/or prevailing Tennessee practice. Determinations with respect to technologies are made using criteria developed by the BlueCross BlueShield Association's Technology Evaluation Center. The criteria are as follows:

1. The technology must have final approval from the appropriate governmental regulatory bodies.
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
3. The technology must improve the net health outcome.
4. The technology must be as beneficial as any established alternatives.
5. The improvement must be attainable outside the investigational settings.

The medical policies specifically state whether a technology is considered Medically Necessary, Not Medically Necessary, Investigational, or Cosmetic. Definitions of these terms are found within the Medical Policy Manual Glossary. Providers may view the BlueCross BlueShield of Tennessee Medical Policy Manual in its entirety on the company website at <http://www.bcbst.com/providers/mpm.shtml>.

Many policies also contain a Medical Appropriateness section. This section contains the criteria used in determining whether a particular technology is appropriate in a particular case (i.e., for a specific individual).

BlueCross BlueShield of Tennessee recognizes the occasional need for "Pilot Programs" for procedures and services which may not meet the Medical Necessity criteria established by BlueCross BlueShield of Tennessee Medical Policy, but for which there is recognized promise or other compelling reasons to test their usefulness. These Pilot Programs will allow testing for both medical and cost effectiveness of alternative Providers, procedures and services in order to determine the impact on BlueCross BlueShield of Tennessee and its Members.

### **Medical Policy Appeals**

BlueCross BlueShield of Tennessee network Providers may appeal a draft or active medical policy. A medical policy appeal is a formal notice from a network Provider stating dissatisfaction with any medical policy determination. The dissatisfaction could be questioning the Investigational status of a medical policy or the Medical Appropriateness criteria contained in a medical policy. Published, peer-reviewed studies supporting the appealing Providers position must be submitted with each medical policy appeal.

***The medical policy appeal process follows:***

- Provider submits a written request for appeal of a medical policy, along with full-text copies of supporting documentation to the Provider Appeals Department.
- Provider Appeals Coordinator sends the request to the division representative for the Medical Policy Research & Development Department.
- Medical Policy Research & Development Department reviews the appeal and supporting documentation.
- The appeal decision is returned to the Provider Appeals Department with a detailed response for the Provider.
- A written response is sent via registered mail to the network Provider.

Network Providers may submit a written medical policy appeal along with supporting documentation to:

Provider Appeals Coordinator  
Provider Network Management  
BlueCross BlueShield of Tennessee  
1 Cameron Hill Circle, Ste 0039  
Chattanooga, TN 37402, 0039

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## **J. Directing Members to Participating Providers in Members' Network**

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When a Member needs additional care outside your practice, you can assist them by directing them to participating Providers in the Member's network. Members seeking care outside their network will have significant reductions in benefits or no benefits. An illustration of the increased Member liability for out-of-network utilization follows:

**Example:**

Physician charges = \$300.00

BlueCross BlueShield of Tennessee maximum allowed = \$180.00

***Utilizing an in-network Provider***

Provider network Physician discount = \$120.00

BlueCross BlueShield of Tennessee payment = \$150.00 (or 80% of \$180 maximum allowed)

Member payment = \$30.00

***Utilizing an out-of-network Provider***

Provider network Physician discount = \$0

BlueCross BlueShield of Tennessee payment = \$108.00 (or 60% of \$180 maximum allowed)

Member payment = \$192.00

By helping your patients utilize **in-network** Providers, you can help ensure they receive the highest level of benefits. An online directory of participating Providers by network-type is available on the company website, [www.bcbst.com](http://www.bcbst.com). Both Members and Providers may access the Provider directories from any page of our site by selecting "Find a Doctor!" located on the right-hand side of the screen.

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## K. Utilization Management Resources

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The following tools are utilized in the clinical decision process:

***First Tool- Member's contract***

The Member's contract is the first tool in the clinical decision process. If the service is provided within the contract, then it may require evaluation of Medical Appropriateness.

***Second Tool-Medical Policy***

The Medical Policy is the second tool in the clinical decision process. The Medical Policy Manual will provide policy statements and Medical Appropriateness criteria to determine Medical Necessity.

***Third Tool-Clinical Guidelines***

The Utilization Management criteria are the third tool in the clinical decision process. Clinical guidelines include MCG, and BCBST Utilization Management Guidelines. If the contract addresses the service, but Medical Policy does not, the Clinical Guidelines should be applied to the request for services.

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## **X. CASE MANAGEMENT**

The BlueCross BlueShield of Tennessee Case Management Programs promote Member empowerment regarding health care decisions, Member education on health conditions and options, as well as the tools and resources necessary to assist the Member/family when making health care decisions. The BlueCross BlueShield of Tennessee Case Management Programs also offer quality and cost effective coordination of care for Members with complicated care needs, chronic illnesses and/or catastrophic illnesses or injuries.

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### **A. Components**

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- Lifestyle/Health Education Program
  - ⇒ Lifestyle/Health Education is a self-directed program involving identifying Members with potential health risks and then empowering them with the tools and educational materials necessary to make the most informed decisions regarding their health.
- Complex Case Management
  - ⇒ Complex Case Management is the collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes. The goal is to facilitate the delivery of appropriate individual health care services across the continuum of care in various settings for Members with complex and catastrophic conditions. The Complex Case Management Program monitors compliance with NCQA standards in order to maintain accreditation. Related activities to Case Management include care coordination, complex condition management, population health management through wellness, disease and chronic care management, and promoting transitions of care services.
- Transplant Case Management
  - ⇒ Transplant Case Management focuses on the entire spectrum of transplant care. The care of the Member is managed from the time of the evaluation for a transplant until services are no longer needed. BlueCross BlueShield of Tennessee helps its Members in need of bone marrow or solid organ transplants receive quality care by directing them to Practitioners in the national transplant health networks. The facilities within this network and the Practitioners who practice there have been specifically selected for their expertise and quality outcomes in transplant cases.
- Population Health Management
  - ⇒ Population Health Management focuses on Wellness, Care Coordination, High-Risk Maternity, Chronic Care, and Complex Case Management.

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### **B. Case Management Criteria and Guidelines**

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- ⇒ MCG criteria (formerly Milliman Care Guidelines®)
- ⇒ NCQA Measures (National Committee for Quality Assurance)
- ⇒ Case Management Society of America (CMSA) Practice Guidelines
- ⇒ BlueCross BlueShield of Tennessee adopted guidelines
- ⇒ BlueCross BlueShield of Tennessee Medical Policy

**Case Management Referral Criteria**

The following list (not intended to be all-inclusive) are referral guides to recommend a Member for any of the care management programs:

**Lifestyle/Health Education Referral Criteria:**

If a Member could benefit from educational materials on these health conditions, please refer them to the Lifestyle/Health Education program.

**Telephone 1-800-818-8581      Fax 1-888-328-0394**

**Lifestyle/Health Education**

Allergies  
Asthma  
Arthritis  
Cardiovascular Diseases  
Diabetes  
Kidney Diseases  
Migraines  
Pregnancy  
Respiratory Diseases

**Emergency Services Management**

ER visits greater than (3) three within a 3-month period

**Bariatric Surgery Management**

**Disease Management Referral Criteria:**

**Telephone 1-800-818-8581      Fax 1-888-328-0394**

**Chronic Condition Program**

*(Additional service purchased by employer)*

Asthma  
Chronic obstructive pulmonary disease (COPD)  
Congestive heart failure (CHF)  
Coronary artery disease (CAD)  
Diabetes

**Complex Case Management Referral Criteria:**

**Telephone 1-800-818-8581      Fax 1-888-328-0394**

**Complex Case Management**

|   |                         |
|---|-------------------------|
| Air ambulance outside USA   | High risk OB            |
| AIDS  | Hospice services        |
| Severe burns (> 30% of body)  | Lupus                   |
| Cancer  | Multiple Trauma         |
| Cerebral vascular accident (CVA)  | Neurological conditions |
| Complex home health care, continuous home infusion therapy needs, and all private duty nursing patients | Perinatal infections    |
| Crohn's disease   | Renal failure           |
| Cystic fibrosis   | Sickle cell anemia      |
| Elevated lead levels  | Spinal cord injury      |
| End stage disease of any organ  | Traumatic brain injury  |
| Hemochromatosis   | Ulcerative colitis      |
| High risk infant  | Vent dependency         |

**Transplant Case Management Referral Criteria:**

**Telephone 1-888-207-2421      Fax 423-535-5260**

**Transplant Case Management**

Bone marrow  
Solid organ  
Stem cell

**Requests for case management should include the following information:**

- Requesting Practitioner's name and telephone number;
- BlueCross BlueShield of Tennessee Member name, BlueCross BlueShield of Tennessee ID number and telephone number;
- Diagnosis and current clinical information;
- Current treatment setting (e.g., hospital, home health, rehabilitation, etc.);
- Reason for request for case management (e.g., patient has COPD with frequent hospital admissions); and
- Level of urgency of care management need.

After receipt of request for case management, a case manager will make an initial call to the referral source within two (2) working days. **If an urgent request is needed, please specify in the phone or fax message.**

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## **C. Complex Case Management Team and Process**

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### **Complex Case Management Team and Process**

The Complex Case Management Team consists of registered nurses who are case managers, medical directors who are available for consultations, social workers who address psychosocial aspects and facilitate service provision for Members with barriers to care, and benefit specialists who have claims and benefit management experience. In the event of terminal illness, severe injury, major trauma, cognitive or physical disability, case managers work with a Member's primary caregivers to coordinate the most appropriate, cost-effective treatment path based on the Member's unique situation.



Case managers stay in regular contact with Members throughout treatment, coordinate clinical and health plan coverage issues, and help families utilize available community resources.

After obtaining Member consent for case management participation, the case manager will collaborate with the Member, Practitioner and other appropriate Providers to coordinate and facilitate an individualized plan of treatment to meet the Member's health care needs.

The case manager will continue to evaluate the Member's progress and health care needs and communicate findings with the Member and Practitioner. When the Member becomes clinically stable and/or the plan of treatment has met the Member's needs, catastrophic case management services may be discontinued or referred to a less intensive case management program.

Prior to discontinuation of case management services, the case manager will communicate the following information to the Member:

- Reason for and specific future date for discontinuing case management services;
- Instructions for continuing prior authorization of continued services, if necessary;
- Explanation of transition of Member's case to another care management program; and
- Instructions for requesting case management services if Member's clinical condition regresses.

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## **D. Transplant Case Management**

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The Transplant Case Management Team consists of registered nurses specifically trained in the areas of solid organ and bone marrow transplantation, medical directors, who are available for consultations, and benefit specialists who have claims and transplant benefit management experience.

It is critically important, to both the Practitioner and Member, that BlueCross BlueShield of Tennessee Transplant Case Management be contacted as soon as you think the Member may need an evaluation for transplant:

- If Prior authorization from Transplant Case Management is not obtained, the transplant and related services may not be covered or reimbursement will be reduced substantially.
- Most Members' health care benefits plans encourage Members to receive transplant services at an In Transplant Network facility (see definition below).
- Transplants performed outside of the BlueCross BlueShield of Tennessee In-Transplant Network may not be covered or BlueCross BlueShield of Tennessee reimbursement will be greatly limited (depending on the Member's health care benefits plan).
- If the Member does have access to Out-of-Transplant Network Benefits, those Benefits are subject to the Transplant Maximum Allowable Charge (TMAC). **Member's liability beyond the TMAC may be substantial.**

Not all BlueCross BlueShield of Tennessee In-Network Practitioners and hospitals (e.g., Blue Networks P and S) are in the BlueCross BlueShield of Tennessee In-Transplant Network. Seeking care outside the BlueCross BlueShield of Tennessee In-Transplant Network can reduce benefits and require substantial payment by the Member. Please check with BlueCross BlueShield of Tennessee Transplant Case Management to see which hospitals are in the BlueCross BlueShield of Tennessee In-Transplant Network before referring Members for transplant evaluation.

**BlueCross BlueShield of Tennessee In-Transplant Network  
The Blue Distinction Centers (BDCT) for Transplant**

BlueCross BlueShield of Tennessee and the BlueCross BlueShield Association administers and contracts with the transplant centers that make up The Blue Distinction Centers for Transplant.

This national network of transplant centers offers comprehensive transplant services through a coordinated, streamlined program of transplant management. Participating centers are major clinical programs and leading research institutions located throughout the country. The BDCT currently contracts for: heart, single or bilateral lung, combination heart-bilateral lung, liver, (including living donor), pancreas, simultaneous pancreas-kidney, and bone marrow/stem cell (autologous/allogeneic). **BDCT does not contract for Kidney Transplants.** (For information on Kidney Transplants, see *Kidney Transplants* in this section).

For further information about becoming a BDCT facility or questions specifically regarding the BlueCross BlueShield Association or BDCT program, contact the Blue Distinction Centers for Transplant **1-800-263-7893**.

Participating facilities receive a BDCT Procedure Manual from the BlueCross BlueShield Association. This manual contains detailed instructions, forms and contact lists for Participating and Referring BlueCross BlueShield Plans. BlueCross BlueShield of Tennessee is a Referring and a Participating Plan in the BDCT Network. The guidelines outlined in the BDCT Procedure Manual must be followed, **in addition to** those outlined in this manual, for maximum allowable reimbursement of transplants and transplant-related services.

**In-Network, but not in In-Transplant Network**

These facilities (e.g., Participating Blue Networks P and S, BlueCard®/BlueCard® PPO) may receive a reduced level of reimbursement for some Members. If Member benefits are available, reimbursement will be subject to the Transplant Maximum Allowable Charge (TMAC) for the global transplant period. Member is liable for any amounts in excess of the TMAC up to contracted fee schedule amount.

**Out-of-Network**

If a facility is not contracted with BDCT; the Member's BlueCross BlueShield of Tennessee Network (e.g., Blue Networks P and S, BlueCard®/BlueCard® PPO); or otherwise contracted with the local BlueCross BlueShield Plan, the facility is Out-of-Transplant Network. Members may have benefits at these facilities, but benefits and allowable reimbursement are subject to the TMAC. Out-of-network deductible and out-of-pocket maximum will apply. Amounts over the TMAC do not apply to the out of pocket maximum and are not covered. Reimbursement and benefits are reduced as compared with In-Transplant Network benefits and reimbursement. Amounts in excess of the TMAC are non-covered and may result in substantial Member liability.

**BlueCard®** The BlueCard program links participating health care Practitioners and the independent BlueCross BlueShield plans across the country and around the world. **Not all Members have BlueCard coverage. Not all BlueCard facilities participate in the BlueCross BlueShield of Tennessee In-Transplant Network.** Transplants for BlueCross BlueShield of Tennessee Members that occur at BlueCard® facilities, not in the BlueCross BlueShield of Tennessee In-Transplant Network, will be reimbursed in accordance with the Member's health care benefits plan and may be subject to the TMAC. To determine eligibility and benefits of a BlueCard® Member call 1-800-676-BLUE (2583). Provide the operator with the Member's ID, including alpha-prefix. You will be transferred to the Member's home BlueCross BlueShield Plan. For additional information regarding BlueCard®, see the BlueCard® website [www.bluecard.com](http://www.bluecard.com) or Section XVI. in this Manual.

**Referrals, Case Management, and Prior Authorization**

**Referrals**

All transplants require prior authorization and coordination by a BlueCross BlueShield of Tennessee Transplant Case Manager. It is very important that Members be referred to BlueCross BlueShield of Tennessee In-Transplant Network facilities or there will be significant reduction in benefits, including no benefits for some Members.

**Case Management**

By notifying Transplant Case Management prior to evaluation, the Practitioner and the Member can make informed decisions based on the Benefits available to the Member. The Transplant Case Manager will work with the Member and Practitioner to determine if the transplant-related service is medically appropriate as well as identify high-risk Members who will need additional assistance. The Transplant Benefits Specialists in this department can also let the Member know about other benefits, such as travel, that may be available to the Member, if they utilize the In-Transplant Network. **Contact Transplant Case Management at 1-888-207-2421 prior to all Member referrals for any transplant-related medical care, including evaluation to ensure that the services are covered and that the Member receives the highest level of benefits available.**

**Denials**

Transplant cases determined by Transplant Case Management Program not to be Medically Necessary and Medically Appropriate will be reviewed by our Medical Director. The Member and the Practitioner will be given the determination in writing.

**Appeals**

Refer to Section VIII. UM Program and Section XIII. Provider Dispute Resolution, in this Manual.

**Prior Authorization**

The transplant facility must provide the BlueCross BlueShield of Tennessee Transplant Case Manager with the Member name, identification number(s), type of transplant, and proposed dates of service (inpatient/outpatient). The facility is required to submit clinical information to obtain prior authorization for the transplant once the Member has been evaluated. The facility must notify BlueCross BlueShield of Tennessee within one (1) business day of a transplant services admission (inpatient/outpatient).

BDCT facilities must also notify the Referring BlueCross BlueShield Plan (if appropriate per BDCT Practitioner Procedures Manual) and the BlueCross BlueShield Association and submit the appropriate forms provided in the BDCT Practitioner Procedures Manual.

**Length of Stay**

The facility must notify BlueCross BlueShield of Tennessee to obtain initial authorization as well as provide clinical updates through out the transplant procedure and recovery. The BlueCross BlueShield of Tennessee Transplant Case Manager will authorize the initial admission for transplant and will outline the schedule for clinical updates required for extending the stay.

**Transplant Global Period**

Transplant benefits and reimbursement are calculated as a global period. TMAC charges apply to any and all inpatient and outpatient charges during the following time periods. Participating facilities, contracted to provide transplant services, may be eligible for additional reimbursement beyond the global rate, (outlier charges). To be eligible for outlier reimbursement the facility must contact BlueCross BlueShield of Tennessee for authorization of the outlier days. Prior authorized outlier days will be reimbursed in accordance with the contracted per diem rate if the Member is inpatient in excess of the following predetermined length-of-stay days:

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- Bone Marrow/Stem Cell: 50 days, plus pre-transplant treatment days
- Lung: 38 days
- Liver: 39 days
- Liver/Kidney: 39 days
- Heart: 38 days
- Combination Heart-Bilateral Lung: 43 days
- Simultaneous Pancreas-Kidney: 34 days

### Transitional Care/Discharge

Facilities must notify BlueCross BlueShield of Tennessee of a transplant Member's proposed transition/discharge from care and obtain BlueCross BlueShield of Tennessee's agreement to the proposed Member transition/discharge plan and follow-up recommendation.

### Claims

Claims should be submitted to BlueCross BlueShield of Tennessee according to the facility's contract and participation in the BlueCross BlueShield of Tennessee In-Transplant Network or other Networks as described previously in this section.

### Blue Distinction Centers for Transplant (BDCT) Facilities –

The Participating BDCT Facility must submit the **global transplant claim** to the Member's Home Plan as outlined in the BDCT Practitioner Procedures Manual when:

- Facility is contracted with BDCT for the transplant type;
- Member's BlueCross BlueShield Home Plan is a Referring Plan in BDCT; and
- Transplant has been authorized.

### ***The Participating BDCT Facility must follow these steps when submitting a global transplant claim:***

1. Collect all itemized bills for transplant services included in the BDCT global rate (hospital, professional, ancillary, and procurement/harvesting charges). These bills are to be submitted in paper copy, using CMS-1450 and/or CMS-1500 claim forms. All eligible transplant services and applicable global rates are listed in the Hospital Participation Agreement (BDCT Contract).
2. Attach the completed Institutional Billing Summary Form (found in the BDCT Procedures Manual) to the bundled claims.
3. Attach a completed copy of the BDCT Referral Authorization Form (blank form available in the BDCT Procedures Manual) so that the Referring Plan's Transplant Coordinator can identify the bundled claims as BDCT global claims.
4. Mail bundled claims and attachments, in one envelope, to the Member's Home Plan Transplant Coordinator, designated in the Billing Section of the BDCT Referral Authorization Form submitted by the Referring Plan.

Mail BlueCross BlueShield of Tennessee Member claims to:

Transplant Benefits Specialist  
BlueCross and BlueShield of Tennessee  
1 Cameron Hill Circle CH 2.3  
Chattanooga, TN 37402

5. Collect any applicable deductibles and coinsurance from the Member.

**Note:** See *BDCT Procedures Manual* for a complete listing of BDCT Referring BlueCross BlueShield Plans and all referenced forms. Participating BDCT Practitioners may obtain additional copies of the *BDCT Procedures Manual* from BDCT.

**Out-of-Transplant Network Facilities (In Tennessee)**

Participating BlueCross BlueShield of Tennessee facilities, not participating in BDCT for the transplant type must submit transplant claims to BlueCross BlueShield of Tennessee as outlined in the Participating Practitioner's Institutional Agreement between the facility and BlueCross BlueShield of Tennessee. These claims should be mailed to:

Transplant Benefits Specialist  
BlueCross and BlueShield of Tennessee  
1 Cameron Hill Circle CH 2.3  
Chattanooga, TN 37402

If the Member's BlueCross BlueShield Home Plan is NOT a Referring Plan in BDCT, and the Member is NOT a BlueCross BlueShield of Tennessee Member, contact the Member's BlueCross BlueShield Home Plan for billing and claims instructions.

**Note:** *Transplants performed outside of the BlueCross BlueShield of Tennessee In-Transplant Network may not be covered or BlueCross BlueShield of Tennessee reimbursement will be greatly limited (depending on the Member's health care benefits plan). If the Member does have access to Out-of-Transplant Network Benefits, those Benefits are subject to the Transplant Maximum Allowable Charge (TMAC). BlueCross BlueShield of Tennessee will pay all associated transplant-related claims during the global period (including pre-transplant stem cell transplant services such as mobilization and harvest) on a claim-by-claim basis according to when claims are filed until the benefit is exhausted.*

**Transplant Maximum Allowable Charge (TMAC)**

The global TMAC is calculated based on data provided by Blue Distinction Centers for Transplant (BDCT). If the BDCT global rate includes pre-transplant services, the TMAC rate will also include those services. The Member's Out-of-Pocket Maximum does not apply to charges beyond the TMAC. The reimbursement amount will be based on the TMAC as calculated at the time of the transplant. **Member's liability beyond the TMAC may be substantial.**

**Coordination of Benefits**

When BlueCross BlueShield of Tennessee will be paying secondary to other commercial insurance or other insurance will be paying secondary to BlueCross BlueShield of Tennessee, Transplant Case Management should be notified.

If secondary to Medicare, Transplant Case Management will not review for Medical Appropriateness. Payment will be handled according to Medicare Guidelines. This excludes the Federal Employee Program (FEP).

If secondary to Commercial Carrier, Transplant Case Management will review for Medical Appropriateness. Approved transplants will be paid according to the Member's health care benefit plan. If other (primary) Commercial Insurance denies benefits, Transplant Case Management will coordinate benefits and handle as if BlueCross BlueShield of Tennessee were primary.

**Travel, Meals and Lodging**

Some Members have Travel Benefits. If the Member has Travel Benefits (as defined in the

Member's health care benefits plan), these benefits are paid to the Member, not the Practitioner. Examples of travel expenses include: travel expenses for evaluation of a Member prior to a covered procedure; transportation to and from the site of a covered procedure, meals, and lodging expenses for the Member and one caregiver. Travel benefits may vary.

### Transitional Care

Should the facility or Member contract change after the transplant has been medically approved, but before the transplant has occurred, Transplant Case Management will notify the Member and Practitioner of the change and how benefits and reimbursement will be affected.

### Kidney Transplants

Kidney transplants are handled differently than transplants contracted by BDCT. BlueCross BlueShield of Tennessee Members may access any Kidney Transplant facility identified as participating in the Member's Network of Acute Care Hospitals contracted to provide kidney transplants (e.g., Blue Networks P and S, BlueCard<sup>®</sup>/BlueCard<sup>®</sup> PPO). **BDCT does not contract with hospitals to provide Kidney Transplants (kidney alone).**

Facilities will be reimbursed according to surgical Per Diems and/or Diagnosis Related Group (DRG) Rates and/or case rates outlined in the Institutional Agreement between the facility and BlueCross BlueShield of Tennessee.

### Covered Health Services

Medically Necessary and Appropriate services and supplies are covered under the Member's health care benefits plan and provided to the Member, when he or she is the recipient of one of the following organ transplants if covered under the Member's health care benefits:

- |                         |                   |                      |
|-------------------------|-------------------|----------------------|
| ➤ Bone Marrow/Stem Cell | ➤ Lung            | ➤ Kidney/Small Bowel |
| ➤ Heart                 | ➤ Liver           | ➤ Small Bowel/Liver  |
| ➤ Heart/Lung            | ➤ Pancreas        |                      |
| ➤ Kidney                | ➤ Pancreas/Kidney |                      |

Benefits may be available for other organ transplant procedures, which, in BlueCross Blue Shield of Tennessee's sole discretion, are not Investigational and which are Medically Necessary and Medically Appropriate. Requests for authorization for other, non-organ transplants (e.g., cornea, skin) should be directed to BlueCross BlueShield of Tennessee Utilization Management.

The transplant and transplant related services may not be covered or will be reduced (depending on the Member's benefits) if the transplant and transplant related services are not approved by Transplant Case Management.

The transplant and transplant related services may not be covered or will be reduced (depending on the Member's health care benefits plan) if the Member does not accept Transplant Case Management.

Additional benefits, such as travel, may be available to the Member, if the In-Transplant Network is utilized. Transplant Case Management will review the Member's health care benefits plan to determine if this or other benefits exist. If available, these benefits are reimbursed to the Member, not the Practitioner.

### Donor Organ Procurement

The cost of Donor Organ Procurement is included in the total cost of the Member's organ transplant. It is included in the global TMAC calculation or any contracted global or case rate. Donor services are covered only to the extent not covered by the health coverage of the Donor.

- Covered Services for the donor are limited to those services and supplies directly related to the transplant service itself:
  - Testing for the donor's compatibility;
  - Removal of the organ from the donor's body;
  - Preservation of the organ; and
  - Transportation of the organ to the site of transplant.

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- Services not Covered for the donor include:
  - Complications of donor organ procurement.
  - Payment to an organ donor or the donor's family as compensation for an organ, or payment required to obtain written consent to donate an organ; and
  - Donor services including screening and assessment procedures not prior authorized by the Member's health care benefits plan.

### Conditions/Limitations

- Transplant Case Management will coordinate all transplant services, including pre-transplant evaluation.
- If Transplant Case Management is not notified, the transplant and related procedures may not be covered.
- Transplants performed outside of the BlueCross BlueShield of Tennessee In-Transplant Network may not be covered or BlueCross BlueShield of Tennessee reimbursement will be greatly limited (depending on the Member's health care benefits plan).

**Note:** If the Member does have access to Out-of-Transplant Network Benefits, those benefits are subject to the global Transplant Maximum Allowable Charge (TMAC). Not all BlueCross BlueShield of Tennessee participating network Practitioners and hospitals (Blue Networks, P and S, BlueCard®/BlueCard® PPO) are in the BlueCross BlueShield of Tennessee In-Transplant Network. **Member's liability beyond the TMAC may be substantial.**

### Exclusions

- If the Member does not receive prior authorization, the transplant and related services will not be covered or reimbursement will be reduced substantially;
- Any service specifically excluded under the Member's health care benefits plan, except as otherwise provided in this section;
- Services or supplies not specified as Covered Services under this section;
- If the Member receives prior authorization through Transplant Case Management, but does not obtain services through the In-Transplant Network, he/she will be responsible for payment to the Practitioner and/or hospital for any additional charges not covered under the Member's health care benefits plan. These charges may be substantial;
- Any attempted covered procedure that was not performed, except where such failure is beyond the Member's control;
- Any non-Covered Services;
- Services which are covered under any private or public research fund, regardless of whether the Member applied for or received amounts from such fund;
- Any non-human, artificial or mechanical organ;
- Payment to an organ donor or the donor's family as compensation for an organ, or payment required to obtain written consent to donate an organ;
- Donor services including screening and assessment procedures which have not received prior authorization from BlueCross BlueShield of Tennessee;
- Removal of an organ from a Member for the purposes of transplantation into another person, except as covered by the Donor Organ Procurement provision;
- For bone marrow transplants, any registry charges other than the one from which the bone marrow is received are not covered. All charges incurred as a result of the testing/typing are considered to be expenses of the Member to the extent that the donor has no other coverage;
- Harvest, procurement, and storage of stem cells, whether obtained from peripheral blood, cord blood, or bone marrow when reinfusion is not scheduled; and
- Other non-organ transplants (e.g. cornea, skin) are not covered under this section, but may be covered as an Inpatient Hospital Service or Outpatient Facility Service, if Medically Necessary.

## **E. Ancillary Care Management**

### **1. Healthy Maternity**

The Healthy Maternity program provides prenatal health education and resources to expectant Members who self-enroll during their pregnancy. The focus of the program is to encourage comprehensive and timely prenatal care as well as supportive case management and resources. Care managers with maternity experience will provide education and resources during a healthy pregnancy at each trimester and during the 7th, 8th and 9th month of pregnancy. The Care Managers contact the Member at post-delivery to assess depression and follow up for the 6-week postpartum follow up.

### **2. Behavioral Health Care Management**

Behavioral Health Care Management licensed behavioral health clinicians working with medical case managers to determine the most appropriate care settings and the Practitioners best suited to treat each unique situation. The program identifies high-risk Members for assessment opportunities to manage a Member's total care for improved treatment outcomes.

- All care for Members is fully integrated with other programs such as Medical Case Management, Disease Management, Behavioral Health Disease Management, Disability Benefits, EAPs, and others per employer group's request.
- Behavioral Health Case Managers:
  - help Members by identifying the most appropriate treatment and Provider for the condition(s);
  - are physically located with BlueCross BlueShield of Tennessee Medical Case Managers, increasing referral, coordination, and consultation, thus resulting in better Member outcomes due to a higher degree of integration.
- Cases are reviewed by Behavioral Health Medical Directors, Pharmacists, and/or BlueCross BlueShield of Tennessee Medical Directors, as needed.
- Members with frequent visits to emergency rooms and high cost claims are reviewed for case management support.

### **3. Disease Management (Chronic Care) Program**

(Note: There is an eligibility requirement for this program.)

BlueCross Blue Shield of Tennessee's comprehensive chronic care management services are available to Commercial insured Blue Networks P, S, and E Members. The program is an optional add-on for its Administrative Services Only (ASO) accounts.

This comprehensive chronic care management program is for Members with Coronary Artery Disease (CAD), Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Diabetes, and/or Asthma. Members with these conditions, and for which BCBST is the primary carrier, receive telephone and mail outreach. Chronic Care Management Program takes a whole person approach recognizing that Members face a wide variety of health care issues and concerns. Registered Nurses provide support across a broad spectrum of health conditions and needs in order to actively engage Members in better managing their overall care.

Registered Nurses provide whole-person support using evidence-based, unbiased information, including tools and resources that help your patients to:

- understand their diagnoses
- become motivated to actively manage their health
- learn important self-care skills
- increase their compliance with physician treatment plans



This information does not replace Practitioner care. Rather, it prepares Members to make health care decisions in partnership with their Practitioner.

The Disease Management (Chronic Care) Program also includes an integrated 24/7 Nurseline available to all eligible Members. Each Covered household receives a welcome letter and magnet. Members are encouraged to call the 24/7 Nurseline to speak with a Registered Nurse about any symptoms, medical conditions, and other health information.

**4. Nurseline**

(There is an eligibility requirement for this program.)

BlueCross Blue Shield of Tennessee's Nurseline is a 24/7 Registered Nurse service offered to its Administrative Services Only (ASO) accounts. Members are encouraged to call the 24/7 Nurseline to speak with a Registered Nurse about symptoms, medical conditions, or for other health information.

**5. NICU Care Management by ProgenyHealth (Progeny)**

BlueCross Blue Shield of Tennessee's NICU Care Management Program is available to Commercial insured and Administrative Services Only (ASO) Blue Networks P, S, E, and M Members. Progeny provides comprehensive care coordination of all Intensive Care Nursery admissions from birth through discharge from the hospital by a team of NICU experienced nurses and board-certified neonatologists and pediatricians.

Enrollment begins when the Facility, Practitioner, or BCBST notifies Progeny of a delivery and admission to the NICU. Focus is on early implementation of discharge planning services to help ensure that all necessary DME and health care services are in place prior to the infant's anticipated discharge date.

Utilization and Case Management is provided for all NICU babies during their hospital stay and continuing throughout the first year of life. Families work with dedicated case managers who provide education support and care coordination services. Secure 24/7 web-based application "BabyTrax" is available for families and Providers. An electronic breast pump gift is offered to all mothers of enrolled babies who agree to breast milk feed.

Progeny works collaboratively with NICU Providers to promote effective and efficient utilization of resources while promoting an evidence-based approach to care. Progeny works with Providers to decrease unnecessary readmissions and ER visits through family education and intervention of its dedicated case management staff.

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**F. Evaluation of Care Management Programs**

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The Care Management programs are evaluated on an annual basis and revised as needed. The programs are reviewed to add or modify activities necessitating the quality improvement of effective and efficient service to BlueCross BlueShield of Tennessee Members. Member satisfaction data is collected and reviewed to add or modify activities necessitating the quality improvement of effective and efficient service to BlueCross BlueShield of Tennessee Members.

## XI. PREVENTIVE CARE

Preventive care benefits vary according to the Member's health care benefits plan. Providers can verify Member benefits by calling the Provider Service line, 1-800-924-7141, the BlueCross BlueShield of Tennessee Customer Service number listed on the front of the Member's ID card, or via BlueAccess, the secure area on the company website, [www.bcbst.com](http://www.bcbst.com).

Providers may also review preventive health guidelines and other preventive services information on the company website, [www.bcbst.com](http://www.bcbst.com) or by visiting [www.bcbst.com/providers/preventive-services.shtml](http://www.bcbst.com/providers/preventive-services.shtml). Paper copies of these guidelines are available upon request by calling 423-535-6705.

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## XII. QUALITY IMPROVEMENT PROGRAM (QIP)

### A. Introduction

BlueCross BlueShield of Tennessee, Inc. is committed to improving the quality and safety of care and service to its Members. BlueCross BlueShield of Tennessee demonstrates this commitment through the implementation of a comprehensive Quality Improvement Program (QIP), which provides the structure that supports quality improvement activities.

The purpose of the QIP is to assess and improve the quality and safety of clinical care and service received by our Members. This is achieved by planning and implementing quality improvement activities that are integrated and coordinated across departmental lines. This purpose is accomplished by creating an infrastructure and a set of business processes that support the achievement of high quality outcomes in care and service as an integral part of the way we do business.

The QIP includes a written program description, work plan, program evaluation and a committee structure that supports the program. The QIP reflects goals that support the mission and objectives of BlueCross BlueShield of Tennessee. The QIP is integrated throughout the organization with each department sharing the responsibility for improving care or service to Members. Additionally, the QIP is compliant with all relevant federal and state regulations and complies with accrediting agency standards. Continuous Quality Improvement (CQI) processes are incorporated into the entire health care delivery system of BlueCross BlueShield of Tennessee.

### B. Scope

The scope of the population served by the QIP includes all Members. Participation in QIP activities include, but are not limited to:

- Primary Care Practitioners and Specialty Providers
- Institutional Settings (hospital, skilled nursing facilities, home health agencies, pharmacies, long term care facilities, and rehabilitation facilities)
- Non-institutional Settings (free-standing surgical centers, urgent care centers, emergency departments and physical therapy)
- Internal Operations

### C. Authority and Structure

#### Authority and Responsibility

The BlueCross BlueShield of Tennessee Board of Directors (BOD) has the ultimate responsibility and accountability for the quality and safety of care and services rendered, and for the QIP. The BOD reviews and approves the QIP annually. The BOD has formally delegated the oversight of the QIP and associated quality improvement activities to the Enterprise Quality Oversight Committee. This Committee meets at least quarterly and is responsible for, but not limited to, the review and approval of the QIP. A complete committee structure is in place to support the QIP's clinical and service quality activities and oversee the development and implementation of the QIP. Additionally, designated regional Physicians are also involved in Quality Improvement (QI) activities and responsible for the implementation of the QIP. Network Practitioners are actively

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involved in the QIP through their participation in appropriate committees, development of clinical policies, adoption of clinical practice guidelines, peer review, review of Utilization Management (UM) criteria modifications and medical policy review.

### **Confidentiality**

Any employee or participating Practitioner engaging in Continuous Quality Improvement (CQI) activities must uphold the established principles of Member and Practitioner confidentiality. Employees, Contractors and Practitioners will sign an affidavit of confidentiality. CQI data and reports are only accessible to those individuals participating in the QIP and those agencies responsible for ascertaining the existence of an ongoing and effective program. Summary results may be released through marketing requests for information. Any request for information from attorneys or consumers must be submitted in writing to the Legal Department indicating the purpose of the request.

### **Conflict of Interest**

No person may participate in the review and evaluation of any case or issue in which he or she has been personally or professionally involved or where a conflict of interest may exist, which potentially compromises objective evaluation. A Practitioner serving on any committee or subcommittee, acting as a Physician advisor, or serving as peer reviewer will disqualify themselves from evaluating or reviewing a case in which he/she or his/her immediate associates have been personally or professionally involved, or if a direct personal or economic interest exists.

### **Quality Improvement Activities**

A defined methodology ensures a systematic approach to the collection of objective, statistically valid data, in order to evaluate and improve quality of care and the services offered to Members and Practitioners. The collected data also provides an opportunity to assess structure, processes and outcomes for improvement opportunities.

BlueCross BlueShield of Tennessee focuses on clinical and service objectives and issues that are relevant for a significant portion of our Members. Reviewing the results of population assessments identifies important aspects of clinical care that significantly impact Members and Providers. Some of these activities may include but are not limited to:

- Fostering a supportive environment to help Practitioners and Providers improve the safety of practices.
- Evaluating and acting on opportunities to improve the quality of clinical and non-clinical aspects of care and service, including the availability, accessibility, coordination and continuity of care.
- Developing and promoting health, disease and risk management activities that identify and evaluate medical and behavioral health risks and implementation of actions to control or eliminate those risks.

### **Program Evaluation and Workplan**

The overall effectiveness of the QIP is evaluated at least annually and documented in a written QI Program Evaluation. The evaluation addresses:

- Progress and status of annual goals
- Completed and ongoing QI activities
- Trending of clinical, service and other performance measurements
- Analysis of results for demonstrated improvements in quality
- Opportunities for improvement
- Overall effectiveness of the QIP
- Goals and recommendation for the workplan for the following year

Based on the annual program evaluation, the QIP is revised and a QI workplan is developed. The purpose of the annual workplan is to focus on the QIP goals, objectives and planned projects/activities for the forthcoming year. The annual workplan also identifies responsible party(ies)/person(s), timeframes for achievement of activities, and committee reporting. The workplan is utilized as an action plan to document the status of activities and achievement of goals throughout the year.

Information about the QIP, the organization's progress toward goals and the organization's performance data will be made available to Members, health plan staff and Providers/Practitioners annually. For more information about the Quality Improvement Program, please call 423-535-6705.

### Clinical Practice Guidelines

BlueCross BlueShield of Tennessee adopts and disseminates clinical practice guidelines that are relevant to its membership for the provision of preventive and nonpreventive health, acute and chronic medical and behavioral health services. These guidelines are intended to assist Practitioners in making appropriate health care decisions for specific clinical circumstances.

BlueCross BlueShield of Tennessee policy and procedure directs that nationally recognized guidelines be utilized when available. All clinical practice guidelines are reviewed at least annually, with more frequent review being initiated if new national standards are published prior to the review date.

Adopted Clinical Practice Guidelines can be viewed online via direct links found in the *Health Care Practice Recommendations (HCPR) Manual* located on the company Web site at <http://www.bcbst.com/providers/hcpr>.

Paper copies of these guidelines are available upon request by calling 423-535-6705.

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## D. Medical Management Corrective Action Plan

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**PURPOSE:** This procedure statement outlines how BlueCross BlueShield of Tennessee, Inc., and its affiliated companies, ("the Plan") may initiate corrective actions if a participating Provider fails to comply with applicable medical management requirements set forth in section I, below. This statement also outlines how the Plan will process denials of initial applications. The Plan's medical management programs include Provider credentialing, utilization review, quality management and Member grievance resolution activities that are overseen by professional review committees. The Plan's Board of Directors has designated the Enterprise Quality Oversight Committee and its subcommittees (the "Committees") as the professional review committees responsible for performing peer review activities in accordance with the Federal Health Care Quality Improvement Act (the "HCQIA"), TCA section 63-1-150 and other applicable laws governing the organization and operation of professional peer review or medical review committees (the "Peer Review Laws").

The Plan's staff has been authorized to provide necessary support services to the Committees. Members of the Board, Committee Members, staff Members and anyone providing information to those Committees are intended to be protected against liability to the fullest extent permitted by the Peer Review Laws. The terms of this Procedure statement have been incorporated by reference into the Plan's Provider participation applications and agreements. As partial consideration for being permitted to apply to become a participating Provider and, if applicable, selected to participate in the Plan, participating Providers agree that they shall not seek to hold the Plan or such individuals liable for acts taken in good faith in accordance with this Procedure statement.

This procedure only applies to matters that involve Committee actions. Matters that do not involve Committee actions include: the non-acceptance of a participation application because the Provider fails to satisfy the Plan's pre-credentialing application standards (e.g. failure to provide evidence of licensure

or insurance), the termination of a Provider's participation other than by reason of that Provider's failure to comply with applicable participation requirements (e.g. the participation agreement is terminated without cause); and disputes related to claims payment or authorization decisions. Such matters must be resolved in accordance with the Plan's Provider Dispute Resolution Procedure statement.

Records or information concerning the activities of the Committees shall be treated and maintained as privileged and confidential peer review records to the fullest extent permitted by the Peer Review Laws. Reports to the Committees, the Board of Directors or regulatory agencies concerning actions taken pursuant to this procedure statement shall not alter the status of such records or information as privileged and confidential information.

## **I. PARTICIPATION REQUIREMENTS**

The Plan's Chief Medical Officer or his designee (the "Chief Medical Officer") will monitor participating Providers' performance to ensure that they comply with the Plan's participation requirements. The following is intended to provide a non-exclusive summary of those participation requirements:

- A. Participating Providers shall cooperate, in good faith, to facilitate the Plan's medical management activities. Such cooperation includes returning telephone calls, responding to written inquiries or requests from the Plan, providing information and documents requested by the Plan and cooperating with Plan staff Members as they perform their medical management activities.
- B. Participating Providers shall render or order Medically Necessary and Appropriate services for Member-patients.
- C. Participating Providers shall obtain prior authorization of services in accordance with applicable Plan medical management program policies and procedures.
- D. Participating Providers shall comply with accepted professional standards of care, conduct and competence.
- E. Participating Providers shall continue to satisfy the Plan's credentialing requirements as set forth in the Plan's Credential Process, including, without limitation:
  - 1. The Provider's licenses or certifications must be in good standing.
  - 2. The Provider's liability insurance coverage must remain in full force and effect.
  - 3. There have been no unreported material changes in the Provider's status such that the credentialing information submitted to the Plan is no longer accurate.

## **II. CORRECTIVE ACTIONS**

### **A. INVESTIGATION**

The Plan's staff will investigate and report any apparent non-compliance with the participation requirements to the Chief Medical Officer or his designee, after making a reasonable effort to obtain material facts concerning that matter. Providers must submit requested information and fully cooperate with those staff members as a condition of their continued participation in the Plan. Staff members or the Chief Medical Officer may, at their discretion:

- 1. Consult with the Provider;
- 2. Review material documents, including Members' medical records; or
- 3. Contact other Providers or persons who have knowledge concerning the matter being investigated.

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### B. BASIS OF ACTIONS

The Chief Medical Officer or a Committee may initiate a corrective action if a participating Provider does not comply with applicable participation requirements, and:

1. There is a reasonable belief that the action will promote the objectives of the Plan's medical management program.
2. There has been a reasonable effort to obtain the facts concerning the Provider's alleged non-compliance.
3. The proposed action is reasonably warranted by the facts known after the investigation has been completed.

### C. ACTIONS BY THE CHIEF MEDICAL OFFICER

Upon determining that a participating Provider has not complied with the Plan's participation requirements, the Chief Medical Officer may initiate corrective actions including, without limitation:

1. Counseling the Provider concerning specific actions that should be taken to address identified problems. A summary of the counseling session and the plan of corrective action will be included in the Provider's credentialing file.
2. Submitting information regarding the Provider's conduct to the appropriate Committee for further consideration and action.
3. Imposing corrective actions, following the issuance of a "notice of corrective action" including without limitation:
  - a. Imposing practice restrictions, such as, focused review, mandatory prior authorizations for specified treatments or services, mandatory consultation, preceptorship, continuing medical education, closure of the Provider's practice to new Members, and/or imposition of a practice improvement plan.
  - b. Terminating the Provider's participation.
  - c. Imposing financial penalties such as an increased withhold, a one-time financial penalty (e.g. the cost of services incurred as a consequence of the Provider's non-compliance) or the denial of fees for inappropriate or unauthorized services.
4. Imposing a summary suspension. The Chief Medical Officer shall notify the Provider, by certified mail, of the summary suspension of the Provider's participation, if such action is necessary to protect Members' health and welfare or to protect the Plan's reputation or operations.
  - a. If the Chief Medical Officer or a Committee requires additional time to investigate allegations concerning a Provider's conduct, competence, practices or reputation, the summary suspension shall remain in effect pending the completion of that investigation. Such investigation must be completed within fourteen (14) days after the imposition of the summary suspension.
  - b. If, after such investigation, it is determined that the Provider's conduct, competence, practices or reputation may result in an imminent danger to Members' health or welfare, or impair the Plan's reputation or operations, the suspension shall continue in effect unless the Provider's participation is reinstated following a hearing conducted in accordance with section III, below.
  - c. The Chief Medical Officer shall make appropriate arrangements to have other Providers render services to Members who are under the care of the suspended Provider. The suspended Provider shall cooperate in referring Members to such other Providers in accordance with this Corrective Action Plan and the terms of his or her participation agreement.



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- d. If a Provider is a Member of a medical group or IPA, the Medical Director of that group or IPA shall be notified, in writing, of the imposition of corrective actions pursuant to this section.

### D. ACTIONS BY THE COMMITTEE

#### 1. Committee Meetings

If the Chief Medical Officer refers the matter to a Committee, that Committee shall consider information submitted to it concerning a Provider's non-compliance with the Plan's participation requirements during its next regularly scheduled meeting or at a special meeting called by the Chief Medical Officer to consider that matter.

Members of the Committee may participate in such meetings in person or by telephone conference call and may take actions by consent. Any meeting of a Committee concerning a Provider's alleged non-compliance shall be conducted in confidence and any information concerning such meetings shall be maintained as privileged and confidential information to the fullest extent permitted by applicable Peer Review Laws.

#### 2. Committee Investigations

A Committee may direct the Chief Medical Officer or his designee to further investigate and submit additional information concerning a Provider's alleged non-compliance. The Committee may also request that the Provider submit specified information or attend a meeting to respond to questions concerning such alleged non-compliance. The Provider otherwise has no right to participate in Committee proceedings.

#### 3. Corrective Actions

The Committee may request the Chief Medical Officer to take any of the corrective actions described in section II.C, above. In addition, the Committee may take any of the Corrective Actions described in section II. C. above except for II.C.4. (imposing a summary suspension). The Credentialing Committee may deny or revoke a Provider's Credentials.

### E. NOTICE OF CORRECTIVE ACTION

The Chief Medical Officer or the Chairperson of the Committee shall immediately notify the Provider, by certified or overnight mail, of the imposition of a corrective action. If the Provider is a member of an IPA or medical group, a copy of that notice shall also be sent to the Medical Director of that IPA or medical group. That corrective action shall become effective as of the date of that letter, unless the Chief Medical Officer or Committee elect to defer the effective date of that action.

The notice letter shall include:

1. A description of the corrective action,
2. A general description of the basis of that action,
3. A statement explaining how to request an appeal to the imposition of that action (to the extent that action is subject to appeal), specifying that such an appeal must be requested within thirty (30) days after the date of that notice letter.
4. If applicable, a statement that the action may be reported to the State licensing board or other entities as mandated by law if the Provider doesn't request an appeal or if that action is affirmed following exhaustion of the appeal process.

**III. APPEAL PROCEDURES**

**A. APPEAL OF NON-REPORTABLE ACTION BY A PARTICIPATING PROVIDER**

**1. Written Appeal**

- a. The Provider may appeal by submitting a written statement of his position within thirty (30) days of receipt of the notice of imposition of the corrective action. The written appeal will be reviewed by the Committee or Chief Medical Officer imposing the corrective action. A written response will be sent to the Provider within sixty (60) days of our receipt of the written appeal.
- b. The Provider must comply with the terms and conditions of the corrective action while the appeal is pending, unless specifically directed otherwise by the Committee or Chief Medical Officer.

**2. Informal Subcommittee Meeting**

- a. The Committee, in its sole discretion, may offer an informal subcommittee meeting to the Provider. The subcommittee will consist of individuals from the Committee and its purpose is to have an informal and open discussion with the Provider. The Provider has the option of accepting this offer for an informal subcommittee meeting, or may proceed to the next level of appeal as defined in this Section. The Provider does not waive any appeal rights by participating in the subcommittee meeting and may proceed with any appeals should the Committee uphold its decision after the subcommittee meeting.
- b. If an informal subcommittee is granted, the Provider may not be represented by an attorney and the meeting shall not be tape recorded or recorded by a court reporter.
- c. After the conclusion of the meeting, the subcommittee will make a recommendation to the appropriate Committee or the Chief Medical Officer concerning continued imposition of the corrective action. The subcommittee's recommendation will be considered at the next regularly scheduled Committee meeting unless the Chief Medical Officer calls a special meeting to consider that report. The Committee may accept, modify or reverse the subcommittee's recommendation, at its discretion. The Provider shall not have the right to appeal or to otherwise participate in the Committee's deliberations concerning the subcommittee's recommendation. The Committee shall notify the Provider of its decision within ten (10) working days after the date of that meeting.

**3. Binding Arbitration**

- a. After the final decision by BCBST, all parties agree to take any dispute to binding arbitration. The Provider shall make a written demand that the adverse action be submitted to binding arbitration pursuant to the Commercial Arbitration Rules of the American Arbitration Association (current ed.). Either party may make a written demand for binding arbitration within thirty (30) days after it receives the Plan's response. The venue for the arbitration shall be in Chattanooga, TN unless otherwise agreed. The arbitration shall be conducted by a panel of three (3) qualified arbitrators, unless the parties otherwise agree. The arbitrators may sanction a party, including ruling in favor of the other party, if appropriate, if a party fails to comply with applicable procedures or deadlines established by those Arbitration Rules.
- b. The claimant shall pay the applicable filing fee established by the American Arbitration Association, but the filing fee may be reallocated or reassessed as part of an arbitration award either, in whole or in part, at the discretion of the arbitrator/arbitration panel if the claimant prevails upon the merits. If the claimant withdraws its demand for arbitration, then claimant forfeits its filing fee and it may not be assessed against BCBST.

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- c. Each party shall be responsible for one-half of the arbitration agency's administrative fee, the arbitrators' fees and other expenses directly related to conducting that arbitration. Each party shall otherwise be solely responsible for any other expenses incurred in preparing for or participating in the arbitration process, including that party's attorney's fees.
- d. The arbitrators: shall be required to issue a reasoned written decision explaining the basis of their decision and the manner of calculating any award; shall limit review to whether or not the Plan's action was arbitrary and capricious; may not award punitive or exemplary damages; may not vary or disregard the terms of the Provider's participation agreement, the certificate of coverage and other agreements, if applicable; and shall be bound by controlling law; when issuing a decision concerning the matter at issue. Emergency relief such as injunctive relief may be awarded by an arbitrator/arbitration panel. A party shall make application for any such relief pursuant to the Optional Rules for Emergency Measures of Protection of the American Arbitration Association (most recent edition). The arbitrators' award, order or judgment shall be final and binding upon the parties. That decision may be entered and enforced in any state or federal court of competent jurisdiction. The arbitration award may only be modified, corrected or vacated for the reasons set forth in the United States Arbitration Act (9 USC § 1).
- e. This arbitration provision supersedes any prior arbitration clause or provision contained in any other document. This arbitration clause may be modified or amended by BCBST and the Provider will receive notice of any modifications through updates to the Provider Manual.

### B. APPEAL OF NON-REPORTABLE ACTION BY AN APPLICANT

- 1. Written Appeal
  - a. The Provider may appeal by submitting a written statement of his position within thirty (30) days of receipt of the notice of the denial of application. The written appeal will be reviewed by the Committee or Chief Medical Officer. A written response will be sent to the Provider within sixty (60) days of our receipt of the written appeal.
- 2. Binding Arbitration
  - a. If the Provider is still not satisfied with the Committee's decision, he may make a written request that the matter be submitted to binding arbitration in accordance with the procedure set forth in section III.A.3 above.

### C. APPEAL OF A POTENTIALLY REPORTABLE ACTION BY PARTICIPATING PROVIDERS OR APPLICANTS

- 1. Informal Subcommittee Meeting
  - a. The Committee, in its sole discretion, may offer an informal subcommittee meeting to the Provider. The subcommittee will consist of individuals from the Committee and its purpose is to have an informal and open discussion with the Provider. The Provider has the option of accepting this offer for an informal subcommittee meeting, or may proceed to the next level of appeal as defined in this Section. The Provider does not waive any appeal rights by participating in the subcommittee meeting and may proceed with any appeals should the Committee uphold its decision after the subcommittee meeting.
  - b. If there is an informal subcommittee meeting, the Provider may not be represented by an attorney and the meeting shall not be tape recorded or recorded by a court reporter.

- c. After the conclusion of the meeting, the subcommittee will make a recommendation to the appropriate Committee or the Chief Medical Officer concerning continued imposition of the corrective action. The subcommittee's recommendation will be considered at the next regularly scheduled Committee meeting unless the Chief Medical Officer calls a special meeting to consider that report. The Committee may accept, modify or reverse the subcommittee's recommendation, at its discretion. The Provider shall not have the right to appeal or to otherwise participate in the Committee's deliberations concerning the subcommittee's recommendation. The Committee shall notify the Provider of its decision within ten (10) working days after the date of that meeting.

2. Hearing

a. Appointment of the Hearing Officer

The Provider may request a hearing regardless of whether or not there was an informal subcommittee meeting. In that event, the Chief Medical Officer shall appoint a qualified designee to serve as the Hearing Officer within thirty (30) working days after receiving that request. The Hearing Officer:

- 1. Shall not receive a financial benefit from the outcome of the hearing and shall not act as a prosecutor or advocate for the Plan.
- 2. May not be in direct economic competition with the Provider requesting the hearing.
- 4. Shall be acting as member of the Committee while performing his or her duties.

b. Notice of Hearing

The Hearing Officer will contact the Provider to establish a mutually acceptable date, time, and place for the hearing; which shall be conducted not less than thirty (30) days after that date. The formal hearing shall be conducted within 120 days of appointment of the Hearing Officer unless both parties agree to extend this time limit. If the parties are unable to agree, the Hearing Officer shall schedule the hearing. The Hearing Officer shall then issue a written notice of hearing to the Provider summarizing: 1) the scheduled time, date and place where the hearing will be conducted; 2) the applicable hearing procedure; 3) a detailed description of the basis of the corrective action, including any acts or omissions which the Provider is alleged to have committed (the "Allegations"); and 4) a statement concerning whether that action may be reportable to the State licensing agency or other entities as mandated by law in accordance with applicable Peer Review Laws.

c. Hearing Procedure

The hearing will be an informal proceeding. Formal rules of evidence or legal procedure will not be applicable during the hearing. The Hearing Officer may reschedule or continue the hearing at his or her discretion or upon reasonable request of the parties. The Provider may forfeit the right to a hearing; however, if he or she fails to appear at the hearing without good cause, the right to schedule another hearing is also forfeited. In addition to any procedure adopted by the Hearing Officer:

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1. The Provider has the right to be represented by an attorney or other representative. If the Provider elects to be represented, such representation shall be at his or her own expense.
2. The hearing will be recorded by a court reporter.
3. The Provider and the Plan must provide the other party with a list of witnesses expected to testify on its behalf during the hearing and any documentary evidence that it expects to present during the hearing, as soon as possible following issuance of the notice of hearing. Either party may amend that list at any time not less than ten (10) working days before the date of the hearing.
4. Each party has the right to inspect and copy any documentary information that the other party intends to present during the hearing, at the inspecting party's expense, upon reasonable advance notice, at the location where such records are maintained.
5. During the hearing, each party has the right to:
  - i. call witnesses,
  - ii. cross-examine opposing witnesses, and
  - iii. submit a written statement at the close of the hearings.
6. Following the hearing, each party may obtain copies of the record of the hearing, upon payment of the charges for that record. Each party shall also receive a copy of the Hearing Officer's report and recommendation.

d. Hearing Officer's Report

The Hearing Officer will issue a written report and recommendation within thirty (30) days after the conclusion of the hearing. That written report will set forth the Hearing Officer's recommendation concerning the imposition of the corrective action, if any, and the basis for that recommendation.

e. Action by the Committee

The Hearing Officer's report will be submitted to the appropriate Committee for consideration during its next regularly scheduled meeting, unless the Chief Medical Officer calls a special meeting to consider that report. The Committee may accept, modify or reverse the Hearing Officer's recommendation, at its discretion. The Provider shall not have the right to appeal or to otherwise participate in the Committee's deliberations concerning the Hearing Officer's report. The Committee shall notify the Provider of its decision within ten (10) working days after the date of that meeting. The committee's decision is the final internal action by BCBST. In the event the decision is an adverse decision as defined by applicable federal and/or state laws, BCBST will report to the appropriate agencies or Boards as required by the applicable federal or state laws.

f. Appeal of Decision

Any action based upon or related to the Committee's decision must be submitted to binding arbitration in accordance with paragraph III.A.3 above.

#### IV. REPORTING CORRECTIVE ACTIONS

##### A. REPORTING TO REGULATORY AGENCIES

Certain actions must be reported in accordance with both state and federal law, including without limitation, the National Practitioner Data Bank (NPDB). The Chief Medical Officer will consult with the Plan's General Counsel prior to initiating any corrective action, if there is a question concerning whether it will be a reportable action.

1. The following actions must generally be reported:
  - a. All professional review actions adversely affecting a Provider's participation in the Plan for longer than thirty (30) days based upon the Provider's professional conduct or competence.
  - b. A summary suspension that remains in effect for longer than fourteen (14) days.
2. Reports required by federal or state law, including without limitation the NPDB, must include:
  - a. the name of the Provider,
  - b. a description of the facts and circumstances that form the basis for that action, and
  - c. any other relevant information requested by that licensing board.
3. The following actions are generally not reportable:
  - a. Actions that do not adversely affect the Provider's participation for longer than thirty (30) days.
  - b. Actions based upon the Provider's failure to comply with participation requirements that are not directly related to the Provider's professional conduct or competence.

##### B. INTERNAL REPORTING REQUIREMENTS

All corrective actions whether reportable to a licensing board or not, must be reported to the following persons:

1. The involved Provider.
2. The Plan's General Counsel.
3. The Plan's Provider Networks and Contracting Department.
4. The Medical Director of each participating Medical Group or IPA if the Provider is a member of that entity.

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## XIII. PROVIDER DISPUTE RESOLUTION PROCEDURE

**PURPOSE:** To address and resolve any and all matters causing participating providers (“Providers”) or BlueCross BlueShield of Tennessee or its affiliated companies (“BCBST”) to be dissatisfied with any aspect of their relationship with the other party (a “Dispute”). Providers are encouraged to contact a representative of BCBST’s Provider Network Management Division if they have any questions about this procedure statement or concerns related to their network participation.

**Note:** Non-contracted, non-participating, and out-of-state Providers may also use this Provider Dispute Resolution Procedure pursuant to the terms hereof and in accordance with BCBST policy.

### I. INTRODUCTION.

- A.** This Procedure describes the exclusive method of resolving any Disputes related to a Provider’s participation in BCBST’s network(s). It is incorporated by reference into the participation agreement between the parties (the “Participation Agreement”) and shall survive the termination of that Agreement.
- B.** This Procedure shall only be applicable to resolve Disputes that are subject to BCBST’s or the Provider’s control, such as claims, administrative or certification issues. It shall not be applicable to issues involving third parties that are not within a party’s control (e.g. determinations made by a customer purchasing administrative services only (“ASO Customers”) from BCBST).
- C.** This Procedure shall not be applicable to actions that may be reportable pursuant to the Federal Health Care Quality Improvement Act. Matters involving peer review evaluation of an applicant’s professional qualifications, conduct or competence must be resolved pursuant to BCBST’s “Medical Management Corrective Action Plan” (Section XII. D in this Manual).
- D.** The initiation of a Dispute shall not require a party to delay or forgo taking any action that is otherwise permitted by the Participation Agreement.
- E.** This Procedure statement establishes specific time periods for parties to respond to inquiries and requests for reconsideration. If it is not reasonably possible to provide a final response within those time periods, the responding party may, in good faith, advise the other party that it needs additional time to respond to that matter. In such cases, the responding party shall advise the other party of the status of that matter at least once every thirty (30) days until it submits a final response to the other party.
- F.** A party must commence an action to resolve a Dispute pursuant to this Dispute Resolution Procedure within eighteen (18) months of the date of the event causing that Dispute occurred (e.g. the date of the letter informing the Provider of a determination) or, with respect to a Provider request for reimbursement of unpaid or underpaid claims, within eighteen (18) months of the date the Provider received payment or, in the event of an unpaid claim, the date the Provider received notice that the claim was denied. This provision shall not extend the period during which a Participating Provider must submit a claim to BCBST pursuant to applicable provisions of the provider’s agreement(s) with



BCBST, although the Provider may commence a dispute related to the denial of a claim that was not filed in a timely manner within eighteen (18) months after receiving notice of the denial of that claim. If BCBST discovers a matter creating a Dispute with a Participating Provider during an audit, which is in progress at the end of the eighteen (18) month period referenced in this paragraph, it shall have one hundred twenty days (120) from the conclusion of that audit to initiate a Dispute concerning that matter. The failure to initiate a Dispute within that period specified in this subsection shall bar any type of action related to the event causing that Dispute, unless the parties agree to extend the time period for initiating an action to resolve that Dispute pursuant to this procedure statement.

- G. ALL DISPUTES WILL BE SUBJECT TO BINDING ARBITRATION IF THEY CAN NOT BE RESOLVED TO THE PARTIES' SATISFACTION PURSUANT TO SECTIONS II (A-B) OF THIS PROCEDURE STATEMENT.**

## **II. DESCRIPTION OF THE DISPUTE RESOLUTION PROCEDURE.**

### **A. INQUIRY/RECONSIDERATION**

Providers should contact a representative of the BCBST division or department that is directly involved in any matter that may cause a Dispute between the parties. (e.g. the Claims Service Department if there is a question concerning a claims related issue). If Providers do not know whom to contact, they may contact a representative of the Provider Network Management Division for assistance in directing their inquiries to the appropriate BCBST representative. BCBST may initiate an inquiry by contacting the Provider or the person that the Provider designates to respond to such inquiries (e.g. an office manager). If a party cannot respond immediately to the other party's inquiry, it shall make a good faith effort to investigate and respond to that inquiry within thirty (30) days.

### **B. APPEAL.**

If not satisfied, a party may submit a written appeal within sixty (60) days after receiving the other party's response to its inquiry/reconsideration. That request shall state the basis of the Dispute, why the response to its inquiry/reconsideration is not satisfactory, and the proposed method of resolving the Dispute. The receiving party will make a good faith effort to respond, in writing, within sixty (60) days after receiving that appeal.

### **C. BINDING ARBITRATION.**

If the parties do not resolve their Dispute, the next and final step is binding arbitration. If a party is not satisfied with an adverse decision, then it shall make a written demand that the Dispute be submitted to binding arbitration pursuant to the Commercial Arbitration Rules of the American Arbitration Association (current ed.). Either party may make a written demand for binding arbitration within sixty (60) days after it receives a response to its appeal. The venue for the arbitration shall be Chattanooga, TN unless otherwise agreed. The arbitration shall be conducted by a panel of three (3) qualified arbitrators, unless the parties otherwise agree. The arbitrators may sanction a party, including ruling in favor of the other party, if appropriate, if a party fails to comply with applicable procedures or deadlines established by those Arbitration Rules.

Each party shall be responsible for one-half of the arbitration agency's administrative fee, the arbitrators' fees and other expenses directly related to conducting that arbitration. Each party shall otherwise be solely responsible for any other expenses incurred in preparing for or participating in the arbitration process, including that party's attorney's fees.

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The claimant shall pay the applicable filing fee established by the American Arbitration Association, but the filing fee may be reallocated or reassessed as part of an arbitration award either, in whole or in part, at the discretion of the arbitrator/arbitration panel if the claimant prevails upon the merits. If the claimant withdraws its demand for arbitration, then the claimant forfeits its filing fee and it may not be assessed against BCBST.

The arbitrators: shall consider each claimant's demand individually and shall not certify or consider multiple claimants' demands as part of a class action; shall be required to issue a reasoned written decision explaining the basis of their decision and the manner of calculating any award; shall limit review to whether or not the Plan's action was arbitrary or capricious; may not award punitive, extra-contractual, treble or exemplary damages; may not vary or disregard the terms of the Provider's participation agreement, the certificate of coverage and other agreements, if applicable; and shall be bound by controlling law; when issuing a decision concerning the Dispute. Emergency relief such as injunctive relief may be awarded by an arbitrator/arbitration panel. A party shall make application for any such relief pursuant to the Optional Rules for Emergency Measures of Protection of the American Arbitration Association (most recent edition). The arbitrators' award, order or judgment shall be final and binding upon the parties. That decision may be entered and enforced in any state or federal court of competent jurisdiction. That arbitration award may only be modified, corrected vacated for the reasons set forth in the United States Arbitration Act (9 USC § 1).

This arbitration provision supersedes any prior arbitration clause or provision contained in any other document. This arbitration clause may be modified or amended by BCBST and the Provider will receive notice of any modifications through updates to the Provider Manual.

### **D. EFFECTIVE DATE.**

This procedure statement was adopted by BCBST on June 1, 1997.

Last date of revision, April 1, 2018

### **Notices for arbitration should be sent to:**

BlueCross BlueShield of Tennessee. Inc.  
Attention: General Counsel  
1 Cameron Hill Circle  
Chattanooga, TN 37402

The Provider Dispute Form has been replaced with the following fillable forms located on our company website:

Provider Reconsideration Form

<http://www.bcbst.com/providers/forms/ProviderReconsiderationForm16PED988.pdf>

Provider Appeal Form

<http://www.bcbst.com/providers/forms/ProviderAppealForm16PED987.pdf>.

**Note:** Additional information on reconsideration and appeals processes can be found on the Provider Page on BlueCross website, bcbst.com.

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## XIV. CREDENTIALING

### A. Introduction

The BlueCross BlueShield of Tennessee (BCBST) Credentialing Program was established August 1, 1995. The Credentialing Program is designed around goals that reflect the BlueCross BlueShield of Tennessee mission, as well as regulatory and accrediting requirements.

In order to establish consistent standards for network participation, and to meet regulatory requirements, BlueCross BlueShield of Tennessee developed Network Participation Criteria. Practitioners applying for network admission are asked to complete an application through the Council for Affordable Quality Healthcare (CAQH) for individual professionals. BCBST partners with CAQH Solutions, which offers Providers a single point of entry for application information. Organizational Providers will utilize the BCBST Facility application information. Utilizing the CAQH application or Organizational Provider application, BlueCross BlueShield of Tennessee conducts a preliminary evaluation for network participation. Practitioners must complete the application in its entirety, submit the required documentation, and complete the credentialing process prior to network participation.

Verifying credentials of Practitioners and other Health Care Professionals/Providers is an essential component of an integrated health care system. The Credentialing process incorporates an ongoing assessment of the quality-of-care services provided by those Practitioners and other Health Care Professionals/Providers who wish to participate in the BCBST network. Major components of the credentialing program include:

- Credentialing Committee
- Policies and Procedures
- Initial Credentialing Process
- Recredentialing Process
- Delegated Credentialing Activities

The BCBST Credentialing Committee (the Committee) is a peer review committee and is subject to the rights and privileges set forth in TCA Section 63-1-150. The Committee shall conduct peer review of those cases meeting the Exception Criteria of the Credentialing and Recredentialing of Practitioners policy (CR.0255) (and other situations that involve peer review functions) and will evaluate each case individually.

The Committee may, in its discretion, allow credentialing or continued credentialing of certain Practitioners or Organizations who fall within the exception criteria and deny credentialing or terminate credentials of other Practitioners or Organizations who also fall within the exception criteria. It shall be within the Committee's discretion to assess and evaluate the facts of each individual case and determine whether it is in the best interest of BCBST's Members and BCBST for a Practitioner or Organizations to be credentialed or credentialing continued. In its discretion, the Committee may deny all Practitioners or Organizations who fall within a certain exception criteria if the Committee determines that the health and welfare of BCBST Members could be jeopardized by credentialing such Practitioners or Organizations or continuing their credentialing. (Policy CR.0277 Credentialing Committee Discretion Policy)

Practitioners or Organizational Providers have the right to review information (received from outside sources excluding peer review protected information) submitted with their application; correct erroneous information within thirty (30) days of receipt of completed application by contacting us at the address, phone number and/or email address listed below; or be informed of the status of their credentialing/recredentialing application upon request. Inquiries regarding the Credentialing process and/or Credentialing applications should be addressed to the following:

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### Mailing Address:

BlueCross BlueShield of Tennessee  
Attn: Credentialing Department  
1 Cameron Hill Circle, Ste 0007  
Chattanooga, TN 37402-0007

### Telephone Inquiries:

|             |                |
|-------------|----------------|
| (Toll Free) | 1-800-357-0395 |
| (Fax)       | 1-423-535-8357 |
| (Fax)       | 1-423-535-6711 |

**E-mail:** Credentials@bcbst.com

**Note:** For denial/appeal process refer to the Medical Management Corrective Action Plan in Section XI. Quality Improvement Program in this Manual for detailed description of appeal rights.

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## B. Credentialing Application

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Credentialing applications are used to uniformly identify and gather specific information for all Practitioners and Organizational Providers that wish to participate with BlueCross BlueShield of Tennessee. The BlueCross BlueShield of Tennessee Credentialing standards apply to all licensed independent Practitioners or Practitioner groups who have an independent relationship with BlueCross BlueShield of Tennessee. The BlueCross BlueShield of Tennessee Credentialing Program determines whether Practitioners and other Health Care Professionals, licensed by the State and under contract to BlueCross BlueShield of Tennessee, are qualified to perform their services and meet the minimum requirements defined by National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS), and the TennCare Risk Agreement. Verification of all required credentials is imperative.

**Once Practitioners and Organizational Providers have completed the credentialing process, they will receive written notification within ten (10) days from BlueCross BlueShield of Tennessee's Credentialing Department. Note: *This notification does not guarantee acceptance in BlueCross BlueShield of Tennessee networks; Practitioners and Organizational Providers are not considered participating in BlueCross BlueShield of Tennessee networks until they receive an acceptance letter from BlueCross BlueShield of Tennessee's Contracting Department. Our goal is to complete credentialing and contracting a Provider within thirty (30) days of receiving a completed application.***

### CAQH APPLICATIONS SHOULD REFLECT THE FOLLOWING, ALONG WITH THEIR STANDARD REQUIREMENTS TO BE CONSIDERED COMPLETE:

- Detailed Explanation of any malpractice suit within the last five (5) years (NPDB reports or self-reported)
- Detailed Explanation of any question(s) answered, "Yes" on the application
- Letter of agreement signed by admitting Physician when Practitioner does not have current Hospital Privileges (If applicable)
- Copy of Certificate from Nationally Recognized Accrediting Body -- NP & PA (ANCC, AANP, if applicable)
- Ownership and Disclosure of Interest Statement
- Group Grid
- Other Supporting Documentation sent to Provider from BCBST

### Letter for NPs and PAs must include:

- The name and address of supervisory Physician;
- Verification the Physician is responsible for the care and treatment rendered;
- Verification the Physician is physically at the offices where treatment is being rendered and is interacting and overseeing the NP/PA as specified in the Rules and Regulations for the State in which they practice;
- Verification that protocol exists and is located at the premises where the NP/PA practices as required by state law; and
- APN License (NP only).

**Electronic Funds Transfer (EFT);**

- Providers are required to enroll in the EFT process. For enrollment information, Enrollment information is available on the CAQH Solutions website at <https://solutions.cagh.org>.
- If you completed the Electronic Funds Transfer Information under Section V—Payment Information of the Credentialing Application, please include a VOIDED check with the appropriate account number when returning your application.

The applying Provider will receive notification from BCBST when all documents have been received and the review process has begun. If all necessary documentation is not received within thirty (30) days of the documentation request date, the application will be closed as incomplete. The Provider has the right to correct erroneous information within thirty (30) days of receipt as well as check the status of application at any time during the credentialing/recredentialing process.

If you have any questions or need assistance contact Provider Service line at 1-800-924-7141 and say “Credentialing and Contracting” when prompted.

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## C. Credentialing Policies

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BlueCross BlueShield of Tennessee has written policies and procedures for both the initial and recredentialing process of Practitioners and Organizational Providers. The following policies are subject to change and should only be referenced as a guideline. Final determination of credentialing status is a decision of the BlueCross BlueShield of Tennessee Corporate Credentialing Committee. For specific assistance, please contact your Provider Relations Consultant (see Section I for region-specific telephone number) or call the BlueCross BlueShield of Tennessee Credentialing Department at 1-800-357-0395.

**Note: *Primary Care Practitioner and OB/GYN office site visits are performed by BlueCross BlueShield of Tennessee within six (6) months of the credentialing event.***

### 1. Credentialing Process for Practitioner:

The following information is required and/or must be verified for Practitioners:

- A current, valid, full, unrestricted license to practice in the state of jurisdiction.
- History of, or current license probation will be subject to peer review.
- Current, valid, unrestricted Prescriptive Authority (ability to prescribe medication in accordance with State law) within the scope of the Practitioner's practice, if applicable.
- Work history for the last five years with documented gaps in employment over 90 days.
- Malpractice coverage in amounts of not less than \$1,000,000 per occurrence and \$3,000,000 aggregate (exceptions made for State Employees).
- Clinical privileges in good standing at a licensed facility designated by the Practitioner as the primary admitting facility. (Any exceptions to this will be determined by the BCBST Credentialing Committee).
  - National Practitioner Data Bank (NPDB) report or Claims History Report from all malpractice carriers for the last five (5) years.
  - Board certification verification if the practitioner indicates certified on application
  - BlueCross BlueShield of Tennessee recognizes the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Academy of Pediatrics (AAP), American Dental Association (ADA), and the American Board of Podiatric Surgery (ABPS) for recognized specialty designation.
  - Absence of history of federal and/or state sanctions (Medicare, Medicaid, or TennCare).
  - Verification of a current, valid, unrestricted state license is sufficient for a Practitioner's degree. Verification of board certification or highest level of education is necessary for specialty designation.
  - History of, or criminal conviction or indictment will be subject to peer review.

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- Current Clinical Laboratory Improvement Amendments (CLIA) Certificate, if applicable.
- Twenty-four (24) hour, seven (7)-day-a-week call coverage or arrangements with a BlueCross BlueShield of Tennessee credentialed Practitioner.
- Statement from applicant regarding:
  - \* Current physical or mental problems that may affect ability to provide health care;
  - \* Current or past substance use disorder;
  - \* History of loss of license and or felony convictions;
  - \* History of loss or limitation of privileges or disciplinary activity; and
  - \* An attestation to correctness/completeness of the application.
- Office site visit to each potential Primary Care Practitioner and OB/GYN's office including documentation of a structured review of the site and medical record maintenance process. (See Credentialing XVII.D Practice Site Evaluations/Medical Record Practices.)
- Verification the Physician is physically at the offices where treatment is being rendered and is interacting and overseeing the NP/PA as specified in the Rules and Regulations for the State in which they practice;
- Verification that Protocol exists and is located at the premises where NP/PA practices as required by state law.

### Specific requirements for specialties listed:

#### **Audiologist/Speech Therapist/Physical Therapist/Occupational Therapist:**

- Current Licensure in State of Tennessee in Specialty will verify education.
- If not practicing in Tennessee, education may be verified by certificate from:
  - \* American Occupational Therapy Certification Board;
  - \* American Speech-Language-Hearing Association;
  - \* Physical Therapist Certificate of Fitness, if applicable; **or**
  - \* Verification of highest level of education in specialty requested.
- No call coverage required.
- Clinical privileges not required.
- DEA certificate not required.

#### **Chiropractor:**

- Clinical privileges not required.
- DEA certificate not required.

#### **CRNA:**

If credentialing is required, call coverage and hospital privileges are required.

#### **Dentist:**

Minimum and exception criteria apply with the exception of:

- Clinical privileges not required.

#### **Dietician/Nutritionist:**

Minimum and exception criteria apply with the exception of:

- Licensed as a Dietician/Nutritionist.
- Minimum of a BA degree from an accredited U.S. college or university, with course approved by the American Dietetic Association's Commission for a Didactic Program in Dietetics.
- Must undergo a 6- to 12-month practice program or internship at a healthcare facility, community agency, or food service corporation, or do the equivalent in combination with their undergraduate course work.
- Completion of a Commission on Accreditation of Dietetics Education (CADE) accredited Didactic Program in Dietetics and pass the national board examination administered by the Commission on Dietetic Registration (CDR).
- Clinical privileges not required.
- Call coverage not required.
- DEA certificate not required.

**Genetic Counselor**

Minimum and exception criteria with the exception of:

- Licensed as a Genetic Counselor.
- Clinical privileges not required.
- Call coverage not required.
- DEA certificate not required.
- Certificate from National Society of Genetic Counselors (NSGC).
- Education must be from one of the 30 accredited universities that offer Genetic Counseling.

**Health Department Practitioner**

- Minimum and exception criteria apply.

**Hospital Based (if practicing outside the hospital setting):**

- Must be credentialed and all Minimum and Exception Criteria applies.
- Any hospital-based Practitioner with additional practice sites are then evaluated and credentialed to that site's highest standard according to the type of practice (i.e., Primary Care).

**Lactation Specialist**

Minimum and exception criteria apply with the exception of:

- Licensed as a Registered Nurse at a minimum.
- Certification with IBCLC: Global Certification for Lactation Consultant.
- Clinical privileges not required.
- Call coverage not required.
- DEA certificate not required.

**Neuropsychologist (Ph.D.):**

Minimum and Exception criteria apply in addition to:

- Clinical privileges not required.
- License must specify "Health Services Provider".
- Ph. D. degree required.

**Nurse Practitioners or Nurse Mid-Wife:**

Minimum and Exception criteria apply in addition to:

- RN License.
- Advanced Practice Nurse (APN) certificate in TN and applicable prescriptive authority for contiguous states.
- Certificate of Fitness required for Nurse Practitioners (NP), if applicable.
- If Prescriptive Authority includes a DEA certificate, all schedules must be verified.
- Certification most applicable to the nurse specialty from one of the following bodies:
  - \* American Nurses Credentialing Center;
  - \* American Academy of Nurse Practitioners;
  - \* American College of Nurse-Midwives Certification Council;
  - \* National Certification Corporation of Obstetric and Neonatal Nursing Specialties; or
  - \* National Certification Board of Pediatric Nurse Practitioners and Nurses.
- Written statement from the BlueCross BlueShield of Tennessee credentialed Practitioner that has a valid oversight specialty who supervises the health care professional. Such statement must include:
  - \* The name and address of the supervising Practitioner;
  - \* Verification the Practitioner is responsible for the care and treatment rendered by the NP;
  - \* Verification the Physician is physically at the offices where treatment is being rendered and is interacting and overseeing the NP as specified in the Rules and Regulations for the State in which they practice;



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- \* Verification that Protocol exists and is located at the premises where NP practices as required by state law.
- \* If practicing in a setting other than Family Medicine or OB/GYN, must provide a detailed scope of practice. Application will be considered adverse.

### **Exclusion:**

- Clinical privileges not required (must have an arrangement with a credentialed Practitioner who has clinical privileges at a credentialed hospital facility).
- DEA certificate not required, however if applicant has DEA certificate it must be verified.

### **Optometrist:**

Minimum and Exception criteria apply in addition to:

- State license must contain Therapeutic Certification.
- Hospital privileges are not required.

### **Pathologist**

If credentialing is required, call coverage and hospital privileges are required.

### **Physical Therapist/Occupational Therapist**

Minimum and Exception criteria apply in addition to:

- Current Licensure in State of Tennessee in Specialty will verify education. If not practicing in Tennessee, education may be verified by certificate from: American Occupational Therapy Certification Board, Physician Therapist Certificate of Fitness, if applicable or Verification of highest level of education in specialty requested.

### **Exclusion:**

- No call coverage required
- Clinical privileges not required
- DEA certificate not required, however, if application has DEA certificate , all schedules must be verified.

### **Physician Assistant:**

Minimum and Exception criteria apply in addition to:

- Certificate from the National Commission on Certification of Physician Assistants (NCCPA), if applicable.
- Written Statement from the BlueCross BlueShield of Tennessee credentialed Practitioner that has a valid PCP specialty who supervises the health care professional. Such statement shall include:
  - \* The name and address of the supervising Practitioner;
  - \* Verification that the Practitioner is responsible for the care and treatment rendered by Physician Assistant (PA);
  - \* Verification the Physician is physically at the offices where treatment is being rendered and is interacting and overseeing the PA as specified in the Rules and Regulations for the State in which they practice;
  - \* Verification that Protocol exists and is located at the premises where PA practices as required by state law.
  - \* If practicing in a setting other than Family Medicine or OB/GYN, must provide a detailed scope of practice. Application will be considered adverse.

### **Exclusion:**

- Clinical privileges not required (must have an arrangement with a credentialed Practitioner who has clinical privileges at a credentialed hospital facility).
- DEA certificate not required, however, if applicant has DEA certificate, all schedules must be verified.

**Physician Assistants-Surgical Assist:**

- PA must be licensed, meet all other general provider requirements
- Supervising Surgeon must be credentialed with BCBST in a surgical specialty. (General, Urology, Neurology, Orthopedic, etc)
- PA must meet all State practice protocol requirements as verified with attestation.
- PA's Hospital and ASF privilege criteria must be verified.
- PA must provide proof of graduation from an accredited PA program.

**PA must maintain ongoing certification by the NCCPA (which will include satisfactory completion of the NCCPA examination and all other ongoing certification requirements) and completion of NCCPA examination/certification.**

**Pharmacist - Clinical**

BCBST/BCT staff Pharmacists (and PBM Management)

Minimum and Exception criteria apply in addition to:

- Collaborative agreement between Pharmacy and Physician

**Exclusion:**

- Clinical privileges not required.
- Call coverage not required.

**Pharmacist - Immunizing**

BCBST/BCT staff Pharmacists (and PBM Management)

Minimum and Exception criteria apply in addition to:

- Certification of accredited immunizing program

**Podiatrist**

Minimum and Exception criteria apply in addition to:

- Clinical privileges not required unless, current privileges are indicated, they will be verified.

**Radiologist**

If credentialing is required, call coverage and hospital privileges are required.

**Sleep Medicine**

This specialty is designated only for Medical Doctors and Doctors of Osteopathy.

**Speech Language Pathologist**

Minimum and Exception criteria apply in addition to:

- Certificate of Clinical Competence – Speech Language Pathology (CCC-SLP) from American Speech-Language-Hearing Association (ASHA) – **Not Required.**  
**However, if applicant has ASHA Certificate, it must be verified. If certificate has expired, certificate must be verified by previous certificate verification.**

**Urgent Care Physician**

All Minimum and Exception Criteria apply unless, acting as PCP, with exception of:

- Clinical privileges.
- Call Coverage.
- Site Visit.

## **2. Credentialing Process for Behavioral Health Practitioner/Provider**

The following information is the minimum criteria required and/or must be verified for Behavioral Health Practitioners:

- Current, valid, unrestricted state license within the scope of the Practitioner's practice.
- Current, valid, unrestricted Prescriptive Authority (ability to prescribe medication in accordance with State law) within the scope of the Practitioner's practice, if applicable.

## 2. Credentialing Process for Behavioral Health Practitioner/Provider (cont'd)

The following information is the minimum criteria required and/or must be verified for Behavioral Health Practitioners:

- Work history for last five (5) years for initial credentialing: Last three (3) years' work history for recredentialing. Explanation for all lapses of employment exceeding ninety (90) days.
- Proof of malpractice coverage in amounts of not less than \$1,000,000 per case and \$3,000,000 aggregate.
- National Practitioner Data Bank or Claims History Report from all malpractice carriers for the last five (5) years.
- Clinical privileges in good standing at a facility designated by the Practitioner as the primary admitting facility. If Practitioner does not have clinical privileges, Practitioner must have a coverage arrangement with a BCBST credentialed Practitioner/Provider, if applicable to scope of practice.
- Twenty-four (24)-hours-a-day, seven (7)-days-a-week call coverage
- Completed Education or Board certification in all practice specialties.

### Specific requirements for specialties listed:

#### Psychiatrist

- Minimum and exception criteria

#### Addictionologist (non-Psychiatrist)

- Minimum and Exception criteria apply in addition to:
- Certified by the American Society of Addiction Medicine (ASAM) as an addiction specialist.

#### Addictionologist (Buprenorphine – Based Therapy for medication assisted treatment of substance abuse)

- Minimum and Exception criteria apply in addition to:
- DEA certificate with additional buprenorphine endorsement.
- Certified by the American Society of Addiction Medicine (ASAM) as an addiction specialist.
- Certified in buprenorphine therapy in the state where practice is to occur.

#### Psychologist or Psychoanalyst

- Minimum and Exception criteria apply in addition to:
- DEA certificate not required, verify if applicable.
- Doctoral degree (PhD, EdD, PsyD) in clinical psychology or counseling psychology from an accredited college or university and meet one of the following:
  1. Doctorate degree received from a college or university program on the American Psychological Association (APA) accredited list of counseling psychology or clinical psychology programs, or
  2. Completion of a pre-doctoral APA approved clinical internship at the time of graduation, or
  3. Listed in the National Register of Health Services Providers in Psychology, or
  4. Diplomate of the American Board of Professional Psychology (ABPP) under the clinical psychology or counseling psychology categories.

**Licensed Clinical Social Worker (LCSW)**

- Minimum and Exception criteria apply in addition to:
- Master's degree or higher from a graduate school or social work accredited by the Council on Social Work Education (CSWE).

**Professional Counselors/ Mental Health Counselors/ Licensed Substance Use Disorder Treatment Professionals**

- Minimum and Exception criteria apply in addition to:
- Master's degree or higher in mental health discipline.
- State licensed or certified at the highest level of independent practice in the state where practice is to occur.
- In states without licensure or certification, provider applicant must be a Certified Clinical Mental Health Counselor (CCMHC) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) OR meet all requirements to become a CCMHC (documentation of eligibility from NBCC required).

**Marriage & Family Therapist**

- Minimum and Exception criteria apply in addition to:
- Master's degree or higher in a mental health discipline.
- State licensed or certified at the highest level of independent practice in the state where practice is to occur, OR certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT) OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).

**Pastoral Counselors**

- Minimum and Exception criteria apply in addition to:
- Master's degree or higher in mental health discipline.
- Must be licensed as a pastoral counselor and have certificate by the American Association of Pastoral Counselors.

**Licensed Senior Psychological Examiner (SPE)**

- Minimum and Exception criteria apply in addition to:
- Master's degree in Mental Health Counseling.

**Employee Assistance Professional (EAP) Counselor**

- Minimum and Exception criteria apply in addition to:
- Certified as a Certified Employee Assistance Professional (CEAP).

**Assistant Behavior Analyst (ABA)**

- Minimum and Exception criteria apply in addition to:
- Certified as an Assistant Behavior Analyst (BCaBA) by the Behavioral Analyst Certification Board.
- Minimum of a Bachelor's Degree from an accredited university.

**Note:** Additional TennCare Requirements:

- Degree must be for a BACB approved institution of higher education having the BACB required coursework and practice experience.

**Certified Behavior Analyst (CBA)**

- Minimum and Exception criteria apply in addition to:
- Certified as Board Certified Behavior Analyst – Doctoral (BCBA D) by Behavior Analyst Certification Board (BCBA).  
**Note:** Acceptable TennCare equivalents:
  1. Currently licensed in the state of Tennessee for the independent practice of psychology, or
  2. Currently a Qualified Mental Health Professional licensed in the state of Tennessee with the scope of practice to include behavior analysis; and Credential verification by the Managed Care Organization.
- Master's or Doctorate degree from an accredited university that must be conferred in behavior analysis, education, or psychology, or in a degree program in which the candidate completed a (BACB) approved course sequence.
- Certified by Behavior Analyst Certification Board (BCBA).

**The following information is required and/or must be verified for Behavioral Health Organizational Providers:**

- Licensed in the state of TN.
- Professional liability coverage of \$1,000,000 per case/ \$3,000,000 aggregate.
- Malpractice claims history for past five (5) years. NPDB reports or self-reported.
- Accreditation by: The Joint Commission, CARF, Council of Accreditation (COA), AOA, HFAP, AAAHC, Det Norske Veritas (DNV GL), CHAP. If not accredited, a site visit review or copy of state site visit.
- Certification from Medicare, Medicaid, TRICARE or state agencies if applicable.
- DEA certificate, if applicable.
- Staff roster for outpatient mental health and/or substance use disorder clinics.

**Inpatient Detoxification/Inpatient Substance Abuse Disorder Rehabilitation**

- **Minimum criteria with the exception of:**
- Must have 24 hours/7-days-week skilled nursing staff.
- Oversight from a Medical Director.
- Must have an Addictionologist either on staff or contracted or Medical Director must have three (3) years' experience treating patients with substance use disorder.

**Inpatient Psychiatric/ Residential Psychiatric or Substance Abuse Disorder**

- **Minimum criteria with the exception of:**
- 24 hour/7-days-a-week skilled nursing staff.
- Oversight from a Medical Director.

**Crisis Stabilization Unit**

- **Minimum criteria with the exception of:**
- Program must be part of a TJC accredited hospital or health care organization that provides psychiatric services or accredited by AOA, TRICARE, CARF or COA.
- Formal written agreement with TJC accredited provider for emergency psychiatric, substance use disorder, or medical care if not available on site.

**Partial Hospitalization (Psychiatric or Substance Abuse Disorder)**

- **Minimum criteria with the exception of:**
- Must operate 3-5 days per week and at least 4-6 hours per day.
- Oversight from a Medical Director or licensed Program Director.
- Must be under the supervision of a Physician.

**Intensive Outpatient (Psychiatric or Substance Abuse Disorder)**

- **Minimum criteria with the exception of:**
- Must have the supervision of a licensed clinician.
- Must provide services at least three (3) hours per day, 2-4 days per week.

**Outpatient Mental Health and/or Substance Abuse Disorder Clinic**

- **Minimum criteria with the exception of:**
- Must have a governing body and an organized professional staff.
- Must have, or have a formal contract with, a multi-disciplinary staff that includes at least one licensed psychiatrist, one licensed psychologist (psychologist must also be licensed to perform psychological testing), and at least one licensed masters- or doctoral-level mental health clinician.
- Must have written credentialing criteria for all clinical staff.
- All non-licensed staff must have direct clinical supervision by licensed staff; non-licensed staff may not provide the predominant portion of any major intervention modality, other than educational services.
- Must receive oversight from a licensed behavioral health professional.

**Applied Behavior Analysis (ABA)**

**NOTE:** *Services will be provided at an Outpatient Mental Health Clinic level of intensity.*

- Minimum criteria with the exception of:
- Must receive oversight from a licensed behavioral health or BACB (Behavior Analyst Certification Board) certified professional.
- All non-licensed/ non-BACB certified staff must have direct clinical supervision by qualified licensed staff with an Autism Spectrum Disorder (ASD) specialty or BACB certification in accordance with BACB recommended clinically appropriate supervision (i.e., a minimum of 1.5 hours for every 10 hours of direct service).
- BCaBA® (Board Certified Assistant Behavior Analyst®) staff must be supervised by BCBA® (Board Certified Behavior Analyst®) or BCBA-D® (Board Certified Behavior Analyst-Doctoral®) supervisors in accordance with BACB requirements.
- All non-licensed staff (paraprofessionals/tutors/therapists) must have completed criminal background checks, drug screening (including random testing), and confirmation of required ABA specific training.

**Crisis Stabilization Unit**

- **Minimum criteria with the exception of:**
- Program must be part of a Joint Commission accredited hospital or health care organization that provides psychiatric services or Program is part of a facility accredited by AOA, TRICARE, or CARF or COA accredits the program itself, as an observation/holding bed program that provides psychiatric services.
- Program must meet state licensure/certification and Medicaid requirements (as applicable).
- Program must meet all applicable federal, state and local laws and regulations.
- Program must attest to a formal written agreement with Joint Commission accredited Provider for emergency psychiatric, substance abuse, and/or medical care if such care is not available on site.
- Combination of licensed mental health professional, mental health workers, and other appropriate paraprofessional staff.

**Community Mental Health Center**

- **Minimum criteria with the exception of:**
- Licensed as a Mental Health Outpatient Facility.
- Formal CMS designation.

Behavioral Health Organizational providers (facilities and programs) must be evaluated at credentialing and recredentialing. Those who are accredited by an accrediting body accepted by BlueCross BlueShield of Tennessee must have their accreditation status verified. In addition, non-accredited organizational providers must undergo a structured site visit to confirm that they meet BlueCross BlueShield of Tennessee standards. Standing with state and federal authorities and programs will be verified.

### 3. Recredentialing Process

All Practitioners/Providers will be recredentialed at a minimum of every **three** years. The date of recredentialing will be based on the date of initial credentialing.

In addition to the information that will be verified by primary or secondary sources, BlueCross BlueShield of Tennessee will include and consider collected information regarding the participating Practitioner's performance within the health plan, including information collected through the health plan's quality management program.

Recredentialing will begin approximately three (3) to six (6) months prior to the expiration of the credentialing cycle. Providers are sent a letter stating their file will be placed in a recredentialing status and BCBST will retrieve their application from CAQH to begin the recredentialing process. To help ensure the recredentialing process is handled expediently with no interruptions in network participation we encourage the Practitioner to visit the CAQH ProView™ website, <https://proview.caqh.org>, to update their information.

Failure to comply with the request may result in immediate disenrollment from the Provider network. Credentialing information that is subject to change must be re-verified from primary sources during the recredentialing process. The Provider must attest to any limits on his/her ability to perform essential functions of the position and attest to absence of current illegal drug use.

### 4. BlueCross BlueShield of Tennessee Approved Specialties

BlueCross BlueShield of Tennessee recognizes and maintains the current list of specialties of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), American Academy of Pediatrics (AAP), the American Board of Podiatric Surgery (ABPS), and the American Dental Association (ADA) Boards or others as deemed necessary by peer review to support business needs.

Practitioners must designate a specialty on the credentialing application. To be listed in any BlueCross BlueShield of Tennessee Provider directory in the specialty requested, the Practitioner must meet one of the following requirements:

- Recognized Board Certification, or
- **Practitioners:** Successful completion of residency or fellowship in the applied specialty as recognized by one of the listed Boards.
- **Other Health Care Professionals:** Licensure and additional certification, if applicable in the field of specialty.

#### American Board of Medical Specialties (ABMS)

- I. **American Board of Allergy and Immunology**
  - A. Allergy and Immunology
  - B. Clinical and Laboratory Immunology
- II. **American Board of Anesthesiology**
  - A. Anesthesiology
  - B. Critical Care Medicine
  - C. Pain Management

- III. **American Board of Colon and Rectal Surgery**
  - A. Colon and Rectal Surgery
- IV. **American Board of Dermatology**
  - A. Clinical and Laboratory Dermatological Immunology
  - B. Dermatology
  - C. Dermatopathology
  - D. Pediatric Dermatology
- V. **American Board of Emergency Medicine**
  - A. Emergency Medicine
  - B. Medical Toxicology
  - C. Pediatric Emergency Medicine
  - D. Sports Medicine
  - E. Undersea-Hyperbaric Medicine
- VI. **American Board of Family Practice**
  - A. Family Practice
  - B. Geriatric Medicine
  - C. Sports Medicine
- VII. **American Board of Internal Medicine**
  - A. Internal Medicine
  - B. Cardiovascular Disease
  - C. Endocrinology, Diabetes, and Metabolism
  - D. Gastroenterology
  - E. Hematology
  - F. Infectious Disease
  - G. Medical Oncology
  - H. Nephrology
  - I. Pulmonary Disease
  - J. Rheumatology
  - K. Adolescent Medicine
  - L. Clinical & Laboratory Immunology
  - M. Clinical Cardiac Electrophysiology
  - N. Critical Care Medicine
  - O. Geriatric Medicine
  - P. Interventional Cardiology
  - Q. Sports Medicine
- VIII. **American Board of Medical Genetics, Inc.**
  - A. Clinical Biochemical Genetics
  - B. Clinical Cytogenetics
  - C. Clinical Genetics
  - D. Clinical Molecular Genetics
  - E. Molecular Genetic Pathology
  - F. PHD Medical Genetics
- IX. **American Board of Neurological Surgery**
  - A. Neurological Surgery
- X. **American Board of Nuclear Medicine**
  - A. Nuclear Medicine
- XI. **American Board of Obstetrics and Gynecology**
  - A. Critical Care Medicine
  - B. Gynecologic Oncology
  - C. Gynecology
  - D. Maternal and Fetal Medicine
  - E. Obstetrics
  - F. Obstetrics and Gynecology
  - G. Reproductive Endocrinology



- XII. American Board of Ophthalmology**
  - A. Ophthalmology
- XIII. American Board of Orthopedic Surgery**
  - A. Hand Surgery
  - B. Orthopedic Surgery
- XIV. American Board of Otolaryngology**
  - A. Otolaryngology
  - B. Otology/Neurotology
  - C. Pediatric Otolaryngology
  - D. Plastic Surgery within the head and neck
- XV. American Board of Pathology**
  - Anatomic & Clinical Pathology
  - A. Anatomic Pathology
  - B. Blood Banking Transfusion Medicine
  - C. Chemical Pathology
  - D. Clinical Pathology
  - E. Cytopathology
- XV. American Board of Pathology (cont'd)**
  - F. Dermatopathology
  - G. Forensic Pathology
  - H. Hematology
  - I. Medical Microbiology
  - J. Molecular Genetic Pathology
  - K. Neuropathology
  - L. Pediatric Pathology
- XVI. American Board of Pediatrics**
  - A. Adolescent medicine
  - B. Clinical & laboratory immunology
  - C. Developmental-behavioral pediatrics
  - D. Medical toxicology
  - E. Neonatal-Perinatal medicine
  - F. Neurodevelopmental disabilities
  - G. Pediatric cardiology
  - H. Pediatric critical care medicine
  - I. Pediatric emergency medicine
  - J. Pediatric endocrinology
  - K. Pediatric gastroenterology
  - L. Pediatric hematology-oncology
  - M. Pediatric infectious disease
  - N. Pediatric nephrology
  - O. Pediatric pulmonology
  - P. Pediatric rheumatology
  - Q. Pediatrics
  - R. Sports medicine
- XVII. American Board of Physical Medicine and Rehabilitation**
  - A. Pain Management
  - B. Pediatric Rehabilitation Medicine
  - C. Physical Medicine and Rehabilitation
  - D. Spinal Cord Injury Medicine
- XVIII. American Board of Plastic Surgery, Inc.**
  - A. Hand Surgery
  - B. Plastic Surgery
  - C. Plastic Surgery within the head and neck
- XIX. American Board of Preventive Medicine**
  - A. Aerospace Medicine
  - B. Medical Toxicology
  - C. Occupational Medicine
  - D. Preventive Medicine
  - E. Undersea and Hyperbaric Medicine

- XX. American Board of Psychiatry and Neurology**
  - A. Addiction Psychiatry
  - B. Child And Adolescent Psychiatry
  - C. Clinical Neurophysiology
  - D. Forensic Psychiatry
  - E. Geriatric Psychiatry
  - F. Neurodevelopmental Disabilities
  - G. Neurology
  - H. Neurology with special qualification in Child Neurology
  - I. Pain Management
  - J. Pediatric Neurology
  - K. Psychiatry
- XXI. American Board of Radiology**
  - A. Diagnostic Radiology
  - B. Neuroradiology
  - C. Nuclear Radiology
  - D. Pediatric Radiology
  - E. Radiation Oncology
  - F. Radiological Physics
  - G. Radiology
  - H. Vascular & Interventional Radiology
- XXII. American Board of Surgery**
  - A. Hand Surgery
  - B. Pediatric Surgery
  - C. Surgery
  - D. Surgical Critical Care
  - E. Vascular Surgery
- XXIII. American Board of Thoracic Surgery**
  - A. Thoracic Surgery
- XXIV. American Board of Urology, Inc.**
  - A. Urology

**American Osteopathic Association Boards (AOA)**

- I. American Osteopathic Board of Anesthesiology**
  - A. Addiction Medicine
  - B. Anesthesiology
  - C. Critical Care Medicine
  - D. Pain Management
- II. American Osteopathic Board of Dermatology**
  - A. Dermatology
  - B. Dermatopathology
  - C. MOHS-Micrographic Surgery
- III. American Osteopathic Board of Emergency Medicine**
  - A. Emergency Medical Services
  - B. Emergency Medicine
  - C. Medical Toxicology
  - D. Sports Medicine
- IV. American Osteopathic Board of Family Practice**
  - A. Addiction Medicine
  - B. Adolescent and Young Adult Medicine
  - C. Family Practice
  - D. Geriatric Medicine
  - E. Sports Medicine

- V. American Osteopathic Board of Internal Medicine**
  - A. Addiction Medicine
  - B. Allergy/Immunology
  - C. Cardiology
  - D. Clinical Cardiac Electrophysiology
  - E. Critical Care Medicine
  - F. Endocrinology
  - G. Gastroenterology
  - H. Geriatric Medicine
  - I. Hematology
  - J. Hematology/Oncology
  - K. Infectious Disease
  - L. Internal Medicine
  - M. Medical Oncology
  - N. Nephrology
  - O. Oncology
  - P. Pulmonary Disease
  - Q. Rheumatology
  - R. Sports Medicine
- VI. American Osteopathic Board of Neurology and Psychiatry**
  - A. Addiction Medicine
  - B. Child and Adolescent Neurology
  - C. Child and Adolescent Psychiatry
  - D. Neurology
  - E. Neurology/Psychiatry
  - F. Psychiatry
  - G. Sports Medicine
- VII. American Osteopathic Board of Neuromusculoskeletal Medicine**
  - A. Neuromusculoskeletal Medicine
  - B. Osteopathic Manipulative Medicine
  - C. Sports Medicine
- VIII. American Osteopathic Board of Nuclear Medicine**
  - A. In Vivo and In Vitro Nuclear Medicine
  - B. Nuclear Cardiology
  - C. Nuclear Imaging and Therapy
  - D. Nuclear Medicine
- IX. American Osteopathic Board of Obstetrics and Gynecology**
  - A. Gynecologic Oncology
  - B. Gynecology
  - C. Maternal and Fetal Medicine
  - D. Obstetrics
  - E. Obstetrics and Gynecologic Surgery
  - F. Obstetrics and Gynecology
  - G. Reproductive Endocrinology
- X. American Osteopathic Board of Ophthalmology and Otorhinolaryngology**
  - A. Facial Plastic Surgery
  - B. Ophthalmology
  - C. Otorhinolaryngology
  - D. Otorhinolaryngology and Facial Plastic Surgery
- XI. American Osteopathic Board of Orthopedic Surgery**
  - A. Orthopedic Surgery
- XII. American Osteopathic Board of Pathology**
  - A. Anatomic Pathology
  - B. Anatomic Pathology and Laboratory Medicine
  - C. Blood Banking Transfusion Medicine
  - D. Chemical Pathology
  - E. Cytopathology
  - F. Dermatopathology

- XII. American Osteopathic Board of Pathology (cont'd)**
  - G. Forensic Pathology
  - H. Hematology
  - I. Laboratory Medicine
  - J. Medical Microbiology
  - K. Neuropathology
- XIII. American Osteopathic Board of Pediatrics**
  - A. Adolescent and Young Adult Medicine
  - B. Neonatology
  - C. Pediatric Allergy and Immunology
  - D. Pediatric Cardiology
  - E. Pediatric Endocrinology
  - F. Pediatric Hematology/Oncology
  - G. Pediatric Infectious Disease
  - H. Pediatric Intensive Care
  - I. Pediatric Nephrology
  - J. Pediatric Pulmonary Medicine
  - K. Pediatrics
  - L. Sports Medicine
- XIV. American Osteopathic Board of Preventive Medicine**
  - A. Occupational Medicine
  - B. Preventive Medicine/Aerospace Medicine
  - C. Preventive Medicine/Occupational-Environmental Medicine
  - D. Public Health/General Preventive Medicine
- XV. American Osteopathic Board of Proctology**
  - A. Proctology
- XVI. American Osteopathic Board of Radiology**
  - A. Angioplasty and Interventional Radiology
  - B. Body Imaging
  - C. Diagnostic Radiology
  - D. Diagnostic Ultrasound
  - E. Neuroradiology
  - F. Nuclear Radiology
  - G. Pediatric Radiology
  - H. Radiation Oncology
  - I. Radiation Therapy
  - J. Radiology
- XVII. American Osteopathic Board of Rehabilitation Medicine**
  - A. Rehabilitation Medicine
  - B. Sports Medicine
- XVIII. American Osteopathic Board of Surgery**
  - I. General Vascular Surgery
  - II. Neurological Surgery
- XVIII. American Osteopathic Board of Surgery (cont'd)**
  - III. Plastic and Reconstructive Surgery
  - IV. Surgery
  - V. Surgical Critical Care
  - VI. Thoracic Cardiovascular Surgery
  - VII. Urological Surgery

**American Board of Dental Sleep Medicine**

- A. Dental Sleep Medicine

**American Academy of Pediatrics (AAP)**

- A. Pediatric Heart Surgery
- B. Pediatric Neurosurgery
- C. Pediatric Orthopedics
- D. Pediatric Urology

**American Board of Oral and Maxillofacial Pathology**

- A. Oral Pathology

**American Board of Oral and Maxillofacial Surgery**

**American Board of Orthodontics**

- A. Orthodontics

**American Board of Pain Management**

- A. Pain Management

**American Board of Pediatric Dentistry**

- A. Pediatric Dentistry

**American Board of Periodontology**

- A. Periodontology

**American Board of Podiatric Orthopedics & Primary Podiatric**

- A. Podiatry (DPM)

**American Board of Podiatric Surgery (ABPS)**

- A. Podiatry (DPM)

**American Board of Prosthodontics**

- A. Prosthodontics

**American Chiropractic Neurology Board, Inc.**

- A. Chiropractic neurology

**Other Health Care Professionals:**

- II. Audiology
- III. Addictionologist (Non Psychiatrist)
- IV. Associate Behavior Analyst
- V. Certified Behavior Analyst
- VI. Certified Registered Nurse Anesthetist (CRNA)
- VII. Chiropractor (DC)
- VIII. Chiropractor Neurologist
- IX. Dietitian
- X. Employee Assistance Professional Counselor
- XI. Endodontist
- XII. Family Practice with Obstetrical Fellowship
- XIII. General Dentistry
- XIV. General Practice
- XV. Licensed Clinical social Worker (LCSW)
- XVI. Licensed Professional Counselor
- XVII. Licensed Senior Psychological Examiner (LSPE)
- XVIII. Marriage and Family Therapist
- XIX. Mental Health Counselor/Licensed Substance Abuse Treatment Professionals
- XX. Midwife (CNM)

- XXI. Neuropsychology (Ph.D.)
- XXII. Nurse (RN)
- XXIII. Nurse Clinician
- XXIV. Nurse Practitioner
- XXV. Nurse Practitioner, Acute Care
- XXVI. Nurse Practitioner, Adult Health
- XXVII. Nurse Practitioner, Family Practice
- XXVIII. Nurse Practitioner, Gerontology and Adult Health
- XXIX. Nurse Practitioner, Neonatal
- XXX. Nurse Practitioner, Oncology
- XXXI. Nurse Practitioner, Pediatrics
- XXXII. Nurse Practitioner, Psychological/Mental Health
- XXXIII. Nurse Practitioner, Women's Health
- XXXIV. Nutrition
- XXXV. Occupational Therapy (OT)
- XXXVI. Optometry
- XXXVII. Pastoral Counselor
- XXXVIII. Pediatric Anesthesiology
- XXXVII. Pediatric Genetics
- XXXVIII. Pediatric Ophthalmology
- XXXIX. Pediatric Plastic Surgery
- XL. Pharmacist - Clinical
- XLI. Pharmacist – Immunizing
- XLII. Physical Therapy (PT)
- XLIII. Physician Assistant – Surgical Assist
- XLIV. Physician Assistant (PA)
- XLV. Professional Counselor
- XLVI. Prosthetist/Orthotist
- XLVII. Psychiatrist
- XLVIII. Psychologist or Psychoanalyst
- XLIX. Psychology (Ph.D.)
- L. Speech Pathology/Speech Therapy (ST)
- LI. Therapeutic Optometry
- LII. Urgent Care

## 5. Credentialing Process for Organizational Providers

Obtaining valid/current copies of the following information as submitted with the credentialing application, is essential to ensure that decisions are based on the most accurate, current information available.

The following types of Organizational Providers require verification of specific requirements to be considered by the Credentialing Committee. The following lists these requirements:

## BlueCross BlueShield of Tennessee Provider Administration Manual

| Organizational<br>Type                  | Requirements   |
|---|--|
| <b>Acute Care Facility</b>              | <p><b>1) <i>TN: Licensed as Acute Care Facility</i></b><br/> Other States: Licensed in accordance with that state's licensing laws</p> <p>2) \$1 million/\$3 million Malpractice and claims history, NPDB reports, or self-reported</p> <p>3) DEA certificate, if applicable</p> <p>4) CLIA certificate, if applicable</p> <p>5) Medicare Part A (new facilities which have not obtained subject to Committee exception)</p> <p>6) TJC or AOA or CHAP or AAAHC</p> <p>7) If not accredited, copy of State Site Survey required</p> <p>8) Leapfrog Compliance, if available</p> <p>9) General Liability Insurance</p> <p>10) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</p> <p>11) An attestation to the correctness and completeness of the application</p> |
| <b>Ambulatory Infusion Center (AIC)</b> | <p><b>1) <i>TN: Licensed as Ambulatory Surgery Facility</i></b><br/> Other States: Licensed in accordance with that state's licensing laws</p> <p>2. \$1 million/\$3 million Malpractice and claims history, NPDB reports, or self-reported</p> <p>3. Medicare certificate</p> <p>4. Accredited by a BCBST approved accrediting body as an AIC</p> <p>5. Medical Director credentialed by BCBST</p> <p>6. General Liability Insurance</p> <p>7. History of federal or state sanctions (Medicare or TennCare)</p> <p>8. An Attestation to the correctness and completeness of application</p>   |
| <b>Ambulatory Surgery Facility</b>      | <p><b>1) <i>TN: Licensed as Ambulatory Surgery Facility</i></b><br/> Other States: Licensed in accordance with that state's licensing laws</p> <p>2) \$1 million/\$3 million Malpractice and claims history, NPDB reports, or self-reported</p> <p>3) CLIA certificate, if applicable</p> <p>4) TJC or AOA or CHAP or AAAHC or AAAASF and Medicare Part B with copy of site audit</p> <p>5) General Liability Insurance</p> <p>6) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</p> <p>7) An attestation to the correctness and completeness of the application</p>  |
| <b>Birthing Centers</b>                 | <p><b>1) <i>TN: Licensed as Birthing Center</i></b><br/> Other States: Licensed in accordance with that state's licensing laws</p> <p>2) \$1 million/\$3 million Malpractice and claims history, NPDB reports, or self-reported</p> <p>3) CLIA certificate, if applicable</p> <p>4) TJC or AOA or CHAP or AAAHC or Medicare Part B</p> <p>5) General Liability Insurance</p> <p>6) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</p> <p>7) An attestation to the correctness and completeness of the application</p>   |
| <b>Dialysis Facility</b>                | <p><b>1) <i>State of Tennessee End Stage Renal Disease (ESRD) Facility License</i></b><br/> Other States: Licensed in accordance with that state's licensing laws</p> <p>2) Not currently sanctioned by Medicare/Medicaid</p> <p>3) \$1 million/\$3 million Malpractice and claims history, NPDB reports, or self-reported</p> <p>4) Medicare Part A Certification</p> <p>5) CLIA certificate</p> <p>6) General Liability Insurance</p> <p>7) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</p> <p>8) An attestation to the correctness and completeness of the application</p>  |

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| Organizational Type                    | Requirements  |
|--|---|
| <b>DME Providers</b>                   | <p><b>1) <i>TN: Licensed as a DME Provider</i></b><br/> Other States: Licensed in accordance with that state's licensing laws</p> <p>2) Not currently sanctioned by Medicare/Medicaid</p> <p>3) \$1 million/\$3 million Malpractice and claims history, NPDB reports, or self-reported</p> <p>4) Medicare Part B required</p> <p>5) DEA certificate, if applicable</p> <p>6) Pharmacy License, if applicable</p> <p>7) TJC or CHAP or AAAHC or ACHC or BOC or The Compliance Team or ABC or NBAOS or CARF or HQAA required</p> <p>8) General Liability Insurance</p> <p>9) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</p> <p>10) An attestation to the correctness and completeness of the application</p> |
| <b>Health Department</b>               | <p>1) State Tort Insurance</p> <p>2) CLIA certificate</p>   |
| <b>Home Infusion Therapy Providers</b> | <p><b>1) <i>TN: Licensed as a Home Infusion Therapy Provider (Pharmacy License)</i></b><br/> Other States: Licensed in accordance with that state's licensing laws</p> <p>2) Not currently sanctioned by Medicare/Medicaid</p> <p>3) \$1 million/\$3 million Malpractice and claims history, NPDB reports, or self-reported</p> <p>4) Medicare Part B</p> <p>5) DEA certificate, if applicable</p> <p>6) TJC or CHAP or AAAHC, collect but not required</p> <p>7) General Liability Insurance</p> <p>8) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</p> <p>9) An attestation to the correctness and completeness of the application</p>   |
| <b>Home Health Providers</b>           | <p><b>1) <i>TN: Licensed as a Home Health Provider</i></b><br/> Other States: Licensed in accordance with that state's licensing laws</p> <p>2) Not currently sanctioned by Medicare/Medicaid</p> <p>3) \$1 million/\$3 million Malpractice and claims history, NPDB reports, or self-reported</p> <p>4) Medicare Part A</p> <p>5) CLIA certificate, if applicable</p> <p>6) TJC or CHAP or AAAHC, collect but not required</p> <p>7) If not accredited, copy of state or CMS site audit</p> <p>8) General Liability Insurance</p> <p>9) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</p> <p>10) An attestation to the correctness and completeness of the application</p>                                   |
| <b>Hospice Provider</b>                | <p><b>1) <i>TN: Licensed as a Hospice Provider</i></b><br/> Other States: Licensed in accordance with that state's licensing laws</p> <p>2) Not currently sanctioned by Medicare/Medicaid</p> <p>3) \$1 million/\$3 million Malpractice and claims history, NPDB reports, or self-reported</p> <p>4) Medicare Part A</p> <p>5) CLIA certificate, if applicable</p> <p>6) TJC or AOA or CHAP or AAAHC, collect but not required</p> <p>7) General Liability Insurance</p> <p>8) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</p> <p>9) An attestation to the correctness and completeness of the application</p>  |



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| Organizational Type   | Requirements   |
|---|--|
| <b>Independent Lab</b>  | <ol style="list-style-type: none"> <li>1) <b><i>TN: Licensed as a Laboratory</i></b><br/>Other States: Licensed in accordance with that state's licensing laws</li> <li>2) Not currently sanctioned by Medicare/Medicaid</li> <li>3) \$1 million/\$3 million Malpractice and claims history, NPDB reports, or self-reported</li> <li>4) History of Professional liability claims that resulted in settlements or judgments</li> <li>5) Medicare Part B</li> <li>6) TJC or CAP, collect if applicable but not required</li> <li>7) CLIA certificate, Draw station – CLIA not required</li> <li>8) General Liability Insurance</li> <li>9) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</li> <li>10) An attestation to the correctness and completeness of the application</li> </ol> |
| <b>Inpatient Rehabilitation Facility</b>  | <ol style="list-style-type: none"> <li>1) <b><i>TN: Licensed as a Inpatient Rehabilitation Facility</i></b><br/>Other States: Licensed in accordance with that state's licensing laws</li> <li>2) Not currently sanctioned by Medicare/Medicaid</li> <li>3) \$1 million/\$3 million Malpractice and claims history, NPDB reports, or self-reported</li> <li>4) Medicare Part A</li> <li>5) CLIA certificate , if applicable</li> <li>6) DEA certificate , if applicable</li> <li>7) TJC or CARF or AOA accreditation (no exception)</li> <li>8) General Liability Insurance</li> <li>9) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</li> <li>10) An attestation to the correctness and completeness of the application</li> </ol>  |
| <b>Non-Licensed DME Providers (Non-motorized equipment only e.g. walker; canes; crutches)</b> | <ol style="list-style-type: none"> <li>1) Not currently sanctioned by Medicare/Medicaid</li> <li>2) \$1 million/\$3 million Malpractice and claims history, NPDB reports, or self-reported</li> <li>3) History of Professional liability claims that resulted in settlements or judgments</li> <li>4) Medicare Part B</li> <li>5) TJC or CHAP or AAAHC, if applicable but not required</li> <li>6) General Liability Insurance</li> <li>7) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</li> <li>8) An attestation to the correctness and completeness of the application</li> </ol>  |
| <b>Orthotic/ Prosthetic Supplier</b>  | <ol style="list-style-type: none"> <li>1) <b><i>American Board for Certification in Orthotics and Prosthetics Accreditation OR Medicare B Certification</i></b></li> <li>2) General Liability Insurance</li> <li>3) \$1 million/\$3 million Malpractice (exception for Breast Prosthetic suppliers ONLY to have product liability coverage \$500 thousand) and claims history, NPDB reports, or self-reported</li> <li>4) History of Professional liability claims that resulted in settlements or judgments</li> <li>5) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</li> <li>6) An attestation to the correctness and completeness of the application</li> </ol>  |
| <b>Outpatient Diagnostic</b>  | <ol style="list-style-type: none"> <li>1) \$1 million/\$3 million Malpractice and claims history, NPDB reports, or self-reported</li> <li>1) History of Professional liability claims that resulted in settlements or judgments</li> <li>2) Medicare Part B Certification</li> <li>3) General Liability Insurance</li> <li>4) CLIA certification, if applicable</li> <li>5) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</li> <li>6) An attestation to the correctness and completeness of the application</li> </ol>   |

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| Organizational Type                                   | Requirements  |
|---|---|
| <b>Outpatient Mental Health Providers</b>             | <ol style="list-style-type: none"> <li>1) Licensed by the State of Tennessee Department of Health and Retardation.</li> <li>2) \$1 million/\$3 million Malpractice and claims history, NPDB reports, or self-reported</li> <li>3) General Liability Insurance</li> <li>4) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare) Medicare Certification, not required</li> <li>5) An attestation to the correctness and completeness of the application</li> </ol>   |
| <b>Outpatient Rehabilitation Facility</b>             | <ol style="list-style-type: none"> <li>1) Not currently sanctioned by Medicare/Medicaid</li> <li>2) \$1 million/\$3 million Malpractice and claims history, NPDB reports, or self-reported</li> <li>3) History of Professional liability claims that resulted in settlements or judgments</li> <li>4) Medicare Part A (<i>If Provider is licensed under the Tennessee Department of Mental Health and Developmental Disabilities and provides services to pediatric patients, evidence of the State License site audit</i>)</li> <li>5) TJC or CORF, collect but not required.</li> <li>6) CLIA certificate required if onsite laboratory.</li> <li>7) General Liability Insurance</li> <li>8) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</li> <li>9) An attestation to the correctness and completeness of the application</li> </ol> |
| <b>Pain Management Center</b>                         | <ol style="list-style-type: none"> <li>1) <b><i>TN: Licensed as an Ambulatory Surgical Facility</i></b><br/>Other States: Licensed in accordance with that state's licensing laws</li> <li>2) \$1 million/\$3 million Malpractice and claims history, NPDB reports, or self-reported</li> <li>3) DEA certificate, if applicable</li> <li>4) CARF accreditation or American Academy of Pain Management accreditation</li> <li>5) General Liability Insurance</li> <li>6) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</li> <li>7) An attestation to the correctness and completeness of the application</li> </ol>  |
| <b>Professional Support Services Licensure (PSSL)</b> | <ol style="list-style-type: none"> <li>1) <b><i>TN: Licensed as a Professional Support Service</i></b></li> <li>2) \$1 million/\$2 million Malpractice and claims history, NPDB reports, or self-reported</li> <li>3) Medicare certificate</li> <li>4) Member of DIDS (Division of Intellectual Disability Services)</li> <li>5) History of Medicare/Medicaid sanction – no prior history</li> <li>6) General Liability</li> <li>7) An attestation to the correctness and completeness of the application</li> </ol>  |
| <b>Skilled Nursing Facility (No Swing Beds)</b>       | <ol style="list-style-type: none"> <li>1) <b><i>TN: Licensed as a Skilled Nursing Facility</i></b><br/>Other States: Licensed in accordance with that state's licensing laws</li> <li>2) Not currently sanctioned by Medicare/Medicaid</li> <li>3) \$1 million/\$3 million Malpractice and claims history, NPDB reports, or self-reported</li> <li>4) Medicare Part A</li> <li>5) CLIA certificate, if applicable</li> <li>6) DEA certificate, if applicable</li> <li>7) TJC or CHAP or AAAHC or AOA, collect but not required</li> <li>8) If not accredited, copy of state or CMS site audit</li> <li>9) General Liability Insurance</li> <li>10) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</li> <li>11) An attestation to the correctness and completeness of the application</li> </ol>  |

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| Organizational Type | Requirements  |
|---------------------|---|
| Urgent Care Centers | <ol style="list-style-type: none"><li>1) State Business License</li><li>2) Oversight by a Medical Director that is currently credentialed by BCBST</li><li>3) Accreditation by Urgent Care Association of America (UCAOA) or a certificate from Certified Urgent Care( CUC) Program</li><li>4) \$1 million to \$3million in Malpractice Insurance and claims history, NPDB reports, or self-reported</li><li>5) History of federal and/or state sanctions (Medicare, Medicaid or TennCare)</li><li>6) General Liability Insurance</li><li>7) An attestation to the correctness and completeness of the application</li></ol>              |
| Sleep Labs          | <ol style="list-style-type: none"><li>1) \$1 million/\$3 million Malpractice and claims history, NPDB reports, or self-reported</li><li>2) Medicare Certification Part B</li><li>3) Accreditation by American Academy of Sleep Medicine (AASM) or JC</li><li>4) General Liability Insurance</li><li>5) History of any professional liability claims that resulted in settlements or judgments</li><li>6) Medical Director who is a Diplomat of the ABSM</li><li>7) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</li><li>8) An attestation to the correctness and completeness of the application</li></ol> |

Organizational Providers must be recredentialed every 3 years to meet federal and state regulatory guidelines. During the recredentialed process the initial credentialing information must be resubmitted.

## 6. BlueCross BlueShield of Tennessee Recognized Accrediting Bodies

BlueCross BlueShield of Tennessee recognizes the following accrediting bodies:

- Accreditation Association for Ambulatory Health Care (AAAHHC)
- Accreditation Commission for Health Care, Inc. (ACHC)
- American Academy of Nurse Practitioners (AANP)
- American Academy of Pain Management (AAPM)
- American Academy of Sleep Medicine (AASM)
- American Accreditation HealthCare Commission/URAC (AAHCC/URAC)
- American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- American Association for Marriage and Family Therapy (AAMFT)
- American Board of Genetic Counseling
- American Board of Medical Specialties (ABMS)
- American Board of Certification in Orthotics, Prosthetics, and Pedorthics (ABC)
- American Board of Dental Sleep Medicine
- American Board of Professional Psychology (ABPP)
- American College of Nurse – Midwives Certification Council
- American College of Radiology (ACR)
- American Medical Association (AMA)
- American Nurse Credentialing Center (ANCC)
- American Osteopathic Association (AOA)
- American Psychological Association (APA)
- American Society of Addiction Medicine (ASAM)
- American Speech-Language-Hearing Association (ASHA)
- Board for Orthotist/Prosthetist Certification (BOC)
- Centers for Medicare & Medicaid Services (CMS)
- Certified Clinical Mental Health Counselor (CCMHC)
- Board of Certification (BOC)
- (COLA) formerly known as the Commission on Office Laboratory Accreditation

BlueCross BlueShield of Tennessee recognizes the following accrediting bodies (cont'd):

- College of American Pathologists (CAP)
- Commission for the Accreditation of Birth Centers (CABC)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Continuing Care Accreditation Commission (CCAC)
- Community Health Accreditation Program (CHAP)
- Comprehensive Outpatient Rehabilitation Facilities (CORF)
- Council on Accreditation (COA)
- Council on Social Work Education (CSWE)
- Det Norske Veritas Germanischer Lloyd (DNV GL)
- Food and Drug Administration (FDA)
- HealthCare Quality Association on Accreditation (HQAA)
- International Board of Certification of Lactation Consultants (IBCLC)
- National Association of Boards of Pharmacy
- National Board for Certified Counselors (NBCC)
- National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties (NCC)
- National Commission on Certification of Physician Assistants (NCCPA)
- National Committee for Quality Assurance (NCQA)
- National Society of Genetic Counselors (NSGC)
- Pediatric Nursing Certification Board
- The Compliance Team, Inc.
- The Joint Commission (TJC)
- The Medical Quality Commission (TMQC)
- The National Board of Accreditation for Orthotic Suppliers (NBAOS)
- Tricare

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## **D. Practice Site Evaluation/Medical Record Practices**

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### **Practice Site Standards**

BlueCross BlueShield of Tennessee has adopted practice site standards for all credentialed Practitioners that provide ambulatory care to Members. These standards were developed to assure Members have access to care in a clean, safe, organized and physically accessible environment.

Clinical Risk Management (CRM) monitors Member complaints received regarding the quality of office sites. Practitioners will be advised in writing of specific complaints received about the quality of the office site. Credentialed Practitioners with two (2) office quality complaints within a six (6) month period, that include but is not limited to complaints about physical accessibility, adequacy of waiting area and cleanliness of site, will be referred to Clinical Quality Assurance Department to request an onsite review for compliance with the standards listed below within sixty (60) days of 2nd Member complaint. CRM will investigate the severity of all complaints received. BCBST may act on one complaint if it is determined necessary.

Primary Care Practitioner (PCP) practice sites and OB/GYN sites not previously reviewed and currently occupied by a network Practitioner will be evaluated prior to, or within sixty (60) days of initial credentialing. Practitioners will receive site review results with suggestions for improvement, if applicable, at the conclusion of the audit. Non-compliant sites will be reported to Clinical Risk Management Committee and re-audited within six (6) months.

Sites non-compliant on re-audit will be reviewed by Clinical Risk Management for placement on a Practice Improvement Plan and a 2nd re-audit planned within six (6) months.

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Current established site review standards listed below have been adopted by BCBST. Compliance with all required elements noted with an asterisk (\*), and an overall score of 80 percent achieved is required to meet these site review standards. These standards are subject to change and revisions will be posted in quarterly updates.

### Site Review Standards

|      |  |
|------|--|
| *1.  | The office is to be handicap accessible.   |
| *2.  | The office is to be clean, and organized, with adequate examining room and waiting room space.   |
| *3.  | The office should have adequate lighting in waiting room and treatment area.   |
| *4.  | Examining rooms should be designed for patient privacy.  |
| 5.   | There should be evidence of compliance with BlueCross BlueShield of Tennessee appointment availability standards for routine and urgent care.  |
| *6.  | Appropriate procedures should be in place for after-hours coverage. Voice mail messaging/answering machines should include instructions for reaching the Practitioner on call.   |
| *7.  | There should be an individual medical record for each patient.   |
| *8.  | Current medical records should be available at the site where services are provided and readily accessible.  |
| *9.  | Medical records should be kept in a secure location. Sites with Electronic Medical Records should provide evidence of a secure off site record retention/recovery process.   |
| *10. | There should be evidence of a medical record confidentiality plan/policy that includes Protected Health Information (PHI).   |
| *11. | There should be evidence of a fire safety/emergency action plan with evidence of staff education. This plan must be written at locations with 10 or more employees. Pathways to doors should be clear and well marked.   |
| *12. | Emergency Supplies and procedures should be available for scope of practice. Minimum requirements include: <ul style="list-style-type: none"><li>➤ Epinephrine and O<sub>2</sub> for PCP sites</li><li>➤ Delivery kit for OB/GYN</li><li>➤ Crash cart and O<sub>2</sub> at sites that perform stress test or services that require sedation.</li></ul> |
| *13. | The office has infection control procedures that include appropriate disposal of bio- hazardous material. Hand washing facilities should be in/near treatment rooms and OSHA standards and MSDS/SDS information should be available to staff.  |
| *14. | There should be a process for the appropriate disposal of needles and other sharps.  |
| 15.  | There should be a process for inventory control of all stock and sample medications.   |
| *16. | There should be evidence of an inventory control process for dispensing controlled substances and disposal of expired or unused portions of drugs.   |
| *17. | Controlled substances must be maintained in a locked area.   |
| *18. | Evidence of CLIA registration with site-specific address is required for any practice location where lab is performed.   |
| *19. | If radiology services are provided, a current state inspection compliance notice should be posted with the date of the last inspection.  |
| 20.  | Radiology technique should be posted near the radiology equipment if not generated by radiology equipment.   |
| *21. | For Physician Extenders, there should be a protocol on site and evidence of supervising Physician oversight, as required by practice type and state regulations.   |
| 22.  | There should be a sign posted that Physician Extenders may provide care, where applicable.   |
| 23.  | Professional staff should be licensed appropriately with evidence of licensure on file.  |
| 24.  | Member rights and responsibilities should be posted or otherwise made available to Members.  |

### **Comprehensive Medical Record Standards**

Network Practitioners are expected to maintain medical records in detail consistent with good medical/professional practice, which permits effective internal/external review and/or medical audit and facilitates appropriate care and treatment by any health care practitioner.

Practitioner performance will be evaluated against the standards listed below through random solicitation of records for review, and evaluation of records obtained as part of routine health plan operations and quality of care reporting processes.

Clinical staff will schedule onsite medical record reviews for no less than five (5) percent of credentialed Primary Care Practitioners annually to evaluate against published standards. Suggestions for improvement will be documented and shared with Practitioner or Practitioner representative if applicable. In addition, medical record reviews will be performed during the annual HEDIS<sup>®</sup> project and analysis performed to identify Practitioners with educational needs.

Random comprehensive medical record reviews may also be performed for any credentialed Practitioner upon request of the Clinical Risk Management Department.

Practitioners with illegible records and those with appropriateness of care or potential utilization of care concerns noted during review will be referred to the Clinical Risk Management Department for further review.

Medical record data is utilized to evaluate potential coordination of care concerns and to provide supplemental data for internal/external quality reports.

#### **Medical Record Keeping Practices**

1. Medical records should be legible.
2. Member identification is to be on each page of the record.
3. Each recorded chart entry is to be dated and identified by the author. Stamped signatures are not acceptable.
4. The medical records should be readily accessible to the Practitioner during normal office hours.

#### **Documentation**

5. All medical records are to contain a current Member problem list, which addresses chronic and significant recurrent/acute conditions.
6. All medication allergies, absence of allergies, and/or adverse reactions are to be consistently documented and prominently displayed in all medical records.
7. An initial history and physical examination should be documented for new patients within 12 months of Member first seeking care or within 3 visits, whichever occurs first. Past medical history that includes behavioral health history, serious accidents, illnesses and surgeries, and gestational and birth history for pediatric patients under age 6 should be documented.
8. Each medical record is to contain an updated list of medications the Member is taking, or documentation that the Member is presently not taking any medications.
9. Each medical record is to contain tobacco, alcohol, and/or substance use history (for Members 12 years and over and seen three (3) or more times).
10. The medical record of all Members age 18 years and over should contain documentation of whether a medical advance directive has been executed for Medicaid/Medicare Members.
11. If the Member has executed an advance directive, a copy should be on file within the office.

### **Appropriateness of Care**

12. Each visit should include documentation of Member's chief complaint or purpose for visit. Clinical assessment and physical examination should be documented and correspond to Member's stated complaint or visit purpose and/or ongoing care for chronic illnesses.
13. Working diagnosis or medical impressions that logically follow from the clinical assessment and physical examination should be recorded.
14. Rationale for treatment decisions should appear Medically Appropriate and be substantiated by documentation in the record, with laboratory tests performed at appropriate intervals.
15. Records should substantiate the Member's clinical problems and treatment in a manner such that another Practitioner can determine the Member's overall clinical course under the reviewed Practitioner's management.

### **Continuity and Coordination of Care**

16. There should be documentation of unresolved problems from past visits, and abnormal consults or diagnostic tests through follow-up phone call or return office visit.
17. Medical records should contain documentation of appropriate use of consultants, which includes Behavioral Health Providers, and documentation of medical services performed by a referral specialist/Practitioner.
18. If diagnostic and/or therapeutic ancillary services were performed, there should be a copy of the written report of the service in the record.

### **Education and Preventive Care**

19. Each medical record should contain evidence that age/sex appropriate preventive screenings/immunizations are offered in accordance with *Clinician's Handbook of Preventive Services* or the American Academy of Pediatrics, as applicable.
20. Care for high-risk conditions should be documented in accordance with BlueCross BlueShield of Tennessee's *Health Care Practice Recommendations*.
21. There should be documentation of Member education/instructions.

### **Facility Site Standards**

Non-accredited facilities applying for Initial Credentialing with BlueCross BlueShield of Tennessee networks must meet and maintain compliance with the site standards listed below.

Non-compliant sites for currently credentialed Providers will be referred to the BlueCross BlueShield of Tennessee Clinical Risk Management Committee for review. The credentialing process will be halted for all non-credentialed Providers until BlueCross BlueShield of Tennessee facility site standards are met.

### **Physical Assessment**

1. The facility is to be handicap accessible.
2. The facility should be clean and organized with adequate lighting and work space in treatment rooms to conduct patient exams effectively.

### **After Hours Coverage**

3. Appropriate procedures should be in place for after-hours coverage, where applicable.

### **Medical Record Keeping**

4. There should be an individual medical record for each Member.
5. Medical records should be kept in a secure location.
6. There should be evidence of a medical record confidentiality plan/policy that includes Protected Health Information (PHI).
7. Medical records should be legible and maintained in detail consistent with good medical/professional practice, which permits effective internal/external review and/or medical audit and facilitate follow-up treatment.

**Safety**

8. Emergency supplies and procedures should be available for the scope of practice.
9. Policy and procedures should be available and reviewed annually regarding administrative, operational, safety, disaster management and infection control.
10. There should be evidence of staff education to include safety, disaster management and infection control.
11. There should be infection control measures consistent with OSHA guidelines.
12. There should be a Quality Improvement plan monitoring all aspects of performance of care/services with evidence of staff review.
13. Evidence of CLIA registration is required if lab is performed in the facility.
14. If radiology services are provided, a current state inspection compliance notice should be posted with the date of the last inspection.
15. Radiological technique should be posted near the radiology equipment.
16. There should be a process for inventory control of all stock and sample medications and medical supplies.
17. There should be evidence of an inventory control process for dispensing controlled substances and disposal of expired or unused portions of drugs.
18. Controlled substances must be maintained in a locked area.
19. The facility should maintain equipment in a safe manner consistent with the manufacturer's recommendations.
20. Member Rights and Responsibilities should be posted, or available in the facility.
21. Professional staff should be licensed appropriately with evidence of licensure on file.
22. The facility should have a defined process to ensure professional performance of its staff by:
  - a) Completing credentialing process for independent Practitioners.
  - b) Completing credentialing functions according to state, federal and NCQA standards.
  - c) Utilizing the current license, relevant training and experience, current competence and privileges at a hospital in the credentialing process.

The facilities' files will be audited by a BCBST Credentialing Representative to ensure the credentialing process meets the above criteria.



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## **XV. Provider Networks**

Participation in BlueCross BlueShield of Tennessee Provider Networks requires satisfaction of applicable network participation and credentialing requirements.

Providers interested in expanding their participation in BlueCross BlueShield of Tennessee Provider Networks, or needing to communicate any changes in their practice may call their local Provider Network Manager. (See Section II. BlueCross BlueShield of Tennessee Quick Reference Guide, for specific contact numbers.)

Providers may initiate a request for a copy of their own contract by calling the BlueCross Provider Service line, 1-800-924-7141. Say “Contracts” when prompted. Written requests should be mailed to:

BlueCross BlueShield of Tennessee  
1 Cameron Hill Cr, Ste 0007  
Chattanooga, TN 37402-0007

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### **A. Network Participation Criteria**

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BlueCross BlueShield of Tennessee has established Network Participation Criteria detailing the terms and conditions for participation in BlueCross BlueShield of Tennessee Provider Networks. These terms and conditions will be consistently applied to all Providers regardless of participation status. These terms and conditions will apply to any Provider who:

- is a Network Provider;
- is recruited by the Plan;
- requests participation or re-applies for participation;
- re-applies following voluntary or involuntary termination of Provider’s participation;
- has a significant change in practice, or
- other intervening event or activity, which initiates a re-application and/or reconsideration of the Provider’s current participation status.

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### **B. Changes in Practice**

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Certain federal and state regulations may require BlueCross BlueShield of Tennessee contracted Providers to timely notify us of any changes to their street address, telephone numbers, office hours, and any other changes that impact availability.

If you have moved, acquired an additional location, changed your status for accepting patients, or made other changes to your practice:

- Call the BlueCross Provider Service line, 1-800-924-7141, Monday through Thursday, 8 a.m. to 6 p.m. (ET); Friday, 9 a.m. to 6 p.m. (ET). Choose the “touchtone” option or say “Contracts” when prompted, to update your information; **and**
- Update your Provider profile on the Council for Affordable Quality Healthcare (CAQH®) website at <http://proview.caqh.org/Login/Index?ReturnUrl=%2f>.

The following changes may require reconsideration for continued participation of a currently contracted Provider, immediate termination of a contracted Provider, review of the initial application by a non-contracted Provider, or re-application for participation by a non-contracted Provider.

BlueCross BlueShield of Tennessee reserves the right to interpret and apply these criteria in its sole discretion and judgment. Any Provider adversely affected by BlueCross BlueShield of Tennessee's application of these criteria will be entitled to the appropriate appeals procedure set forth in the Provider Dispute Resolution Procedure or set forth in this Manual.

**Practitioner**

Including but not limited to:

- Change in practice locations;
- Change in practice specialty;
- Change in ownership;
- Entering into or exiting from a group practice;
- Change in hospital privileges;
- Change in insurance coverage;
- Disciplinary or corrective action by licensing agency, federal agency (DEA, Medicare, Medicaid, etc.) or peer review committee;
- Malpractice claim(s) and/or judgment(s);
- Indictment, arrest, conviction or moral turpitude allegation;
- Adverse or adversarial relationship with BlueCross BlueShield of Tennessee;
- Any material change, which affects the Practitioner's ability to perform its obligations to Members and/or BlueCross BlueShield of Tennessee;
- Any material change in the information submitted on the pre-application or application.

**Institutional or Ancillary Providers**

- Change in ownership;
- Malpractice claim(s) and/or judgment(s);
- Change in insurance coverage;
- Disciplinary or corrective action by licensing agency, federal agency (DEA, Medicare, Medicaid, etc.) or peer review committee. Disciplinary action includes (without Limitation) any change in license status, such as probation, or any extraordinary conditions or training mandated by any licensing agency, federal agency, or peer review committee beyond those normal educational requirements for all Providers to maintain a license.
- Adverse or adversarial relationship with BlueCross BlueShield of Tennessee;
- Any material change which affects the organization's ability to perform its obligations to Member(s) and/or BlueCross BlueShield of Tennessee;
- Any material change in the information submitted on the pre-application or application.

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**C. Providers Denied Participation**

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Providers denied participation in a BlueCross BlueShield of Tennessee Network for other than network need, may not be considered for reapplication for a minimum of one (1) year from the date of denial. Providers will be given reason for denial as well as notice when they may reapply to networks as determined by and at the Provider Participation Standards Committee's sole discretion. This requirement may be waived by BlueCross BlueShield of Tennessee in its sole discretion.

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## **D. Removal of Providers from BCBST Provider Network**

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The Provider Participation Standards Committee (PPSC) will review and take action on all requests for removal of Providers from BCBST Provider Networks including, but not limited to, lack of minimum participation standards, no malpractice insurance, aberrant billing practice, pattern of out of network referrals, or Providers that have (1) been arrested or indicted (2) been convicted of a crime (3) committed fraud or (4) been accused or convicted of any offense involving moral turpitude in any jurisdiction, in addition to the other reasons set forth in the Provider's Agreement. If PPSC determines a Provider falls within any of these termination reasons, a Provider may be immediately terminated from the BCBST Networks or BCBST may refuse participation in any BCBST Networks.

PPSC may also address any material breach of contracts that can lead to terminating a network Provider. In either event, Provider shall not be considered, at the discretion of BCBST, for network participation for a minimum of two (2) years after the date of the resolution of the offense or allegation, except as otherwise provided by applicable laws. Provider's initial or continued participation shall not be considered, at the discretion of BCBST, unless the charges are dismissed or otherwise resolved in the Provider's favor.

The PPSC has delegated the responsibility for initiating administrative terminations to the Provider Network Operations (PNO) Department. If the PNO staff confirms all BCBST policies and procedures were followed related to such administrative terminations, notice of termination may be sent without committee review. If the PNO staff determines there are unique circumstances that warrant a committee level review, the termination action will be brought to PPSC. A list of the reasons for administrative termination of a Provider's participation include, without limitation:

- Loss of License
- Medicare/Medicaid or SCHIP Sanctions
- Loss of BCBST Credentials or failure to complete the BCBST Credentialing or Recredentialing process
- Lack of Network Specific Admitting Privileges (for provision for coverage by a BCBST participating Provider)
- Lack of Network Specific 24 Hour Coverage
- Retired/Deceased/Moved out of State
- Excluded from participation in the Medicare/Medicaid and/or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TennCare program
- Advocacy revoked by the Tennessee Medical Foundation
- Lack of Electronic Funds Transfer
- Lack of Paperless Claims Filing
- No Claims Activity Within 18 Consecutive Months (Provider NPI does not appear on claims in previous 18 months)

A quarterly report will be submitted to PPSC reflecting administrative terminations.

Providers that are removed from a BCBST Participating Network may reapply in accordance with the Network Participation Criteria or the timeframe set forth in the Provider's termination notice.

In those cases where a Provider is removed from all BCBST participating networks, credentials will be suspended the effective date of contract termination. Upon exhaustion of the contract termination appeal process, credentials will be discontinued.

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## **E. Provider Termination Appeal Process**

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Providers, whose network participation has been terminated for cause through the Committee, shall be entitled to due process in accordance with the procedural remedies set forth below:

- All Provider Network Management contract termination for cause notices are communicated to the Provider via certified mail to the last known address, located in the BlueCross BlueShield of Tennessee (BCBST) Providers' file.
- Termination notices sent to Providers will include instructions on appealing the termination decision.

Providers whose network participation has been terminated without cause through the Committee, shall not be entitled to a written appeal, but will proceed straight to binding arbitration.

### **1. APPEAL OF NON-REPORTABLE ACTION BY A PARTICIPATING PROVIDER**

#### **a. Written Appeal**

- i. The Provider may appeal by submitting a written statement of their position within thirty (30) days of the date of the letter of notice to the Provider. The written appeal will be reviewed by the Committee and a written response will be sent to the Provider within sixty (60) days of our receipt of the written appeal.

#### **b. Binding Arbitration**

- i. After the final decision by BCBST, all parties agree to take any dispute to binding arbitration. The Provider shall make a written demand that the adverse action be submitted to binding arbitration pursuant to the Commercial Arbitration Rules of the American Arbitration Association (current ed.). Either party may make a written demand for binding arbitration within thirty (30) days after it receives the Plan's response. The venue for the arbitration shall be in Chattanooga, TN unless otherwise agreed. The arbitration shall be conducted by a panel of three (3) qualified arbitrators, unless the parties otherwise agree. The arbitrators may sanction a party, including ruling in favor of the other party, if appropriate, if a party fails to comply with applicable procedures or deadlines established by those Arbitration Rules.
- ii. The claimant shall pay the applicable filing fee established by the American Arbitration Association, but the filing fee may be reallocated or reassessed as part of an arbitration award either, in whole or in part, at the discretion of the arbitrator/arbitration panel if the claimant prevails upon the merits. If the claimant withdraws its demand for arbitration, the claimant forfeits its filing fee and it may not be assessed against BCBST.
- iii. Each party shall be responsible for on-half of the arbitration agency's administrative fee, the arbitrators' fees and other expenses directly related to conducting that arbitration. Each party shall otherwise be solely responsible for any other expenses incurred in preparing for or participating in the arbitration process, including that party's attorney's fees.
- iv. The arbitrators: shall be required to issue a reasoned written decision explaining the basis of their decision and the manner of calculating any award; shall limit review to whether or not the Plan's action was arbitrary and capricious; may not award punitive or exemplary damages; may not vary or disregard the terms of the Provider's participation agreement, the certificate of coverage and other agreements, if applicable; and shall be bound by controlling law; when issuing a decision concerning the matter at issue.

Emergency relief such as injunctive relief may be awarded by an arbitrator/arbitration panel. A party shall make application for any such relief pursuant to the Optional Rules for Emergency Measures of Protection of the American Arbitration Association (most recent edition). The arbitrators' award, order or judgment shall be final and binding upon the parties. That decision may be entered and enforced in any state or federal court of competent jurisdiction. The arbitration award may only be modified, corrected or vacated for the reasons set forth in the United States Arbitration Act (9 USC § 1).

- v. This arbitration provision supersedes any prior arbitration clause or provision contained in any other document. This arbitration clause may be modified or amended by BCBST and the Provider will receive notice of any modification through updates to the Provider Manual.

**2. APPEAL OF NON-REPORTABLE ACTION BY AN APPLICANT**

**a. Written Appeal**

- i. A Provider may appeal by submitting a written statement of his position within thirty (30) days of receipt of the notice of the denial of application. The written appeal will be reviewed by the Committee. A written response will be sent to the Provider within sixty (60) days of our receipt of the written appeal.

**b. Binding Arbitration**

- i. If the Provider is still not satisfied with the Committee's decision, they may make a written request that the matter be submitted to binding arbitration in accordance with the procedure set forth in section 1.b above.

**3. APPEAL OF A POTENTIALLY REPORTABLE ACTION BY PARTICIPATING PROVIDERS OR APPLICANTS**

**a. Written Appeal**

A Provider may appeal by submitting a written statement of his position within thirty (30) days of receipt of the notice of the denial of application. The written appeal will be reviewed by the Committee. A written response will be sent to the Provider within sixty (60) days of our receipt of the written appeal.

**b. Hearing**

**i. Appointment of the Hearing Officer**

The Provider may request a hearing. In that event, the Chairperson of the Committee shall appoint a qualified designee to serve as the Hearing Officer within thirty (30) working days after receiving that request. The Hearing Officer:

1. Shall not receive a financial benefit from the outcome of the hearing and shall not act as a prosecutor or advocate for the Plan.
2. May not be in direct economic competition with the Provider requesting the hearing.
3. Must be qualified to evaluate the issues likely to be presented during the hearing.
4. Shall be acting as member of the Committee while performing his or her duties.

**ii. Notice of Hearing**

The Hearing Officer will contact the Provider to establish a mutually acceptable date, time, and place for the hearing; which shall be conducted not less than thirty (30) days after that date. The formal hearing shall be conducted within 120 days of appointment of the Hearing Officer unless both parties agree to extend this time limit. If the parties are unable to agree, the Hearing Officer shall schedule the hearing. The Hearing Officer shall then issue a written notice of hearing to the Provider summarizing: 1) the scheduled time, date and place where the hearing will be conducted; 2) the applicable hearing procedure; 3) a description of the basis for the Hearing, including any acts or omissions which the Provider is alleged to have

committed (the "Allegations"); and 4) a statement concerning whether that action may be reportable to the State licensing agency or other entities as mandated by law.

iii. Hearing Procedure

The hearing will be an informal proceeding. Formal rules of evidence or legal procedure will not be applicable during the hearing. The Hearing Officer may reschedule or continue the hearing at his or her discretion or upon reasonable request of the parties. The Provider may forfeit the right to a hearing; however, if he or she fails to appear at the hearing without good cause, the right to schedule another hearing is also forfeited. In addition to any procedure adopted by the Hearing Officer:

1. The Provider has the right to be represented by an attorney or other representative. If the Provider elects to be represented, such representation shall be at his or her own expense.
2. The hearing will be recorded by a court reporter
3. The Provider and the Plan must provide the other party with a list of witnesses expected to testify on its behalf during the hearing and any documentary evidence that it expects to present during the hearing, as soon as possible following issuance of the notice of hearing. Either party may amend that list at any time not less than ten (10) working days before the date of the hearing.
4. Each party has the right to inspect and copy any documentary information that the other party intends to present during the hearing, at the inspecting party's expense, upon reasonable advance notice, at the location where such records are maintained.
5. During the hearing, each party has the right to:
  - a. Call witnesses
  - b. Cross-examine opposing witnesses
  - c. Submit a written statement at the close of the hearings
6. Following the hearing, each party may obtain copies of the record of the hearing, upon payment of the charges for that record. Each party shall also receive a copy of the Hearing Officer's report and recommendation.

iv. Hearing Officer's Report

The Hearing Officer will issue a written report and recommendation within thirty (30) days after the conclusion of the hearing. That written report will set forth the Hearing Officer's recommendation, and the basis for that recommendation.

v. Action by the Committee

The Hearing Officer's report will be submitted to the appropriate Committee for consideration during its next regularly scheduled meeting, unless a special meeting is called to consider that report. The Committee may accept, modify or reverse the Hearing Officer's recommendation, at its discretion. The Provider shall not have the right to appeal or to otherwise participate in the Committee's deliberations concerning the Hearing Officer's report. The Committee shall notify the Provider of its decision within ten (10) working days after the date of that meeting. The committee's decision is the final internal action by BCBST. In the event the decision is an adverse decision as defined by applicable federal and/or state laws, BCBST will report to the appropriate agencies or Boards as required by the applicable federal or state laws. This is the final action of BCBST and the Committee will take the appropriate action at the Conclusion of the Committee decision

vi. Dispute regarding the Decision

Any action based upon or related to the Committee's decision must be submitted to binding arbitration in accordance with paragraph 1.b above.

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## **F. Participation in BCBST Networks**

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BlueCross BlueShield of Tennessee Provider Network Management participation criteria for 1) Practitioners; 2) Institutional Providers; and 3) Ancillary Providers in BlueCross BlueShield of Tennessee Networks follow:

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## BlueCross BlueShield of Tennessee Commercial Provider Administration Manual

### 1. Minimum Practitioner Network Participation Criteria

Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCross BlueShield of Tennessee, Inc. and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.

|             | Network Attribute   | PPO<br>Blue Network P<br>(Preferred)/<br>BlueAdvantage | PPO<br>Blue Network S (Select)                   | Preferred Dental/<br><br>FEP Dental                 |
|-------------|---|--|--|---|
| <b>I.</b>   | <b>Tennessee/Contiguous Counties</b>  | Required   | Required   | Required  |
| <b>II.</b>  | <b>State License</b>  |  |  |   |
|             | 1. License to practice is Current and Valid   | Required   | Required   | Required  |
|             | 2. License to practice is Unrestricted as to services performed   | Required   | Required   | Required  |
|             | 3. If the Provider's medical license has been revoked, suspended or not renewed (a license "revocation") by any jurisdiction, for cause, or the Provider has surrendered or agreed to surrender license to avoid such a revocation, Provider will be considered for participation at a minimum of one (1) year after the date that Provider's license was re-instated, except as otherwise provided by applicable laws. If such a license revocation action is pending or initiated against a Provider, Provider's participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider maintains licensure. | Required   | Required   | Required  |
| <b>III.</b> | <b>Malpractice Insurance</b>  | \$1 million/\$3 million<br>unless State<br>employee    | \$1 million/\$3 million<br>unless State employee | \$1 million/\$3 million<br>unless State<br>employee |
| <b>IV.</b>  | <b>Accept Terms of Contract</b>   | Required   | Required   | Required  |
| <b>V.</b>   | <b>Board Certified/Eligible</b>   | Required   | Required   | Required for Specialists                            |

## BlueCross BlueShield of Tennessee Commercial Provider Administration Manual

### Minimum Practitioner Network Participation Criteria (cont'd)

Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCross BlueShield of Tennessee, Inc. and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.

|              | Network Attribute  | PPO<br>Blue Network P<br>(Preferred)/<br>BlueAdvantage      | PPO<br>Blue Network S (Select)                            | Preferred Dental/<br><br>FEP Dental         |
|--------------|--|---|---|---|
| <b>VI.</b>   | <b>Must be able to meet Credentialing and Recredentialing Requirements</b>   | Required  | Required  | Required                                    |
| <b>VII.</b>  | <b>Successful Site Evaluation</b>  | Required for Primary Care and High Volume Specialists       | Required for Primary Care and High Volume Specialists     | N/A   |
|              | Factors reviewed at site visit are:<br>Accessibility/appearance, Risk Management Policies/Procedures, access/availability of medical services, medical records administration, and valid certification for regulated services and personnel. |   |   |   |
| <b>VIII.</b> | <b>Admitting Privileges</b>  |   |   |   |
|              | Maintain admitting privileges ( <i>or provision for coverage by a BCBST participating Provider</i> ) with a BCBST network hospital*  | Required  | Required  | Required if hospital services are performed |
|              | <i>*Any exceptions must be approved by BCBST</i>   |   |   |   |
| <b>IX.</b>   | <b>Availability Standards</b><br><i>Network participation is dependent on the business needs of BlueCross BlueShield of Tennessee, Inc. and its affiliates</i>   |   |   |   |
|              | <b>1. Primary Care</b>   | No limits to size. Must meet Network Availability Standards | Limited Network. Must meet Network Availability Standards | N/A   |
|              | <b>2. Hospital Based</b>   | Affiliated with Participating Hospital                      | Affiliated with Participating Hospital                    | N/A   |
|              | Anesthesiology ( <i>includes CRNAs</i> )   | Fee Schedule  | Fee Schedule  | N/A   |
|              | Pathology  | Fee Schedule  | Fee Schedule  | N/A   |
|              | Radiology  | Fee Schedule  | Fee Schedule  | N/A   |
|              | Emergency Room   | Fee Schedule  | Fee Schedule  | N/A   |
|              | Hospital required to deliver   | Yes   | Yes   | N/A   |

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## BlueCross BlueShield of Tennessee Commercial Provider Administration Manual

### Minimum Practitioner Network Participation Criteria (cont'd)

Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCross BlueShield of Tennessee, Inc. and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.

|           | Network Attribute  | PPO<br>Blue Network P<br>(Preferred)/<br>BlueAdvantage  | PPO<br>Blue Network S (Select)  | Preferred Dental/<br>FEP Dental                                   |
|-----------|--|---|---|---|
|           | <b>3. Specialists</b>  | No limits to size.<br>Must meet Network<br>Availability Standards   | Limited Network.<br>Must meet Network<br>Availability Standards   | No limits to size.<br>Must meet Network Availability<br>Standards |
| <b>X.</b> | <b>Member Access Standards</b>   |   |   |   |
|           | <b>1.</b> Agrees to provide care to members within BCBST standards   | Required  | Required  | Required  |
|           | <b>2.</b> Demonstrates a practice history, which BCBST deems consistent and comparable with Providers' ability to comply with these standards. | Required  | Required  | Required  |
|           | <b>2.1 Regular:</b> Routine Examination, Preventive Care, Physical Exam  | <b>Adult</b> - Annual;<br>Within a year of the last<br>scheduled physical after<br>coverage becomes<br>effective, or if last physical<br>is greater than one year,<br>within 3 months.<br><b>Children</b> - According to the<br>American Academy of<br>Pediatrics periodicity<br>schedule | <b>Adult</b> - Annual;<br>Within a year of the last<br>scheduled physical after<br>coverage becomes effective,<br>or if last physical is greater<br>than one year, within 3<br>months.<br><b>Children</b> - According to the<br>American Academy of<br>Pediatrics periodicity<br>schedule | N/A   |
|           | <b>2.2 Prenatal Care:</b>  |   |   |   |
|           | <b>First Trimester</b>   | To be seen in the first<br>trimester, ≤ 6 weeks of<br>woman's questioning<br>pregnancy  | To be seen in the first<br>trimester, ≤ 6 weeks of<br>woman's questioning<br>pregnancy  | N/A   |

## BlueCross BlueShield of Tennessee Commercial Provider Administration Manual

### Minimum Practitioner Network Participation Criteria (cont'd)

Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCross BlueShield of Tennessee, Inc. and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.

|  | Network Attribute                                      | PPO<br>Blue Network P<br>(Preferred)/<br>BlueAdvantage          | PPO<br>Blue Network S (Select)                                  | Preferred Dental/<br><br>FEP Dental |
|--|--|---|---|-------------------------------------|
|  | <b>Second Trimester</b>                                | If the first appointment is beyond the 1st trimester, ≤ 15 days | If the first appointment is beyond the 1st trimester, ≤ 15 days | N/A                                 |
|  | <b>2.3 Urgent Care (Adult &amp; Child)</b>             | ≤ 48 hours  | ≤ 48 hours  | N/A                                 |
|  | <b>2.4 Emergency Care (Adult &amp; Child)</b>          | Immediate - refer to facility-based providers                   | Immediate - refer to facility-based providers                   | N/A                                 |
|  | <b>2.5 Specialty Care (Adult &amp; Child)</b>          | As practitioner deems appropriate for condition or follow-up    | As practitioner deems appropriate for condition or follow-up    | N/A                                 |
|  | <b>2.6 Wait Times</b>                                  |   |   | N/A                                 |
|  | <b>1) Office Wait Time</b> (including lab and X-ray)   | ≤ 45 minutes  | ≤ 45 minutes  | N/A                                 |
|  | <b>2) Member Telephone Call</b> (during office hours): |   |   | N/A                                 |
|  | Urgent   | ≤ 15 minutes  | < 15 minutes  | N/A                                 |
|  | Routine  | 24 hours  | 24 hours  | N/A                                 |
|  | <b>3) Member Telephone Call</b> (after office hours):  |   |   | N/A                                 |
|  | Urgent   | ≤ 30 minutes  | < 30 minutes  | N/A                                 |
|  | Routine  | ≤ 90 minutes  | ≤ 90 minutes  | N/A                                 |
|  | <b>2.7 7Day/24 Hour Coverage</b> through Par Providers | Required  | Required  | N/A                                 |
|  | <b>3. Open Practice</b>                                | No  | No  | N/A                                 |
|  | <b>4. Service Area Definition</b>                      | TN & Contiguous Counties  | TN & Contiguous Counties  | TN & Contiguous Counties            |

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## BlueCross BlueShield of Tennessee Commercial Provider Administration Manual

### Minimum Practitioner Network Participation Criteria (cont'd)

Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCross BlueShield of Tennessee, Inc. and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.

|             | Network Attribute   | PPO<br>Blue Network P<br>(Preferred)/<br>BlueAdvantage | PPO<br>Blue Network S (Select) | Preferred Dental/<br><br>FEP Dental |
|-------------|---|--|--------------------------------|-------------------------------------|
| <b>XI.</b>  | <b>Reimbursement</b>  |  |                                |                                     |
|             | 1. Agrees to the price and reimbursement schedule for the Network   | Required   | Required                       | Required                            |
|             | 2. Agrees to the reimbursement methodology:   | Required   | Required                       | Required                            |
|             | 3. Agrees not to balance bill member  | Required   | Required                       | Required                            |
|             | 4. Administrative Services Only (ASO) Available   | Yes  | Yes                            | Yes                                 |
|             | 5. Acceptance of Electronic Funds Transfer (EFT)  | Required   | Required                       | Required                            |
|             | 6. Electronic Claims Submission   | Required   | Required                       | Required                            |
| <b>XII.</b> | <b>Quality Improvement/Utilization Review/Medical Management Program</b>  |  |                                |                                     |
|             | 1. Cooperate with BCBST QI & UM Programs  | Required   | Required                       | Required                            |
|             | 2. Maintain a QI/UM Plan  | Required   | Required                       | N/A                                 |
|             | 3. Demonstrate practice style and history, which BCBST deems consistent and comparable with BCBST quality management program standards and practices. | Required   | Required                       | Required                            |
|             | 4. Meet BCBST acceptable practice pattern analysis performance parameters related to quality of care, patient satisfaction and cost efficiency.       | Required   | Required                       | N/A                                 |

## BlueCross BlueShield of Tennessee Commercial Provider Administration Manual

### Minimum Practitioner Network Participation Criteria (cont'd)

Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCross BlueShield of Tennessee, Inc. and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.

|              | Network Attribute   | PPO<br>Blue Network P<br>(Preferred)/<br>BlueAdvantage | PPO<br>Blue Network S (Select) | Preferred Dental/<br><br>FEP Dental |
|--------------|---|--|--------------------------------|-------------------------------------|
| <b>XIII.</b> | <b>General Provisions</b>   |  |                                |                                     |
|              | 1. Meet member satisfaction standards - Based on member complaints, grievances, and satisfaction survey   | Required   | Required                       | Required                            |
|              | 2. Demonstrate willingness to cooperate with other Providers, hospitals and health care facilities  | Required   | Required                       | Required                            |
|              | 3. Agree to participate in exclusive arrangements   | Required/Negotiated                                    | Required/Negotiated            | N/A                                 |
|              | 4. Satisfactory record on fraud and abuse and billing practices   | Required   | Required                       | Required                            |
|              | 5. Practice style which is consistent with current standards of medical delivery  | Required   | Required                       | Required                            |
|              | 6. Prescribing pattern, which is consistent with BCBST's quality management program.  | Required   | Required                       | Required                            |
|              | 7. If the Provider's Drug Enforcement Administration Certificate, Controlled Dangerous Substances Certificate, or any schedules thereof have been revoked, suspended or not renewed (a "revocation") by any jurisdiction, for cause, or surrendered to avoid imposition of such revocation, Provider shall not be considered for participation at a minimum of one (1) year after the date that Provider was re-issued a certificate or schedule, except as otherwise provided by applicable laws. If such a certificate or schedule revocation action is pending or initiated against a Provider, Provider's participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider retains certification or schedules. | Required   | Required                       | Required                            |

## BlueCross BlueShield of Tennessee Commercial Provider Administration Manual

### Minimum Practitioner Network Participation Criteria (cont'd)

Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCross BlueShield of Tennessee, Inc. and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.

|  | Network Attribute   | PPO<br>Blue Network P<br>(Preferred)/<br>BlueAdvantage | PPO<br>Blue Network S(Select) | Preferred Dental/<br>FEP Dental |
|--|---|--|-------------------------------|---------------------------------|
|  | <b>8.</b> If the Provider has: (1) been indicted; (2) been convicted of a crime; (3) committed fraud; or (4) been accused or convicted of any offense involving moral turpitude in any jurisdiction, Provider may be immediately terminated from the BCBST Networks or BCBST may refuse participation in any BCBST Networks. In either event, Provider will be considered, at the discretion of BCBST for participation for a minimum of two (2) years after the date of the resolution of the offense or allegation, except as otherwise provided by applicable laws. Provider's initial or continued participation shall not be considered, at the discretion of BCBST, unless the charges are dismissed or otherwise resolved in the Provider's favor. | Required   | Required                      | Required                        |
|  | <b>9.</b> Not currently excluded from Medicare, Medicaid or Federal Procurement and NonProcurement Program(s), or SCHIP.  | Required   | Required                      | Required                        |
|  | <b>10.</b> Abide by Terms of BCBST Provider Dispute Resolution Procedure  | Required   | Required                      | Required                        |
|  | <b>11.</b> Exclusivity Allowed  | No   | Yes                           | No                              |
|  | <b>12.</b> Defined Service Area   | Statewide  | Statewide                     | Statewide                       |

## BlueCross BlueShield of Tennessee Commercial Provider Administration Manual

### Minimum Practitioner Network Participation Criteria (cont'd)

Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCross BlueShield of Tennessee, Inc. and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.

|  | Network Attribute  | PPO<br>Blue Network P<br>(Preferred)/<br>BlueAdvantage | PPO<br>Blue Network S (Select) | Preferred Dental/<br><br>FEP Dental |
|--|--|--|--------------------------------|-------------------------------------|
|  | <p><b>13.</b> If Provider has established an adversarial relationship with BCBST, members or participating Providers that might reasonably prevent the Provider from acting in good faith and in accordance with applicable laws or the requirements of BCBST's agreements with that Provider, other Providers, members or other parties. Provider may not be considered for initial or continued participation in BCBST Networks. As examples, such adversarial relationships include, but are not limited to: credible evidence of making defamatory statements about BCBST; initiating legal or administrative actions against BCBST in bad faith; BCBST's prior or pending termination of the Provider's participation agreement for cause; or prior or pending collection actions against members in violation of an applicable hold harmless requirement. This participation criteria is not intended to prevent the Provider from fully and fairly discussing all aspects of a patient's medical condition, treatment or coverage (i.e. to "gag" the Provider from discussing relevant matters with members). Involving Members or third parties in disputes with BCBST prior to receiving a final determination of that dispute in accordance with BCBST's Provider Dispute Resolution Procedure may be deemed, however, to constitute an adversarial relationship with BCBST.</p> | Required   | Required                       | Required                            |
|  | <p><b>14.</b> Provider's network participation agreement has not been terminated, for other than administrative reasons, within the past year. Examples of administrative terminations are failure to complete the credentialing/recredentialing process or failure to maintain hospital privileges at a network hospital, no claims activity in previous 18 months. For administrative terminations, Provider may reapply upon cure of the deficiency.</p>  | Required   | Required                       | Required                            |



## BlueCross BlueShield of Tennessee Commercial Provider Administration Manual

### 2. Minimum Institutional Provider Network Participation Criteria

**Acute Care Hospitals, Ambulatory Surgical Facilities, Birthing Centers, Dialysis Centers, Inpatient Rehabilitation, Outpatient Rehabilitation, Skilled Nursing Facilities, Mobile X-ray Labs, and Sleep Centers.** Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BCBST and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.

|             | Network Attribute   | PPO<br>Blue Network P (Preferred)/<br>BlueAdvantage | PPO<br>Blue Network S (Select)                |
|-------------|---|---|---|
| <b>I.</b>   | <b>Tennessee/Contiguous Counties</b>  | Required  | Required                                      |
| <b>II.</b>  | <b>State License</b>  |   |   |
|             | 1. License is Current and Valid.  | Required, as applicable<br>(see Exhibit B-1)        | Required, as applicable<br>(see Exhibit B-1)  |
|             | 2. License is Unrestricted as to services performed.  | Required, as applicable<br>(see Exhibit B-1)        | Required, as applicable<br>(see Exhibit B-1)  |
|             | 3. If the Provider's license has been revoked, suspended or not renewed (a license "revocation") by any jurisdiction, for cause, or if the Provider has surrendered license or agreed to surrender license to avoid such a revocation, the Provider will be considered for participation at a minimum of one (1) year after the date that license was re-issued, except as otherwise provided by applicable laws. If such a license revocation action is pending or initiated against a Provider, the Provider's participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider retains license. | Required  | Required                                      |
| <b>III.</b> | <b>Malpractice Insurance</b>  | \$1 million/\$3 million unless State employee       | \$1 million/\$3 million unless State employee |
| <b>IV.</b>  | <b>Medicare Certification Requirements</b>  | Required, as applicable<br>(see Exhibit B-1)        | Required, as applicable<br>(see Exhibit B-1)  |

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## BlueCross BlueShield of Tennessee Commercial Provider Administration Manual

### Minimum Institutional Provider Network Participation Criteria (Cont'd)

**Acute Care Hospitals, Ambulatory Surgical Facilities, Birthing Centers, Dialysis Centers, Inpatient Rehabilitation, Outpatient Rehabilitation, Skilled Nursing Facilities, Mobile X-ray Labs, and Sleep Centers.** Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BCBST and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.

|                               | Network Attribute  | PPO<br>Blue Network P (Preferred)/<br>BlueAdvantage          | PPO<br>Blue Network S (Select)                             |
|-------------------------------|--|--|--|
| <b>V.</b>                     | <b>Accreditation Requirements</b>  | Required, as applicable<br>(see Exhibit B-1)                 | Required, as applicable<br>(see Exhibit B-1)               |
| <b>VI.</b>                    | <b>Accept Terms of Contract</b>  | Required   | Required   |
| <b>VII.</b>                   | <b>Meet Credentialing and Recredentialing Requirements</b>   | Required   | Required   |
| <b>Availability Standards</b> |  |  |  |
| <b>VIII.</b>                  | Network participation is dependent on the business needs of BlueCross BlueShield of Tennessee, Inc. and its affiliates   |  |  |
|                               | 1. Institutional Providers   | No limits to size. Must meet Network Availability Standards. | Limited Network. Must meet Network Availability Standards. |
| <b>IX.</b>                    | <b>Member Access Standards</b>   |  |  |
|                               | 1. Agrees to provide care to members within BCBST standards  | Required   | Required   |
|                               | 2. Demonstrates a medical delivery history, which BCBST deems consistent and comparable with Providers ability to comply with these standards.   | Required   | Required   |
|                               | 3. Service Area Definition   | TN & Contiguous Counties                                     | TN & Contiguous Counties                                   |
|                               | 4. Hospitals that are contracted in out-of-state counties which are contiguous to Tennessee must meet the minimum criteria to justify commercial network participation. Minimum criteria includes but is not limited to satisfaction of minimum claim volume and membership thresholds as well as market impact analysis | Required   | Required   |

## BlueCross BlueShield of Tennessee Commercial Provider Administration Manual

### Minimum Institutional Provider Network Participation Criteria (cont'd)

**Acute Care Hospitals, Ambulatory Surgical Facilities, Birthing Centers, Dialysis Centers, Inpatient Rehabilitation, Outpatient Rehabilitation, Skilled Nursing Facilities, Mobile X-ray Labs, and Sleep Centers.** Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BCBST and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.

|             | Network Attribute   | PPO<br>Blue Network P (Preferred)/<br>BlueAdvantage                       | PPO<br>Blue Network S (Select)  |
|-------------|---|---|---|
| <b>X.</b>   | <b>Reimbursement</b>  |   |   |
|             | 1. Agrees to the price and reimbursement schedule for the Network   | Required  | Required  |
|             | 2. Agrees to the reimbursement methodology:   | Required  | Required  |
|             | 3. Agrees not to balance bill member  | Required  | Required  |
|             | 4. Delegation   | Subject to minimum criteria and approval by Delegated Oversight Committee | Subject to minimum criteria and approval by Delegated Oversight Committee |
|             | 5. Administrative Services Only (ASO) Available   | Yes   | Yes   |
|             | 6. Acceptance of Electronic Funds Transfer (EFT)  | Required  | Required  |
|             | 7. Electronic Claims Submission   | Required  | Required  |
| <b>XI.</b>  | <b>Quality Improvement/Utilization Review/Medical Management Program</b>  |   |   |
|             | 1. Cooperate with BCBST QI & UM Programs  | Required  | Required  |
|             | 2. Maintain a QI/UM Plan  | Required  | Required  |
|             | 3. Demonstrate medical delivery style and history, which BCBST deems consistent and comparable with BCBST quality management program standards and practices. | Required  | Required  |
| <b>XII.</b> | <b>General Provisions</b>   |   |   |
|             | 1. Meet Member satisfaction standards – Based on member complaints, grievances, and satisfaction survey   | Required  | Required  |
|             | 2. Demonstrate willingness to cooperate with other Providers, hospitals and health care facilities  | Required  | Required  |
|             | 3. Agree to participate in exclusive arrangements   | Required/Negotiated   | Required/Negotiated   |
|             | 4. Satisfactory record on fraud and abuse and billing practices   | Required  | Required  |

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## BlueCross BlueShield of Tennessee Commercial Provider Administration Manual

### Minimum Institutional Provider Network Participation Criteria (cont'd)

**Acute Care Hospitals, Ambulatory Surgical Facilities, Birthing Centers, Dialysis Centers, Inpatient Rehabilitation, Outpatient Rehabilitation, Skilled Nursing Facilities , Mobile X-ray Labs, and Sleep Centers.** Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BCBST and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.

|  | Network Attribute  | PPO<br>Blue Network P (Preferred)/<br>BlueAdvantage | PPO<br>Blue Network S (Select) |
|--|--|---|--------------------------------|
|  | <b>5.</b> Medical Delivery style which is consistent with current standards of medical delivery  | Required  | Required                       |
|  | <b>6.</b> Claims filing method   | CMS-1450  | CMS-1450                       |
|  | <b>7.</b> If any person who has an ownership interest of the Provider has: (1) been indicted (2) been convicted of a crime (3) committed fraud or (4) been accused or convicted of any offense involving moral turpitude in any jurisdiction, Provider may be immediately terminated from the BCBST Networks or BCBST may refuse participation in any BCBST Networks. In either event Provider will be considered, at the discretion of BCBST, for participation for a minimum of two (2) years after the date of the resolution of the offense or allegation, except as otherwise provided by applicable laws. Provider's initial or continued participation shall not be considered, at the discretion of BCBST, unless the charges are dismissed or otherwise resolved in the Provider's favor. | Required  | Required                       |
|  | <b>8.</b> Not currently excluded from Medicare, Medicaid or Federal Procurement and NonProcurement Program(s) or SCHIP.  | Required  | Required                       |
|  | <b>9.</b> Term of Contract   | See Exhibit B-1                                     | See Exhibit B-1                |
|  | <b>10.</b> Abide by Terms of BCBST Provider Dispute Resolution Procedure   | Required  | Required                       |
|  | <b>11.</b> Exclusivity Allowed   | No  | Yes                            |
|  | <b>12.</b> Defined Service Area  | Statewide   | Statewide                      |

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## BlueCross BlueShield of Tennessee Commercial Provider Administration Manual

### Minimum Institutional Provider Network Participation Criteria (cont'd)

**Acute Care Hospitals, Ambulatory Surgical Facilities, Birthing Centers, Dialysis Centers, Inpatient Rehabilitation, Outpatient Rehabilitation, Skilled Nursing Facilities , Mobile X-ray Labs, and Sleep Centers.** Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BCBST and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.

|  | Network Attribute   | PPO<br>Blue Network P (Preferred)/<br>BlueAdvantage | PPO<br>Blue Network S (Select) |
|--|---|---|--------------------------------|
|  | <b>13.</b> Provider has not established an adversarial relationship with BCBST or its affiliates, members or participating Providers that might reasonably prevent the Provider from acting in good faith and in accordance with applicable laws or the requirements of BCBST's agreements with that Provider, other Providers, members or other parties. As examples, such adversarial relationships include, but are not limited to: credible evidence of making defamatory statements about BCBST; initiating legal or administrative actions against BCBST in bad faith; BCBST's prior or pending termination of the Provider's participation agreement for cause; or prior or pending collection actions against members in violation of an applicable hold harmless requirement. This participation criteria is not intended to prevent the Provider from fully and fairly discussing all aspects of a patient's medical condition, treatment or coverage (i.e. to "gag" the Provider from discussing relevant matters with members). Involving Members or third parties in disputes with BCBST prior to receiving a final determination of that dispute in accordance with BCBST's Provider Dispute Resolution Procedure may be deemed, however, to constitute an adversarial relationship with BCBST. | Required  | Required                       |
|  | <b>14.</b> Provider's network participation agreement has not been terminated, for other than administrative reasons, within the past year. Examples of administrative terminations are failure to complete the credentialing/recredentialing process, no claims activity in previous 18 months. For administrative terminations, Provider may reapply upon cure of the deficiency.   | Required  | Required                       |

# BlueCross BlueShield of Tennessee Commercial Provider Administration Manual

## Exhibit B-1 Minimum Institutional Provider Network Participation Criteria

| Network Attribute                             | PPO<br>Blue Network P (Preferred)/<br>BlueAdvantage  | PPO<br>Blue Network S (Select)   |
|---|--|--|
| <b>State License Requirements</b>             |  |  |
| Acute Care Hospitals                          | <b>TN:</b> Licensed as an Acute Care Facility<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws                    | <b>TN:</b> Licensed as an Acute Care Facility<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws                    |
| Ambulatory Surgical Facility (ASF)            | <b>TN:</b> Licensed as an Ambulatory Surgery Facility<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws            | <b>TN:</b> Licensed as an Ambulatory Surgery Facility<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws            |
| Ambulatory Surgical Facility, Birthing Center | <b>TN:</b> Licensed as a Birthing Center<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws                         | <b>TN:</b> Licensed as a Birthing Center<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws                         |
| Dialysis Center                               | <b>TN:</b> Licensed as a Dialysis Center<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws                         | <b>TN:</b> Licensed as a Dialysis Center<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws                         |
| Inpatient Rehabilitation                      | <b>TN:</b> Licensed as an Inpatient Rehabilitation Facility<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws      | <b>TN:</b> Licensed as an Inpatient Rehabilitation Facility<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws      |
| Outpatient Rehabilitation                     | <b>TN:</b> Does not license Outpatient Rehabilitation Facilities<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws | <b>TN:</b> Does not license Outpatient Rehabilitation Facilities<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws |
| Skilled Nursing Facility (SNF)                | <b>TN:</b> Licensed as a Skilled Nursing Facility<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws                | <b>TN:</b> Licensed as a Skilled Nursing Facility<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws                |
| Sleep Labs/Centers                            | <b>TN:</b> Does not license Sleep Centers<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws                        | <b>TN:</b> Does not license Sleep Centers<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws                        |
| Mobile X-ray Lab                              | <b>TN:</b> Does not license Mobile X-ray Labs<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws.                   | <b>TN:</b> Does not license Mobile X-ray Labs<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws.                   |
| Pain Management Centers                       | <b>TN:</b> Licensed as an Ambulatory Surgery Facility<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws.           | <b>TN:</b> Licensed as an Ambulatory Surgery Facility<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws.           |

**Exhibit B-1 (Cont'd)**  
**Minimum Institutional Provider Network Participation Criteria**

| Network Attribute                                      | PPO<br>Blue Network P (Preferred)/ BlueAdvantage          | PPO<br>Blue Network S (Select)                            |
|--|---|---|
| <b>Accreditation and/or Certification Requirements</b> |   |   |
| Acute Care Hospital                                    | JC, AOA, CHAP or ACHC and Medicare A or State Site Survey | JC, AOA, CHAP or ACHC and Medicare A or State Site Survey |
| Ambulatory Surgical Facility (ASF)                     | JC, AOA, AAAHC, or AAAASF, and Medicare B                 | JC, AOA, AAAHC, or AAAASF, and Medicare B                 |
| Ambulatory Surgical Facility, Birthing Center          | JC, AOA, CHAP, ACHC or Medicare B                         | JC, AOA, CHAP, ACHC or Medicare B                         |
| Dialysis Center  | Medicare A  | Medicare A  |
| Inpatient Rehabilitation                               | JC, CARF or AOA and Medicare A                            | JC, CARF or AOA and Medicare A                            |
| Outpatient Rehabilitation                              | Medicare A or Mental Health License                       | Medicare A or Mental Health License                       |
| Skilled Nursing Facility                               | Medicare A  | Medicare A  |
| Sleep Labs/Centers                                     | AASM and Medicare B                                       | AASM and Medicare B                                       |
| Mobile X-ray Lab                                       | Medicare Part B   | Medicare Part B   |
| Pain Management Centers                                | CARF or American Academy of Pain Management               | CARF or American Academy of Pain Management               |
|  |   |   |

## BlueCross BlueShield of Tennessee Commercial Provider Administration Manual

### 3. Minimum Ancillary Provider Network Participation Criteria

Home Health, Home Infusion, Durable Medical Equipment (includes Specialty DME and Prosthetic/Orthotic DME), Hospice and Independent Laboratory  
Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCross BlueShield of Tennessee, Inc. and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.

|             | Network Attribute  | PPO<br>Blue Network P (Preferred)/<br>BlueAdvantage | PPO<br>Blue Network S (Select)               |
|-------------|--|---|--|
| <b>I.</b>   | <b>Tennessee/Contiguous Counties</b>   | Required  | Required                                     |
| <b>II.</b>  | <b>State License</b>   |   |  |
|             | 1. License to practice is Current and Valid  | Required, as applicable<br>(see Exhibit B-1)        | Required, as applicable<br>(see Exhibit B-1) |
|             | 2. License to practice is Unrestricted as to services performed.   | Required, as applicable<br>(see Exhibit B-1)        | Required, as applicable<br>(see Exhibit B-1) |
|             | 3. If the Provider's license has been revoked or not renewed (a license "revocation") by any jurisdiction, for cause, or surrendered to avoid such a revocation, Provider will be considered for participation a minimum of one (1) year after the date that license was re-issued, except as otherwise provided by applicable laws. If such a license revocation action is pending or initiated against a Provider, the Provider's participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider retains license. | Required  | Required                                     |
| <b>III.</b> | <b>Minimum Insurance Requirements</b>  | Required, as applicable<br>(see Exhibit B-1)        | Required, as applicable<br>(see Exhibit B-1) |
| <b>IV.</b>  | <b>Medicare Certification Requirements</b>   | Required, as applicable<br>(see Exhibit B-1)        | Required, as applicable<br>(see Exhibit B-1) |



## BlueCross BlueShield of Tennessee Commercial Provider Administration Manual

### Minimum Ancillary Provider Network Participation Criteria (cont'd)

Home Health, Home Infusion, Durable Medical Equipment (includes Specialty DME and Prosthetic/Orthotic DME), Hospice and Independent Laboratory  
Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCross BlueShield of Tennessee, Inc. and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.

|              | Network Attribute  | PPO<br>Blue Network P (Preferred)/<br>BlueAdvantage              | PPO<br>Blue Network S (Select)                                   |
|--------------|--|--|--|
| <b>V.</b>    | <b>Accreditation Requirements</b>  | Required, as applicable<br>(See Exhibit B-1)                     | Required, as applicable<br>(See Exhibit B-1)                     |
|              |  |  |  |
| <b>VI.</b>   | <b>Accept Terms of Contract</b>  | Required   | Required   |
|              |  |  |  |
| <b>VII.</b>  | <b>Meet Credentialing and Recredentialing Requirements</b>   | Required   | Required   |
|              |  |  |  |
| <b>VIII.</b> | <b>Availability Standards</b><br><b>Network participation is dependent on the business needs of BlueCross BlueShield of Tennessee, Inc. and its affiliates</b> |  |  |
|              | 1. Ancillary Providers   | Limited Network. Must meet<br>Network Availability<br>Standards. | Limited Network. Must meet<br>Network Availability<br>Standards. |
|              |  |  |  |
| <b>IX.</b>   | <b>Member Access Standards</b>   |  |  |
|              | 1. Agrees to provide care to members within BCBST standards  | Required   | Required   |
|              | 2. Demonstrates a medical delivery history, which BCBST deems consistent and comparable with Providers' ability to comply with these standards.                | Required   | Required   |
|              | 3. Service Area Definition   | TN & Contiguous Counties   | TN & Contiguous Counties   |

## BlueCross BlueShield of Tennessee Commercial Provider Administration Manual

### Minimum Ancillary Provider Network Participation Criteria (cont'd)

Home Health, Home Infusion, Durable Medical Equipment (includes Specialty DME and Prosthetic/Orthotic DME), Hospice and Independent Laboratory  
Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCross BlueShield of Tennessee, Inc. and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.

|             | Network Attribute   | PPO<br>Blue Network P (Preferred)/<br>BlueAdvantage                       | PPO<br>Blue Network S (Select)  |
|-------------|---|---|---|
| <b>X.</b>   | <b>Reimbursement</b>  |   |   |
|             | 1. Agrees to the price and reimbursement schedule for the Network   | Required  | Required  |
|             | 2. Agrees to the reimbursement methodology:   | Required  | Required  |
|             | 3. Agrees not to balance bill member  | Required  | Required  |
|             | 4. Delegation   | Subject to minimum criteria and approval by Delegated Oversight Committee | Subject to minimum criteria and approval by Delegated Oversight Committee |
|             | 5. Administrative Services Only (ASO) Available   | Yes   | Yes   |
|             | 6. Acceptance of Electronic Funds Transfer (EFT)  | Required  | Required  |
|             | 7. Electronic Claims Submission   | Required  | Required  |
| <b>XI.</b>  | <b>Quality Improvement/Utilization Review/Medical Management Program</b>  |   |   |
|             | 1. Cooperate with BCBST QI & UM Programs  | Required  | Required  |
|             | 2. Maintain a QI/UM Plan  | Required  | Required  |
|             | 3. Demonstrate medical delivery style and history, which BCBST deems consistent and comparable with BCBST quality management program standards and practices. | Required  | Required  |
|             | 4. Agrees to Rapid Response Requirement   | Required, as applicable<br>(See Exhibit B-1)                              | Required, as applicable<br>(See Exhibit B-1)                              |
| <b>XII.</b> | <b>General Provisions</b>   |   |   |
|             | 1. Meet Member satisfaction standards – Based on member complaints, grievances, and satisfaction survey   | Required  | Required  |
|             | 2. Demonstrate willingness to cooperate with other Providers, hospitals and health care facilities.   | Required  | Required  |

## BlueCross BlueShield of Tennessee Commercial Provider Administration Manual

### Minimum Ancillary Provider Network Participation Criteria (cont'd)

Home Health, Home Infusion, Durable Medical Equipment (includes Specialty DME and Prosthetic/Orthotic DME), Hospice and Independent Laboratory

Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCross BlueShield of Tennessee, Inc. and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.

|  | <b>Network Attribute</b>  | <b>PPO<br/>Blue Network P (Preferred)/<br/>BlueAdvantage</b> | <b>PPO<br/>Blue Network S (Select)</b>       |
|--|---|--|--|
|  | <b>3.</b> Agree to participate in exclusive arrangements  | Required/Negotiated  | Required/Negotiated                          |
|  | <b>4.</b> Satisfactory record on fraud and abuse and billing practices  | Required   | Required                                     |
|  | <b>5.</b> Medical Delivery style which is consistent with current standards of medical delivery   | Required   | Required                                     |
|  | <b>6.</b> Claims filing method  | Required, as applicable<br>(See Exhibit B-1)                 | Required, as applicable<br>(See Exhibit B-1) |
|  | <b>7.</b> Must provide all services   | No   | No   |
|  | <b>8.</b> CLIA Certificate  | Required for Independent<br>Labs only                        | Required for Independent<br>Labs only        |
|  | <b>9.</b> Valid contract with ExpressScripts®   | Required for Home Infusion<br>only                           | Required for Home Infusion<br>only           |
|  | <b>10.</b> If any person who has an ownership interest of the Provider has: (1) been indicted (2) been convicted of a crime (3) committed fraud or (4) been accused or convicted of any offense involving moral turpitude in any jurisdiction, Provider may be immediately terminated from the BCBST Networks or BCBST may refuse participation in any BCBST Networks. In either event Provider will be considered, at the discretion of BCBST, for participation for a minimum of two (2) years after the date of the resolution of the offense or allegation, except as otherwise provided by applicable laws. Provider's initial or continued participation shall not be considered, at the discretion of BCBST, unless the charges are dismissed or otherwise resolved in the Provider's favor. | Required   | Required                                     |

## BlueCross BlueShield of Tennessee Commercial Provider Administration Manual

### Minimum Ancillary Provider Network Participation Criteria (Cont'd)

Home Health, Home Infusion, Durable Medical Equipment (includes Specialty DME and Prosthetic/Orthotic DME), Hospice and Independent Laboratory  
Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCross BlueShield of Tennessee, Inc. and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.

|  | Network Attribute   | PPO<br>Blue Network P (Preferred)/<br>BlueAdvantage | PPO<br>Blue Network S (Select) |
|--|---|---|--------------------------------|
|  | <b>11.</b> Not currently excluded from Medicare, Medicaid or Federal Procurement and NonProcurement Program(s), or SCHIP.   | Required  | Required                       |
|  | <b>12.</b> Term of Contract   | See Exhibit B-1                                     | See Exhibit B-1                |
|  | <b>13.</b> Abide by Terms of BCBST Provider Dispute Resolution Procedure  | Required  | Required                       |
|  | <b>14.</b> Exclusivity Allowed  | No  | Yes                            |
|  | <b>15.</b> Defined Service Area   | Statewide   | Statewide                      |
|  | <b>16.</b> Provider has not established an adversarial relationship with BCBST, members or participating Providers that might reasonably prevent the Provider from acting in good faith and in accordance with applicable laws or the requirements of BCBST's agreements with that Provider, other Providers, members or other parties. As examples, such adversarial relationships include, but are not limited to: credible evidence of making defamatory statements about BCBST; initiating legal or administrative actions against BCBST in bad faith; BCBST's prior or pending termination of the Provider's participation agreement for cause; or prior or pending collection actions against members in violation of an applicable hold harmless requirement. This participation criteria is not intended to prevent the Provider from fully and fairly discussing all aspects of a patient's medical condition, treatment or coverage (i.e. to "gag" the Provider from discussing relevant matters with members). Involving Members or third parties in disputes with BCBST prior to receiving a final determination of that dispute in accordance with BCBST's Provider Dispute Resolution Procedure may be deemed, however, to constitute an adversarial relationship with BCBST. | Required  | Required                       |
|  | <b>17.</b> Provider's network participation agreement has not been terminated, for other than administrative reasons, within the past year. Examples of administrative terminations are failure to complete the credentialing/recredentialing process, no claims activity in previous 18 months. For administrative terminations, Provider may reapply upon cure of the deficiency.   | Required  | Required                       |

**Exhibit B-1**  
**Minimum Ancillary Provider Network Participation Criteria**

| Network Attribute   | PPO<br>Blue Network P (Preferred)/<br>BlueAdvantage   | PPO<br>Blue Network S (Select)  |
|---|---|---|
| <b>State License Requirements</b>   |   |   |
| Home Health   | <b>TN:</b> Licensed as a Home Health Provider<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws                                       | <b>TN:</b> Licensed as a Home Health Provider<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws                                       |
| Home Infusion Therapy   | <b>TN:</b> Licensed as a Home Health Provider<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws                                       | <b>TN:</b> Licensed as a Home Infusion Therapy Provider<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws                             |
| Durable Medical Equipment   | <b>TN:</b> Licensed as a Home Infusion Therapy Provider<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws                             | <b>TN:</b> Licensed as a Durable Medical Equipment Supplier<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws                         |
| Prosthetic/Orthotic Durable Medical Equipment Suppliers   | <b>TN:</b> does not license Prosthetic/Orthotic Durable Medical Equipment Suppliers<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws | <b>TN:</b> does not license Prosthetic/Orthotic Durable Medical Equipment Suppliers<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws |
| Specialty Durable Medical Equipment Suppliers ( <i>Non-Licensed offering non-motorized equipment only, e.g. walker, canes</i> ) | <b>TN:</b> does not license Prosthetic/Orthotic Durable Medical Equipment Suppliers<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws | <b>TN:</b> does not license Specialty Durable Medical Equipment Suppliers<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws           |
| Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)                             | <b>TN:</b> does not license Specialty Durable Medical Equipment Suppliers<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws           | <b>TN:</b> does not license Specialty Durable Medical Equipment Suppliers<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws           |
| Hospice   | <b>TN:</b> Licensed as a Hospice Provider<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws   | <b>TN:</b> Licensed as a Hospice Provider<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws   |

# BlueCross BlueShield of Tennessee Commercial Provider Administration Manual

## Exhibit B-1 (cont'd) Minimum Ancillary Provider Network Participation Criteria

| Network Attribute   | PPO<br>Blue Network P (Preferred)/<br>BlueAdvantage   | PPO<br>Blue Network S (Select)  |
|---|---|---|
| <b>State License Requirements (cont'd)</b>  |   |   |
| Independent Laboratory  | <b>TN:</b> Licensed as a Medical Laboratory<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws | <b>TN:</b> Licensed as a Medical Laboratory<br><b>Contiguous:</b> Licensed in accordance with that state's licensing laws |
| <b>Minimum Insurance Requirements</b>   |   |   |
| Malpractice Insurance   | \$1 million/\$3 million unless State employee   | \$1 million/\$3 million unless State employee   |
| Comprehensive Insurance (DME Only)  | \$1 million/\$3 million unless State employee   | \$1 million/\$3 million unless State employee   |
| Product Liability (Breast Prosthesis Only)  | \$500,000   | \$500,000   |
| <b>Medicare Certification Requirements</b>  |   |   |
| Home Health   | Medicare Part A   | Medicare Part A   |
| Home Infusion Therapy   | Medicare Part B   | Medicare Part B   |
| Durable Medical Equipment   | Medicare Part B   | Medicare Part B   |
| Prosthetic/Orthotic Durable Medical Equipment Suppliers   | Medicare Part B   | Medicare Part B   |
| Specialty Durable Medical Equipment Suppliers ( <i>Non-Licensed offering non-motorized equipment only, e.g. walker, canes</i> ) | Medicare Part B   | Medicare Part B   |
| Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)                             | Medicare Part B   | Medicare Part B   |
| Hospice   | Medicare Part A   | Medicare Part A   |
| Independent Laboratory  | Medicare Part B   | Medicare Part B   |
| <b>Accreditation Requirements</b>   |   |   |
| Home Health   | N/A   | N/A   |
| Home Infusion Therapy   | N/A   | N/A   |
| Durable Medical Equipment   | JC or CHAP or AAAHC, BOC, The Compliance Team, ABC, NBAOS, CARF, HQAA, ACHC   | JC or CHAP or AAAHC, BOC, The Compliance Team, ABC, NBAOS, CARF, HQAA, ACHC   |
| Prosthetic/Orthotic Durable Medical Equipment Suppliers   | N/A   | N/A   |

**BlueCross BlueShield of Tennessee Commercial Provider Administration Manual**

**Exhibit B-1 (cont'd)  
Minimum Ancillary Provider Network Participation Criteria**

| <b>Network Attribute</b>  | <b>PPO<br/>Blue Network P (Preferred)/<br/>BlueAdvantage</b> | <b>PPO<br/>Blue Network S (Select)</b> |
|---|--|--|
| Specialty Durable Medical Equipment Suppliers ( <i>Non-Licensed offering non-motorized equipment only, e.g. walker, canes</i> ) | JC or CHAP or AAAHC, if applicable                           | JC or CHAP or AAAHC, if applicable     |
| Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)                             | N/A  | N/A                                    |
| Hospice   | N/A  | N/A                                    |
| Independent Laboratory  | N/A  | N/A                                    |
| <b>Agrees to Rapid Response Requirement</b>   |  |  |
| Home Health   | Yes  | Yes                                    |
| Home Infusion Therapy   | Yes  | Yes                                    |
| Durable Medical Equipment   | Yes  | Yes                                    |
| Prosthetic/Orthotic Durable Medical Equipment Suppliers   | N/A  | N/A                                    |
| Specialty Durable Medical Equipment Suppliers ( <i>Non-Licensed offering non-motorized equipment only, e.g. walker, canes</i> ) | N/A  | N/A                                    |
| Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)                             | N/A  | N/A                                    |
| Hospice   | N/A  | N/A                                    |
| Independent Laboratory  | N/A  | N/A                                    |
| <b>Claims Filing Method</b>   |  |  |
| Home Health   | CMS-1450   | CMS-1450                               |
| Home Infusion Therapy   | CMS-1500   | CMS-1500                               |
| Durable Medical Equipment   | CMS-1500   | CMS-1500                               |
| Prosthetic/Orthotic Durable Medical Equipment Suppliers   | CMS-1500   | CMS-1500                               |
| Specialty Durable Medical Equipment Suppliers ( <i>Non-Licensed offering non-motorized equipment only, e.g. walker, canes</i> ) | CMS-1500   | CMS-1500                               |

# BlueCross BlueShield of Tennessee Commercial Provider Administration Manual

## Exhibit B-1 (cont'd) Minimum Ancillary Provider Network Participation Criteria

| Network Attribute  | PPO<br>Blue Network P (Preferred)/<br>BlueAdvantage | PPO<br>Blue Network S (Select) |
|--|---|--------------------------------|
| Medical Supply Durable Medical<br>Equipment Suppliers (Soft good<br>supplies only, e.g., ostomy supplies)                                | CMS-1500  | CMS-1500                       |
| Hospice  | CMS-1450  | CMS-1450                       |
| Independent Laboratory   | CMS-1500  | CMS-1500                       |
| <b>Must Provide all Services</b>   |   |                                |
| Home Health  | N/A   | N/A                            |
| Home Infusion Therapy  | N/A   | N/A                            |
| Durable Medical Equipment  | N/A   | N/A                            |
| Prosthetic/Orthotic Durable Medical Equipment<br>Suppliers   | N/A   | N/A                            |
| Specialty Durable Medical Equipment Suppliers ( <i>Non-<br/>Licensed offering non-motorized equipment only, e.g.<br/>walker, canes</i> ) | N/A   | N/A                            |
| Medical Supply Durable Medical<br>Equipment Suppliers (Soft good<br>supplies only, e.g., ostomy supplies)                                | N/A   | N/A                            |
| Hospice  | N/A   | N/A                            |
| Independent Laboratory   | N/A   | N/A                            |
| <b>Services must be available in all counties of a CSA<br/>(subcontracting permitted)</b>  |   |                                |
| Home Health  | N/A   | N/A                            |
| Home Infusion Therapy  | N/A   | N/A                            |
| Durable Medical Equipment  | N/A   | N/A                            |
| Prosthetic/Orthotic Durable Medical Equipment<br>Suppliers   | N/A   | N/A                            |

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**Exhibit B-1 (cont'd)  
Minimum Ancillary Provider Network Participation Criteria**

| <b>Network Attribute</b>  | <b>PPO<br/>Blue Network P (Preferred)/<br/>BlueAdvantage</b> | <b>PPO<br/>Blue Network S (Select)</b> |
|---|--|--|
| Specialty Durable Medical Equipment Suppliers <i>(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)</i> | N/A  | N/A                                    |
| Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)                           | N/A  | N/A                                    |
| Hospice   | N/A  | N/A                                    |
| Independent Laboratory  | N/A  | N/A                                    |

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## **G. Provider Identification Number Process**

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Before submitting claims to BlueCross BlueShield of Tennessee, a Provider must request and be assigned an individual provider identification number or contact us to register their National Provider Identifier (NPI). The purpose of this number is to identify the Provider and ensure accurate distribution of payments, remittance advices (Explanation of Payments (EOPs)), and 1099 forms. **The assigned provider number or NPI in no way signifies that the Provider participates in any or all BlueCross BlueShield of Tennessee networks.**

Inquiries regarding the need for a new provider number or to register their NPI should be directed to:

- BlueCross BlueShield of Tennessee Provider Service line, 1-800-924-7141, and just say “Network contracting” when prompted.

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## XVI. BLUECARD® PROGRAM

The BlueCard Program links participating health care providers and the independent BlueCross and/or BlueShield plans across the country and around the world through a single electronic network for claims processing and reimbursement.

The BlueCard Program also allows Members who are away from (traveling or living) their **Home Plan's\*** service area to receive medical care from participating Providers wherever services may be required and in many instances, to receive the same level of benefits they would receive if the services were rendered in their Home Plan's service area.

The program allows Providers to submit claims for BlueCross and/or BlueShield plan Members from other BlueCross and BlueShield plans, including international BlueCross and BlueShield plans, directly to the Provider's local plan (**Host Plan\*\***). That plan will be the Provider's contact for claims filing, claims payment, adjustments, inquiries, and problem resolution.

\***Home Plan** is the plan that "owns" the Member's coverage

\*\***Host Plan** is the Practitioner's local BlueCross BlueShield Plan – for Tennessee Practitioner's treating Members of other Blue Plans, it is BlueCross BlueShield of Tennessee.

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### A. How the Program Works

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1. A BlueCross and/or BlueShield Member is outside his/her Home Plan's service area and needs health care services.
2. The Member locates a participating Provider\* by calling the BlueCard Provider Finder at 1-800-810-BLUE (2583) or by accessing the BlueCard Provider Finder website at [www.bcbs.com/healthtravel/finder.html](http://www.bcbs.com/healthtravel/finder.html).
3. The Member presents his/her BlueCross and/or BlueShield ID card. The Member's identification number should begin with a **three-character alpha prefix**.
4. The Provider should verify the Member's eligibility and benefits by calling BlueCard Eligibility at **1-800-676-BLUE (2583)**, the customer service number on the back of the Member's ID card, or online via the secure BlueAccess link on the company website, [www.bcbst.com](http://www.bcbst.com). (See subsection B. "How to Identify a BlueCard Member" to determine the Member's BlueCross BlueShield Plan.) Note: A BlueCard Member's coverage and utilization management requirements may differ from those of BlueCross BlueShield of Tennessee. The facility is responsible for obtaining any necessary inpatient prior authorizations; however, the Practitioner may elect to confirm a prior authorization has been obtained. See subsection L. "Prior Authorization Requirements").
5. The Provider should submit claims to BlueCross BlueShield of Tennessee.
6. BlueCross BlueShield of Tennessee will electronically forward the claim to the Member's Home Plan with the Provider's network participation status and the maximum allowable based on the Provider's agreement with BlueCross BlueShield of Tennessee.
7. The Member's Home Plan will determine the benefits to be provided based on the Member's eligibility, contract provisions, the Provider's network status, and the maximum allowable. The Home Plan will transmit back to BlueCross BlueShield of Tennessee the finalized adjudication information (e.g., reason for denial, amount applied to deductible, amount paid, etc.).
8. BlueCross BlueShield of Tennessee will notify the Provider via the Explanation of Payment (EOP) of the final adjudication results.
9. The Member's Home Plan will notify the Member of his/her benefits via an Explanation of Benefits (EOB).

\*If the Member receives services from a non-participating Provider, the Member is responsible for:

- paying the charges at the time the services are rendered;
- submitting the claim to BlueCross BlueShield of Tennessee; and
- any amounts not paid by his/her benefit plan, including amounts exceeding the maximum allowable.

---

## B. How to Identify a BlueCard Member

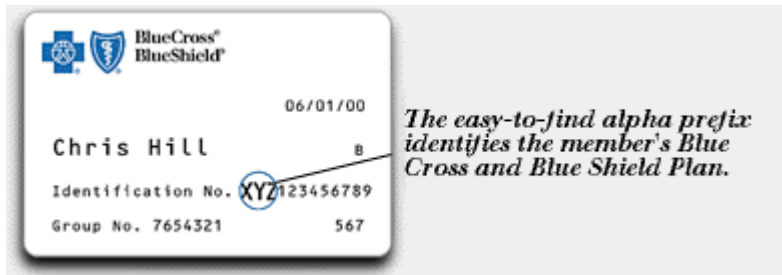
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BlueCard Members will carry BlueCross and/or BlueShield identification cards that include one or more of the following identifiers:

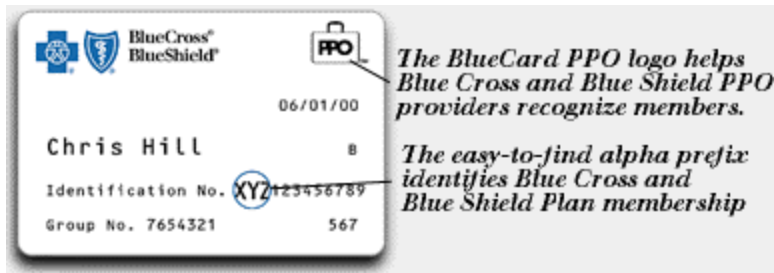
- Subscriber identification number begins with an alpha-prefix
- Suitcase logo (empty or PPO inside)
- Member's Plan name other than BlueCross BlueShield of Tennessee reflected on back of ID card

Sample copies of the BlueCard ID cards follow:

### BlueCard Traditional ID Card



### BlueCard PPO ID Card



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## C. BlueCard Traditional

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- BlueCard Traditional Members have identification cards with either no suitcase or with an “empty” suitcase logo.
- BlueCard Traditional Members are often required to use a participating Provider within their Home Plan's service area. Therefore, Providers should verify the level of benefits (in-network vs. out-of-network) they will receive for services provided these Members.
- For dates of service prior to 1/1/09, the maximum allowable was based on Blue Network C. Effective for dates of service 1/1/09, and after, the maximum allowable is based on Blue Network P.

---

## D. BlueCard PPO

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- BlueCard PPO Members have identification cards with a “PPO” inside a suitcase logo.
- Benefits are provided at the in-network level if the Provider is participating in the local BlueCross and/or BlueShield Plan’s BlueCard PPO Network.
- The maximum allowable is based on Blue Network P.

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## E. BlueCard Alternative PPO Network

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- Alternative PPO Network Members have identification cards that include the local BlueCross and/or BlueShield’s alternative PPO Network name listed.
- Benefits are provided at the in-network level if the Provider is participating in the local BlueCross and/or BlueShield’s designated Alternative PPO Network.
- Alternative PPO Network Members do not have access to a Wrap Network.
- The maximum allowable is based on Blue Network S.

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## F. Medicare Advantage Private-Fee-for-Service (PFFS)

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### **MEDICARE ADVANTAGE | PFFS**

A Medicare PFFS plan is a plan offered by an organization that pays Physicians and Providers on a fee-for-service basis. This is no specific network that Providers sign up for to service PFFS Members. Members can obtain services from any licensed Physician or Provider in the United States who is qualified to be paid by Medicare and accepts the plan’s terms of payment.

The maximum allowable for Covered Services will be equivalent to the current Medicare payment amount.

Please refer to the Member identification card for instructions on how to access terms and conditions. Providers may also locate this information on our website at <http://www.bcbst.com/providers/BenefitHighlights.shtml>.

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## G. Medicare Advantage PPO

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Beginning 1/1/2010, Medicare Advantage PPO network sharing is available in all the Centers for Medicare & Medicaid Services (CMS)-approved Medicare Advantage (MA) PPO BlueCross and/or BlueShield Plans local service areas.

This network sharing allows MA PPO Members from Blue Plans to obtain in-network benefits when traveling or living in the service areas of the other two Plans if the Member receives care from a contracted MA PPO Provider.

The maximum allowable is based on the Blue Advantage PPO Network. If you are not a contracted Blue Advantage PPO Network Provider and you provide services for any Blue Medicare Advantage out-of-area Member, the maximum allowable will be based on the Medicare allowed amount for Covered Services.

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## H. BlueCard Claim Filing

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Claims for the following services should be submitted to BlueCross BlueShield of Tennessee unless the Provider contracts directly with the Member's Home Plan:

- Medical services (including secondary claims)
- Routine hearing
- Routine vision

Claims for the following services should be submitted directly to the Member's Home Plan:

- Stand-alone Dental
- Prescription Drugs

Effective 10/14/2012, all Blue Plans implemented new claims filing procedures for **Ancillary Providers**. It is very important that **ALL Providers understand the impact of this change**.

File the claim accordingly for the Ancillary Provider as outlined below:

- **Independent Clinical Lab** – Lab Providers should file claims to the Blue Plan in whose state the specimen was drawn, which will be determined by which state the referring Provider is located.
- **Durable Medical Equipment (DME)/Home Medical Equipment (HME)** – DME/HME Providers should file claims to the Blue Plan in whose state the equipment was shipped to, or purchased at a retail store.
- **Specialty Pharmacy** – Specialty pharmacies should file the claim to the Blue Plan in whose state the ordering Physician is located.

**Note:** *If the Provider contracts with more than one Blue Plan in a state for the same product type (i.e., PPO or Traditional), the Provider may file the claim with either Plan.*

**Note:** *Contiguous County Providers should file claims according to these guidelines regardless of Network status.*

Providers utilizing outside vendors to provide services (example: sending blood specimen for special analysis that cannot be done by the lab where the specimen was drawn) should utilize in-network participating Ancillary Providers to reduce the possibility of additional Member liability for Covered benefits. A list of in-network participating Providers may be obtained by contacting their Provider Network Manager (See *Section II. BlueCross BlueShield of Tennessee Quick Reference Guide* in this Manual) or call BlueCard at 1-800-705-0391.

Claims should be filed with the identification number as it appears on the Member's ID card omitting any dashes or spaces within the identification number. Additionally, Ancillary Provider claims must include the name of the referring Physician or **the claim will be rejected**.

When submitting electronically, follow the guidelines found in this Manual (Section VI. Billing and Reimbursement – Filing Electronic Claims). Providers needing additional information regarding electronic claims filing can call BlueCross BlueShield of Tennessee eBusiness Solutions at 423-535-5717.

## BlueCross BlueShield of Tennessee Provider Administration Manual

When submitting paper claims, mail to:

BlueCross BlueShield of Tennessee  
Claims Service Center  
1 Cameron Hill Circle, Ste 0002  
Chattanooga, TN 37401-0002

When submitting paper claims for secondary benefits (secondary to a commercial carrier or to Medicare), please include the primary carrier's Explanation of Payment.

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### I. BlueCard and Medicare Crossover Claims

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Each BlueCross and/or BlueShield Plan independently contracts with the Centers for Medicare and Medicaid Services (CMS) for crossover claims.

Since the CMS Coordination of Benefits Agreement allows insurance carriers to select which claims cross over automatically, Providers may see some variation in crossover processes; i.e., type of bill, Provider location state, Medicare Administrative Contractor for Jurisdiction C (DME MAC), and Medicare payment versus Beneficiary liability among the BlueCross and/or BlueShield Plans.

Providers are encouraged to review their Medicare Summary Notice (MSN) to determine if Medicare crossed over a specific claim to the Member's Home Plan. If the MSN indicates the claim was crossed over, the Member's Home Plan will process the claim directly. If the MSN does not indicate the claim crossed over, the Provider should submit a paper claim with a copy of Medicare's MSN to:

BlueCross BlueShield of Tennessee  
Claim Service Center  
1 Cameron Hill Circle, Ste 0002  
Chattanooga, TN 37401-0002

Providers may request status for Medicare crossover claims online via the secure BlueAccess link on the company website, [www.bcbst.com](http://www.bcbst.com).

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### J. BlueCard Program Reimbursement

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BlueCross BlueShield of Tennessee will reimburse Providers for BlueCard Program claims submitted according to BlueCross BlueShield of Tennessee claims filing guidelines when:

- The Member is eligible for benefits
- The services are covered under the Member's plan\*
- The Provider has not already been paid for the services

\*The Home Plan determines what services are considered eligible under the Member's plan including all medical policy determinations (e.g., Medical Necessity, Investigational; routine, etc.).



## K. Medical Records

BlueCross BlueShield of Tennessee will forward requests for medical information and/or copies of records as requested by the Member's Home Plan. The medical information and/or records should be returned to BlueCross BlueShield of Tennessee as quickly as possible to reduce any delays in claims processing. Because we are interested in servicing you in the most efficient manner possible, Providers are encouraged to submit medical records using the following guidelines:

- Submit any request letters from us as the first page of your medical record.
- Providers are encouraged to fax the requested information to the number listed on the request letter. This allows for direct storage into our image repository.
- Submit only the requested information.
- Claim copies are not necessary when submitting requested medical records. Any claim copies submitted must be behind the medical record. If attached to the front, it will be mistaken for a claim needing adjudication rather than a medical record needing review.

**Note:** Medical record requests are based on the Home Plan's medical policies and may differ from those of BlueCross BlueShield of Tennessee.

## L. Prior Authorization Requirements

Each BlueCross and/or BlueShield Plan determines its medical policies related to prior authorization requirements. Home Plans may require prior authorization based on the type of service or location of service. The services requiring prior authorization may vary from those determined by BlueCross BlueShield of Tennessee.

Providers may elect to verify any prior authorization requirements via telephone or by utilizing BlueAccess, BlueCross BlueShield of Tennessee's secure area on its website, [www.bcbst.com](http://www.bcbst.com).

## M. Inquiries

The following grid lists examples of specific inquiries and provides direction to the appropriate contact:

| Inquiry                              | Contact           | Description   |
|--------------------------------------|-------------------|---|
| Verification of eligibility/benefits | Home Plan         | 1-800-676-BLUE or by accessing BlueCard within BlueAccess |
| Prior Authorizations                 | Home Plan         | See back of Member's ID card                              |
| Electronic claims submissions        | Host Plan (BCBST) | BCBST eBusiness Solutions<br>423-535-5717                 |
| General questions                    | Host Plan (BCBST) | BlueCard Host Service<br>1-800-705-0391                   |
| Processed claims                     | Host Plan (BCBST) | BlueCard Host Service<br>1-800-705-0391                   |

## BlueCross BlueShield of Tennessee Provider Administration Manual

| <b>Inquiry</b>                                 | <b>Contact</b>    | <b>Description</b>   |
|--|-------------------|--|
| Status requests                                | Host Plan (BCBST) | BlueCard Host Service<br>1-800-705-0391 or by accessing BlueCard within BlueAccess           |
| Claim rejected "Home Plan will handle direct"  | Home Plan         | Customer Service Number located on back of Member's ID card                                  |
| Claim rejected "Additional information needed" | Host Plan (BCBST) | BlueCard Host Service<br>1-800-705-0391  |
| Overpayments                                   | Host Plan (BCBST) | BlueCard Host Service<br>1-800-705-0391  |
| Appeals Host                                   | Plan (BCBST)      | Follow guidelines found in this Manual (Section XIII. Provider Dispute Resolution Procedure) |

Providers interested in more information regarding the BlueCard Program can call BlueCross BlueShield of Tennessee's BlueCard Service Department at 1-800-705-0391.

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## XVII. VISION CARE

### A. BCBST Employee Group 44 Plan

Effective Jan. 1, 2013, EyeMed Vision Care began processing vision claims for BCBST Group 44 employees. Benefits, allowances and exclusions remain the same. EyeMed participating Providers should file Group 44 claims\* directly to EyeMed Vision Care.



\*Claims for services due to illness or injury to the eye are Covered under Members' medical plan. These claims should continue to be filed to BCBST for reimbursement.

Providers not contracted with EyeMed will continue to receive the same reimbursement by submitting an out-of-network claim form to EyeMed on behalf of the Member or by collecting from the Member and having the Member submit the claim to EyeMed for reimbursement. The EyeMed out-of-network claim form is available on the company website at <http://www.bcbst.com/members/vision/OON+Claim+Form+-+8.2008.pdf>. Contact EyeMed at 1-888-581-3648 for more information on becoming a contracted Provider.


BCBST employees with vision benefits through EyeMed can be identified by group number 109844 reflected on the Member ID card.

The following ID card identifies BlueCross BlueShield of Tennessee Group 44 Members:

Front

|   |   |
|---|---|
|  |   |
| <b>CHRIS B HALL</b>   |   |
| Subscriber ID<br><b>ZEE123456789</b>  | <b>MEDICAL/DENTAL/VISION</b>  |
| Group No. 109844  |  |
| RXBIN 610014  | <b>Copayments:</b><br>OV \$30<br>SPEC \$45<br>ER \$250<br>V \$30<br>UC \$75         |
| RXGRP BCTCOMM<br><b>BLUE NETWORK: P</b>   | <b>RX04</b><br>RX \$10/\$35/\$50  |

Back

|   |  |
|---|--|
|   | <b>bcbst.com</b><br>Member Service: 1-800-565-9140<br>Network Provider Outside Tennessee:<br>1-800-810-2583 (BLUE)<br>To use your Behavioral Health benefits:<br>1-800-888-3773<br>Provider Service: Eligibility, Prior Authorization and Claims 1-800-924-1411<br>Pharmacists: 1-800-924-1557<br>NICU & subsequent 1st authorization:<br>1-888-832-2006<br>Prior authorization needed for Advanced Imaging 1-888-493-3211<br>GRID/GRID+ 1-800-523-1478<br>VisionBlue: EyeMed 1-877-342-0737 |
| Providers: Submit claims to your local BCBS Plan. Prior authorization required for admissions and certain medical services.   | Dentists- in and out of Tennessee:<br>File dental claims to:<br>BCBST Claims Service Ctr., 1 Cameron Hill Circle, Suite 0002, Chattanooga, TN 37402-0002   |
| Avoid additional costs. Show this card to your provider and ask for a prior authorization check. See your benefit materials for details. This card does not guarantee benefits eligibility. 257 (01/13) |  |

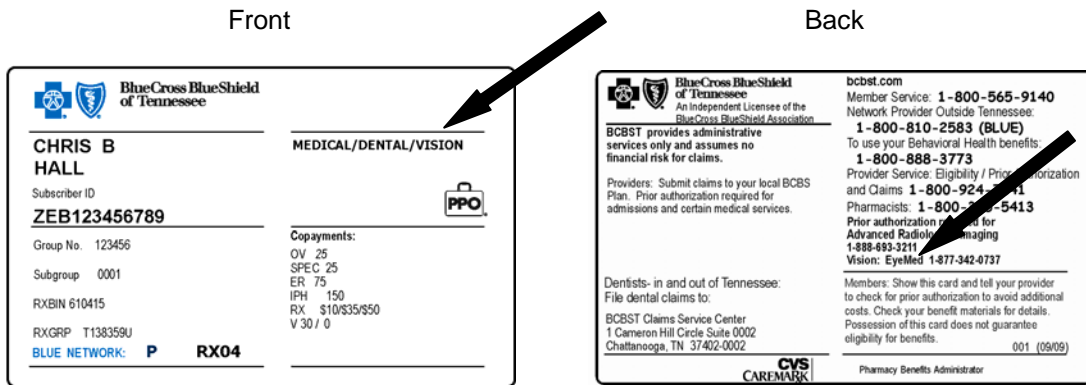
**Note:** This change affects BCBST employee Group 44 plan only.

## B. VisionBlue – Network-based vision coverage plan

VisionBlue is a network-based routine vision care program offered by BlueCross BlueShield of Tennessee in partnership with EyeMed VisionCare.

Benefits for services due to illness or injury are covered under the Member's medical plan.

The following ID card identifies BlueCross BlueShield of Tennessee Members also subscribing to VisionBlue:



Providers holding a contract with EyeMed provide services at the in-network benefit level and file claims directly with EyeMed. Members who seek services from out-of-network Providers (those not having a contract with EyeMed) must file their claim directly to EyeMed to receive the out-of-network benefits.

The following list reflects **standard** VisionBlue benefits offered by BlueCross BlueShield of Tennessee. However, benefits vary Plan by Plan; Therefore, Providers should always check eligibility and benefits prior to rendering services.

## VisionBlue Summary of Benefits

| Benefit   | In-Network Member Cost  | Out-of-Network Reimbursement             | Benefit Frequency  |
|---|---|--|--|
| <b>VISION EXAMINATION</b>   |   |  |  |
| <b>Comprehensive Eye Examination</b>  | \$10 or \$20 copay  | up to \$35                               | One exam within a 12-month period<br>For each Member covered under the plan                                    |
| Plans with materials coverage also include benefits listed below              |   |  |  |
| <b>Contact Lenses Fit And Follow-Up</b>                                       |   |  | One exam within a 12-month period<br>For each Member covered under the plan                                    |
| Standard  | \$55 copay  | up to \$0                                |  |
| Premium   | 10% off retail  | up to \$0                                |  |
| <b>VISION MATERIALS</b>   |   |  |  |
| <b>Standard Plastic Lenses</b>  |   |  | One set of lenses within a 12-month period<br>For each Member covered under the plan                           |
| Single Vision   | \$10 or \$25 copay  | up to \$30                               |  |
| Bifocal   | \$10 or \$25 copay  | up to \$45                               |  |
| Trifocal  | \$10 or \$25 copay  | up to \$60                               |  |
| <b>Frames</b>   | \$0 copay up to (\$100, \$120, \$150) allowance, 20% off balance over allowance | Up to (\$50,\$60,\$75)                   | One pair of frames within a 12- or 24-month period for each member covered under the plan                      |
| <b>Contacts</b>   |   |  | One set of lenses within a 12-month period for each member covered under the plan (in lieu of eyeglass lenses) |
| Conventional  | \$0 copay up to (\$100, \$120, \$150) allowance, 15% off balance over allowance | Out of network up to (\$80, \$96, \$120) |  |
| Disposable  | \$0 copay up to (\$100, \$120, \$150) allowance                                 | Out of network up to (\$80, \$96, \$120) |  |
| Medically Necessary   | Paid in Full  | Up to \$200                              |  |
| <b>Lens Options</b>   |   |  | One set of lenses within a 12-month period<br>For each Member covered under the plan                           |
| Standard Polycarbonate  | \$40 copay  | Up to \$0                                |  |
| Standard Polycarbonate (For covered Dependent children under 19 years of age) | \$0 copay   | Up to \$5                                |  |
| UV Treatment  | \$15 copay  | Up to \$0                                |  |
| Tint  | \$15 copay  | Up to \$0                                |  |

### VisionBlue Summary of Benefits (cont'd)

| Benefit   | In-Network Member Cost                                | Out-of-Network Reimbursement | Benefit Frequency |
|---|---|------------------------------|-------------------|
| Standard Plastic Scratch Coating                | \$15 copay  | Up to \$0                    |                   |
| Standard Progressive Lenses (add on to Bifocal) | \$65 copay  | Up to \$45                   |                   |
| Premium Progressive Lenses (add on to Bifocal)  | \$65 copay, 20% off retail price less \$120 allowance | Up to \$45                   |                   |
| Standard Anti-Reflective Coating                | \$45 copay  | Up to \$0                    |                   |

**Note:**

- This document serves as a summary of the benefits that are detailed in the Member's Evidence of Coverage. These benefits are subject to the Covered Services and Limitations on Covered Services, Exclusions from Covered Services, and Schedule of Benefits sections of the Member's Evidence of Coverage.
- When applicable benefits are paid after the copay amounts listed above and to the allowance listed. Members are responsible for amounts above the allowance.
- Members may see any vision care Provider. However, contracted Providers in the BCBST network have agreed to limit certain charges and provide additional discounts once the allowance has been reached. Members are responsible for all charges that exceed the out-of-network reimbursement.

### ***VisionBlue Frequently Asked Questions***

**Why was EyeMed Vision Care chosen to administer the new VisionBlue product?**

- By choosing EyeMed, BlueCross BlueShield of Tennessee is able to allow Members a variety of private Practitioners as well as retail outlets.

**Will I submit VisionBlue claims to BCBST or EyeMed?**

- To determine if claims should be submitted to BCBST or EyeMed, simply flip the Member's card over. If it is a VisionBlue Member, the back of the card will read "Vision: EYEMED 1-877-342-0737". All other vision claims should be sent to BCBST. In addition, if a claim is sent to BCBST in error, it will be returned to the Provider with instructions to resubmit to EyeMed.

**How can I contact EyeMed directly?**

- EyeMed has dedicated an entire customer service line for BCBST Members and Providers. The number to call is 1-877-342-0737.

**Who do I contact to verify eligibility and check claim status for Members that have routine benefits provided through EyeMed?**

- You would need to contact EyeMed Customer Service at 1-877-342-0737.

***VisionBlue Frequently Asked Questions*** (Cont'd)

**If the services rendered are medical in nature and not considered routine, where should I submit the claim?**

- Claims of medical services should be filed directly to the Member's medical insurance carrier.

**I am interested in becoming a provider with EyeMed. Who should I contact?**

- Please contact EyeMed directly by calling 1-877-342-0737.

**Will my current patients with BCBST vision be changing to this new product?**

- No, not at this time. The only exception would be if an employer group chose to add or change to this product.



## C. Essential Health Benefits (EHB) Medical Plan

New Health Care Reform Plans from BCBST have Pediatric vision benefits built into the medical plan. The Affordable Care Act (ACA) mandates that certain additional services be covered, to include, but not limited to pediatric vision care services for Members under 19 years of age.

A sample copy of the BlueCross BlueShield of Tennessee EHB ID card follows:

**BlueCross BlueShield of Tennessee**

**CHRIS B HALL**

Member ID: **ABC123456789**

Group No. 123456

Medical Includes: Pediatric Dental and Vision

PPO

Copayments:

RXBIN 610014

RXGRP BCTCOMM

BLUE NETWORK: **P** **RX04**

**BlueCross BlueShield of Tennessee**

An Independent Licensee of the BlueCross BlueShield Association

Providers: Submit claims to your local BCBS Plan. Prior authorization required for admissions and certain medical services.

**Dentists-In and Out of Tennessee:**  
File dental claims to:  
BCBST Claims Service Ctr., 1 Cameron Hill Circle, Suite 0002, Chattanooga, TN 37402-0002

bcbst.com  
Member Service: 1-800-565-9140  
Network Provider Outside Tennessee: 1-800-810-2583 (BLUE)

To use your Behavioral Health benefits:  
1-800-888-3773  
Provider Service: Eligibility / Prior Authorization and Claims: 1-800-924-7141  
Pharmacists: 1-800-922-1557  
NICU & subsequent 1st yr authorizations: 1-888-832-2006  
Prior authorization required for Advanced Imaging: 1-888-693-3211  
GRID/GRID+ 1-800-523-1478  
VisionBlue: EyeMed 1-877-342-0737

Avoid additional costs. Show this card to your provider and ask for a prior authorization check. See your benefit materials for details. This card does not guarantee benefits eligibility. 903 (07/13)

Adults are **not** covered for vision services under the EHB medical plan. Adult coverage is available as a separate vision supplemental plan providing coverage to individuals 19 years and older. Benefits vary; therefore, Providers should always check eligibility and benefits prior to rendering services.

A sample copy of a Vision Supplemental Plan ID card follows:

**BlueCross BlueShield of Tennessee**

**CHRIS B HALL**

Member ID: **ABC123456789**

Group No. 123456

Medical Includes: Pediatric Dental and Vision

MEDICAL/DENTAL/VISION

PPO

Copayments:

RXBIN 610014

RXGRP BCTCOMM

BLUE NETWORK: **P** **RX04**

**BlueCross BlueShield of Tennessee**

An Independent Licensee of the BlueCross BlueShield Association

Providers: Submit claims to your local BCBS Plan. Prior authorization required for admissions and certain medical services.

**Dentists-In and Out of Tennessee:**  
File dental claims to:  
BCBST Claims Service Ctr., 1 Cameron Hill Circle, Suite 0002, Chattanooga, TN 37402-0002

bcbst.com  
Member Service: 1-800-565-9140  
Network Provider Outside Tennessee: 1-800-810-2583 (BLUE)

To use your Behavioral Health benefits:  
1-800-888-3773  
Provider Service: Eligibility / Prior Authorization and Claims: 1-800-924-7141  
Pharmacists: 1-800-922-1557  
NICU & subsequent 1st yr authorizations: 1-888-832-2006  
Prior authorization required for Advanced Imaging: 1-888-693-3211  
GRID/GRID+ 1-800-523-1478  
VisionBlue: EyeMed 1-877-342-0737

Avoid additional costs. Show this card to your provider and ask for a prior authorization check. See your benefit materials for details. This card does not guarantee benefits eligibility. 903 (07/13)

VisionBlue plan benefits may be checked by calling the VisionBlue EyeMed phone number listed on the back of the Member ID card.

**Essential Health Benefits Medically Necessary and Appropriate Routine Vision Care Services**

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**Covered Services**

1. Routine vision services, including services and supplies to detect or correct refractive errors of the eyes.

**Limitations**

1. Vision Examinations are covered once every Annual Benefit Period.
2. Eyeglass frames are covered once every Annual Benefit Period.
3. Eyeglass lenses or contact lenses are covered once every Annual Benefit Period.
4. Prescription Sunglasses will be handled as any other lens.
5. Benefits are not available more frequently than as specified in Attachment C: Schedule of Benefits.
6. Discounts do not apply for benefits provided by other group benefit plans or promotional offers.

**Exclusions:**

1. Medical and/or surgical treatment of the eye, eyes, or supporting structure, including surgeries to detect or correct refractive errors of the eyes.
2. Eye exercises and/or therapy.
3. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses.
4. Medical and/or surgical treatment of the eye, eyes or supporting structures.
5. Charges for lenses and frames ordered while insured but not delivered within 60 days after Coverage is terminated, or vision testing examinations that occur after the date of termination.
6. Charges for non-prescription sunglasses, photosensitive, anti-reflective or other optional charges when the charge exceeds the amount allowable for regular lenses.
7. Charges filed for procedures determined by the Plan to be special or unusual, (i.e. orthoptics, vision training, subnormal vision aids, aniseikonic lenses, tonography, corneal refractive therapy, etc.)
8. Charges for lenses that do not meet the Z80.1 or Z80.2 standards of the American National Standards Institute.
9. Charges in excess of the Covered benefit as established by the Plan.
10. Oversized Lenses.
11. Corrected eyewear required by an employer as a condition of employment, and safety eyewear unless specifically Covered under the plan.
12. Non-prescription lenses and frames, and non-prescription sunglasses (except for 20% discount).
13. Services or materials provided by any other group benefit providing vision care.
14. Two pairs of glasses in lieu of bifocals.
15. Charges for replacement of broken, lost, or stolen lenses, contact lenses, or frames.
16. Charges for services or materials from an Ophthalmologist, Optometrist or Optician acting outside the scope of his or her license.
17. Charges for any additional service required outside basic vision analyses for contact lenses, except fitting fees.

The BlueCross BlueShield of Tennessee EHB Summary of Benefits follows:

**EHB Summary of Benefits**

| <b>EHB Pediatric Vision</b>   |  |                                 |
|---|--|---------------------------------|
| <b>Benefit</b>  | <u>EyeMed Network</u>  | <u>Out-of-Network</u>           |
| Exam with Dilation as Necessary   | \$0 Copayment  | 60% of Maximum Allowable Charge |
| <b>Contact Lens Fit and Follow-Up:</b>  |  |                                 |
| (Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.) |  |                                 |
| Standard Contact Lens Fit and Follow-Up:  | \$0 Copayment  | 60% of Maximum Allowable Charge |
| Premium Contact Lens Fit and Follow-Up:   | \$0 Copayment  | 60% of Maximum Allowable Charge |
| <b>Frames:</b>  |  |                                 |
| Designated available frame at provider location   | 100% Coverage for Provider designated frames   | 60% of Maximum Allowable Charge |
| <b>Standard Lenses (Glass or Plastic):</b>  |  |                                 |
| Single Vision   | \$0 Copayment  | 60% of Maximum Allowable Charge |
| Bifocal   | \$0 Copayment  | 60% of Maximum Allowable Charge |
| Trifocal  | \$0 Copayment  | 60% of Maximum Allowable Charge |
| Lenticular  | \$0 Copayment  | 60% of Maximum Allowable Charge |
| Standard Progressive Lens   | \$0 Copayment  | 60% of Maximum Allowable Charge |
| <b>Lens Options:</b>  |  |                                 |
| UV Treatment  | \$0 Copayment  | 60% of Maximum Allowable Charge |
| Tint (Fashion & Gradient & Glass-Grey)  | \$0 Copayment  | 60% of Maximum Allowable Charge |
| Standard Plastic Scratch Coating  | \$0 Copayment  | 60% of Maximum Allowable Charge |
| Standard Polycarbonate  | \$0 Copayment  | 60% of Maximum Allowable Charge |
| Photocromatic / Transitions Plastic   | \$0 Copayment  | 60% of Maximum Allowable Charge |
| <b>Contact Lenses:</b>  |  |                                 |
| <b>(Contact lens includes materials only)</b>   | 100% Coverage for Provider designated contact lenses   |                                 |
| Extended Wear and Extended Wear Disposables   | Up to 6 months supply of monthly or 2 week disposable, single vision spherical or toric contact lenses | 60% of Maximum Allowable Charge |
| Daily Wear / Disposables  | Up to 3 months supply of daily disposable, single vision spherical contact lenses                      | 60% of Maximum Allowable Charge |

## XVIII. DENTAL PROGRAM

**Note:** BlueCross BlueShield of Tennessee has written policies and procedures for both the initial and re-credentialing process of Practitioners and Organizational Providers. Dentists must be able to meet these credentialing and re-credentialing requirements. See Section XIV. Credentialing, in this Manual for additional information.

### A. Standard DentalBlue Covered Services and Limitations

The standard DentalBlue Program provides a wide range of benefits to Cover most services associated with dental care.

If more than one procedure or course of treatment can be used to accomplish the same treatment goal, meets generally accepted standards of professional dental care, and offers a favorable prognosis for the patient's condition, then benefits may be based on the lowest cost procedure or treatment. This will be at our sole discretion.

If a Member transfers from the care of one Dentist to another during the course of treatment, or if more than one Dentist renders services for one dental procedure, benefits will not exceed those that would have been provided had one Dentist rendered the service. Benefits will also not be paid for incomplete treatment.

#### Examinations

**Covered:** Standard exams including comprehensive, periodic, detailed/ extensive and periodontal oral evaluations (exams). Emergency exams, including limited oral evaluations (exams).

**Limitations:** No more than one standard exam in any 6-month period. No more than one emergency exam in any 12-month period. No more than one detailed/extensive or periodontal exam in any 36-month period. An additional comprehensive exam (D0150) will be considered for each participating Provider once in a 36-month period, assuming the same Provider has not performed a detailed/extensive or periodontal exam within the same 36-month period.

**Exclusions:** Re-evaluations and consultations.

#### X-rays

**Covered:** Full mouth series, intraoral and bitewing radiographs (X-rays).

**Limitations:** No more than one full mouth set of X-rays in any 36-month period. A full mouth set of X-rays is defined as either an intraoral complete series or panoramic X-ray. Benefits provided for either include benefits for all necessary intraoral and bitewing films taken on the same day. No more than four bitewing films in any 12-month period. Bitewing films must be taken on the same date of service.

**Exclusions:** Extraoral, skull and bone survey, sialography, TMJ, and tomographic survey X-ray films, cephalometric films and diagnostic photographs. Cephalometric films and diagnostic photographs may be covered as orthodontic benefits under Coverage D.

#### Cleanings, Fluoride Treatment

**Covered:** Adult and child prophylaxis (cleaning). Child and adult (subject to age limitations) fluoride treatments, performed with or without a prophylaxis.

**Limitations:** No more than one of any prophylaxis or periodontal maintenance procedure in any 6-month period. Periodontal maintenance procedures are subject to additional limitations listed under *Basic Periodontics* later in this section, and may be subject to a different Coverage level under the terms of the Member's Contract. No more than one fluoride treatment in any 12-month period, for Members under age 19. Fluoride must be applied separately from prophylaxis paste.

### Sealants, Space Maintainers

**Covered:** Other Preventive Services, including sealants, preventive resins, and space maintainers.

**Limitations:** No more than one sealant or preventive resin per first or second molar tooth per lifetime, for Dependents under age 16. Space maintainers for Dependents under age 14. No more than one recementation in any 12-month period.

**Exclusions:** Nutritional and tobacco counseling, oral hygiene instructions.

### Basic Restorative Services

**Covered:** Basic restorative services, including amalgam restorations (silver fillings), resin composite restorations (tooth colored fillings), stainless steel crowns. Palliative emergency treatment for the relief of pain. Other restorative services, including repair of full and partial dentures.

**Limitations:** No more than one amalgam or resin restoration per tooth surface in any 12-month period. Replacement of existing amalgam and resin composite restorations covered only after 12 months from the date of initial restoration. Replacement of stainless steel crowns covered only after 36 months from the date of initial restoration. No more than one repair per denture per 24 months.

**Exclusions:** Gold foil restorations.

### Major Restorative Services

**Covered:** Single tooth restorations, including crowns (resin, porcelain,  $\frac{3}{4}$  cast, and full cast), inlays and onlays (metallic, resin and porcelain), and veneers.

**Limitations:** Only for the treatment of severe carious lesions or severe fracture on permanent teeth, and only when teeth cannot be adequately restored with an amalgam or resin composite restoration (filling). For permanent teeth only. For Dependents under age 12, benefits will not be provided for cast crowns or laminate veneers. Replacement of single tooth or fixed partial denture restorations Covered only after 60 months from the date of initial placement.

**Exclusions:** Temporary and provisional crowns.

### Prosthodontic Services - Fixed Bridges

**Covered:** Fixed partial dentures (bridges), including pontics, retainers, and abutment crowns, inlays, and onlays (resin, porcelain,  $\frac{3}{4}$  and full cast).

**Limitations:** Only for treatment where a missing tooth or teeth cannot be adequately restored with a removable partial denture. For permanent teeth only, no benefits for Dependents under age 16. Replacement of fixed partial dentures or single tooth restoration Covered only after 60 months from the date of initial placement. Prosthodontic Services - Removable Dentures

**Covered:** Complete, immediate and partial dentures.

**Limitations:** If, in the construction of a denture, the Member and the Dentist decide on a personalized restoration or to employ special rather than standard techniques or materials, benefits provided shall be limited to those that would otherwise be provided for the standard procedures or materials (as determined by the Plan). Benefits are not provided for Dependents under age 16. Replacement of removable dentures Covered only after 60 months from the date of initial placement.

**Exclusions:** Interim (temporary) dentures.

### **Other Major Restorative & Prosthodontic Services**

**Covered:** Crown and bridge services including core buildups, post and core, recementation, and repair. Denture services including adjustment, relining, rebasing and tissue conditioning.

**Limitations:** The benefits provided for crown and bridge restorations include benefits for the services of crown preparation, temporary or prefabricated crowns, impressions and cementation. Benefits will not be provided for a core build-up separate from those provided for crown construction, except in those circumstances where benefits are provided for a crown because of severe carious lesions or fracture is so extensive that retention of the crown would not be possible. Post and core services are covered only when performed in conjunction with a Covered crown or bridge. Crown and bridge repair and re-cementation are covered separately only after 12 months from the date of initial placement. Denture adjustments are covered separately from the denture only after 6 months from the date of initial placement. No more than one denture reline or rebase in any 36-month period.

**Exclusions:** Other major restorative services including protective restoration and coping. Other prosthodontic services including overdenture, precision attachments, connector bars, stress breakers and coping metal. Interim pontic and retainer crowns.

### **Basic Endodontics**

**Covered:** Pulpotomy, pulpal therapy.

**Limitations:** For primary teeth only. Not covered when performed in conjunction with major endodontic treatment. The benefits for basic endodontic treatment include benefits for X-rays, pulp vitality tests, and protective restoration provided in conjunction with basic endodontic treatment. However, pulp vitality tests and protective restorations are not Covered when billed separately from other endodontic services.

**Exclusions:** Pulpal debridement.

### **Major Endodontics**

**Covered:** Root canal treatment and re-treatment, apexification, pulpal regeneration, apicoectomy services, root amputation, retrograde filling, hemisection, pulp cap.

**Limitations:** No more than one root canal treatment, re-treatment pulpal regeneration, or apexification per tooth in 60-month period. No more than one apicoectomy per root per lifetime. The benefits for major endodontic treatment include benefits for x-rays, pulp vitality tests, pulpotomy, pulpectomy and sedative fillings and temporary filling material provided in conjunction with major endodontic treatment. However, pulp vitality tests and protective restorations are not Covered when billed separately from other endodontic services.

**Exclusions:** Implantation, canal preparation, and incomplete endodontic therapy.

### **Basic Periodontics**

**Covered:** Non-surgical periodontics, including periodontal scaling and root planing, full mouth debridement and periodontal maintenance procedure.

**Limitations:** No more than one periodontal scaling and root planing per quadrant in any 24month period. No more than one full mouth debridement per lifetime. No more than one of any prophylaxis (cleanings) or periodontal maintenance procedure in any 6month period. Cleanings are subject to

additional limitations listed under Preventive Services, and may be subject to a different Coverage level under the terms of the Member's Contract. Benefits for periodontal maintenance are provided only after active periodontal treatment (surgical or non-surgical), and no sooner than 90 days after completion of such treatment. Benefits for periodontal scaling and root planing, full mouth debridement, periodontal maintenance and prophylaxis are not provided when more than one of these procedures is performed on the same day.

**Exclusions:** Provisional splinting, scaling in the presence of gingival inflammation, antimicrobial medication and dressing changes.

### **Major Periodontics**

**Covered:** Surgical periodontics including gingivectomy, gingivoplasty, gingival flap procedure, crown lengthening, osseous surgery and bone and tissue grafting.

**Limitations:** No more than one major periodontal surgical procedure in any 36-month period. Benefits provided for major periodontics include benefits for services related to 90 days of postoperative care.

**Exclusions:** Tissue regeneration and apically positioned flap procedure.

### **Basic Oral Surgery**

**Covered:** Non-surgical or simple extractions.

**Limitations:** Benefits provided for basic oral surgery include benefits for suturing and postoperative care.

**Exclusions:** Benefits for general anesthesia or intravenous sedation when performed in conjunction with basic oral surgery.

### **Major Oral Surgery**

**Covered:** Surgical extractions (including removal of impacted teeth and wisdom teeth), coronectomy, and other oral surgical procedures typically not Covered under a medical plan.

**Limitations:** Benefits provided for major oral surgery include benefits for local anesthesia, suturing and postoperative care. Benefits for general anesthesia or intravenous (IV) sedation are provided only in connection with major oral surgery procedures, and only when provided by a Dentist licensed to administer such agents.

**Exclusions:** Any related oral surgery typically Covered under a medical plan, but not limited to, excision of lesions and bone tissue, treatment of fractures, suturing, wound and other repair procedures, TMJ and related procedures. Orthognathic surgery and treatment for congenital malformations. Harvesting of bone for use in autogenous grafting.

### **Orthodontics Services**

**Covered:** Exams, photographic images, diagnostic casts, cephalometric X-rays, installation and adjustment of orthodontic appliances and treatment to reduce or eliminate an existing malocclusion.

**Limitations:** The need for orthodontic services must be diagnosed, identifying a handicapping malocclusion that is both abnormal and correctable, and a Treatment Plan must be submitted to and approved by the Plan. The Plan reserves the right to review the Member's dental records, including necessary X-rays, photographs, and models to determine whether orthodontic treatment is Covered. Orthodontic services may be limited to Dependents under a specified age limit, as defined under the terms of the Member's Contract: Orthodontic services may be limited by a Maximum Allowable Charge, Calendar Year Deductible and lifetime maximum as defined under the terms of the Member's Contract. Multiple occurrences of orthodontic treatment may be

allowed subject to the lifetime maximum. All orthodontic services shall be deemed to be concluded on the last date treatment performed during Member's Coverage, even if a prior approved Treatment Plan has not been completed.

**Exclusions:** Replacement or repair of any lost, stolen and damaged appliance furnished under the Treatment Plan. Surgical procedures to aid in orthodontic treatment.

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**B. Other General Exclusions**

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BlueCross BlueShield of Tennessee's dental plan does not provide benefits for the following services supplies or charges to include, but not limited to:

1. Dental services received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trustee or similar person or group.
2. Charges for services performed by the Member or Member's spouse, or Member's or Member's spouse's parent, sister, brother or child.
3. Services rendered by a Dentist beyond the scope of his/her license.
4. Dental services which are free, or for which the Member is not required or legally obligated to pay or for which no charge would be made if the Member had no dental Coverage.
5. Dental services to the extent that charges for such services exceed the charge that would have been made and collected if no Coverage existed hereunder.
6. Dental services covered by any medical insurance coverage, or by any other non-dental contract or certificate issued by Blue Cross Blue Shield of Tennessee or any other insurance company, carrier, or plan. For example, removal of impacted teeth, tumors of lip and gum, accidental injuries to the teeth, etc.
7. Any court-ordered treatment of a Member unless benefits are otherwise payable.
8. Courses of treatment undertaken before the Member became Covered under this program.
9. Any services performed after the Member ceased to be eligible for Coverage.
10. Dental care or treatment not specifically listed under the terms of the Member's Contract.
11. Any treatment or service that the Plan determines is not Necessary Dental Care that does not offer a favorable prognosis that does not meet generally accepted standards of professional dental care, or that is experimental in nature.
12. Services or supplies for the treatment of work related illness or injury, regardless of the presence or absence of Workers' Compensation coverage. This exclusion does not apply to injuries or illnesses of an employee who is (1) a sole-proprietor of the Group; (2) a partner of the Group; or (3) a corporate officer of the Group, provided the officer filed an election not to accept Workers' Compensation with the appropriate government department.
13. Charges for any hospital or other surgical or treatment facility and any additional fees charged by a Dentist for treatment in any such facility.



14. Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes. This does not exclude those services provided under Orthodontic benefits (if applicable).
15. Replacement of tooth structure lost from wear or attrition.
16. Dental services resulting from loss or theft of a denture, crown, bridge or removable orthodontic appliance.
17. Diagnosis for, or fabrication of, adjustment or maintenance and cleaning of maxillofacial prosthesis, appliances or restorations necessary to correct bite problems or restore the occlusion or correct temporomandibular joint dysfunction (TMJ) or associated muscles.
18. Diagnostic dental services such as diagnostic tests and oral pathology services.
19. Adjunctive dental services including all local and general anesthesia, sedation, and analgesia (except as provided under major oral surgery).
20. Charges for the treatment of desensitizing medicaments, drugs, occlusal guards and adjustments, mouthguards, microabrasion, behavior management, and bleaching.
21. Charges for the treatment of professional visits outside the dental office or after regularly scheduled hours or for observation.
22. Charges for the inhalation of nitrous oxide/analgesia, anxiolysis.

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## C. Clinical Criteria Requirements

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The following criteria are based on procedure codes as defined in the *American Dental Association's (ADA) Current Dental Terminology CDT 2005 manual*.

These criteria were formulated from information gathered from practicing dentists, dental schools, ADA clinical articles and guidelines, insurance companies, as well as other dental related organizations. They are designed as *guidelines* for consideration of payment and payment decisions and *are not intended to be all-inclusive or absolute*.

Requests for information regarding treatment using these codes, such as radiographs, periodontal charting, or descriptive narratives, are determined by generally accepted dental standards for consideration of payment. Additional narrative information is appreciated when there may be a special situation.

Unspecified codes (e.g., D0999, D2999, D3999, D4999, D5899 D5999, D6999, D7999, D8999, D9999) will be clinically reviewed and considered for payment if a narrative and/or appropriate radiographs are included with the claim. In some instances, the State legislature will define the requirements for dental procedures.

The following grid lists CDT codes and the required documentation that should accompany claims to BlueCross BlueShield of Tennessee for review. Only attach the required documentation for the codes listed; Attaching documentation to claims for procedures NOT listed will result in claims processing delays.

## BlueCross BlueShield of Tennessee Provider Administration Manual

| CDT Code   | Description            | Documentation Required with Claim  |
|--|------------------------|--|
| D2510; D2520; D2530  | Inlays                 | Preoperative radiographs<br><br>Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio; whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.                                     |
| D2542 – D2544  | Onlays                 | Preoperative radiographs<br><br>Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio; whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.                                     |
| D2610; D2620; D2630  | Inlays                 | Preoperative radiographs<br><br>Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio; whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.                                     |
| D2642 – D2644  | Onlays                 | Preoperative radiographs<br><br>Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio; whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.                                     |
| D2650 – D2652  | Inlays                 | Preoperative radiographs<br><br>Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio; whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.                                     |
| D2662 – D2664  | Onlays                 | Preoperative radiographs<br><br>Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio; whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.                                     |
| D2710; D2712; D2720 – D2722; D2740; D2750 – D2752; D2780 – D2783; D2790 – D2792; D2794 | Crowns                 | Preoperative radiographs^<br><br>Teeth #7 -#10 and #23 - #26<br><br>Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio; whether performed for cosmetics, attrition, vertical dimension, special construction, splinting. |
| D2960 – D2962  | Veneers                | Preoperative radiographs<br><br>Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio; whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.                                     |
| D6600 – D6615; D6624; D6634  | Inlays/Onlays          | Preoperative radiographs and Perio Charting<br><br>Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio; whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.                  |
| D0999 – D9999  | Unspecified Procedures | Preoperative radiographs<br><br>Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio; whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.                                     |

^ Radiographs required when filing more than one specific procedure.

**Note:** To help ensure claims process timely, please do **not** attach radiographs or perio charting unless submitting a claim for one of the above listed procedures. Effective 1/1/2008, BlueCross BlueShield of Tennessee will no longer return X-rays to the Provider. Because X-rays are considered part of the patient's clinical record, the dentist office should retain the original image and only submit a **copy** of the X-ray with the claim.

BCBST accepts electronic attachments, such as X-rays or perio charts through National Electronic Attachment (NEA). Currently BCBST is not able to accept Explanation of Benefits (EOBs) from other insurance carriers electronically. For more information, please call NEA at 1-800-782-5150, ext. 2.

## D. Essential Health Benefits (EHB) Medical Plan

New Health Care Reform plans from BCBST have Pediatric dental benefits built into the medical plan. The Affordable Care Act (ACA) mandates that certain additional services be covered, including, but not limited to pediatric oral care services for Members under 19 years of age.

A sample copy of the BlueCross BlueShield of Tennessee EHB ID card follows:

**BlueCross BlueShield of Tennessee**

**CHRIS B HALL**

Member ID: **ABC123456789**

Group No. 123456

RxBIN 610014

RXGRP BCTCOMM

**BLUE NETWORK: P RX04**

**Medical Includes:**  
Pediatric Dental and Vision

**PPO**

**Copayments:**

**BlueCross BlueShield of Tennessee**  
An Independent Licensee of the BlueCross BlueShield Association

Providers: Submit claims to your local BCBS Plan. Prior authorization required for admissions and certain medical services.

**Dentists-In and Out of Tennessee:**  
**File dental claims to:**  
BCBST Claims Service Ctr., 1 Cameron Hill Circle, Suite 0002, Chattanooga, TN 37402-0002

bcbst.com  
Member Service: 1-800-565-9140  
Network Provider Outside Tennessee: 1-800-810-2583 (BLUE)  
To use your Behavioral Health benefits: 1-800-888-3773  
Provider Service: Eligibility / Prior Authorization and Claims 1-800-924-7141  
Pharmacists: 1-800-922-1957  
NICU & subsequent 1st yr authorizations: 1-888-832-2006  
Prior authorization required for Advanced Imaging 1-888-893-3211  
GRID/GRID+ 1-800-523-1478  
VisionBlue: EyeMed 1-877-342-0737

Avoid additional costs. Show this card to your provider and ask for a prior authorization check. See your benefit materials for details. This card does not guarantee benefits eligibility. 903 (07/13)

Adults are **not** covered for dental services under the EHB medical plan. Adult coverage is available as a separate dental supplemental plan providing coverage to individuals 19 years and older. Benefits vary; therefore, Providers should always check eligibility and benefits prior to rendering services.

A sample copy of a Dental Supplemental Plan ID card follows:

**BlueCross BlueShield of Tennessee**

**CHRIS B HALL**

Member ID: **ABC123456789**

Group No. 123456

RxBIN 610014

RXGRP BCTCOMM

**BLUE NETWORK: P RX04**

**Medical Includes:**  
Pediatric Dental and Vision

**MEDICAL/DENTAL/VISION**

**PPO**

**Copayments:**

**BlueCross BlueShield of Tennessee**  
An Independent Licensee of the BlueCross BlueShield Association

Providers: Submit claims to your local BCBS Plan. Prior authorization required for admissions and certain medical services.

**Dentists-In and Out of Tennessee:**  
**File dental claims to:**  
BCBST Claims Service Ctr., 1 Cameron Hill Circle, Suite 0002, Chattanooga, TN 37402-0002

bcbst.com  
Member Service: 1-800-565-9140  
Network Provider Outside Tennessee: 1-800-810-2583 (BLUE)  
To use your Behavioral Health benefits: 1-800-888-3773  
Provider Service: Eligibility / Prior Authorization and Claims 1-800-924-7141  
Pharmacists: 1-800-922-1957  
NICU & subsequent 1st yr authorizations: 1-888-832-2006  
Prior authorization required for Advanced Imaging 1-888-893-3211  
GRID/GRID+ 1-800-523-1478  
VisionBlue: EyeMed 1-877-342-0737

Avoid additional costs. Show this card to your provider and ask for a prior authorization check. See your benefit materials for details. This card does not guarantee benefits eligibility. 903 (07/13)

The following grid lists pediatric dental benefits included in the BlueCross BlueShield of Tennessee Essential Health Benefits plan:

| Pediatric Dental Benefits included in the BCBST EHB Medical Plan   |                       |   |
|--|-----------------------|---|
| Covered Services   | Network Dentist       | Out-of-Network Dentist                                |
| <b>Coverage A</b> Diagnostic and Preventive Services; Exams; Cleanings; X-rays   | 100%                  | 100% of the Maximum Allowable Charge after Deductible |
| <b>Coverage B</b> Basic and Restorative Services; Basic Restorative; Basic Endodontics; Oral Surgery; Basic Periodontics           | 80%                   | 80% of the Maximum Allowable Charge after Deductible  |
| <b>Coverage C</b> Major Restorative and Prosthodontic Services; Major Restorative; Major Endodontics; Major Periodontics; Implants | 50%                   | 50% of the Maximum Allowable Charge after Deductible  |
| <b>Coverage D</b> Medically Necessary Orthodontia for Members under age 19.<br>Prior Authorization is required.                    | 50% after Deductible* | 50% of the Maximum Allowable Charge after Deductible* |

\*Percent may vary by medical plan

## Dental Services – Pediatric Dental

The Essential Health Benefits plan provides a wide range of benefits to Cover most services associated with dental care for dependents under age 19.

If a Member transfers from the care of one Dentist to another during the course of treatment, or if more than one Dentist renders services for one dental procedure, benefits will not exceed those that would have been provided had one Dentist rendered the service.

When more than one treatment alternative exists, meets generally accepted standards of professional dental care, and offers a favorable prognosis for the individual's condition, BCBST reserves the right to provide payment for the least expensive Covered Service alternative.

### Diagnostic Services

- A. Exams
  - 1. Covered
    - a. Standard exams including comprehensive, periodic, detailed/extensive limited and periodontal oral evaluations (exams).
  - 2. Limitations
    - a. No more than one standard exam in any 6 month period.
  - 3. Exclusions
    - a. Re-evaluations and consultations.
- B. X-rays
  - 1. Covered
    - a. Full mouth series, intraoral and bitewing radiographs (x-rays).

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2. Limitations
  - a. No more than one full mouth set of x-rays in any 60 month period. A full mouth set of x-rays is defined as either an intraoral complete series or panoramic x-ray. Benefits provided for either include benefits for all necessary intraoral and bitewing films taken on the same day.
  - b. No more than four bitewing films in any 6 month period. Bitewing films must be taken on the same date of service.
3. Exclusions
  - a. Extraoral, skull and bone survey, sialography, and tomographic survey x-ray films, cephalometric films and diagnostic photographs.

### **Preventive Services**

- A. Prophylaxis (Cleanings)
  1. Covered
    - a. Child prophylaxis (cleaning) for primary and permanent teeth.
  2. Limitations
    - a. No more than one of any prophylaxis or periodontal maintenance procedure in any 6 month period.
    - b. Periodontal maintenance procedures are subject to additional limitations listed below under Basic Periodontics, and may be subject to a different Coverage level under Attachment C: Schedule of Benefits.
- B. Fluoride Treatment
  1. Covered
    - a. Topical fluoride treatments, performed with or without a prophylaxis.
  2. Limitations
    - a. No more than one fluoride treatment in any 6 month period.
    - b. Fluoride must be applied separately from prophylaxis paste.
- C. Other Preventive Services
  1. Covered
    - a. Sealants, preventive resin restorations, space maintainers.
    - b. Palliative (emergency) treatment for the relief of pain.
  2. Limitations
    - a. No more than 1 sealant, preventive resin restoration, or resin infiltration per first or second molar tooth per 36 months. Resin infiltrations are subject to a different Coverage level under Attachment C: Schedule of Benefits.
    - b. No more than one re-cementation in any 12 month period.
  1. Exclusions
    - a. Nutritional and tobacco counseling, oral hygiene instructions provided by a Dentist.

### **Basic Restorative Services**

- A. Fillings and Stainless Steel Crowns
  1. Covered
    - a. Amalgam restorations (silver fillings), resin composite restorations (tooth colored fillings), resin infiltrations, stainless steel crowns.
  2. Limitations
    - a. No more than one amalgam or resin restoration per tooth surface in any 12 month period.
    - b. Replacement of existing amalgam and resin composite restorations Covered only after 12 months from the date of initial restoration.
    - c. Replacement of stainless steel crowns Covered only after 60 months from the date of initial restoration.
    - d. No more than 1 sealant, preventive resin restoration, or resin infiltration per first or

second molar tooth per 36 months. (Sealant/Preventive resins are subject to additional limitations listed under Preventive Services, and may be subject to a different Coverage level under Attachment C: Schedule of Benefits.)

3. Exclusions
  - a. Gold foil restorations.

#### **Other Basic Restorative Services**

1. Covered
  - a. Repair of full and partial dentures and bridges
  - b. Crown and Inlay re-cementation.
  - c. Denture services including adjustments, relining, rebasing and tissue conditioning.
  - d. General anesthesia and IV sedation only when administered by a properly licensed Dentist in a dental office in conjunction with covered surgery procedures or when necessary due to concurrent medical conditions.
2. Limitations
  - a. No more than one repair per denture per 24 months.
  - b. Denture adjustments are Covered separately from the denture only after 6 months from the date of initial placement.
  - c. No more than one denture reline or rebase in any 36 month period.

### **Major Restorative & Prosthodontic Services**

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#### **Single Tooth Restorations**

1. Covered
  - a. Crowns (resin, porcelain,  $\frac{3}{4}$  cast, and full cast), inlays and onlays (metallic, resin and porcelain), and veneers.
2. Limitations
  - a. Only for the treatment of severe carious lesions or severe fracture on permanent teeth, and only when teeth cannot be adequately restored with an amalgam or resin composite restoration (filling).
  - b. For permanent teeth only.
  - c. Replacement of single tooth restorations or fixed partial dentures. Covered only after 60 months from the date of initial placement.
3. Exclusions
  - a. Temporary and provisional crowns.

#### **Multiple Tooth Restorations – Bridges**

1. Covered
  - a. Fixed partial dentures (bridges), including pontics, retainers, and abutment crowns, inlays, and onlays (resin, porcelain,  $\frac{3}{4}$  and full cast).
2. Limitations
  - a. Only for treatment where a missing tooth or teeth cannot be adequately restored with a removable partial denture.
  - b. For permanent teeth only.
  - c. Replacement of fixed partial dentures or single tooth restorations. Covered only after 60 months from the date of initial placement.
3. Exclusions
  - a. Interim pontic and retainer crowns.

**Removable Prosthodontics - Dentures**

1. Covered
  - a. Complete, immediate and partial dentures.
2. Limitations
  - a. If, in the construction of a denture, the Member and the Dentist decide on a personalized restoration or to employ special rather than standard techniques or materials, benefits provided shall be limited to those which would otherwise be provided for the standard procedures or materials (as determined by the Plan).
  - b. for permanent teeth only.
  - c. Replacement of removable dentures Covered only after 60 months from the date of initial placement.
3. Exclusions
  - a. Interim (temporary) dentures.

**Other Major Restorative & Prosthodontic Services**

1. Covered
  - a. Crown and bridge services including core buildups, post and core, and repair.
  - b. Implants and Implant supported prosthetics, including local anesthetic.
2. Limitations
  - a. The benefits provided for crown and bridge restorations include benefits for the services of crown preparation, temporary or prefabricated crowns, impressions and cementation.
  - b. Benefits will not be provided for a core build-up separate from those provided for crown construction, except in those circumstances where benefits are provided for a crown because of severe carious lesions or fracture is so extensive that retention of the crown would not be possible.
  - c. Post and core services are Covered only when performed in conjunction with a Covered crown or bridge.
  - d. Crown, inlay, onlay, and veneer repair are Covered separately only after 12 months from the date of initial placement.
  - e. Implant limited to one per tooth per 60 months.
  - f. Bone graft for implant is covered if implant is covered.
  - g. Implant debridement is limited to one per tooth per 60 months and is covered if implant is covered.
  - h. Replacement of implant supported prosthesis is covered only after 60 months from the date of any prosthesis placement.
3. Exclusions
  - a. Other major restorative services including protective restoration and coping.
  - b. Other prosthodontic services including overdenture, precision attachments, connector bars, stress breakers and coping metal.
  - c. Temporary and interim implant abutment.

**Endodontics (treatment of the dental pulp or root canal)**

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**Basic Endodontics**

1. Covered
  - a. Pulpotomy, pulpal therapy.
2. Limitations
  - a. For primary teeth only.
  - b. Not Covered when performed in conjunction with major endodontic treatment.
  - c. The benefits for basic endodontic treatment include benefits for x-rays, pulp vitality

tests, and protective restoration provided in conjunction with basic endodontic treatment. However, pulp vitality tests and protective restorations are not Covered when billed separately from other endodontic services.

3. Exclusions
  - a. Pulpal debridement.

### **Major Endodontics**

1. Covered Services
  1. Root canal treatment and re-treatment, apexification, pulpal regeneration, apicoectomy services, root amputation, retrograde filling, hemisection, pulp cap.
2. Limitations
  - a. The benefits for major endodontic treatment include benefits for x-rays, pulp vitality tests, pulpotomy, pulpectomy and protective restoration and temporary filling material provided in conjunction with major endodontic treatment. However, pulp vitality tests and protective restorations are not Covered when billed separately from other endodontic services.
3. Exclusions
  - a. Implantation, canal preparation, and incomplete endodontic therapy.

## **Periodontics**

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### **Basic Periodontics**

1. Covered
  - a. Non-surgical periodontics, including periodontal scaling and root planing, full mouth debridement and periodontal maintenance procedure.
2. Limitations
  - a. No more than one periodontal scaling and root planing per quadrant in any 24 month period.
  - b. No more than one full mouth debridement per lifetime.
  - c. No more than four of any prophylaxis (cleanings) or periodontal maintenance procedure in any 12 month period. Cleanings are subject to additional limitations listed under Preventive Services, and may be subject to a different Coverage level under Attachment C: Schedule of Benefits.
  - d. Benefits for periodontal maintenance are provided only after active periodontal treatment (surgical or non-surgical), and no sooner than 90 days after completion of such treatment.
  - e. Benefits for periodontal scaling and root planing, full mouth debridement, periodontal maintenance and prophylaxis are not provided when more than one of these procedures is performed on the same day.
3. Exclusions
  - a. Provisional splinting, scaling in the presence of gingival inflammation, antimicrobial medication and dressing changes.

### **Major Periodontics**

1. Covered
  - a. Surgical periodontics including gingivectomy, gingivoplasty, gingival flap procedure, crown lengthening, osseous surgery and bone and tissue grafting.
  - b. Benefits provided for major periodontics include benefits for services related to 90 days of postoperative care.
2. Limitations
  - a. No more than one major periodontal surgical procedure in any 36 month period.
3. Exclusions
  - a. Tissue regeneration and apically positioned flap procedure.



## Oral Surgery

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### Basic Oral Surgery

1. Covered
  - a. Non-surgical or simple extractions.
2. Limitations
  - a. Benefits provided for basic oral surgery include benefits for suturing and postoperative care.
3. Exclusions
  - a. Benefits for general anesthesia or intravenous sedation when performed in conjunction with basic oral surgery.
  - b.

### Major Oral Surgery

1. Covered
  - a. Surgical extractions (including removal of impacted teeth), coronectomy, and other oral surgical procedures typically not Covered under a medical plan.
  - b. Benefits provided for major oral surgery include benefits for local anesthesia, suturing and postoperative care.
2. Limitations
  - a. Benefits for general anesthesia or intravenous (IV) sedation are provided only in connection with major oral surgery procedures, and only when provided by a Dentist licensed to administer such agents.
3. Exclusion
  - a. Oral surgery typically Covered under a medical plan, including but not limited to, excision of lesions and bone tissue, treatment of fractures, suturing, wound and other repair procedures and related procedures.
  - b. Harvesting of bone for use in autogenous grafting.

## General Pediatric Dental Exclusions

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Pediatric Dental Coverage does not provide benefits for the following services, supplies or charges:

1. Services rendered by a Dentist beyond the scope of his or her license.
2. Dental services which are free, or for which the Member is not required or legally obligated to pay or for which no charge would be made if he/she had no dental Coverage.
3. Dental services covered by any medical insurance coverage, or by any other non-dental contract or certificate issued by BlueCross BlueShield of Tennessee or any other insurance company, carrier, or plan. For example, removal of impacted teeth, tumors of lip and gum, accidental injuries to the teeth, etc.
4. Dental care or treatment not specifically listed in Attachment C: Schedule of Benefits.
5. Any treatment or service that the Plan determines is not Necessary Dental Care that does not offer a favorable prognosis that does not meet generally accepted standards of professional dental care, or that is experimental in nature.
6. Charges for any hospital or other surgical or treatment facility and any additional fees charged by a Dentist for treatment in any such facility.
7. Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes including cosmetic orthodontia.
8. Replacement of tooth structure lost from wear or attrition.
9. Dental services resulting from loss or theft of a denture, crown, bridge or removable orthodontic appliance.

10. Charges for a prosthetic device that replaces one or more lost, extracted or congenitally missing teeth before the Coverage becomes effective under the Plan unless it also replaces one or more natural teeth extracted or lost after the Coverage became effective.
11. Diagnosis for, or fabrication of, adjustment or maintenance and cleaning of maxillofacial prosthesis, appliances or restorations necessary to correct bite problems or restore the occlusion.
12. Diagnostic dental services such as diagnostic tests and oral pathology services.
13. Adjunctive dental services including all local and general anesthesia, sedation, and analgesia (except as provided under a covered surgery).
14. Charges for the treatment of desensitizing medicaments, drugs, occlusal guards and adjustments, mouthguards, microabrasion, behavior management, and bleaching.
15. Charges for the treatment of professional visits outside the dental office or after regularly scheduled hours or for observation.
16. Charges for the inhalation of nitrous oxide/analgesia, anxiolysis.

**Dental Services - Orthodontia - Pediatric Only**

Orthodontia when performed in conjunction with Medically Necessary and Appropriate orthognathic Surgery for Members under age 19. Prior Authorization for Medically Necessary orthodontia must be obtained from the Plan, or benefits will be reduced or denied.

1. Covered
  - a. Medically Necessary and Appropriate non-cosmetic orthodontia when performed in conjunction with orthognathic Surgery for Members under age 19.
2. Exclusions
  - a. Orthodontia for Members over age 19.
  - b. Cosmetic orthodontia.

**Dental Supplement Plan Options**

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The following grid reflects basic options for Dental Supplement Plans for Members age 19 or older that may be added to an Essential Health Benefits medical plan. These Members will have "MEDICAL/DENTAL/VISION" reflected on their ID card.

## BlueCross BlueShield of Tennessee Provider Administration Manual

| Basic options for Dental Supplement Plans<br>Benefits for individuals over age 18 |            |                   |                        |
|---|------------|-------------------|------------------------|
| COINSURANCE   | DEDUCTIBLE | ANNUAL<br>MAXIMUM | Cosmetic<br>ORTHO*     |
| 100%/80%/50%  | \$50       | \$1,000           | No                     |
| 100%/80%/50%  | \$50       | \$1,000           | Child (1K)*            |
| 100%/80%/50%  | \$50       | \$1,500           | No                     |
| 100%/80%/50%  | \$50       | \$1,500           | Child<br>(1.5K)*       |
| 100%/80%/50%  | \$50       | \$2,000           | No                     |
| 100%/80%/50%  | \$50       | \$1,000           | Child &<br>Adult (1K)* |
| 100%/80%/0%   | \$25       | \$1,000           | No                     |
| 100%/70%/70%  | \$250      | \$2,500           | No                     |
| 100%/90%/60%  | \$50       | \$1,000           | No                     |
| 100%/90%/60%  | \$50       | \$1,000           | Child (1K)*            |
| Personal Dental<br>Schedule Plan  | \$50       | \$1,000           | No                     |

\*Cosmetic Orthodontia is also payable to those under age 19 on these plans

### **E. Predeterminations**

The Predetermination of Benefits program allows the Dentist and the Member to know exactly what kinds of treatment are covered. If a course of treatment will exceed \$200.00, the treatment plan and estimated charges should be submitted to BlueCross BlueShield of Tennessee for review before the work starts. In order to review, the predetermination must be on an ADA dental claim form and "Dentist's Pre-Treatment Estimate" box should be checked and a description of each service and charge should be submitted along with all supporting aids such as preoperative X-rays and/or photographs. **Do not include the date(s) that the work will be started.**

BlueCross BlueShield of Tennessee will review the claim and other information submitted and notify the Member and the Provider via the Dental Pre-Determination of Benefits form of its decision and estimated dental benefits available.

Rev 03/15

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**F. ADA/BlueCross BlueShield of Tennessee Dental Claim Form**

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Dental claims must be completed on one of the three most current standard American Dental Association (ADA) claim form or BlueCross BlueShield of Tennessee claim form using the most appropriate ADA *Current Dental Terminology (CDT)* codes. To help avoid processing delays, claim forms should be completed with special attention given to the critical fields listed below. If the format or data inserted in these fields is not valid, the claim **will be** returned to the Provider for correction or resubmission.

- Member name
- Member date of birth
- BlueCross BlueShield of Tennessee subscriber ID number\* (Not Social Security Number)
- Date of service
- Procedure code
- Total charges
- Tooth number (as appropriate)
- Tooth surface (as appropriate)
- Area of oral cavity (as appropriate)
- Provider tax ID number/NPI number
- Signature of treating dentist (or authorized representative for the treating dentist)

\*Enter the subscriber identification number **exactly** as it is listed on the Member's BlueCross BlueShield of Tennessee ID card.

BlueCross BlueShield of Tennessee began phasing in **non**-Social Security Number (SSN) identification numbers in 2004 to help protect Member privacy.

Some claim form fields may request the Member's Social Security number. However, because BlueCross BlueShield of Tennessee moved to non-SSN identification numbers, it may not be able to identify the Member by the SSN. This is particularly true for new groups, which do not require Members to provide their SSN.

When submitting the subscriber ID number, do not include data in front of the ID number, such as "ID#", "SSN" or "#". The imaging equipment will read this extra data as part of the number, which may result in a rejection.

|  |
|--|
| <p><b>Note:</b> <i>The Tennessee Board of Dentistry Code of Professional Conduct Section 5; 5.B.4 states the date of completion is the treatment date. The revised ADA claim form does not take into consideration individual state laws or specific contracting agreements.</i></p> |
|--|

A sample copy and description of an ADA Dental Claim Form follows:

# BlueCross BlueShield of Tennessee Provider Administration Manual

## Dental Claim Form -- Confidential --



of Tennessee  
plans for better health. plans for a better life.™

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### HEADER INFORMATION

1. Type of Transaction (Mark all applicable boxes)  
☐ Statement of Actual Services ☐ Request for Predetermination/Preauthorization  
☐ EPSDT/Title XIX  
 2. Predetermination/Preauthorization Number

### INSURANCE COMPANY/DENTAL BENEFIT PLAN INFORMATION

3. Company/Plan Name, Address, City, State, Zip Code  
 BlueCross BlueShield of Tennessee  
 Claims Service Center  
 1 Cameron Hill Circle Suite 0002  
 Chattanooga, TN 37402-0002

### OTHER COVERAGE

4. Other Dental or Medical Coverage? ☐ No (Skip 5-11) ☐ Yes (Complete 5-11)

5. Name of Policyholder/Subscriber in #4 (Last, First, Middle Initial, Suffix)

6. Date of Birth (MM/DD/CCYY) 7. Gender ☐ M ☐ F 8. Subscriber Identification Number

9. Plan/Group Number 10. Patient's Relationship to Person Named in #5  
☐ Self ☐ Spouse ☐ Dependent ☐ Other

11. Other Insurance Company/Dental Benefit Plan Name, Address, City, State, Zip Code

### POLICYHOLDER/SUBSCRIBER INFORMATION (For Insurance Company Named in #3)

12. Policyholder/Subscriber Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

13. Date of Birth (MM/DD/CCYY) 14. Gender ☐ M ☐ F 15. Subscriber Identification Number

16. Plan/Group Number 17. Employer Name

### PATIENT INFORMATION

18. Relationship to Policyholder/Subscriber in #12 Above  
☐ Self ☐ Spouse ☐ Dependent Child ☐ Other 19. Student Status  
☐ FTS ☐ PTS

20. Name (Last, First, Middle Initial, Suffix), Address, City, State, Zip Code

21. Date of Birth (MM/DD/CCYY) 22. Gender ☐ M ☐ F 23. Patient ID/Account # (Assigned by Dentist)

### RECORD OF SERVICES PROVIDED

|    | 24. Procedure Date (MM/DD/CCYY) | 25. Area of Oral Cavity | 26. Tooth System | 27. Tooth Number(s) or Letter(s) | 28. Tooth Surface | 29. Procedure Code | 30. Description | 31. Fee |
|----|---------------------------------|-------------------------|------------------|----------------------------------|-------------------|--------------------|-----------------|---------|
| 1  |                                 |                         |                  |                                  |                   |                    |                 |         |
| 2  |                                 |                         |                  |                                  |                   |                    |                 |         |
| 3  |                                 |                         |                  |                                  |                   |                    |                 |         |
| 4  |                                 |                         |                  |                                  |                   |                    |                 |         |
| 5  |                                 |                         |                  |                                  |                   |                    |                 |         |
| 6  |                                 |                         |                  |                                  |                   |                    |                 |         |
| 7  |                                 |                         |                  |                                  |                   |                    |                 |         |
| 8  |                                 |                         |                  |                                  |                   |                    |                 |         |
| 9  |                                 |                         |                  |                                  |                   |                    |                 |         |
| 10 |                                 |                         |                  |                                  |                   |                    |                 |         |

### MISSING TEETH INFORMATION

|  |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |    |   |   |   |   |   |   |   |   |   |   |              |  |  |  |
|--|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|----|---|---|---|---|---|---|---|---|---|---|--------------|--|--|--|
| 34. (Place an "X" on each missing tooth) | 1  | 2  | 3  | 4  | 5  | 6  | 7  | 8  | 9  | 10 | 11 | 12 | 13 | 14 | 15 | 16 | A | B | C | D | E | F | G | H | I | J | Fee(s)       |  |  |  |
|  | 32 | 31 | 30 | 29 | 28 | 27 | 26 | 25 | 24 | 23 | 22 | 21 | 20 | 19 | 18 | 17 | T | S | R | Q | P | O | N | M | L | K | 33.Total Fee |  |  |  |

35. Remarks

### AUTHORIZATIONS

36. I have been informed of the treatment plan and associated fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

X \_\_\_\_\_  
 Patient/Guardian signature Date

37. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to the below named dentist or dental entity.

X \_\_\_\_\_  
 Subscriber signature Date

**BILLING DENTIST OR DENTAL ENTITY** (Leave blank if dentist or dental entity is not submitting claim on behalf of the patient or insured/subscriber)

48. Name, Address, City, State, Zip Code

49. NPI 50. License Number 51. SSN or TIN

52. Phone Number ( ) - 52A. Additional Provider ID

### ANCILLARY CLAIM/TREATMENT INFORMATION

38. Place of Treatment  
☐ Provider's Office ☐ Hospital ☐ ECF ☐ Other 39. Number of Enclosures (00 to 99)  
 Radiograph(s) Oral Image(s) Model(s)

40. Is Treatment for Orthodontics?  
☐ No (Skip 41-42) ☐ Yes (Complete 41-42) 41. Date Appliance Placed (MM/DD/CCYY)

42. Months of Treatment Remaining 43. Replacement of Prosthesis?  
☐ No ☐ Yes (Complete 44) 44. Date Prior Placement (MM/DD/CCYY)

45. Treatment Resulting from  
☐ Occupational illness/injury ☐ Auto accident ☐ Other accident

46. Date of Accident (MM/DD/CCYY) 47. Auto Accident State

### TREATING DENTIST AND TREATMENT LOCATION INFORMATION

53. I hereby certify that the procedures as indicated by date are in progress (for procedures that require multiple visits) or have been completed.

X \_\_\_\_\_  
 Signed (Treating Dentist) Date

54. NPI 55. License Number

56. Address, City, State, Zip Code 56A. Provider Specialty Code

57. Phone Number ( ) - 58. Additional Provider ID

Dental Claim Form 01.2008

Rev 12/11

**1. ADA Claim Form Locator Field Description:**

Note: Extended descriptions are reflected on fields commonly filed incorrectly.

**Header Information**

- Field 1           Type of Transaction
- Field 2           Predetermination/Prior authorization Number

**Primary Payer Information**

- Field 3           Primary Payer Name and Address

**Other Coverage Information**

- Field 4           Other Dental or Medical Coverage
- Field 5           Subscriber Name
- Field 6           Subscriber Date of Birth
- Field 7           Gender M/F
- Field 8           Subscriber Social Security Number (SSN) or ID Number if the other coverage is with BlueCross BlueShield of Tennessee, we need the BlueCross BlueShield of Tennessee subscriber ID number – (NOT the SSN)
- Field 9           Plan/Group Number
- Field 10          Relationship to Primary Subscriber
- Field 11          Other Carrier Name

**Primary Subscriber Information**

- Field 12          Name and Address
- Field 13          Date of Birth
- Field 14          Gender
- Field 15          BlueCross BlueShield of Tennessee subscriber ID number – This can be found on the front of the Member ID card.
- Field 16          Plan/Group Number
- Field 17          Employer Name

**Patient Information**

- Field 18          Relationship to Primary Subscriber
- Field 19          Student Status
- Field 20          Name and Address
- Field 21          Patient's Date of Birth (MM/DD/CCYY)
- Field 22          Gender
- Field 23          Patient ID/Account # (Assigned by Dentist)

**Record of Services Provided**

- Field 24          Procedure Date
- Field 25          Area of Oral Cavity - is designated by a two-digit code shown below. Keep in mind area of oral cavity code is NOT the tooth number.

| Area of Oral Cavity Code | Area Description        |
|--------------------------|-------------------------|
| 00                       | Entire Oral Cavity      |
| 01                       | Maxillary (Upper) Arch  |
| 02                       | Mandibular (Lower) Arch |
| 10                       | Upper Right Quadrant    |
| 20                       | Upper Left Quadrant     |
| 30                       | Lower Left Quadrant     |
| 40                       | Lower Right Quadrant    |

- Field 26          Tooth System
- Field 27          Tooth Number(s) or Letter (s) (When the procedure directly involves a tooth or range of teeth, otherwise, leave this field blank. If same procedure is performed on more than a single tooth on the same date of service, report each procedure and tooth involved on separate lines on the claim form. When the procedure involves a range of teeth, the range is reported in this field. This is reflected by a "-" to separate the first and last tooth in the range, e.g., 1-4; 7-10; 22-27, or by the use of commas "," to separate individual tooth numbers or ranges, e.g., 1, 2, 4, 4-10, 3-5, 22-27.)

## BlueCross BlueShield of Tennessee Provider Administration Manual

Field 28      Tooth Surface – Complete this field when the procedure code performed on a tooth involves one or more tooth surfaces. The following single-letter codes are used to identify surfaces:

| Letter Code | Description        |
|-------------|--------------------|
| B           | Buccal             |
| D           | Distal             |
| F           | Facial (or Labial) |
| I           | Incisal            |
| L           | Lingual            |
| M           | Mesial             |
| O           | Occlusal           |

Field 29      Procedure Code  
 Field 29a      Diagnosis Code Pointer (2012 Claim Form Only)  
 Field 29b      Quantity (2012 Claim Form Only)  
 Field 30      Description  
 Field 31      Fee  
 Field 31a      Other Fee(s) (2012 Claim Form Only)  
 Field 32      Total Fee (2012 Claim Form Only)  
 Field 32      Other Fee(s)  
 Field 33      Total Fee

### Missing Teeth Information

Field 33      Identify missing tooth with an “x” (2012 Claim Form Only)  
 Field 34      Identify missing tooth with an “x”

### Diagnosis Code Information

Field 34      Diagnosis Code List Qualifier (2012 Claim Form Only)  
 Field 34a      Diagnosis Code(s) (2012 Claim Form Only)  
 Field 35      Remarks

### Authorizations

Field 36      Patient/Guardian Signature  
 Field 37      Subscriber Signature  
 Field 38      Place of Treatment  
 Field 39      Number of Enclosures (00-99)  
 Field 40      Is treatment for Orthodontics?  
 Field 41      Date Appliance Placed  
 Field 42      Months of Treatment Remaining  
 Field 43      Replacement of Prosthesis?  
 Field 44      Date Prior Placement  
 Field 45      Treatment Resulting from (Check Applicable Box)  
 Field 46      Date of Accident  
 Field 47      Auto Accident State

### Billing Dentist or Dental Entity

Field 48      Name and Address  
 Field 49      10-digit NPI of the Billing Dentist – Do NOT enter the billing entity’s Social Security Number or Tax ID Number (TIN) in this field.  
 Field 50      License Number  
 Field 51      SSN or TIN – This number should match the information filed on the billing entity’s W-9 form  
 Field 52      Phone Number  
 Field 52A      Additional Provider ID

### Treating Dentist and Treatment Location Information

Field 53      Signature (Treating Dentist)/Date

## BlueCross BlueShield of Tennessee Provider Administration Manual

|           |  |
|-----------|--|
| Field 54  | 10-digit NPI of the Billing Dentist – Do NOT enter the billing entity's Social Security Number or Tax ID Number in this field. |
| Field 55  | License Number   |
| Field 56  | Address, City, State, Zip Code   |
| Field 56A | Provider Specialty Code  |
| Field 57  | Phone Number   |
| Field 58  | Additional Provider ID   |

**Note:** When submitting charges on an ADA Dental Claim Form to BlueCross BlueShield of Tennessee, please include the assigned BlueCross BlueShield of Tennessee Individual Provider Identification Number and/or National Provider Identifier (NPI) number. This provider-specific number is located in the upper right hand corner of the assigned BlueCross BlueShield of Tennessee Dental Remittance Advice and may be listed on the dental claim form in Field 49 and 54. Some dental practices choose to obtain a group provider number and/or NPI for payment purposes. In these cases the remittance advice will reflect the group provider number and/or NPI. This group number is used to report payments and should **not** be used when submitting claims. If there is a question on the individual provider number, dentists may contact Dental Customer Service at 1-800-523-1478.

## 2. Tips for Completing a Dental Claim Form

Listed below are some tips that will help ensure claims are processed timely and accurately:

- Type all letters in Upper Case (capital letters)
- Use black ink (if typed) or block letters (if hand written) to reflect a clear impression.
- Enter insured's ID number as shown on ID Card
- BlueCross BlueShield of Tennessee requests that providers use an eight-digit format for all dates (MM\_DD\_CCYY) Example: January 1, 2005 would be written out as 01/01/2005.  
Some paper dental forms will only allow a 2-digit year in the date of service. In these cases, use the format MMDDYY (01/01/05).
- Review each claim to ensure all required fields have been provided.
- Send only original claims and supporting documentation.
- Securely staple any attachments, receipts, etc.
- Be sure to include the BlueCross BlueShield of Tennessee designated Individual Provider Identification Number or NPI in Fields 49 and 54.
- File corrected claims hardcopy and clearly mark "**Corrected Billing**" in the Remarks section of the claim form; Do Not use correction tape or white out. Draw a line through the original information and list the new information above, below or beside the original information. (The original information MUST be visible).

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## G. Orthodontic Claims Processing Guidelines

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Effective August, 1, 2011, Providers no longer need to file a claim for monthly adjustments. Instead, Providers were notified they should file one (1) claim for the **total** charge of the orthodontic treatment plan indicating the initial placement date.

### Exception to above:

In order to initiate the automated monthly adjustment payment process, Providers may need to file a single monthly adjustment claim if the patient is currently in treatment and he/she has:

- changed insurance carrier and now has BlueCross orthodontic benefits; or
- received a new BlueCross ID/Group/or Plan Number.



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The allowed amount for the initial placement is 25 percent of the total covered charge(s) for the orthodontic treatment plan. Monthly adjustments will automatically be processed each month until the Member's orthodontic lifetime maximum is met or the Provider or Member advises BlueCross BlueShield of Tennessee that the Member is no longer in treatment. The maximum allowed amount for monthly adjustments is \$200 payable to the treating dentist listed on the initial orthodontic treatment plan claim.

**Note:** In addition to the above reimbursement guidelines, some group plans allow payment for orthodontic services to be paid in a single claim up to the Member's lifetime maximum or BCBST portion of the charges have been paid. Payment made depends on the group's benefit structure.

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### H. Filing a Dental Claim Form

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Dental claims may be faxed or mailed to BlueCross BlueShield of Tennessee.

#### Billing Requirements for Faxed Paperwork (PWK) Attachments

When paper documentation is necessary to support an electronically submitted claim, you can utilize the PWK06 (paperwork) segment (Loop 2300) to indicate that documentation will be sent to BCBST separately from the electronic claim. The actual supporting documentation would be faxed accompanied with a PWK Fax Cover Sheet. BCBST will match the documentation to your electronic claim using the information supplied from the PWK06 segment and PWK Fax Cover Sheet and utilize that documentation during claims processing and payment. To ensure BCBST matches the documents to an electronic claim for processing; the **documentation and fax sheet should be submitted no later than the day of claims submission.**

**BCBST will only match on the first iteration of PWK06 (ACN) from the ANSI 837 data.**

Ensure your first iteration at claim or line level matches the PWK06 (ACN)

| ANSI 837 Loop | Field Description   | 837P/I Segment |
|---------------|---|----------------|
| 2300          | <b>Attachment Report Type Code</b><br>Use the values indicated in the IG to identify the type of attachment.  | PWK01          |
| 2300          | <b>Attachment Transmission Code</b><br>Use the values indicated in the IG to identify how the attachment will be sent. BCBST accepts supporting documentation by fax only, the value of <b>FX (By Fax)</b> in this data element is the only value accepted. | PWK02          |
| 2300          | <b>Identification Code Qualifier</b><br>Use code value of <b>AC</b> (Attachment Control Number). This data element is required if PWK02 = FX.   | PWK05          |
| 2300          | <b>PWK06 Attachment Control Number</b><br>This is a value assigned by the provider to uniquely identify the attachment. This number must also be included on the "Attachment Fax Sheet".  | PWK06          |

**Example: PWK\*M1\*FX\*\*\*AC\*BCBS1234~**

- Only include your attachment control number (ACN) reported in the PWK06 segment of the claim.
- Complete **ONE (1)** Fax Cover Sheet for each electronic claim for which documentation is being submitted.

**Note:** The PWK Fax Cover Sheet can be found on the company website at <http://www.bcbst.com/docs/providers/PWK-Coversheet.pdf>. Complete the form and fax with documentation to (423) 591-9481.

Mail dental claims to: BlueCross BlueShield of Tennessee  
Claims Service Center  
1 Cameron Hill Cr, Ste 0002  
Chattanooga, TN 37402-0002

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## I. Dental Professional Remittance Advice

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The Dental Professional Remittance Advice is an explanation of payments and deductions. It is necessary for the Provider's office staff to understand the Remittance Advice thoroughly in order to make all billing adjustments accurately. A sample copy of the Dental Professional Remittance Advice can be found on the company website at <http://www.bcbst.com/providers/Sample-Copies-of-Remittance-Advices.page>.

The following instructs Providers how to read a BlueCross BlueShield of Tennessee dental remittance advice when overpayment recovery activity is reflected.

### ***Credit Balance Activity***

BlueCross BlueShield of Tennessee utilizes the Credit Balance Process (Automatic Payment Recovery) to recover overpayment of charges. Credit balances are the result of a credit (amount to be taken back) which exceeds actual payments on a given Dental Remittance Advice (RA). A credit balance will carry forward and be applied against **future** Remittance Advices. Depending on the amount of the credit balance, it may take more than one future RA to deplete the entire balance.

A credit balance carried forward and applied against a subsequent RA **should be applied to the Member's account where the original overpayment occurred**. The following steps should be taken to resolve a credit balance:

#### **Step 1**

Locate the prior Remittance Advice and identify where the credit balance originally occurred.

#### **Step 2**

Determine whether this credit balance is the result of an Online Adjustment or a Manual Credit Adjustment.

##### ➤ ***Online Adjustment***

This type of adjustment occurs when a Provider or Eligible Member initiates an adjustment request. The adjustment will appear on Page one (1) of the Remittance Advice in the claim detail section and is identified by a negative (-) indicator in the "Amount Paid" column. Page two (2) of the Remittance Advice reflects the credit balance due to BlueCross BlueShield of Tennessee, the Remittance total amount, the credit amount applied to this check, and, the check amount (the final dollar amount printed on the check). At the bottom of this page, the Adjustment Reference No., the current balance due to BlueCross BlueShield of Tennessee and the specific claim numbers involved in the Online Adjustment are listed.

##### ➤ ***Manual Adjustment***

This type of adjustment is initiated by BlueCross BlueShield of Tennessee via a Refund Request letter to the Provider outlining specific claims-overpayment information. Once the Provider returns the overpaid amount to BlueCross BlueShield of Tennessee, the amount returned by the provider will be entered manually and the overpaid claim adjusted.

#### **Step 3**

Post Claim Payment and/or Credit Adjustment (amount BlueCross BlueShield of Tennessee took back) to the individual Member's account.

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## **J. Provider Overpayments**

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If a Provider identifies that a payment made by BCBST results in an overpayment, it is the responsibility of the Provider to reimburse BCBST the overpaid amount. The Provider should return the overpayment with a copy of the Remittance Advice (RA) and a cover letter explaining why the payment is being refunded.

Mail to: BlueCross BlueShield of Tennessee  
Receipts Department  
1 Cameron Hill Circle  
Chattanooga, TN 37402

In the event that a Provider receives a BCBST overpayment notification, no action is required unless records conflict with the findings. BCBST will recover the overpayment through an offset to the remittance advice within 30 days from the date of the notification. Please do not send a check for the overpayment. Checks received for solicited overpayments will be returned to the payee.

### **Overpayment Notifications**

An overpayment notification is sent on all overpayments that are identified on claims submitted by Physicians, non-participating facilities and par facilities requiring notification.

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## **K. Electronic Funds Transfer**

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Beginning January 1, 2015, BCBST began executing the July 2013 electronic claims filing requirement pursuant to the BCBST Minimum Practitioner Network Participation Criteria, which requires all network Providers to enroll in the Electronic Funds Transfer (EFT) process. EFT is a free service that sends payments directly to the Provider's financial institution and increases the speed at which they receive payment.

Key advantages to receiving payments electronically are:

- Earlier payments;
- More secure payment process;
- Reduced administrative costs; and
- Less paper storage.

BCBST accepts electronic funds transfer (EFT) enrollment through CAQH Solutions, who offers a universal enrollment tool for providers that provides a single point of entry for adopting EFT and ERA. The CAQH process facilitates compliance with the 2014 EFT/ERA Administrative Simplification mandate under the Affordable Care Act, eliminates administrative redundancies and creates significant time and cost savings. Enrollment information is available on the CAQH Solutions website at <https://solutions.caqh.org>.

To view/print a copy of your remittance advices, ensure you have access to BlueAccess, BCBST's secure area on its websites, [www.bcbst.com](http://www.bcbst.com) and <http://bluecare.bcbst.com>. To register, just click on the "Register Now" link located in the BlueAccess section on the website and follow the simple instructions to obtain a user ID and password.

For more information regarding the EFT Program Process, or for assistance with BlueAccess, please call eBusiness Service at 423-535-5717, Option 2, Monday through Thursday, 8 a.m. to 6 p.m., Friday 9 a.m. to 6 p.m. (ET), or e-mail [eBusiness\\_Service@bcbst.com](mailto:eBusiness_Service@bcbst.com).

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**EnrollHub™** is the new name for the CAQH EFT and ERA enrollment tool.

**Phone:** 1-844-815-9763 available Monday through Thursday 7 a.m. to 9 p.m. (ET),  
Friday 7 a.m. to 7 p.m. (ET)

**e-mail:** [efthenrollhub@caqh.org](mailto:efthenrollhub@caqh.org)

**Website:** [http://www.caqh.org/eft\\_enrollment.php](http://www.caqh.org/eft_enrollment.php)

**CAQH ProView™** is now the provider data collection tool formerly the Universal Provider Datasource®.

**Phone:** 1-844-259-5347 available Monday through Thursday 7 a.m. to 9 p.m. (ET),  
Friday 7 a.m. to 7 p.m. (ET)

**e-mail:** [proview@caqh.org](mailto:proview@caqh.org)

**Website:** <https://proview.caqh.org>

**Note:** Vendor and BCBST shall be bound by the National Automated Clearing House Association rules relating to corporate trade payment entries (the "Rules") in the administration of these ACH Credits.

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## L. Balance Billing

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DentalBlue Providers agree to accept reimbursement made in accordance with the terms of their Provider Contract with BlueCross BlueShield of Tennessee (BCBST), plus any applicable Member copayment/deductible, and coinsurance amounts as the maximum amount payable to the Provider for Covered Services rendered to Members.

DentalBlue Providers **may not** seek payment from a BCBST Member when:

- The Provider failed to comply with BCBST medical management policies and procedures or provided a service which does not meet BCBST standards for Medical Necessity or does not comply with BCBST medical policy;
- The Provider failed to submit or resubmit claims for payment within the time periods required by BCBST (timely filing guidelines); or  
Services rendered are considered Investigational by BCBST and are therefore non-reimbursable, unless **prior** to rendering such services to the Member, Provider has entered into a **procedure-specific** written agreement with the Member, which advised Member of his/her payment responsibilities.

DentalBlue Providers **may** bill the BCBST Member for:

- Non-Covered Services\*;
- Any applicable Deductible/Copay Amounts; and
- Any applicable Co-Insurance Amounts.

When seeking payment from a BCBST Member, please refer to the *Patient Owes* column on your Provider Remittance Advice. This column includes the *Non-covered* total, *Deductible/Copay* total, and *Coinsurance* total. It may also reflect the *Other Insurance* total, which is the amount paid by the patient's other insurance carrier.

Before billing the Member, check both the *Deductible/Copay* and the *Other Insurance* columns to ensure any applicable copayment or other insurance payments have not been received.

**\*When billing a member for non-covered services due to benefit limitations, i.e. dollar maximums, network Providers** may only bill the Member the difference between the maximum dollar limit amount and the allowed amount. The difference between the billed amount and the allowed amount is considered a Provider write-off.

**Example: Dollar Limit**

The Member has a \$1,000 annual maximum. The Member has already used \$800 of his/her annual maximum. This leaves a remaining benefit of \$200.

Claim Billed amount of \$450 and all services would be a Covered Service

Claim Allowed amount of \$325

Remaining annual maximum benefit \$200

Since this claim meets the member's annual maximum and all services were eligible for benefits, the Member would receive the benefit of the discounted amount on the entire claim. The Member liability would be \$125 (difference between allowed amount on the claim and remaining benefit. Provider write-off \$125 (difference between billed amount and allowed amount)

However, on any subsequent claims after the Member has met his/her annual maximum, the DentalBlue Provider does not have to take a Provider write-off for the remainder of the benefit period/calendar year.

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**M. Financial Responsibility for the Cost of Dental Services**

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If a BlueCross BlueShield of Tennessee DentalBlue Network Provider renders a service which is Investigational or does not meet Medically Necessary and Appropriate criteria, the Provider must obtain a written statement from the Member, **prior** to the service(s) being rendered, acknowledging that the Member understands he/she may be responsible for the cost of the specific service(s) and any related services. Providers may also utilize this form in the event a Member requests non-emergency, cosmetic or elective services that are specifically excluded under the Member's health benefits plan. It is essential the signed statement be kept on file, as it may be necessary to provide a copy of the signed statement to BlueCross BlueShield of Tennessee verifying the Member's agreement to the financial responsibility.

To help assist in this process, BlueCross BlueShield of Tennessee developed the *Acknowledgement of Financial Responsibility for the Cost of Dental Services* form for Provider use. This form meets the contractual obligations of BlueCross BlueShield of Tennessee DentalBlue Provider Agreements. **Providers are strongly encouraged to use this form.**

Providers using their own form should insure their form includes the following:

1. The name of the specific service/procedure the Provider will perform;
2. The reason why the Provider believes that BlueCross BlueShield of Tennessee will not provide benefits for the service/procedure; i.e., BlueCross BlueShield of Tennessee considers the service/procedure to be Investigational, Cosmetic or not Medically Necessary and Appropriate;
2. The approximate cost of the service/procedure and associated costs;
3. A statement acknowledging the Member understands that BlueCross BlueShield of Tennessee will not provide benefits for the service/procedure;
4. A statement acknowledging the Member has been advised why BlueCross BlueShield of Tennessee will not cover the service/procedure and that he/she understands and agrees that he/she will be responsible for all the costs and any associated costs;
5. A statement indicating the form is only valid for one (1) service/procedure; and
6. A specific expiration date.

A sample copy of the *Acknowledgement of Financial Responsibility for the Cost of Dental Services* form follows:

**BlueCross BlueShield of Tennessee  
Acknowledgement of Financial Responsibility  
for the Cost of Dental Services  
(For use with DentalBlue)**

To: \_\_\_\_\_;

Re: (Identification of Prescribed Service)

I have been informed that my dental health care benefits insurer or administrator, BlueCross BlueShield of Tennessee, may determine that the above referenced dental service(s) may be an Investigational Service, Cosmetic, may not be a Covered Service or may not be Medically Necessary or Medically Appropriate as those terms are defined in my Member dental health care benefits plan from BlueCross BlueShield of Tennessee. Therefore, the dental service would be excluded from coverage by my dental health care benefits plan. My Dentist has also informed me about alternative treatments, if any, that may be covered by BlueCross BlueShield of Tennessee.

I understand that my Dentist may request that BlueCross BlueShield of Tennessee reconsider that determination by presenting evidence that the referenced dental service(s) is not an Investigational Service, is a Covered Service or the dental service is considered to be Medically Necessary or Medically Appropriate. I also understand that I have the right to request reconsideration of that determination, as described in the Member grievance section of my dental health care benefits plan, either before or after receiving the service(s).

I have been informed that the potential costs of the referenced dental service(s) will be approximately \$\_\_\_\_\_. I understand that, if I elect to receive the dental service(s) and BlueCross BlueShield of Tennessee determines that the dental service(s) is an Investigational Service, is not a Covered Service or the service is not considered to be Medically Necessary or Medically Appropriate, I will be responsible to pay for all costs associated with the dental service(s), including, but not limited to, practitioner costs, facility costs, ancillary charges and any other related expenses. I acknowledge that BlueCross BlueShield of Tennessee may not pay for the dental service(s).

In the event of multiple dental procedures, this form is valid only for one (1) unit of the prescribed dental service(s), unless specifically provided for otherwise.

This form will expire and will no longer be valid six (6) months from the date of execution.

Signature of Patient or Responsible Person

\_\_\_\_\_

Date: \_\_\_\_\_

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**N. Disclaimer**

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Each BlueCross BlueShield of Tennessee Member has his/her own group-specific benefits. To ensure correct benefits, please contact BlueCross BlueShield of Tennessee Customer Service at 1-800-523-1478 to determine specific Member benefits prior to performing services. Or visit us on the company website, [www.bcbst.com](http://www.bcbst.com).

## **XIX. PHARMACY**

### **A. Pharmacy Programs**

#### **Formulary/Prescribing Guidelines**

BlueCross BlueShield of Tennessee commercial pharmacy benefits currently cover most legend drugs for The Food and Drug Administration (FDA) indicated use. Non-FDA approved drugs are considered experimental and are not covered. Appropriate “off-label” utilization of FDA-approved medications may be approved if they are recognized in standard compendia and/or there is supporting evidence listed in a peer-reviewed journal.

Practitioners prescribing controlled substances to BlueCross Members are expected to comply with all existing federal and state laws governing this activity, including checking a patient’s drug utilization in the State’s Controlled Drug Database. The “Controlled Substance Prescribing Documentation Standards” may be monitored through Practitioner site reviews and medical record audits of Members receiving controlled substances upon request from the Clinical Risk Management Department. These adopted standards can be viewed on the company website at [www.bcbst.com/pharmacy/pdf\\_documents/Controlled-Substance-Prescribing.pdf](http://www.bcbst.com/pharmacy/pdf_documents/Controlled-Substance-Prescribing.pdf).

Practitioners who are non-compliant with these documentation standards are monitored by the Pharmacy and Therapeutics Committee and may be referred to the Clinical Risk Management Committee (CRMC) for further review and action.

The BlueCross Corporate Pharmacy Directors (CPD) conduct personal visits with prescribing Practitioners to supply information designed to assist the Practitioner in the provision of quality, cost-effective health care to BlueCross Members. Timely clinical information is presented around specific high incidence medical conditions and is intended to inform the Practitioner of potential gaps in care, compliance and adherence issues as well as opportunities for cost-effective therapeutic options. Data is presented as an aid in the overall management of our Members.

### **B. Plan Exclusions**

A Member’s particular health care plan may exclude certain drug classes or individual drugs (e.g., oral contraceptives, products for hair loss, drugs considered for cosmetic purposes, et al.). A Provider or Member may check with a customer service representative for assistance in determining covered benefits. The customer service phone number is listed on the back of the Member’s identification card, or sign into BlueAccess®, the company’s secure page on its website, [www.bcbst.com](http://www.bcbst.com) for more information on drugs excluded on their health care plan.

### **C. Member Drug Co-Pay/Co-Insurance**

There are many varieties of co-pay/co-insurance structures for BlueCross Members. These may range from 10 or 20 percent co-insurance to a two-tiered drug card co-pay of \$10/\$20 (or other variations) to a three-tiered co-pay of perhaps \$10/\$35/\$50 (or other variations). Generic drugs are in the first tier; preferred brand name products are in the second tier; and for the three-tiered plan, non-preferred brands are in the third tier. For two tiered plans, all brand name products are in the second tier. Co-pays for medications on the specialty pharmacy list may have a multiplier (2X), which requires a higher co-pay for the specialty drug. Select plans require co-pay (usually \$100) for Provider-administered specialty drugs obtained at a Physician’s office.



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## **D. Pharmacy Network**

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The majority of Tennessee pharmacies are in the pharmacy network. Members can locate their plan's pharmacy network information on their health care insurance ID card. These pharmacies are listed in the *BlueCross BlueShield of Tennessee Referral Directory of Network Providers*, which can be accessed on the company website, [www.bcbst.com](http://www.bcbst.com). Additionally, BlueCross uses a national network, which allows Members to obtain prescriptions outside of Tennessee.

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## **E. Claims Submission**

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Claims for Provider-administered drugs administered in a Practitioner's office should be submitted electronically on a CMS-1500 claim form using the most appropriate CPT<sup>®</sup> or HCPCS code and the specific drug's National Drug Code (NDC) number, which is printed on the drug container. The strength of the drug and the number of units administered also must be submitted. Claims for self-administered drugs (Oral, Topical and self-administered injectables) should be electronically submitted through a network pharmacy to the Member's pharmacy benefits manager (PBM). Claims for self-administered drugs will not process through the BlueCross medical claims system.

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## **F. Preferred Formulary**

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The Preferred Formulary is a list of the top therapeutic classes of drugs, which are therapeutically sound and offer a cost advantage for the Member and the Member's sponsoring plan. The Preferred Formulary is updated quarterly and can be accessed on the company website at [https://www.bcbst.com/docs/providers/RX-11-2018-Preferred\\_Formulary\\_and\\_Prescription\\_Drug\\_List\\_Web.pdf](https://www.bcbst.com/docs/providers/RX-11-2018-Preferred_Formulary_and_Prescription_Drug_List_Web.pdf).

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## **G. Prior Authorization**

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Certain drugs with special indications require authorization by the pharmacy benefits manager (PBM) prior to dispensing by a pharmacy. The prescribing Practitioner is responsible for obtaining the necessary authorization from the PBM.

Drugs requiring Prior Authorization (PA) can be found in the Preferred Formulary guidebook and can be accessed on the company website at [https://www.bcbst.com/docs/providers/RX-11-2018-Preferred\\_Formulary\\_and\\_Prescription\\_Drug\\_List\\_Web.pdf](https://www.bcbst.com/docs/providers/RX-11-2018-Preferred_Formulary_and_Prescription_Drug_List_Web.pdf), and is also available through your Provider Network Manager. (See Section II. Quick Reference Telephone Guide in this Manual for appropriate phone numbers.) For BlueCross commercial health benefits plans, Express Scripts<sup>®</sup> (ESI) serves as the pharmacy benefits manager. Requests for prior authorization can be made by calling ESI at 1-877-916-2271 or by faxing the request to 1-877-328-9799.

Reconsideration for denied requests should be faxed directly to the BlueCross BlueShield of Tennessee Pharmacy Management Department at 1-888-343-4232. Often, additional supportive clinical information is necessary for approval of a request for a PA drug.

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## **H. Appeals**

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If a prior authorization request has been denied, a prescribing Physician may file an Appeal by faxing a brief written statement giving medical justification supporting the request. Appeals may be faxed to 1-888-343-4232. If following the appeal process the prior authorization continues to be denied, the Member may pursue the request through the normal grievance process outlined in the Member Handbook.

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## **I. Quantity Limits or Maximum Drug Limitation**

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Some medications have a quantity limit for a given time period. All specialty drugs are limited to a one-month supply. A list of these products can be found in the Preferred Formulary guidebook and can be accessed on the company website at [https://www.bcbst.com/docs/providers/RX-11-2018-Preferred\\_Formulary\\_and\\_Prescription\\_Drug\\_List\\_Web.pdf](https://www.bcbst.com/docs/providers/RX-11-2018-Preferred_Formulary_and_Prescription_Drug_List_Web.pdf), and is also available through your Provider Network Manager. Requests for exceptions to these limits may be faxed to 1-888-343-4232.

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## **J. Pharmacy and Therapeutics Committee**

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All policies and procedures affecting the pharmacy programs are reviewed and approved by the Pharmacy and Therapeutics Committee, which is a panel of pharmacists and Physicians, some of whom are community Practitioners. Any comments or suggestions regarding the commercial pharmacy program may be directed to:

BlueCross BlueShield of Tennessee  
Pharmacy Programs – CH 2.3  
1 Cameron Hill Circle  
Chattanooga, TN 37402

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## **K. Specialty Pharmacy Program**

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BlueCross BlueShield of Tennessee's Specialty Pharmacy Program is available for commercial and Medicare Advantage Members who utilize certain high-cost/high-risk drugs for serious, chronic conditions. Specialty pharmacy medications require complex care, including special handling, patient education and continuous monitoring.

BlueCross has a network of specialty pharmacy vendors for Members and Providers to call to obtain specialty medications. A listing of the specialty pharmacy vendors can be found on the company website at <https://www.bcbst.com/docs/pharmacy/specialty-pharmacy-network.pdf>.

The specialty pharmacy vendor will call the Member to collect the required copayment or coinsurance. This amount is typically paid by credit card. The medication is shipped directly to the Member's home or other designated location. After shipping, the specialty pharmacy vendor will call the Member to verify the medication was received and to answer any questions the Member may have concerning the medication or its administration.

The specialty pharmacy vendor may contact the prescribing Practitioner for specific medication orders, or the Practitioner may contact the specialty pharmacy vendor with drug orders. With the added pharmacy support services available through each vendor, Members have access to:

- Patient care coordinators;
- Pharmacists and nurses;
- Optimize drugs usage, and
- Monitor and manage complex drug regimens.

Certain specialty pharmacy medications administered in any setting other than inpatient hospital may require prior authorization by either the Member's medical benefits plan or his/her pharmacy benefits plan.

A complete listing of self-administered specialty pharmacy medications can be viewed online at [https://www.bcbst.com/docs/providers/RX-11-2018-Preferred\\_Formulary\\_and\\_Prescription\\_Drug\\_List\\_Web.pdf](https://www.bcbst.com/docs/providers/RX-11-2018-Preferred_Formulary_and_Prescription_Drug_List_Web.pdf).

A complete listing of provider-administered specialty pharmacy medications can be viewed online at <https://www.bcbst.com/docs/pharmacy/provider-administered-specialty-pharmacy-list.pdf>.

To obtain a prior authorization for a **self-administered** medication being billed under the Member's pharmacy benefits plan and filed through a pharmacy, the network Practitioner should call Express Scripts® Prior Authorization Desk at **1-877-916-2271**. Specialty Pharmacy vendors may also call this number on behalf of the Practitioner to obtain prior authorization.

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## **L. Specialty Pharmacy Billing Information**

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- Self-administered claims must be electronically submitted through a network pharmacy to the Member's pharmacy benefits manager.
- Self-administered claims taken "on assignment" by the specialty vendor should be faxed to the BlueCross claims department at 423-535-3741.
- Claims for provider-administered medications should be electronically submitted as a medical claim.
- Medical Billing Information
  - Bill at contracted rate
  - Medi-Span as source of AWP
  - Medications billed with unlisted, miscellaneous, non-specific and Not Otherwise Classified (NOC) codes should be billed with a unit of one (1) and require submission of drug name, National Drug Code (NDC), and dosage administered in appropriate form as ordered by Practitioner. Failure to submit this information may result in delay of reimbursement. (See Section VI. Billing and Reimbursement in this Manual for further information.)
  - Medical claims require most appropriate HCPCS or CPT® code. When filing medical claims please include the following information:
    - NPI (*more than one of your subsidiaries may share the same code*)
    - Tax ID (*more than one of your subsidiaries may share the same code*)
    - Appropriate taxonomy code MUST be in Block 33b (*taxonomy code should be specific for specialty pharmacy, HIT, etc*)
    - Name of drug
    - Strength of drug
    - National Drug Code (NDC)
    - Number of units being billed
    - Days Supply if billing an "ambulatory" drug on a medical claim, for example when accepting Assignment of Benefits for Members who have to pay 100 percent up front

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- Medical claims delivered to Member for self-administration use place of service 12 (home) in Block 24b on CMS-1500 claim form
- Medical claims delivered to Physician's office for office administration use Place of Service 11 (office) in Block 24b on CMS-1500 claim form
- Medical claims coming to BlueCross BlueShield of Tennessee as the home plan should follow the billing guidelines for the Specialty Pharmacy Program.

### ➤ Policy for Quarterly Reimbursement Changes

- This policy will be applicable when referenced in the Provider Agreement or BlueCross BlueShield Reimbursement Policy. Reimbursement changes applicable to this policy will be made according to the following schedule:

| Date Reimbursement Data is Published by Source | Date Change Will Be Applied by BlueCross Blue Shield of Tennessee |
|--|---|
| January 1 to March 31                          | July 1  |
| April 1 to June 30                             | October 1   |
| July 1 to September 30                         | January 1   |
| October 1 to December 31                       | April 1   |

### ➤ BlueCard Billing for medical claims (Provider-Administered)

- **Note:** Host claims (i.e. claims filed out of state by out-of-state Provider) will process through Blue Card system.
- The BlueCross BlueShield Association's BlueCard program requires **provider-administered** (Medical claims) specialty drugs to be billed thru the Host Plan as determined by the state in which the prescribing Physician resides and is providing services to the Member.
- **Example 1:** BlueCross BlueShield of Tennessee Member is being treated by a Physician residing in Little Rock, Arkansas. Physician orders a provider-administered specialty pharmacy drug (medical claim) from specialty pharmacy. The specialty pharmacy must bill the drug thru the Host Plan (Arkansas). Member is subject to out-of-network benefits, if that specialty pharmacy is not in the BCBS Arkansas network. Therefore, it may be in the Member's best interest to have his Physician order the specialty drug from a specialty pharmacy that is participating in the BCBS Arkansas plan.
- **Example 2:** Reverse of the Above: BCBS Arkansas Member seeks medical attention in Nashville, TN. The treating Physician in Nashville, TN orders provider-administered specialty pharmacy drug. Specialty pharmacy ships the drug to the Physician's office in Nashville for administration as a Medical Claim and bills the drug thru the Host Plan, e.g. BlueCross BlueShield of Tennessee.
- **Example 3:** BlueCross BlueShield of Tennessee Member visits Physician whose office is in West Memphis, Arkansas, just across the river from Memphis, TN but in a contiguous county to Tennessee. The Arkansas Physician orders a provider-administered drug from a specialty pharmacy in the BCBST preferred specialty pharmacy network. Even though West Memphis, Arkansas is in a contiguous county to Tennessee, and the Physician is in the BCBST network, the specialty pharmacy must file this medical claim to BCBS of Arkansas.

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- Rules of the Tennessee Board of Pharmacy require all pharmacies doing business in Tennessee, which includes the shipping of drugs to a Member or Physician residing in Tennessee, to be licensed by the Tennessee Board of Pharmacy.

**The above BlueCard policy applies *only* to Provider-Administered drugs being filed as a Medical claim unless the drug appears on the list as being both self and provider-admin. This may be billed as a medical claim depending on site of service.**

To obtain a prior authorization for a **Provider-administered** drug being billed as a medical claim, the Provider should call BlueCross Utilization Management Department at **1-800-924-7141**. The improved prior authorization process for provider-administered specialty medications can be found at [https://www.bcbst.com/docs/pharmacy/Improved\\_Prior\\_Authorization\\_Process.pdf](https://www.bcbst.com/docs/pharmacy/Improved_Prior_Authorization_Process.pdf).

In addition to the Member information, the following is required when requesting prior authorization for Provider-Administered specialty drugs:

- Provider NPI Number (more than one of your subsidiaries may share the same number)
- Tax ID Number (more than one of your subsidiaries may share the same number)
- Appropriate Taxonomy Code in Block 33b (taxonomy code should be specific for specialty pharmacy, HIT, etc.)
- HCPCS Code (J, Q or S code)
- Drug Name
- Strength of Drug
- National Drug Code (NDC)
- Number of Units being billed
- Frequency of Dosing
- Dosage
- Days' Supply if billing an "ambulatory" drug on a medical claim (for example, when accepting Assignment of Benefits for Members who have to pay 100 percent up front)
- Clinical Information to support the request (Reference the BlueCross BlueShield of Tennessee Medical Policy Manual)

**Note:**

- New drugs may be periodically added to the specialty pharmacy list and those products requiring authorization are subject to change. Changes will be communicated via BlueAlert newsletter or updates to this Manual. Current and archived BlueAlert issues can be viewed on the company website at <http://www.bcbst.com/providers/newsletters/index.page>.
- The specialty medication section of the BlueCross BlueShield of Tennessee Medical Policy Manual includes decision support trees for Provider-Administered drugs to assist Providers considering use of these medications. Providers can select the appropriate drug from the manual at <http://www.bcbst.com/mpmanual/!SSL/WebHelp/mpmprov.htm> and connect to the decision support tree in the policy.
- Claims for provider-administered medications should be electronically submitted as a medical claim.

The patient prescription form can be used for any BlueCross Specialty Pharmacy vendors. This form and additional program information can also be accessed from the Provider page on the company website at [www.bcbst.com/providers/pharmacy/specialty-pharm-detail.shtml](http://www.bcbst.com/providers/pharmacy/specialty-pharm-detail.shtml).

## XX. BEHAVIORAL HEALTH SERVICES

### A. Introduction

BlueCross BlueShield of Tennessee is committed to providing safe and effective treatment at the most clinically appropriate and least restrictive level of care necessary to meet a Member's care needs. Our commitment begins with providing a credentialed network of behavioral health Providers to meet the access and availability requirements of its Members.

### B. Prior Authorization Guidelines

Prior authorization is required for the following behavioral health levels of care:

- inpatient acute care and inpatient substance use detox
- residential
- partial hospitalization
- intensive outpatient programs
- inpatient and outpatient electroconvulsive therapy (ECT)
- psychological testing
- transcranial magnetic stimulation (TMS)
- applied behavior analysis

**Note:** Always check Member benefits for final determination on authorization requirements as these may vary per Plan. Depending on the specific Member health care plan, benefits for non-prior authorized care may be reduced or may not be available.

*Behavioral health utilization reviews for emergency services are available 24-hours-a-day, 7-days-a-week. Emergency behavioral health services should be authorized at the time of admission.*

### C. Access to Services

#### ***Telephone Access for Referral and Authorization***

Members can directly access emergency behavioral health services 24-hours-a-day, 7-days-a-week. Licensed Clinical Care Managers with at least three (3) years' clinical experience are available to assist Members and Providers with their questions.

BlueCross BlueShield of Tennessee Members can call **1-800-888-3773** or 1-800-924-7141 during normal business hours to arrange routine behavioral health services. Medical or Behavioral Health Providers or their office staff can also use this number to assist Members in setting up appointments for required behavioral health evaluations or treatment.

#### ***Treatment Access to Facilities and Professionals***

BlueCross BlueShield of Tennessee maintains standards to provide access to licensed and approved psychiatric and substance use disorder facilities and treatment programs, as well as licensed behavioral health care professionals.

Facilities must be licensed by the State and may require accreditation by the Joint Commission or the Commission Accreditation of Rehabilitation Facilities, or other recognized accrediting body to be approved for network participation.

Behavioral health care professionals must be state-licensed as one of the following:

- Advanced Practice Nurse (APN)
- Clinical Nurse Specialist/Psychiatric (RN, CNS)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Counselor (LPC)
- Licensed Senior Psychological Examiner (LSPE)
- Psychiatrist (MD, DO)
- Psychologist (Ph.D, Psy.D., Ed.D with MHSP qualification)
- Board Certified Behavior Analyst (BCBA)/Licensed Behavior Analyst (LBA) [Plans with Applied Behavior Analysis (ABA) coverage]

Additional details regarding network eligibility requirements can be found in *Section XIV. Credentialing*, in this Manual.

## D. Behavioral Health Specific Billing Guidelines

The following information will assist you when billing behavioral health professional and facility claims. For general claims filing instructions, please refer to *Section VI. Billing and Reimbursement*, in this Manual.

### 1. Health and Behavior Assessment/Intervention

Performance of a health and behavior assessment may include a health-focused clinical interview, behavioral observations, psychophysiological monitoring, use of health-oriented questionnaires, and interpretation of assessment data. Elements of a health and behavior intervention may include cognitive, behavioral, social, and psychophysiological procedures that are designed to improve the patient's health, ameliorate specific disease-related problems, and improve overall well-being.

The following CPT® codes should be billed with a medical diagnosis: (Please refer to the current International Classification of Diseases [ICD] Codes manual for the most appropriate diagnosis code in effect for the date of service.)

| CPT® Code | Description  |
|-----------|--|
| 96150     | Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires, each 15 minutes face-to-face with the patient; initial assessment. |
| 96151     | Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires, each 15 minutes face-to-face with the patient; re-assessment.      |
| 96152     | Health and behavior intervention, each 15 minutes, face-to-face; individual.   |
| 96153     | Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients).   |
| 96154     | Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present).  |
| 96155     | Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present).   |

## 2. Psychiatric Consultation Guidelines in a Medical Setting

When psychiatric consultation services are required, Providers should call BlueCross BlueShield of Tennessee to verify Member eligibility and benefits. The following guidelines apply:

| If consultation is in: | service may be:  |
|------------------------|--|
| Emergency Room         | performed <b>only</b> by psychiatrist and billed according to contract fee schedule            |
| Hospital Bed           | performed by psychiatrist and/or psychologist and billed according to contract fee schedule    |
| Nursing Home           | performed by all behavioral health professionals and billed according to contract fee schedule |

Psychiatric consultation services must be billed with the appropriate Place of Service code for the medical treatment setting and the CPT® code provided at the time the service was authorized. Claims must be billed on a CMS-1500 claim form or ANSI-837P transaction.

## 3. Facility and Program Services Revenue Codes

As a result of the code set requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), behavioral health facility claims must be filed with the appropriate Revenue Codes. A listing and contract descriptions follow:

| Revenue Code   | Contract Description   |
|--|--|
| 0114, 0124, 0134, 0144, 0154, 0204, 0116, 0126, 0136, 0146, 0156, 0118, 0128, 0138, 0148, 0158 | Hospitalization for Psychiatric and Substance Use Disorders  |
| 0762   | Observation, up to 23 hours  |
| 1001   | <ul style="list-style-type: none"> <li>Non-Acute, Residential Treatment, Psychiatric</li> <li>Non-Acute, Residential Treatment, Eating Disorder</li> </ul>                   |
| 1002   | Non-Acute, Residential Treatment, Substance Use Disorder   |
| 0901   | ECT Inpatient and Outpatient   |
| 0905   | <ul style="list-style-type: none"> <li>Intensive Outpatient, Psychiatric</li> <li>Intensive Outpatient, Eating Disorder</li> </ul>   |
| 0906   | Intensive Outpatient, Substance Use Disorder   |
| 0912, 0913, 0915   | <ul style="list-style-type: none"> <li>Partial Hospital, Psychiatric</li> <li>Partial Hospital, Substance Use Disorder</li> <li>Partial Hospital, Eating Disorder</li> </ul> |
| 0944, 0945   | Ambulatory Detox   |
| 0944, 0529   | Methadone Maintenance (not a covered service in all plans)   |
| 0513   | Ambulatory Follow-up/bridge to outpatient services   |

**Note:** Certain Revenue Codes must also be accompanied by an appropriate CPT®/HCPCS code in order for claims to pay. Please refer to standard billing resource materials for additional information.

### Residential Treatment Facility – Federal Employee Program (FEP)

- Residential Treatment Facility claims for Federal Employee Program (FEP) Members must be billed following the CMS-1450 format.
- Residential Treatment Facility claims for Federal Employee Program (FEP) Members must be billed with a Type of Bill 86x in Form Locator 4.



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## **E. Provider/Member Complaints/Grievances**

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Providers and Members can register complaints or grievances by calling the behavioral health services number or the BlueCross BlueShield of Tennessee Customer Service number, which are listed on the Member ID card.

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## **F. Covered Behavioral Health Services**

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Benefits are available for clinical assessment, diagnosis, referral, as well as inpatient and outpatient services for treatment of Behavioral Health Disorders (mental health and substance use).

Behavioral health services are covered when received from a contracted Provider or a non-contracted Provider depending upon the Member's health care benefits plan. Members should consult their health care benefits plan or call the Customer Service number listed on their ID card for prior authorization requirements, benefit coverage, and information about the Mental Health Parity and Addiction Equity Act of 2008.

### **Program Services**

Program services are covered when received in a licensed behavioral health facility program, or unit for mental health disorders or substance use disorders and when prior authorized by the Member's health care benefits plan. Utilization review services are available 24-hours-a-day, 7-days-a-week for acute care services. Program services include acute care, residential care, partial hospitalization, intensive outpatient programs, and inpatient and outpatient electroconvulsive therapy (ECT) defined as follows:

- **Acute Care**  
Acute care is provided in a hospital licensed by a state to provide treatment for psychiatric or substance use disorders and is accredited by an acceptable accrediting body. Acute care includes 24-hour psychiatric and substance use detoxification (medically managed or medically monitored) care for adults, adolescents and children with distinct criteria for each service. It may also include co-occurring disorders, eating disorder, and other services targeted to treat specific behavioral health disorders.
- **Residential**  
Residential care includes psychiatric and substance use disorder treatment in an accredited program. Residential care is 24-hour-a-day care.
- **Partial Hospitalization and Intensive Outpatient Programs**  
Partial hospitalization and intensive outpatient programs must be provided in licensed facilities that have been accredited by an acceptable accrediting body and/or have passed a structured site visit.
- **Inpatient and Outpatient Electroconvulsive Therapy**  
Electroconvulsive therapy (ECT) is covered when performed in a hospital setting. For most Plans, both inpatient and outpatient ECT requires review and prior authorization.
- **Transcranial Magnetic Stimulation**  
Transcranial Magnetic Stimulation (TMS) has been approved as a treatment for major depressive disorder for all BlueCross lines of business. TMS is a non-invasive method of delivering electrical stimulation to the brain. TMS is not approved for treatment of other diagnoses or conditions.

The therapy is administered in an inpatient, outpatient, or office setting. If needed, a treatment course may be repeated after a 3-month cessation period. All TMS services must be performed by a qualified and trained psychiatrist.

TMS is not allowed for pregnant women or for children under age 18.

Services provided in an outpatient setting must be preauthorized and requests must include a Physician's order.

The following CPT® codes are used for billing TMS services:

|       |   |
|-------|---|
| 90867 | Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management |
| 90868 | Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session   |
| 90869 | Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management                    |

**Note:** Use revenue codes 0510, 0513, and 0920 in conjunction with appropriate CPT® codes when services are initiated in an inpatient setting. Please note that charges for TMS filed by a facility during inpatient care are included in the inpatient reimbursement and are **not** paid separately.

➤ **Psychological Testing**

All providers are required to submit a psychological testing request in order to obtain prior authorization for this service. Testing request should include:

- General information about the member
- Reported difficulties the member is experiencing
- History of treatment and assessment
- Impact testing will have on the diagnosis and treatment of the member
- Specific types of tests should be listed, with only the most common test acronyms used
- Specific number of hours the provider anticipates administration of the individual tests will require

Providers should be aware that educational testing is considered an excluded benefit under BlueCross. Educational testing is to be provided by the school system under federal Mandate PL 94-142. (According to the Child Find mandate of the Individuals with Disabilities Education Act, schools are required to locate, identify, and evaluate **all** children with disabilities from birth through age 21. (20 U.S.C. 1412(a)(3)).) There are also restrictions regarding the use of testing for vocational and legal purposes.

Generally, in depth psychological testing will not be considered Medically Necessary if the diagnostic questions can be addressed through medical, neurological, or psychiatric examination.

Providers should also be aware that psychological testing should be administered by a qualified professional and psychological testing CPT® codes should not be submitted by medical Providers or behavioral health Providers not qualified to administer and interpret testing results.

➤ **Applied Behavioral Analysis (ABA)**

Applied behavior analysis is covered by the Federal Employee Plan (FEP) as of 1/1/2017 and BCBST fully insured plans as of 1/1/2017. Self-funded plans can elect to cover ABA services and will have various dates of effective coverage if elected. It is the Provider's responsibility to verify ABA coverage.

ABA has been approved for the treatment of autism spectrum disorders and has a significant focus on identifying the function of unwanted behavior and development and implementation of a structured treatment plan to decrease undesirable behaviors and increase desirable behaviors. ABA is not: psychological testing, neuropsychology, psychotherapy, cognitive therapy, psychoanalysis, hypnotherapy or long-term counseling.

The following CPT® codes are used for billing ABA services:

| CPT® Code | Description   |
|-----------|---|
| 0359T     | Behavior identification assessment, by the Physician or other qualified health care professional, face-to-face with patient and caregiver(s), includes administration of standardized and non-standardized tests, detailed behavioral history, patient observation and caregiver interview, interpretation of test results, discussion of findings and recommendations with the primary guardian(s)/caregiver(s), and preparation of report |
| 0360T     | Observational behavioral follow-up assessment, includes Physician or other qualified health care professional direction with interpretation and report, administered by one technician; first 30 minutes of technician time, face-to-face with the patient  |
| 0361T     | Observational behavioral follow-up assessment, includes Physician or other qualified health care professional direction with interpretation and report, administered by one technician; each additional 30 minutes of technician time, face-to-face with the patient (List separately in addition to code for primary service)  |
| 0362T     | Exposure behavioral follow-up assessment, includes Physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; first 30 minutes of technician(s) time, face-to-face with the patient  |
| 0363T     | Exposure behavioral follow-up assessment, includes Physician or other qualified health care professional direction with interpretation and report, administered by physician or other qualified health care professional with the assistance of one or more technicians; each additional 30 minutes of technician(s) time, face-to-face with the patient (List separately in addition to code for primary procedure)                        |
| 0364T     | Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; first 30 minutes of technician time   |
| 0365T     | Adaptive behavior treatment by protocol, administered by technician, face-to-face with one patient; each additional 30 minutes of technician time (List separately in addition to code for primary procedure)   |

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| CPT® Code | Description   |
|-----------|---|
| 0366T     | Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; first 30 minutes of technician time  |
| 0367T     | Group adaptive behavior treatment by protocol, administered by technician, face-to-face with two or more patients; each additional 30 minutes of technician time (List separately in addition to code for primary procedure)  |
| 0368T     | Adaptive behavior treatment with protocol modification administered by Physician or other qualified health care professional with one patient; first 30 minutes of patient face-to-face time  |
| 0369T     | Adaptive behavior treatment with protocol modification administered by Physician or other qualified health care professional with one patient; each additional 30 minutes of patient face-to-face time (List separately in addition to code for primary procedure)          |
| 0370T     | Family adaptive behavior treatment guidance, administered by Physician or other qualified health care professional (without the patient present)  |
| 0371T     | Multiple-family group adaptive behavior treatment guidance, administered by Physician or other qualified health care professional (without the patient present)   |
| 0372T     | Adaptive behavior treatment social skills group, administered by Physician or other qualified health care professional face-to-face with multiple patients  |
| 0373T     | Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); first 60 minutes of technicians' time, face-to-face with patient  |
| 0374T     | Exposure adaptive behavior treatment with protocol modification requiring two or more technicians for severe maladaptive behavior(s); each additional 30 minutes of technicians' time face-to-face with patient (List separately in addition to code for primary procedure) |

➤ **Traditional Outpatient Services**

Traditional outpatient medication management and therapy services are covered when provided in an office setting, or within facility-based outpatient settings. Professionals delivering these services must be licensed at the independent practice level in the state in which the services are provided and meet other requirements as formulated by State of Tennessee law, BlueCross BlueShield of Tennessee, and the behavioral health services covered under the Member's health care benefits plan.

## G. Treatment Record Requirements

Providers are expected to develop an initial treatment plan within thirty (30) days of the start date of service and update it every six (6) months or more frequently, as clinically appropriate. Evidence of an individualized treatment plan includes, but is not limited to, the following documentation:

- A Case Formulation Statement that hypothesizes the Member's primary problem(s), states the desired treatment outcomes, describes the therapeutic approach to treatment, and proposes interventions toward desired outcomes;
- Identified problems for which the Member is seeking treatment;
- DSM diagnoses, primary and secondary;
- Measurable, attainable, age-appropriate goals and objectives related to the identified problems;
- Target dates for completion of goals/objectives;
- Information regarding the Member's strengths used to develop strengths-based plan;
- Services to be used for each goal or objective (e.g., medication management, therapy, community-based treatment services);
- Reviews or updates to plans completed at least every six (6) months and to include progress toward established goals or objectives, barriers preventing completion of goals or objectives, and newly established goals and objectives with dates of review;
- Evidence of Member's involvement in treatment planning (*Fulfilling this requirement means that each initial treatment plan and subsequent treatment plan review is signed by a Member, family member, or legally appointed representative.*);
- Progress notes for each service contact documenting the date and time of service, the type of service provided, a summary of treatment interventions used, the treatment plan goals and objectives addressed in the session, and the name and credentials of service Provider;
- Documentation of coordination of care efforts and communications with PCPs, other outside Providers, agencies, judicial system, Member support system, or any other person or entity involved in the Member's treatment;
- Evidence of discharge planning activities to include discharge plans, dates of follow-up appointments, and referrals to other Providers;
- A discharge summary completed and documented within fifteen (15) calendar days following discharge from service, or death; and
- For Providers of multiple services, one comprehensive treatment plan is acceptable as long as at least one goal is written and updated as appropriate, for each of the different services provided to the Member.

**All treatment records must be legible, maintained in a detailed and organized manner, and available at the site where covered services are rendered. Treatment records for ALL LEVELS OF CARE must contain:**

***Identifying Member Information:***

- Member name and at least one other piece of identifying information on every page or electronic screen of treatment record. (date of birth, Member ID#, address);
- Member contact information including address and phone number;
- Employment or school information;
- Marital status;
- Legal status (including state custody);
- Guardianship and/or conservatorship, if applicable; and
- Declaration for Mental Health Treatment form status.

***Consent Forms Signed by Member/Parent/Guardian:***

- Consent for treatment;
- Informed consent for prescribed medications;
- Release of information forms, updated annually, for Member's PCP, for other behavioral health Providers, and for any other Providers or agencies relevant to coordination of care
- For Members with no PCP, documentation must reflect efforts to help a Member to obtain a PCP;
- Release of information form for MCO or payer, communicating to member that Provider will share service participation and treatment progress with MCO;
- For adolescents ages 16 and older, a consent or refusal to discuss behavioral health issues with a parent/guardian; and
- Acknowledgement of review of patient rights and responsibilities.

To equip Members with the information they need to provide informed consent, when residential treatment is being considered for children and adolescents BlueCare Tennessee expects Providers to inform children and adolescents and their parent(s) or legally appointed representative of all their options for residential and/or inpatient placement, alternatives to residential and/or inpatient treatment, and the benefits, risks, and limitations of each.

Likewise, when voluntary inpatient treatment is being considered for adults, BlueCross expects Providers to inform them or their legally appointed representative of all their options for residential and/or inpatient placement, alternatives to residential and/or inpatient treatment, and the benefits, risks, and limitations of each.

***Medication Information Documenting:***

- All medications prescribed (psychotropic medications as well as medications for other physical health conditions), the dosages of each, and the dates of initial prescription and refills;
- If medications are prescribed by an outside Provider, the prescriber is identified;
- Any medication allergies or adverse reactions are clearly noted; and
- For Members being considered for psychotropic treatments, documentation must reflect evidence of informing the Member and parent or guardian of the benefits, risks, and side effects of the medication, alternate medications, and other forms of treatment.

***Current Medical Information and Medical History:***

- A health assessment that includes medical history, screening for current medical problems, currently prescribed medications, and medication history;
- Medication allergies, adverse reactions, and relevant medical conditions are clearly documented as present or absent; and
- Documentation for Children/Adolescents regarding prenatal and perinatal events along with a complete developmental history (physical, psychological, social, intellectual, and academic).

***Psychiatric Information and Psychiatric History:***

- Identification of previous Providers and treatment services;
- Approximate dates of service for previous Providers and treatment services;
- Information regarding outcomes of previous treatment services;
- A mental status evaluation to be completed with 30 days, and to include, at a minimum, as assessment of appearance, affect/mood, speech, thought content, judgement/insight, attention/concentration, and memory;
- A DSM diagnosis consistent with current symptoms;
- Information addressing Member-specific cultural considerations;
- Information regarding the Member's list of strengths;
- A substance use assessment that screens for frequently used over-the-counter medications, alcohol, tobacco, and other drugs and history of prior alcohol and drug treatment episodes (recommended screening tools are available at [www.bcbst.com](http://www.bcbst.com));

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- Current risk assessment (imminent risk of harm, suicidal or homicidal ideation/intent, elopement potential) clearly documented and updated according to written protocols; and
- A crisis plan relevant to Member's risk potential that includes individualized steps for prevention or resolution of crisis. This plan should include, but is not limited to:
  - ❖ Identifying crisis triggers
  - ❖ Steps to prevent, de-escalate, or defuse crisis situations
  - ❖ Names and phone numbers of contacts who can assist Member in resolving crises
  - ❖ The Member's preferred treatment options in the event of a crisis.

### ***Policies and Procedures***

- The Provider must have a policy regarding CFR-42, protection of substance use information.

### ***Supervision and Training for Non-licensed Staff***

- Non-Clinicians
  - ❖ When individuals providing behavioral health treatment services are not required to be licensed or certified, the facility must provide documentation that the individuals are appropriately educated, trained, qualified, supervised, and competent to perform their job responsibilities.
- Clinicians
  - ❖ It is the expectation that ongoing supervision will be provided by Mental Health/Substance Use facilities/CMHC Providers who employ non-licensed clinical staff that complete clinical activities, such as clinical assessments and psychotherapy. The facility should ensure that all non-licensed clinicians are regularly supervised by a licensed clinician. The supervising clinician will have regular, in-person, one-on-one supervision with the non-credentialed clinician to review the treatment and/or services provided to Members.
  - ❖ Under the supervision of an independently licensed clinician, non-licensed master's level clinicians who render behavioral health professional services shall receive clinical supervision specific to the rendered service. The supervision will include a minimum of direct supervision during service initiation, which may be followed by general supervision for the remainder of the service at the discretion of the supervisory Practitioner.
    - Direct supervision means the supervising Provider must be immediately available (i.e., in person, by phone or through telehealth/video conferencing) to furnish assistance and direction throughout the rendered service and may include the Supervisor's review and signing of the treatment plan during service initiation.
    - General supervision means the service is performed under the supervisory clinician's overall direction and control but his or her presence is not required during the performance of the intervention.

### ***Additional record requirements apply to SPECIFIC LEVELS OF CARE.***

#### **Child/Adolescent Residential Treatment Centers:**

- An intake, initial evaluation, and diagnostic assessment completed within 2 hours of admission;
- An initial treatment plan completed within the first seventy-two (72) hours of admission, and an updated treatment plan at least every thirty (30) days or upon completion of the stated goals/objectives;
- Progress notes to be documented daily for each therapeutic contact and the Member's individual progress;
- Documentation of consent by parent/guardian or Member (if 16 years of age or older) to all medication changes;

- Documentation of seclusion/restraint events, notifications, and debriefings with Member and staff;
- Medication administration record (MAR);
- Documentation of coordination with aftercare Providers (including education Providers) throughout the residential stay, and particularly coordination with Providers as the discharge date approaches that includes aftercare appointments and sharing of relevant clinical information for continuity of care; and
- Discharge summary completed within five (5) business days of Member discharge which includes Member's condition at time of discharge or transfer, the reason for discharge or transfer, aftercare appointments, and signature of person preparing the summary.

**Intensive Outpatient Program (mental health and substance use disorders):**

- An intake, initial evaluation, and diagnostic assessment and an initial individualized treatment plan must be completed and documented within three (3) days of treatment;
- Updated treatment plan at least every eight (8) treatment sessions;
- Progress notes for each therapeutic contact, including group sessions, to include date, start and finish times, level of Member participation, daily risk assessment, and signature of service Provider;
- Documentation of evaluation for mental health and substance use disorder services as Medically Necessary and evidence of the provision of needed services with appropriate behavioral health follow-up services planned.

**Outpatient Service Providers:**

- An intake, initial evaluation, or diagnostic assessment completed within the first thirty (30) calendar days of initiation of services and to be updated as needed, and annually at minimum;
- An initial treatment plan completed within the first thirty (30) calendar days of initiation of services, and an updated treatment plan at least every six (6) months;
- A progress note completed for each service contact;
- Documentation of communication with Member's PCP and other behavioral health Providers within two (2) weeks of the intake/diagnostic assessment; annual updates to those Providers, and notification of discharge from services to those Providers; all communication to other Providers must include a summary of treatment services, including medications, and any changes to treatment since the previous communication. Communication with the PCP or other medical Provider must include a request for information to be sent back, to include at a minimum, a medication list;
- A discharge/transfer summary that includes Member's condition at the time of discharge/transfer, the reason for discharge/transfer, aftercare recommendations or appointments as applicable, and the signature of person preparing the summary.

**Substance Use Disorder Services Providers (Inpatient, Residential, & Outpatient):**

- For detoxification services, documentation of supervision by a Tennessee-licensed Physician with a minimum of daily re-evaluations by a Physician or a registered nurse.

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## **H. Behavioral Health Quality Management**

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One of the primary goals of the Behavioral Health Quality Management Program (BHQMP) is to continually improve care and services. Through data collection, measurement, and analysis, aspects of care and service that demonstrate opportunities for improvement are identified and prioritized for quality improvement activities. Data collected for quality improvement activities are frequently related to key industry measures of quality that tend to focus on high-volume



diagnoses or services and for high-risk or special populations. Data collected are valid, reliable and comparable over time. The BHQMP takes the following steps to help ensure a systematic approach to the development and implementation of quality improvement activities:

- Monitoring clinical quality indicators;
- Review and analyze data from indicators;
- Identify opportunities for improvement;
- Prioritize opportunities to improve processes or outcomes of behavioral health care delivery based on risk assessment, ability to impact performance, and resource availability;
- Identify the at-risk population within the total membership;
- Identify the measures to be used to assess performance;
- Collect valid data for each measure and calculate the baseline level of performance;
- Establish performance goals or desired level of improvement;
- Develop interventions that impact performance; and
- Analyze results to determine where performance is acceptable and, where it is not, identify barriers to improving performance.

### Complaints and Quality of Care Concerns

One method of identifying opportunities for process improvement is to collect and analyze the content of Member complaints and other reported quality of care concerns. The BHQMP investigates all reported complaints and quality of care concerns. Data from these investigations are compiled, tracked, and reported to internal committees for analysis and determination of further action or resolution.

### Reporting Adverse Occurrences

Participating Providers are required to report all adverse incidents involving Members to BlueCross BlueShield of Tennessee. Providers must report adverse incidents to BlueCross within twenty-four (24) hours. Adverse incidents are defined as occurrences that represent actual or potential serious harm to the well-being of Members or to others by a Member who is in behavioral health treatment. Report all adverse occurrences to BlueCross using the Adverse Occurrence Report (AOR) form found on the company website at <http://www.bcbst.com/providers/forms/Behavioral-Health-Adverse-Occurrence-Report.pdf>.

Examples of reportable adverse occurrences include, but are not limited to the following:

- Suicide death
- Non-suicide death that occurs in a residential or inpatient treatment setting. Non-suicide deaths of Members receiving outpatient behavioral health treatment services should be reported only if there would be reasonable suspicion that the death was related to behavioral health treatment (e.g., overdose, potential medication error or reaction.)
- Homicide
- Homicide attempt with significant medical intervention\*
- Suicide attempt with significant medical intervention\*
- Allegation of abuse or neglect including peer-to-peer (physical, sexual, verbal)
- Medical emergency occurring in residential or inpatient or treatment settings requiring significant medical intervention\* (e.g., myocardial infarction, medically unstable Member.)
- Accidental injury with significant medical intervention\*
- Use of restraints/seclusion (physical, chemical, mechanical) requiring significant medical intervention\*
- Treatment complications, including (medication errors and adverse medication reactions)
- Elopement (specific to inpatient and residential services only)

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- Sexual behavior with other patients or staff, whether consensual or not, while in a behavioral health treatment setting
- Other occurrences representing actual or potential serious harm to a member not listed above
- \*Significant medical intervention: An event requiring medical intervention that cannot be provided in the behavioral health treatment facility (for example, a myocardial infarction requiring treatment in an emergency department or medical hospital).
- BlueCross may undertake an investigation based on the circumstances of each occurrence, or on any identified trend of adverse occurrences. As a result, Providers may be asked to furnish records, and/or to engage in corrective action to address quality of care concerns and any identified or suspected deviations from a reasonable standard of care. Providers may also be subject to disciplinary action through BlueCross Clinical Risk Management or the BlueCross Credentialing Committee, or both.

### **Site Visits for Quality Reviews and Treatment Record Audits**

BlueCross, or its designee, conducts site visits at Provider facilities or offices to monitor compliance with regulatory and contractual standards. A scheduled or unscheduled quality review may be conducted as part of monitoring an investigation stemming from a Member complaint, adverse occurrence, or other quality issue.

Treatment record audits are conducted annually or more frequently if deemed necessary. Providers will be notified prior to the scheduled audit and will be provided with a copy of the audit tool and a detailed Member list of charts that will be audited.

Following the site visit, the Provider will receive feedback which may require an action plan demonstrating the Provider's compliance with relevant standards in an effort to provide quality care and service to BlueCross Members.

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## XXI. bcbst.com

The company website, [www.bcbst.com](http://www.bcbst.com), is an award-winning, easy-to-use service that enables Providers and Members having Internet capabilities to link to a compilation of informative healthcare information.

### 1. Availity

Availity enables Providers to view information in a secure online environment. If you are not registered, go to <http://www.Availity.com> and click on “Register” in the upper right corner of the home page, select “Let’s get started” and follow the instructions in the Availity registration wizard.

Using Availity Providers can:

- Check Claim Status;
- Verify Benefits, Eligibility and Coverage Details;
- Submit Claims (RTCA);
- View/Print Remittance Advice;
- Submit/Update Prior Authorizations; and
- Much More

#### ***Practice Pattern Analysis (PPA)***

BlueCross BlueShield of Tennessee periodically performs a Practice Pattern Analysis (PPA), which is a quality management study designed to provide Practitioners with important information about their utilization practices and quality of care.

PPAs are not intended to prescribe what constitutes appropriate individual care, but rather are designed to reveal patterns of care that are outside the normal range of practice for a Practitioner’s specialty. PPAs provide useful information to assist Practitioners in evaluating the appropriateness of care and give them an opportunity to compare their overall practice patterns to those of their peers.

#### **National Consumer Cost Tool**

Providers can view their cost data in the National Consumer Cost Tool (NCCT) on Availity prior to the information being made available to Members. This information is available for a 60-day review period.

The National Consumer Cost Tool presents an opportunity for Blues Plans to offer a secure, interactive environment where consumers can evaluate cost-related information, become knowledgeable about the estimated costs of future procedures, and participate more effectively in their health care decisions.

#### ***Patient Review of Physicians***

*Patient Review of Physicians* is an online review system that Blue Members nationwide can use as part of their decision-making when they are selecting a Physician or other professional Provider. BlueCross BlueShield of Tennessee delivers information about Members’ actual experiences with their Providers through an easy-to-use, nationally consistent, online survey and aggregated results display.

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The Blue Cross Blue Shield Association implemented a rigorous process that authenticates, verifies, and moderates reviews prior to posting online. This process helps assure only authenticated Blue Members who verify they have seen the Physician can contribute reviews.

Providers can logon to Availity, navigate to the "Transparency Review" section and choose "Provider Ratings Review" to access a summary of all Provider reviews and perform a number of Provider-specific actions, such as:

- sign up for e-mail or fax alerts when new reviews are received;
- hide up to two (2) reviews; and
- post a response to a review.

Not only is patient review a valuable tool for providing insights into your patient's experiences, it can also attract new patients. While patient reviews are just one of many factors to consider when patients choose a health care Provider, research shows that online patient reviews are one of the most sought after pieces of information for consumers. Approximately 85-90 percent of patient reviews are positive, and some Physicians use them as a means to promote their practice. To assure your overall score is positive, encourage your patients to contribute to your reviews.

## **2. Other Online Reference Materials**

***Provider administration manuals, Medical Policy Manual and Health Care Practice Recommendations Manual***

A number of reference manuals are also available on the company website at <http://www.bcbst.com/providers/manuals.page> giving you access to current administrative processes, and medical policies.

Click on the manual you wish to reference; to search for a specific topic, simply:

- click on the "find" button (little binoculars);
- type in a word or number of words that most describe the topic you wish to find; and
- hit "enter" on your keyboard.

You will be taken to where the first mention of your search is located. To continue searching, just click on the "find again" button (little binoculars with forward arrow).

## **3. Network Directories**

Referring your patients to other participating Providers is not only contractual, but will save substantial out-of-pocket costs for your patients.

The information listed in this online directory is updated daily. As is the case with any directory, the listed Providers' participation in the network is verifiable only up to the date the directory was updated. Providers join, as well as, leave the networks. It is very important to verify health care professionals' and facilities' continued participation in a network before referring a patient.

Although it is the Provider's obligation to notify his/her BlueCross BlueShield of Tennessee patients of any intent to terminate participation in a network, BCBST will also display future termination dates beside the Provider's name once notice is received. It is our intent to publish these termination dates thirty (30) days prior to the actual termination effective date.

We invite you to visit the company website often- Information and new features are added on a regular basis.

## **XXII. BlueCare<sup>®</sup> /TennCareSelect Program Outline**

This section has been removed. Information regarding BlueCare and TennCareSelect can be found in the *BlueCare Tennessee Provider Administration Manual* located on the Provider page on the company websites [www.bcbst.com](http://www.bcbst.com) and <http://bluecare.bcbst.com/>

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## XXIII. Provider Audit Guidelines

### A. Overview

All claims submitted to BlueCross BlueShield of Tennessee and any of their affiliates and/or subsidiaries for reimbursement are subject to audit for the purpose of verifying the information submitted is correct, complete, in accordance with Provider contract requirements, and supported by established coding guidelines.

Claims are routinely analyzed for potential billing and coding irregularities, as well as known areas of potential fraud and abuse. Audit of specific Providers or Provider groups may also be requested by any vested party.

All records requested must be provided; claims payments involved with records not received are subject to immediate recovery as unsubstantiated by documentation.

Audits are based on recognized coding and billing guidelines such as, but not limited to the *UB Coding Editor*, *ICD Manual* and *CPT® Manual* as well as specific Provider contractual language, Medical Policy and Medical Necessity review.

Audit rights are defined in this Manual and any of their affiliates and/or subsidiaries Provider Agreement. Claims found with errors, both overcharges and undercharges, will be submitted for adjustment.

### B. Audit Process

#### Audit Scheduling

All Providers are given advance notice of scheduled audit dates. Once an audit is scheduled, it should not be changed or cancelled except for extenuating circumstances. If scheduled audits are continually delayed, or denied by the Provider, payment for those claims selected for audit will be retracted until the audit is allowed.

#### Medical Record Request Process

When requested by BlueCross or a designated vendor, Provider will be required to furnish in a timely manner medical records and encounter data in electronic or hardcopy format. Medical records may be submitted via our secure file transfer portal (SFTP) that is fully compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and requires minimal set up. All complete medical records must be provided by the beginning of the audit to help ensure a timely audit schedule. Any additional documentation requested during the audit must be provided timely. Medical records not provided at the audit start date may result in retraction of payment. Electronic Health Records (EHR) records must contain a system generated permanent date and time record for all entries as required by HIPPA.

#### Audit Process

All claims are reviewed for correct coding and billing, contract compliance and accurate reimbursement based on applicable regulatory governing agencies and BlueCross guidelines as published in this Manual, Medical Policies and Medical Necessity.

#### Facility Audit Process

Facility Audit schedules audits in advance and medical records are requested a minimum of eight (8) weeks before the scheduled audit date. This provides ample time to compile and submit medical records, I-bills and invoices, and ER tools, as applicable. Audits begin on the scheduled date and it is expected that all documentation has been received prior to the actual start date of the audit. Audit staff will be available daily during the audit to discuss audit findings and will conduct an exit interview with designated staff to provide a general overview of the audit findings (specific details are to be covered in daily



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discussions). Facilities should **not** file corrected claims for issues identified during audit unless instructed to do so by the auditors. Corrections/changes to claims audited should be handled via reconsideration/appeal process as advised during the audit.

### **Audit Accommodations**

BlueCross reserves the right to conduct on-site audits. Adequate and reasonable accommodations will be required during the audit. These accommodations include but are not limited to adequate desk space, location compatible for wireless internet service, lighting, temperature, seating, etc. A single location for the entire audit team without relocation during the audit is expected.

If auditors are expected to connect to the Provider's system for access to medical records, Providers are responsible for ensuring connectivity, communicating instructions, and providing training on computer systems prior to the audit. E-mail communications outline the requirements for remote access given to auditors, but the testing process and validation of access is expected **prior to begin date** of the scheduled audit.

### **Audit Findings**

The Provider will receive a Final Audit Report detailing the results of each audited claim at the audit conclusion, normally within thirty (30) days. The claims found in error may be submitted for adjustment and/or re-adjudication. Providers are expected to correct identified issues immediately.

### **Subsequent Audits**

A decision may be made to expand the audit scope based on audit findings.

Additional follow-up audits may be performed to substantiate the Provider has made any necessary corrections to billing and/or documentation practices according to the billing and coding guidelines cited on a previous audit.

### **Vendor Audits**

BlueCross, or a vendor designated by us, is allowed to perform on-site, desk, or remote audits and inspections of financial and/or medical records, and Utilization Management covering treatment of any BlueCross Member. Such audits and inspections shall be permitted without charge to us or its designated vendor, who shall be provided copies of records involving the audit or inspection without charge.

BlueCross has contracted with claims audit vendors to perform pre and post payment coding, utilization and Medical Necessity audits. BlueCross's claim audit vendors follow CMS auditing procedures similar to those practiced by the Medicare claims audit vendor where Clinical Review Judgment (CRJ) is used to determine if the services provided were Medically Necessary, coded at the appropriate level and/or billed according to recognized utilization standards. CRJ is utilized on all complex audits and involves a thorough review of all submitted medical documentation in order for the reviewer to develop a complete clinical picture of the patient as part of the evaluation. In addition to the complex reviews, BlueCross's claims audit vendors also perform automated audits utilizing proprietary algorithms to identify potential overpayments as a result of billing and coding errors.

### **Submission of Outpatient Claims Following an Audit**

In accordance with CMS ruling 1455-R issued on March 13, 2013, BlueCross will accept outpatient claims from facilities for the outpatient services (emergency room visits, observation services, etc.) performed prior to an inpatient admission when our recovery audit vendor has determined that the inpatient admission was not Medically Necessary. BlueCross will process the outpatient claims according to our normal processing and reimbursement rules.

To prevent delays in reimbursement, hospitals should mark the outpatient claim to indicate that it is the result of a vendor audit, and submit it within 120 days of the date of our remittance advice reflecting recovery of the inpatient claim. If a facility has appealed an audit decision and received a denial, the outpatient claim should be submitted within 120 days of the date of the appeal decision. A copy of the appeal decision should also be submitted to help ensure proper handling of the claim. Additionally, hospitals must maintain documentation to support the services billed on the outpatient claim.

## C. Operational Guidelines for Facility Emergency Department Claims Audit Process

**Step 1:** For all lines of business, effective April 1, 2012, BlueCross will conduct ED audits utilizing the hospital's current designated ED claims level classification tool.

**Step 2:** The facility, within two (2) weeks notification of the audit, will send BlueCross an electronic or hardcopy version of their facility's current ED classification tool(s), the effective dates of the tool(s), guidelines/instructions for appropriate use, and a contact for questions and answers regarding the tool(s).

**Step 3:** If the facility has changed ED tool or modified the logic in its current ED classification tool during the audit period, we reserve the option to use the hospital's previous ED classification tool version upon an observed shift increase of 5 percent or more of ED levels 4 and/or 5.

**Step 4:** The baseline will be established by a comparison of the ED claims billed prior to ED classification tool logic modification or complete tool change against the ED claims billed using the modified version (see illustration below).

- Based upon the ED tool modification date, BlueCross will include six (6) months retrospective claims data during the analysis of the previous ED tool.

If the facility has changed ED tool or modified the logic in its current ED classification tool within three (3) months from the end of the audit period, we will perform the audit using both tools as indicated by the effective dates of the tool(s).

| Example: Determining if analysis is needed |                    |   |  |  |  |
|--|--------------------|---|--|--|--|
| Audit Date:                                | Apr-12             |   |  |  |  |
| Claim Date Range:                          | Dec-10 thru Jan-12 |   |  |  |  |
| Audit Tool Modified                        | Jun-11             |   |  |  |  |
| Comparison                                 | Dec-10 thru May-11 | Audit period using previous ED tool (6 months)            |  |  |  |
|  | Jun-11 thru Jan-12 | Audit period using modified ED tool (3 months or greater) |  |  |  |

| Example: Analysis in determining 5% increase |                                    |                                    |                                    |                                    |             |
|--|------------------------------------|------------------------------------|------------------------------------|------------------------------------|-------------|
| ED Levels                                    | Claims billed<br>December thru May | % of each level to<br>total billed | Claims billed<br>June thru January | % of each level<br>to total billed | % Shift +/- |
| L1   | 200                                | 20%                                | 100                                | 10%                                | -10%        |
| L2   | 200                                | 20%                                | 100                                | 10%                                | -10%        |
| L3   | 300                                | 30%                                | 200                                | 20%                                | -10%        |
| L4   | 200                                | 20%                                | 300                                | 30%                                | 10%         |
| L5   | 100                                | 10%                                | 300                                | 30%                                | 20%         |
| Total  | 1000                               | 100%                               | 1000                               | 100%                               |             |

Results indicate >5% increase in levels 4 and/or 5.  
Outcome: BCBS of TN would audit using previous tool

**Step 5:** BlueCross will notify the facility of the observed shift increase of five (5) percent or more of ED levels 4 and/or 5 and the intent to audit with previous classification tool for all ED claims in the audit **OR** the intent to audit using two (2) tools as indicated by the effective dates of the tool(s).

**Step 6:** BlueCross will perform the audit and communicate findings as usual. Any facility that outsources ED coding to a 3rd party vendor is still obligated to provide an electronic or hardcopy version of their facility's current ED classification tool(s), the effective dates of the tool(s), guidelines/instructions for appropriate use, and a contact for questions and answers regarding the tool(s). In the event the facility or 3rd party vendor does not provide the above-referenced information with the timeframe established by Step 2.

BlueCross reserves the right to conduct ED audits utilizing the following Emergency Room Level Determination audit tool:

## Emergency Room Level Determination

Level: \_\_\_\_\_

**Instructions:** Circle the documented interventions in each level.  
Assign the highest level that meets the criteria listed

**Diagnosis:**

| <b>Level/CPT®</b>   | <b>Possible Interventions</b>   |
|---|---|
| <u>99281</u><br><br>1 Intervention Present                    | <ul style="list-style-type: none"> <li>• VS x 1 – (PR and BP) A completed clinical assessment form</li> <li>• Instructions for specimen collection</li> <li>• OTC meds administered</li> <li>• Uncomplicated suture removal</li> <li>• Simple dressing change</li> <li>• Immunization</li> </ul>  |
| <u>99282</u><br><br>Requires 2 or more of these Interventions | <ul style="list-style-type: none"> <li>• VS x 1 – (PR and BP)</li> <li>• O2 Sat x 1</li> <li>• Neuro Check x 1</li> <li>• Administer prescription drug, PO, topical</li> <li>• Assessment fetal heart tones</li> <li>• Assisting MD with any exam</li> <li>• Basic specimen testing: Accucheck, dipstick, UA clean catch</li> <li>• Complicated or infected suture removal</li> <li>• Enema or disimpaction</li> <li>• Simple cultures (throat, skin, urine, wound)</li> <li>• Simple laceration/abrasion repair (w/Dermabond, w/o sutures)</li> <li>• Simple removal of FB without incision or anesthetic</li> <li>• Venipuncture for lab</li> <li>• Visual acuity exam</li> </ul>   |
| <u>99283</u><br><br>Requires 3 or more of these Interventions | <ul style="list-style-type: none"> <li>• VS x 2 – (PR and BP)</li> <li>• O2 Sat x 2</li> <li>• Neuro checks x 2</li> <li>• Accucheck x 2</li> <li>• Perform or assist w/ minor procedures: suturing, packing, I&amp;D, casting, pelvic procedures beyond routine exam, Foley cath or irrg</li> <li>• Control of nasal hemorrhage</li> <li>• Doppler assessment</li> <li>• Ear or Eye irrigation</li> <li>• EKG x 1</li> <li>• IM/SQ med administered x 1</li> <li>• INT insertion</li> <li>• IV fluids w/o meds</li> <li>• IV push 1- 2</li> <li>• Nasopharyngeal suctioning</li> <li>• Nebulizer treatment x 1</li> <li>• Oxygen therapy</li> <li>• Routine trach care (clean, change dressing, suction)</li> <li>• Telemetry</li> <li>• X-Ray x 1</li> <li>• Access Port</li> </ul> |

### Emergency Room Level Determination (cont'd)

|   |   |
|---|---|
| <p><u>99284</u></p> <p>Requires 3 or more of these Interventions.</p> | <ul style="list-style-type: none"> <li>• VS x 3 – (PR and BP)</li> <li>• O2 Sat x 3</li> <li>• Neuro checks x 3</li> <li>• Accucheck x 3</li> <li>• Blood or blood products administered x 1 unit</li> <li>• Change trach tube</li> <li>• Coordination for admission or observation to any facility</li> <li>• EKG – 2 or more</li> <li>• IM/SQ med administered x 2</li> <li>• IV med drip</li> <li>• IV push x 3 – 4</li> <li>• Insertion nasal/oral airway</li> <li>• Insertion PEG or NG tube</li> <li>• Care of confused, combative pt or change in mental status</li> <li>• Nebulizer treatment x 2</li> <li>• Nonconfirmed overdose</li> <li>• PICC insertion</li> <li>• Use of specialized resources – SS, hearing, visual impairment, police, crisis management.</li> <li>• Radiological testing of 2 – 3 areas</li> </ul> |
| <p><u>99285</u></p> <p>Requires 3 or more of these Interventions.</p> | <ul style="list-style-type: none"> <li>• VS x 4 or more – (PR and BP)</li> <li>• O2 Sat x 4</li> <li>• Neuro cks x 4</li> <li>• Accuchecks x 4</li> <li>• Assisting w/ major procedure: FX reduction/ relocation, endotracheal/ trach tube insertion, endoscopy, thoracentesis, paracentesis, LP, conscious sedation</li> <li>• Decontamination for isolation, hazardous material</li> <li>• IV med administered requiring intensive monitoring</li> <li>• IV push x 5 or more</li> <li>• Multiple (2 or more) IV lines infusing</li> <li>• Nebulizer treatment x 3</li> <li>• Precipitous delivery in ER</li> <li>• Use of chemical or physical restraints</li> <li>• Radiological testing of 4 or more areas</li> </ul>   |
| <p><u>99291</u></p> <p>Critical Care – Requires both criteria</p>     | <ul style="list-style-type: none"> <li>• Time 30 – 74 minutes</li> <li>• Critical Condition</li> <li>• Additional Notes</li> </ul>  |
| <p><u>99292</u></p> <p>Critical Care – Requires both criteria</p>     | <ul style="list-style-type: none"> <li>• Time 75 – 104 minutes</li> <li>• Critical Condition</li> <li>• Additional Notes</li> </ul>   |

Revision: 11/10/2006

#### **NOTES:**

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## **D. Data Mining and Claims Auditing**

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Claims Data Analysis is performed using algorithms that analyze claims data prospectively and retrospectively. Claims are evaluated, both individually and against other claims utilizing edits developed from recognized standards of coding, billing and reimbursement. Claims will be adjusted according to the results of the application of these principles. BlueCross and any of their affiliates and/or subsidiaries reserve the right to periodically evaluate and modify these edits.

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## **E. Reconsideration Process**

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In the event you wish to dispute Provider Audit findings, you may submit a written request for reconsideration and state why you disagree. Additional supporting documentation and medical records applicable to your dispute should be included. Claims audited are subject to the Provider Dispute Resolution Process. See Section XII. Provider Dispute Resolution Procedure in this Manual for detailed information.

## **XXIV. MEDICARE ADVANTAGE**

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- I. Valuable Health Tools for your BlueAdvantage Patients**

- J. Pharmacy**
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## XXIV. MEDICARE ADVANTAGE

### A. Introduction

#### PPO

BlueCross BlueShield of Tennessee offers five Medicare Advantage Preferred Provider Organization (PPO) products: BlueAdvantage Ruby, BlueAdvantage Diamond, BlueAdvantage Sapphire, BlueAdvantage Garnet, and BlueAdvantage Plus (Group). A PPO plan is a plan having a network of contracted Providers who have agreed to treat plan Members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or non-network Providers. Member cost-sharing may be higher when plan benefits are received from non-network Providers.

BlueAdvantage Ruby, BlueAdvantage Diamond, BlueAdvantage Sapphire, BlueAdvantage Garnet, and BlueAdvantage Plus (Group) PPO products and benefits are defined in subsection B.

For Covered Services, contracted Providers may collect no more from the BlueAdvantage Member at the time of service than the applicable cost-sharing amount and, if the Provider does not accept Medicare assignment, the Medicare limiting charge. Members may get Covered Services from out-of-network Providers as long as they participate in Medicare. If a Provider mistakenly collects more from the Member than the designated cost-sharing amount, the Provider must refund the difference to the Member.

#### HMO

Effective January 1, 2018, BlueCross BlueShield of Tennessee no longer offers its BlueChoice or BlueChoice Plus Health Maintenance (HMO) plans.

Reimbursement methodology is defined in subsection C.

### B. Medicare Advantage Products

#### 1. Product Descriptions

- **BlueAdvantage Ruby**

BlueAdvantage Ruby combines the benefits of Medicare Part A and B and includes additional services not covered by Original Medicare, such as a yearly routine physical, routine vision care, an eyewear allowance, preventive dental benefits, and a hearing aid benefit provided through TruHearing. Plus it offers Medicare Part D prescription drug coverage.

- **BlueAdvantage Diamond**

BlueAdvantage Diamond combines the benefits of Medicare Part A and B and includes additional services not covered by Original Medicare, such as a yearly routine physical, routine vision care, an eyewear allowance, preventive dental benefits, and a hearing aid benefit provided through TruHearing. Plus it offers Medicare Part D prescription drug coverage.

- **BlueAdvantage Sapphire**

BlueAdvantage Sapphire combines the benefits of Medicare Part A and B and includes additional services not covered by Original Medicare, such as a yearly routine physical, routine vision care, an eyewear allowance, preventive dental benefits, and a hearing aid benefit provided through TruHearing. Plus it offers Medicare Part D prescription drug coverage.



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- **BlueAdvantage Garnet**

BlueAdvantage Garnet combines the benefits of Medicare Part A and B and includes additional services not covered by Original Medicare, such as a yearly routine physical, routine vision care, an eyewear allowance, preventive dental benefits, and a hearing aid benefit provided through TruHearing. Plus it offers Medicare Part D prescription drug coverage.

- **BlueAdvantage Plus (Group PPO plan)**

BlueAdvantage Plus is a group PPO plan that combines the benefits of Medicare Part A and B and includes additional services not covered by Original Medicare, such as a yearly routine physical. Plus it offers Medicare Part D prescription drug coverage.

**Note:** Effective 1/1/2016, all routine vision care is administered by EyeMed.

Effective 1/1/2017, a hearing aid benefit administered by TruHearing is available to all Members of BlueAdvantage (PPO) Plans (non-group).

## 2. Benefit Highlights

The following grids contain highlights only for services received in network for BlueAdvantage plans effective 1/1/2018.

For a complete outline of Member benefits and cost-sharing amounts, see the BlueAdvantage Summary of Benefits on our company website, <http://www.bcbst.com/providers/medicare-advantage/>.

The following grid highlights 2018 BlueAdvantage (PPO) benefits:

# BlueCross BlueShield of Tennessee Provider Administration Manual

## BlueAdvantage (PPO)

Effective January 1, 2018 through December 31, 2018

| Plan  |                            | Sapphire  |          | Garnet  |          | Ruby  |          | Diamond                                     |          |
|---|----------------------------|---|----------|---|----------|---|----------|---|----------|
|   |                            | IN  | OON      | IN  | OON      | IN  | OON      | IN  | OON      |
| 1. Premium  |                            | 030 SE \$0  |          | 032 M \$0   |          | 012 W \$92  |          | 008 W \$188                                 |          |
|   |                            | 031 NE \$0  |          | 033 W \$0   |          | 013 M \$102                                       |          | 009 M \$217                                 |          |
|   |                            |   |          |   |          | 015 NE \$72                                       |          | 011 NE \$111                                |          |
|   |                            |   |          |   |          | 014 SE \$87                                       |          | 010 SE \$213                                |          |
| 2. OOP Maximum  |                            | \$6,700   | \$10,000 | \$6,700   | \$10,000 | \$4,800   | \$10,000 | \$3,700                                     | \$10,000 |
| 3. Inpatient Hospital Care  |                            | \$300<br>days 1 to 5                              | 50%      | \$300<br>days 1 to 5                              | 50%      | \$260<br>days 1 to 4                              | 50%      | \$175<br>days 1 to 4                        | 50%      |
|   |                            | Unlimited Days                                    |          | Unlimited Days                                    |          | Unlimited Days                                    |          | Unlimited Days                              |          |
| 4. Inpatient Mental Health Care   |                            | \$300<br>days 1 to 5                              | 50%      | \$300<br>days 1 to 5                              | 50%      | \$260<br>days 1 to 4                              | 50%      | \$175<br>days 1 to 4                        | 50%      |
|   |                            | 190 day lifetime max                              |          | 190 day lifetime max                              |          | 190 day lifetime max                              |          | 190 day lifetime max                        |          |
| 5. Skilled Nursing Facility   |                            | \$0 days<br>1 to 20<br>\$167.50 days<br>21 to 100 | 50%      | \$0 days<br>1 to 20<br>\$167.50 days<br>21 to 100 | 50%      | \$0 days<br>1 to 20<br>\$167.50 days<br>21 to 100 | 50%      | \$0 days<br>1 to 20<br>\$135 days 21 to 100 | 50%      |
| 6. Home Health Care   |                            | \$0   | 50%      | \$0   | 50%      | \$0   | 50%      | \$0   | 50%      |
| 7. Hospice  |                            | n/a   |          | n/a   |          | n/a   |          | n/a   |          |
| 8. Doctor Office Visits   |                            |   |          |   |          |   |          |   |          |
|   | primary care               | \$10  | 50%      | \$10  | 50%      | \$15  | 50%      | \$15  | 50%      |
|   | specialist                 | \$35  | 50%      | \$35  | 50%      | \$35  | 50%      | \$30  | 50%      |
| 9. Telemedicine   |                            | \$10  | N/A      | \$10  | N/A      | \$15  | N/A      | \$15  | N/A      |
| 10. Chiropractic Services   |                            | \$20  | 50%      | \$20  | 50%      | \$20  | 50%      | \$20  | 50%      |
| 11. Podiatry Services   |                            | \$25  | 50%      | \$25  | 50%      | \$25  | 50%      | \$20  | 50%      |
| 12. Outpatient Mental Health Care   |                            | \$30  | 50%      | \$30  | 50%      | \$30  | 50%      | \$20  | 50%      |
| partial hospitalization   |                            | \$45  | 50%      | \$45  | 50%      | \$40  | 50%      | \$35  | 50%      |
| 13. Outpatient Substance Abuse  |                            | \$25  | 50%      | \$25  | 50%      | \$25  | 50%      | \$20  | 50%      |
| 14. Outpatient Surgery  |                            |   |          |   |          |   |          |   |          |
|   | Ambulatory Surgical Center | \$275   | 50%      | \$275   | 50%      | \$210   | 50%      | \$125                                       | 50%      |
|   | Outpatient Hospital        | \$325   | 50%      | \$325   | 50%      | \$260   | 50%      | \$175                                       | 50%      |
| 16. Ambulance Services  |                            | \$250   | \$250    | \$250   | \$250    | \$150   | \$150    | \$150                                       | \$150    |
|   | Air                        | 20%   | 20%      | 20%   | 20%      | 20%   | 20%      | 20%   | 20%      |
| 17. Emergency Care / 23 hr observation  |                            | \$80  | \$80     | \$80  | \$80     | \$75  | \$75     | \$50  | \$50     |
|   |                            | WW - \$80 copay                                   |          | WW - \$80 copay                                   |          | WW - \$75 copay                                   |          | WW - \$50 copay                             |          |
| 18. Urgently Needed Care  |                            | \$45  | \$45     | \$45  | \$45     | \$35  | \$35     | \$35  | \$35     |
|   |                            | WW - \$80 copay                                   |          | WW - \$80 copay                                   |          | WW - \$75 copay                                   |          | WW - \$50 copay                             |          |
| 19. Outpatient Rehabilitation Svcs  |                            | \$40  | 50%      | \$40  | 50%      | \$40  | 50%      | \$35  | 50%      |
| 20. DME   |                            | 20%   | 50%      | 20%   | 50%      | 20%   | 50%      | 15%   | 50%      |
| 21. Prosthetics   |                            | 20%   | 50%      | 20%   | 50%      | 20%   | 50%      | 15%   | 50%      |
| 22. Diabetes Self-Monitoring, Training, Nutrition Therapy and Diabetic Supplies/Inserts |                            | \$0   | 20%      | \$0   | 20%      | \$0   | 20%      | \$0   | 20%      |
| 23. Diagnostic Tests, X-Rays, Lab, and Therapeutic Radiology                            |                            |   |          |   |          |   |          |   |          |
|   | Lab                        |   |          |   |          |   |          |   |          |
|   | Free Standing Lab          | \$0   | 50%      | \$0   | 50%      | \$0   | 50%      | \$0   | 50%      |
|   | PCP                        | \$10  | 50%      | \$10  | 50%      | \$15  | 50%      | \$15  | 50%      |
|   | Specialist                 | \$35  | 50%      | \$35  | 50%      | \$35  | 50%      | \$30  | 50%      |
|   | Outpatient                 | \$40  | 50%      | \$40  | 50%      | \$40  | 50%      | \$30  | 50%      |
|   | Coumadin Clinic            |   |          |   |          |   |          |   |          |
|   | PCP/Specialist             | \$0   | 50%      | \$0   | 50%      | \$0   | 50%      | \$0   | 50%      |
|   | Outpatient                 | \$10  | 50%      | \$10  | 50%      | \$10  | 50%      | \$10  | 50%      |
|   | Diagnostic Tests           |   |          |   |          |   |          |   |          |
|   | PCP                        | \$10  | 50%      | \$10  | 50%      | \$15  | 50%      | \$15  | 50%      |
|   | Specialist                 | \$35  | 50%      | \$35  | 50%      | \$35  | 50%      | \$30  | 50%      |
|   | Free Standing Facility     | \$40  | 50%      | \$40  | 50%      | \$40  | 50%      | \$30  | 50%      |
|   | Outpatient                 | \$100   | 50%      | \$100   | 50%      | \$100   | 50%      | \$100                                       | 50%      |
|   | Sleep Studies              |   |          |   |          |   |          |   |          |
|   | Home                       | \$10  | 50%      | \$10  | 50%      | \$15  | 50%      | \$15  | 50%      |
|   | Outpatient                 | \$40  | 50%      | \$40  | 50%      | \$40  | 50%      | \$40  | 50%      |
|   | X-Rays                     |   |          |   |          |   |          |   |          |
|   | PCP                        | \$10  | 50%      | \$10  | 50%      | \$15  | 50%      | \$15  | 50%      |
|   | Specialist                 | \$35  | 50%      | \$35  | 50%      | \$35  | 50%      | \$30  | 50%      |

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| Plan  |  | Sapphire  |     | Garnet  |     | Ruby   |     | Diamond  |     |
|---|--|---|-----|---|-----|--|-----|--|-----|
|   |  | IN  | OON | IN  | OON | IN   | OON | IN   | OON |
|   | Free Standing Radiology Facility                   | \$40  | 50% | \$40  | 50% | \$40   | 50% | \$30   | 50% |
|   | Outpatient   | \$50  | 50% | \$50  | 50% | \$50   | 50% | \$40   | 50% |
|   | Advanced Imaging                                   | \$200   | 50% | \$200   | 50% | \$175  | 50% | \$150  | 50% |
|   | Therapeutic Radiology                              | \$60  | 50% | \$60  | 50% | \$40   | 50% | \$30   | 50% |
| 24. Cardiac/Pulmonary Rehab                             |  | \$30  | 50% | \$30  | 50% | \$30   | 50% | \$30   | 50% |
| 25. Preventive Services and Wellness/Education Programs |  |   |     |   |     |  |     |  |     |
|   | abdominal aortic aneurysm screening                | \$0   | 50% | \$0   | 50% | \$0  | 50% | \$0  | 50% |
|   | bone mass measurement                              | \$0   | 50% | \$0   | 50% | \$0  | 50% | \$0  | 50% |
|   | colorectal screening exams                         | \$0   | 50% | \$0   | 50% | \$0  | 50% | \$0  | 50% |
|   | immunizations/ vaccines                            | \$0   | 50% | \$0   | 50% | \$0  | 50% | \$0  | 50% |
|   | mammograms (annual)                                | \$0   | 50% | \$0   | 50% | \$0  | 50% | \$0  | 50% |
|   | pap smears and pelvic exams                        | \$0   | 50% | \$0   | 50% | \$0  | 50% | \$0  | 50% |
|   | prostate cancer screening exams                    | \$0   | 50% | \$0   | 50% | \$0  | 50% | \$0  | 50% |
|   | wellness exams                                     | \$0   | 50% | \$0   | 50% | \$0  | 50% | \$0  | 50% |
| 26. ESRD/Dialysis                                       |  | 20%   | 20% | 20%   | 20% | 20%  | 20% | 20%  | 20% |
| 27. Prescription Drugs                                  |  | Preferred/Non Preferred Pharmacy Copay \$1/\$6, \$10/\$15, \$42/\$47, \$90/\$95, 33% 2.5x copay 90 day supply retail pharmacy & mail order (preferred pharmacy copay applies to mail order) |     | Preferred/Non Preferred Pharmacy Copay \$1/\$6, \$10/\$15, \$42/\$47, \$90/\$95, 33% 2.5x copay 90 day supply retail pharmacy & mail order (preferred pharmacy copay applies to mail order) |     | Preferred/Non Preferred Pharmacy Copay \$1/\$6, \$5/\$10, \$28/\$33, \$65/\$70, 33% 2.5x copay 90 day supply retail pharmacy & mail order (preferred pharmacy copay applies to mail order) |     | \$Preferred/Non Preferred Pharmacy Copay \$1/\$6, \$5/\$10, \$28/\$33, \$50/\$55, 33% 2.5x copay 90 day supply retail pharmacy & mail order (preferred pharmacy copay applies to mail order) |     |
|   | gap coverage                                       | Tier 1: \$1/ \$6 Preferred Generics Tier 3: \$42/\$47 Diabetic Drugs Only   |     | Tier 1: \$1/ \$6 Preferred Generics Tier 3: \$42/\$47 Diabetic Drugs Only   |     | Tier 1: \$1/ \$6 Preferred Generics Tier 3: \$28/\$33 Diabetic Drugs Only  |     | Tier 1: \$1/ \$6 Preferred Generics Tier 3: \$28/\$33 Diabetic Drugs Only  |     |
|   | formulary  | 5-tier  |     | 5-tier  |     | 5-tier   |     | 5-tier   |     |
|   | B-covered drugs (not including chemotherapy drugs) | 20%   | 50% | 20%   | 50% | 20%  | 50% | 20%  | 50% |
|   | B-covered chemotherapy drugs                       | 20%   | 50% | 20%   | 50% | 20%  | 50% | 20%  | 50% |
| 28. Dental Services Preventive Care                     |  | Preventive \$0 copay for:<br>-up to 2 oral exam(s) every yr<br>-up to 2 cleaning(s) every yr<br>-up to 1 bitewing x-ray every yr<br>\$300 coverage limit every yr                           |     |   |     |  |     |  |     |
|   | comprehensive                                      | not covered   |     | not covered   |     | not covered  |     | not covered  |     |
|   | Medicare covered                                   | \$40  | 50% | \$40  | 50% | \$40   | 50% | \$30   | 50% |
| 30. Hearing Services                                    |  |   |     |   |     |  |     |  |     |
|   | Medicare covered                                   | \$10  |     | \$10  |     | \$10   |     | \$10   |     |
|   | routine  | \$45 (must use TruHearing network provider)   |     | \$45 (must use TruHearing network provider)   |     | \$45 (must use TruHearing network provider)  |     | \$45 (must use TruHearing network provider)  |     |
|   | hearing aids                                       | 2 TruHearing Flyte hearing aids (one per ear per year) - \$599/\$899 copay (must use TruHearing network provider)   |     | 2 TruHearing Flyte hearing aids (one per ear per year) - \$599/\$899 copay (must use TruHearing network provider)   |     | 2 TruHearing Flyte hearing aids (one per ear per year) - \$599/\$899 copay (must use TruHearing network provider)  |     | 2 TruHearing Flyte hearing aids (one per ear per year) - \$599/\$899 copay (must use TruHearing network provider)  |     |
| 31. Vision Services                                     |  |   |     |   |     |  |     |  |     |
|   | Medicare covered exam                              | \$40  |     | \$40  |     | \$40   |     | \$30   |     |
|   | eyewear  | \$75 allowance / every yr   |     | \$75 allowance / every yr   |     | \$175 allowance / every yr   |     | \$175 allowance / every yr   |     |
|   | routine exam                                       | \$40  |     | \$40  |     | \$40   |     | \$30   |     |

## BlueCross BlueShield of Tennessee Provider Administration Manual

### 3. ID Card

Every BlueAdvantage plan Member receives an ID card reflecting the benefit plan and product the Member is enrolled. The ID card provides the following information:

- Member name;
- Member ID number;
- Member copayment amount; and
- Drug coverage indicator

Providers can verify the Member's plan by simply checking his/her Member ID card. When a Member presents to your office, please take a moment to look at the card to help prevent Members from being denied services incorrectly.




Sample copies of the BlueAdvantage ID cards follow:

#### BlueAdvantage PPO

|  |  |  |
|--|--|--|
|             | <b>BlueCross BlueShield of Tennessee</b> | BlueAdvantage<br>XXX   |
| Subscriber Name  |  | Medical/Dental  |
| Subscriber ID<br>ZXDxxxxxxxx   |  | Medicare Contract # H7917xxx   |
| Group No. xxxxxx   |  | Copayments:<br>OV xx<br>SPEC xx<br>ER xx<br>VIS  |
| Issuer 80840<br>RXBIN 610014/RXPCN MEDDPRIME<br>RXGRP BCTMAPD<br>(PCP) Primary Care Provider |  |               |

|  |  |   |
|--|--|---|
|   | <b>BlueCross BlueShield of Tennessee</b><br>An Independent Licensee of the<br>BlueCross BlueShield Association | <b>bcbstmedicare.com</b><br>Member/Provider Service:<br><b>1-800-831-2583</b><br>TTY/TDD Line: <b>711</b> |
| <b>Members:</b> Present this card anytime you receive health care services.<br><b>Providers:</b> Submit claims to your local BlueCross BlueShield Plan not original Medicare. Prior Authorization is required for admissions and other selected medical services. Report all emergency admissions within one working day. Medicare limiting charges apply.         |  |   |
| This card is for identification not for proof of eligibility.  |  |   |
| Submit Claims to: BCBST<br>BlueAdvantage Operations<br>1 Cameron Hill Circle Ste 0002<br>Chattanooga, TN 37402 0002  |  |   |
| Prior Authorization: <b>1-800-924-7141</b><br>Clinical Vendor Prior Authorizations:<br><b>1-888-258-3864</b><br>(Required for: Advanced Radiological Imaging, Musculoskeletal Services and Part B Meds)<br>Pharmacists: <b>1-800-922-1557</b><br>Grid/Grid+ <b>1-800-831-2583</b><br>VisionBlue: EyeMed <b>1-844-261-9034</b><br>TruHearing: <b>1-844-330-8542</b> |  |   |
| CMS-107917<br>400 (04/00)  |  |   |

#### BlueAdvantage Plus (PPO)

|   |  |   |
|---|--|---|
|  | <b>BlueCross BlueShield of Tennessee</b> | BlueAdvantage<br>XXX  |
| Subscriber Name   |  |  |
| Subscriber ID<br>ZXDxxxxxxxx  |  | Medicare Contract # H7917xxx  |
| Group No. xxxxxx  |  | Copayments:<br>OV xx<br>SPEC xx<br>ER xx<br>VIS                                     |
| Issuer 80840<br>RXBIN 610014/RXPCN MEDDPRIME<br>RXGRP BCTMAPD                       |  |  |

|  |  |   |
|--|--|---|
|   | <b>BlueCross BlueShield of Tennessee</b><br>An Independent Licensee of the<br>BlueCross BlueShield Association | <b>bcbstmedicare.com</b><br>Member/Provider Service:<br><b>1-800-818-0962</b><br>TTY/TDD Line: <b>711</b> |
| <b>Members:</b> Present this card anytime you receive health care services.<br><b>Providers:</b> Submit claims to your local BlueCross BlueShield Plan not original Medicare. Prior Authorization is required for admissions and other selected medical services. Report all emergency admissions within one working day. Medicare limiting charges apply. |  |   |
| This card is for identification not for proof of eligibility.  |  |   |
| Submit Claims to: BCBST<br>BlueAdvantage Operations<br>1 Cameron Hill Circle Ste 0002<br>Chattanooga, TN 37402 0002  |  |   |
| Prior Authorization: <b>1-800-924-7141</b><br>Clinical Vendor Prior Authorizations:<br><b>1-888-258-3864</b><br>(Required for: Advanced Radiological Imaging, Musculoskeletal Services and Part B Meds)<br>Pharmacists: <b>1-800-922-1557</b><br>VisionBlue: EyeMed <b>1-844-261-9034</b>  |  |   |
| CMS-107917<br>400 (04/00)  |  |   |

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## C. Reimbursement Methodology

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When billing for services rendered to BlueAdvantage (PPO) Members, Providers should refer to the most current federal, state, or other payer instructions for specific requirements applicable to the CMS-1500 professional and CMS-1450 facility health insurance claim forms. Medical /clinical codes including modifiers should be reported in accordance with the governing coding organization. Please refer to your BlueAdvantage contract for reimbursement specifics.

**Note:** *Unless specified differently in this section, all other commercial billing guidelines apply for BlueAdvantage Members (see Section VI. Billing and Reimbursement, of this Manual).*

### **General Provisions**

Eligible services not priced by the Centers for Medicare & Medicaid Services (CMS) will be based on a reasonable allowable fee as determined by BlueCross BlueShield of Tennessee.

BlueCross reserves the right to request documents submitted to or issued by the Medicare Fiscal Intermediary or Carrier that are necessary to determine the appropriate fee under Medicare-based reimbursement methodology.

Should payments to managed care organizations participating in federal health care programs, such as BlueCross BlueShield of Tennessee or the applicable payor, be adjusted other than through the payment methodology for the applicable federal health care program, BlueCross BlueShield of Tennessee or the applicable payor may implement the same or a similar adjustment to payment rates and/or payments for Covered Services.

Providers have a right to appeal reimbursement under BlueAdvantage. If a Provider has information that Original Medicare would pay more for a service, documentation (e.g. copy of a remittance advice or other official notice of payment for the same service from the Medicare Fiscal Intermediary or Carrier as proof of Medicare payment) may be submitted to BlueCross BlueShield of Tennessee, Attn: BlueAdvantage, 1 Cameron Hill Circle, Ste 0002, Chattanooga, TN 37402-0005 for review, verification, and payment adjustment if appropriate. Please complete and attach a Provider Reconsideration form or Provider Appeal form, whichever is applicable, with your submission. (See subsection K. Provider Appeals Process in this section for submission instructions.)

Details regarding Medicare reimbursement methodologies can be found on the CMS website, [www.cms.gov](http://www.cms.gov). Links to the CMS website for specific Provider types are located in the following grid. In the event CMS changes one or more of the links, refer to CMS website, [www.cms.gov](http://www.cms.gov).

If there is a conflict between the following information and information published by CMS, the information published by CMS will prevail.

## BlueCross BlueShield of Tennessee Provider Administration Manual

| Provider Type  | CMS Link for Detailed Information   |
|--|---|
| Ambulance Services   | <a href="http://www.cms.gov/AmbulanceFeeSchedule/">http://www.cms.gov/AmbulanceFeeSchedule/</a>                                       |
| Ambulatory Surgical Center (ASC)   | <a href="http://www.cms.gov/HospitalOutpatientPPS">http://www.cms.gov/HospitalOutpatientPPS</a>                                       |
| Clinical Laboratory  | <a href="http://www.cms.gov/ClinicalLabFeeSched/">http://www.cms.gov/ClinicalLabFeeSched/</a>   |
| Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) | <a href="http://www.cms.gov/DMEPOSFeeSched/">http://www.cms.gov/DMEPOSFeeSched/</a>   |
| End Stage Renal Disease (ESRD) Center                                    | <a href="http://www.cms.gov/center/esrd.asp">http://www.cms.gov/center/esrd.asp</a>   |
| Federally Qualified Health Centers (FQHC)                                | <a href="http://www.cms.gov/center/fqhc.asp">http://www.cms.gov/center/fqhc.asp</a>   |
| Home Health  | <a href="http://www.cms.gov/HomeHealthPPS/">http://www.cms.gov/HomeHealthPPS/</a>   |
| Hospice  | <a href="http://www.cms.gov/Center/Provider-Type/Hospice-Center.html">http://www.cms.gov/Center/Provider-Type/Hospice-Center.html</a> |
| Acute Inpatient Service  | <a href="http://www.cms.gov/AcuteInpatientPPS/">http://www.cms.gov/AcuteInpatientPPS/</a>   |
| Critical Access Hospitals  | <a href="http://www.cms.gov/center/cah.asp">http://www.cms.gov/center/cah.asp</a>   |
| Hospital - Outpatient Services   | <a href="http://www.cms.gov/HospitalOutpatientPPS/">http://www.cms.gov/HospitalOutpatientPPS/</a>                                     |
| Inpatient Rehabilitation Facility  | <a href="http://www.cms.gov/InpatientRehabFacPPS/">http://www.cms.gov/InpatientRehabFacPPS/</a>                                       |
| Hospitals  | <a href="http://www.cms.gov/center/hospital.asp">http://www.cms.gov/center/hospital.asp</a>   |
| Inpatient Psychiatric Facility (IPF)                                     | <a href="http://www.cms.gov/InpatientPsychFacilPPS/">http://www.cms.gov/InpatientPsychFacilPPS/</a>                                   |

## BlueCross BlueShield of Tennessee Provider Administration Manual

| Provider Type                                 | CMS Link for Detailed Information  |
|---|--|
| Long-Term Care Hospital                       | <a href="http://www.cms.gov/LongTermCareHospitalPPS">http://www.cms.gov/LongTermCareHospitalPPS</a>  |
| Skilled Nursing Facilities                    | <a href="http://www.cms.gov/SNFPSP/">http://www.cms.gov/SNFPSP/</a>  |
| Part B Drugs                                  | <a href="http://www.cms.gov/CompetitiveAcquisforBios/">http://www.cms.gov/CompetitiveAcquisforBios/</a><br><a href="http://www.cms.gov/McrPartBDrugAvgSalesPrice/">http://www.cms.gov/McrPartBDrugAvgSalesPrice/</a> |
| Physicians and Other Healthcare Professionals | <a href="http://www.cms.gov/center/physician.asp">http://www.cms.gov/center/physician.asp</a>  |
| Anesthesia                                    | <a href="http://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html">http://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html</a>  |
| Health Professional Shortage Area (HPSA)      | <a href="http://www.cms.gov/HPSAPSAPhysicianBonuses/">http://www.cms.gov/HPSAPSAPhysicianBonuses/</a>  |
| Rural Health                                  | <a href="http://www.cms.gov/center/rural.asp">http://www.cms.gov/center/rural.asp</a>  |

### **Right of Reimbursement and Recovery (Subrogation)**

The Right of Reimbursement and Recovery (Subrogation) is a provision in the Member's health care benefits plan that permits the Medicare Advantage (MA) plan to conditionally pay the Provider when a third party causes the Member's condition. The MA plan follows Medicare policy where by law, 42 U.S.C. Section 1395y(b)(2) and Section 1862(b)(2)(A)/Section and Section 1862(b)(2)(A)(ii) of the Social Security Act, Medicare may not pay for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance."

Pursuant to 42 U.S.C. Section 1395y(b)(2)(B)(ii)/Section, Section 1862(b)(2)(B)(ii) of the Act and 42 C.F.R. 411.24(e) & (g), CMS may recover from a primary plan or any entity, including a beneficiary, Provider, supplier, Physician, attorney, state agency or private insurer that has received a primary payment. Likewise, the MA plan sponsor may recover in the same manner as CMS.

Similar to Medicare, if responsibility for the medical expenses incurred is in dispute and other insurance will not pay promptly, the Provider may bill the MA plan as the primary payer. If the item or service is reimbursable under MA and Medicare rules, the MA plan may pay conditionally on a case-by-case basis, and will be subject to later recovery if there is a subsequent settlement, judgment, award, or other payment. In situations such as this, the Member may choose to hire an attorney to help them recover damages.



**Specific Provisions**

**1. Radiopharmaceuticals and Contrast Materials**

For Radiopharmaceuticals and Contrast Materials billed on a CMS-1500/ANSI-837P, refer to Section VI. Billing and Reimbursement of this Manual - *Policy for Radiopharmaceuticals and Contrast Materials* for appropriate reimbursement.

**2. Hospital Based Clinic Visits**

Effective for dates of service December 1, 2017, and forward:

- a. When a BlueCross BlueShield of Tennessee (BCBST) Medicare Advantage/Medicare Advantage-Prescription Drug (MA/MA-PD) plan Member receives Evaluation & Management (E&M) professional services with a procedural service or services on the same date of service by the same Provider of care in a provider-based office or clinic setting, whether on-campus or off-campus of the Provider or facility, payment for provider-based clinic professional services includes any technical or facility fees;
- b. The technical or facility fee associated with a provider-based clinic visit using Revenue Code 510 and associated with an office/clinic visit where the MA/MAPD plan Member receives an E&M service or services with a procedural service or services on the same date of service from the same Provider will not be paid and will be identified on Provider remittances/evidence of benefits as Provider responsibility or Provider liability;
- c. Providers and facilities may not bill MA/MAPD Members for the above noted technical or facility fees associated with provider-based clinic visits; and
- d. The 'same provider' means any Physician or other healthcare Practitioner and/or the Provider or facility who owns and/or operates the Provider-based clinic, whether on-campus or off-campus.

**3. Dialysis Clinic Claim Reimbursement for Completed CMS-2728-U03 Form)**

Effective January 1, 2017, initial dialysis clinic claims filed with Type of Bill 072X will require the submission of a completed CMS-2728-U03 form. The online fillable form is located on the CMS website at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms2728.pdf>. Reimbursement will not be considered for dialysis clinic claims if a completed CMS-2728-U03 form is not on file with BlueCross BlueShield of Tennessee. The initial and subsequent claims will be denied requesting that the Provider submit the completed form.

Further information regarding ESRD (End Stage Renal Disease) may be found in subsection D (Risk Adjustment) in this section. Providers may submit the applicable CMS-2728-U03 form by fax to (423) 535-5498, or by mail to BlueCross BlueShield of Tennessee, Attn: BlueAdvantage Revenue Reconciliation, 1 Cameron Hill Cr, Ste 0002, Chattanooga, TN 37402-0002.

**4. Home Health Services**

All Home Health services for BlueAdvantage PPO should be billed on the CMS-1450 claim form using CMS-1450 Type of Bill 032X. When submitting ANSI-837 electronic claims, the Institutional format must be used.

Effective June 1, 2017, HCPCS codes are required for all Medicare Advantage outpatient physical, occupational, and speech therapy services. Skilled nursing, medical social services and home health aide services also require the appropriate HCPCS codes that correspond with the Revenue Code being billed.



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**Note:** These coding changes do not affect current reimbursement.

| Description                                    | Revenue Code | Procedure Code                                     |
|--|--------------|--|
| Home Health Agency Physical Therapy            | 0421         | G0151<br>G0157<br>G0159                            |
| Home Health Occupational Therapy               | 0431         | G0152<br>G0158<br>G0160                            |
| Home Health Speech Therapy                     | 0441         | G0153<br>G0161                                     |
| Home Health Agency Skilled Nursing (RN or LPN) | 0551         | G0493<br>G0494<br>G0495<br>G0496<br>G0299<br>G0300 |
| Home Health Agency Medical Social Services     | 0561         | G0155  |
| Home Health Agency Home Health Aide            | 0571         | G0156  |

Home Health services not billed with the indicated revenue codes and/or procedure codes may be rejected or denied.

To facilitate claims administration, a separate line item must be billed for each date of service and for each service previously indicated. (This includes drug codes for the drugs provided with Home Infusion Therapy (HIT) per diem.)

Supplies on the BlueCross Home Health Agency Non-Routine Supply List should be billed using the indicated revenue codes and HCPCS codes. Units should be billed based on the HCPCS code definition in effect for the date of service. HCPCS code definitions can be found in the Healthcare Common Procedure Coding System (HCPCS) manual.

Supplies not billed with the indicated Revenue Codes and HCPCS codes will be rejected or denied.

Reimbursement for supplies not indicated on the BlueCross Home Health Agency Non-Routine Supply List used in conjunction with the above services are included in the maximum allowable for the Home Health service and will not be reimbursed separately.

Billing of supplies including those provided by third party vendors such as medical supply companies that are used in conjunction with a Home Health visit are the responsibility of the Home Health Agency. Prior authorization will be required for any non-routine supplies used in conjunction with skilled nurse care rendered either in the patient's home or in a facility. Charges for non-routine supplies will not be reimbursed if they are not included and reviewed within the authorization. Supplies not used in conjunction with a Home Health visit are not billable by the Home Health Agency Provider. Charges for routine supplies not billed with associated services may be subject to review prior to claim payment. Third Party reimbursement will only be allowed when there is absence of an associated skilled nursing care within the patient's home or in a skilled nursing facility.

The only supplies that may be billed in addition to the above services are those indicated on the following BlueCross Home Health Agency Non-Routine Supply List and must be authorized with the requested service.

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**The following codes should be used when billing Home Health Agency Non-Routine Supplies with Revenue Code 0270:**

|       |       |       |       |       |       |       |       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|-------|
| A4212 | A4331 | A4357 | A4375 | A4390 | A4407 | A4422 | A4455 | A5056 | A5112 | A7504 | S8185 | T4533 |
| A4248 | A4333 | A4358 | A4376 | A4391 | A4408 | A4423 | A4456 | A5057 | A5113 | A7505 | S8210 | T4534 |
| A4310 | A4334 | A4360 | A4377 | A4392 | A4409 | A4424 | A4459 | A5061 | A5114 | A7506 | T4521 | T4535 |
| A4311 | A4338 | A4361 | A4378 | A4393 | A4410 | A4425 | A4461 | A5062 | A5121 | A7507 | T4522 | T4537 |
| A4312 | A4340 | A4362 | A4379 | A4394 | A4411 | A4426 | A4463 | A5063 | A5122 | A7508 | T4523 | T4540 |
| A4313 | A4344 | A4363 | A4380 | A4395 | A4412 | A4427 | A4481 | A5071 | A5126 | A7509 | T4524 | T4541 |
| A4314 | A4346 | A4364 | A4381 | A4396 | A4413 | A4428 | A4623 | A5072 | A5131 | A7520 | T4525 | T4542 |
| A4315 | A4349 | A4366 | A4382 | A4397 | A4414 | A4429 | A4625 | A5073 | A6413 | A7521 | T4526 | T4543 |
| A4316 | A4351 | A4367 | A4383 | A4398 | A4415 | A4430 | A4626 | A5081 | A6531 | A7522 | T4527 |       |
| A4320 | A4352 | A4368 | A4384 | A4399 | A4416 | A4431 | A5051 | A5082 | A6532 | A7523 | T4528 |       |
| A4321 | A4353 | A4369 | A4385 | A4400 | A4417 | A4432 | A5052 | A5083 | A7047 | A7045 | T4529 |       |
| A4326 | A4354 | A4371 | A4387 | A4404 | A4418 | A4433 | A5053 | A5093 | A7501 | A7524 | T4530 |       |
| A4328 | A4355 | A4372 | A4388 | A4405 | A4419 | A4434 | A5054 | A5102 | A7502 | A7526 | T4531 |       |
| A4330 | A4356 | A4373 | A4389 | A4406 | A4420 | A4435 | A5055 | A5105 | A7503 | A7527 | T4532 |       |

**The following codes should be used when billing Home Health Agency Non-Routine supplies with Revenue Code 0623:**

|       |       |       |       |       |       |       |
|-------|-------|-------|-------|-------|-------|-------|
| A6010 | A6205 | A6221 | A6237 | A6252 | A6407 | A6450 |
| A6011 | A6206 | A6222 | A6238 | A6253 | A6410 | A6451 |
| A6021 | A6207 | A6223 | A6239 | A6254 | A6412 | A6452 |
| A6022 | A6208 | A6224 | A6240 | A6255 | A6413 | A6453 |
| A6023 | A6209 | A6228 | A6241 | A6256 | A6441 | A6454 |
| A6024 | A6210 | A6229 | A6242 | A6258 | A6442 | A6455 |
| A6154 | A6211 | A6230 | A6243 | A6259 | A6443 | A6456 |
| A6196 | A6212 | A6231 | A6244 | A6261 | A6444 | A6457 |
| A6197 | A6213 | A6232 | A6245 | A6262 | A6445 | A6545 |
| A6198 | A6214 | A6233 | A6246 | A6266 | A6446 | A7040 |
| A6199 | A6215 | A6234 | A6247 | A6402 | A6447 | A7041 |
| A6203 | A6219 | A6235 | A6248 | A6403 | A6448 | A7048 |
| A6204 | A6220 | A6236 | A6251 | A6404 | A6449 |       |

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### D. Risk Adjustment

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Risk Adjustment is the process by which the Centers for Medicare & Medicaid Services (CMS) reimburses Medicare Advantage (MA) plans, such as BlueCross BlueShield of Tennessee, for the health status and demographic characteristics of their enrollees. CMS utilizes the Hierarchical Condition Category (HCC) payment model (the ICD Code version required by CMS at the time the service is provided) and encounter data submitted by MA plans to establish risk scores. The primary source of encounter data or ICD codes routinely submitted to CMS is extracted from claims with additional conditions being identified during retrospective chart review and protective health assessments.

CMS looks to Providers to code identified conditions accurately using the ICD coding guidelines with supporting documentation in their medical record.

The Physician's role in risk adjustment includes:

- Accurately reporting the ICD Code version required by CMS at the time the service is provided to the **highest level of specificity** (critical as this determines disease severity).
- Documentation should be complete, clear, concise, consistent and legible.
- Documentation of all conditions treated or monitored at the time of the face-to-face visit in support of the reported diagnoses codes.
- Use of standard abbreviations.
- Medical records should be signed with Physician's credentials present.
- Medical records should identify a treatment plan for conditions present.
- Notifying the Medicare Advantage plan of any erroneous data submitted and following the appropriate procedures to correct erroneous data (see Section VI. Billing and Reimbursement in this Manual for instructions on submitting a Corrected Bill\*).
- Submitting claims data in a timely manner, generally within thirty (30) days of the date of service (or discharge for hospital inpatient admissions).

*\*When a Corrected Bill is filed, BlueCross will recover any payment previously made under the original claim submission from the Provider's remittance advice (a refund request letter will not be sent). Any applicable new payment will be based on the services submitted on the Corrected Bill claim.*

#### **Risk Adjustment Data Validation (RADV) Audits conducted by CMS**

Annually, CMS selects (both random and targeted) Medicare Advantage (MA) Organizations for a data validation audit. CMS utilizes medical records to validate the accuracy of risk adjustment diagnoses submitted by MA organizations. The medical record review process includes confirming that appropriate diagnosis codes and level of specificity were used, verifying the date of service is within the data collection period, and ensuring the Provider's signature and credentials are present. If CMS identifies discrepancies and/or confirms there is not adequate documentation to support a reported diagnosis in the medical record during the data validation process, financial adjustments will be imposed.

#### **Medical Record Documentation Tips for meeting CMS requirements for submission of encounter data and RADV audits:**

##### **Progress Note Requirements:**

- Progress notes must contain patient name and DOS on each page.
- If the progress note is more than one page or two-sided, the pages must be numbered, (i.e., 1 of 2). If pages are not numbered, then the Provider must sign each page of the progress note.
- Progress notes should follow the standard S.O.A.P. format.

##### **Provider Signature Requirements on Progress Note:**

- All progress notes must be signed by the Provider rendering services.
- Provider credentials must either be pre-printed on the progress notes as a stationary or the Provider must sign all progress notes with his/her credentials as part of the signature.
- Dictated notes and consults must be signed by the Provider.
- Provider signature must be legible, i.e., "John Smith Doe, M.D." or "JSD, MD". If a Provider's signature is missing or illegible, an attestation must be completed by the Physician or Physician Extender.

##### **Provider Signature Requirements on Progress Note (cont'd):**

- Stamped signatures are no longer acceptable for Provider documents as of April 28, 2008, as stated by CMS (Medicare Program Integrity Manual, Transmittal 248, Change Request 5971.5550). For risk adjustment purposes (Part C), signature stamps will no longer be acceptable on medical records with dates of service on or after January 1, 2009.
- Electronic Medical Record (EMR) progress notes must have the following wording as part of the signature line: "Electronically signed", "Authenticated by", "Signed by", "Validated by", "Approved by", or "Sealed by". The signed EMR record must be closed to all changes.
- Sign off on medical records should be completed timely.
- Medical records must be signed by a Medical Doctor, (MD), Physicians Assistant (PA), Nurse Practitioner (NP), or Doctor of Osteopathic Medicine (DO).

**Diagnosis Documentation Requirements on Progress Note:**

- Documentation should include evaluation of each diagnosis on the progress note, not just the listing of chronic conditions, i.e., DM w/Neuropathy – meds adjusted, CHF-compensated COPD – test ordered, HTN – uncontrolled, Hyperlipidemia – stable on meds. CMS considers diagnoses listed on the progress note without an evaluation or assessment as a “problem list”, which is not acceptable for risk adjustment submission.
- Use the words “history of” cancer, stroke, etc., to indicate the condition is no longer a current health concern. Avoid using “history of” for conditions the Member still has or for which they are being treated. For example, indicating a history of diabetes is not correct. While the Member has diabetes in his history, it is still a current condition.
- Each progress note must be able to “**stand alone**”. Do not refer to diagnoses from a preceding progress note, problem list, etc.
- Avoid documentation of diagnosis as probable, suspected, questionable, rule out, or working, rather, document or code to the highest degree certainty known for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

**Releasing Medical Records**

BlueCross has the right to request medical records without charge to ensure appropriate coding and/or identify additional diagnosis for risk adjustment data submission to CMS – refer to your Medicare Advantage Provider Agreement (Section C.7) and/or the Model Terms and Conditions of Payment (Section 6). Providers may receive requests from the Risk Adjustment

Department for medical records with specific dates of service for review. Beginning April 2016, BlueCross will use ArroHealth to request and collect medical records. Medical records can be mailed, faxed, e-mailed, or collected on site from the Provider’s office.

Mail to: ArroHealth  
49 Wireless Blvd. Ste 140  
Hauppauge, NY 11788  
Attn: MMR3 Unit - BlueCross BlueShield of Tennessee

Fax to: 1-866-790-4192

e-Mail to: [auditing@arrohealth.com](mailto:auditing@arrohealth.com)

Questions may be addressed to ArroHealth at 1-855-651-1885, or call your BlueCross Provider Relations Consultant (see Section II. BlueCross BlueShield of Tennessee Quick Reference Guide of this Manual for contact phone numbers).

**Confidentiality and General Consent**

Confidentiality of patient information is important to BlueCross. Any information disclosed by you in response to medical record requests for risk adjustment will be treated in accordance with applicable privacy laws. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 C.F.R. § 164.502, you are permitted to disclose the requested data for purpose of treatment, payment and health care operations after you have obtained the “general consent” of the patient. A general consent form should be an integral part of your patient’s medical records file.

A sample copy of the Risk Adjustment Medical Record Request letter follows:



## Request for Medical Records

DATE  
ADDRESSEE  
ADDRESSEE'S TITLE  
COMPANY NAME  
STREET ADDRESS  
CITY, STATE, ZIP

DEAR HEALTH CARE PROVIDER OR OFFICE ADMINISTRATOR:

As a Medicare Advantage (MA) organization, BlueCross BlueShield of Tennessee is required to submit risk adjustment data to the Centers for Medicare & Medicaid Services (CMS). We are beginning our annual Medicare risk adjustment medical records data review to ensure we submit complete risk adjustment data to CMS. We need your help to collect this data. This is a medical record review and not a claims payment audit.

### **ArroHealth (formerly known as MedSave USA) will contact you about data collection**

We are working with ArroHealth on this initiative. In the past, you may have worked with Verisk Health or MedSave USA for data collection. MedSave USA is now ArroHealth. The services performed by Verisk Health transitioned to ArroHealth. BlueCross is a Medicare Advantage organization, so you do not need patient authorization to provide medical records for this review.

We ask you provide a complete copy of the medical records for Medicare Advantage plan patients on the enclosed list for dates of service from Jan. 1, 2015 to present.

You can provide the medical records to ArroHealth by:

- Securely faxing to **1-866-790-4192**
- Calling **1-855-651-1885** to have a scanner technician visit your office
- Securely Emailing to [auditing@arrohealth.com](mailto:auditing@arrohealth.com)
- Mailing the records directly to ArroHealth (please mark the envelope "Confidential"):

ArroHealth  
Attn: MRR3 Unit – BlueCross BlueShield of Tennessee  
49 Wireless Blvd Suite 140  
Hauppauge, NY 11788

ArroHealth is happy to work with your copy partner to acquire medical records. However, your BlueCross provider contract stipulates the release of medical records without charge.

### **Our agreement with ArroHealth complies with HIPAA privacy regulations**

ArroHealth works with us in a role that is defined and covered by the Health Insurance Portability and Accountability Act (HIPAA). As a business associate of BlueCross under HIPAA, ArroHealth is authorized to conduct this review. ArroHealth will maintain the confidentiality of any protected health information (PHI) they receive on our behalf.

### **Please respond within 14 days of receiving this request**

We appreciate your assistance with this data collection. If you have questions, please call ArroHealth at **1-855-651-1885**, Monday through Friday, from 8:30 a.m. to 5:30 p.m. ET. If you still have questions, please contact your BlueCross Provider Relations Consultant.

Sincerely,

J. Todd Ray  
VP & GM Senior Products  
BlueCross BlueShield of Tennessee  
Rev 06/16

## BlueCross BlueShield of Tennessee Provider Administration Manual

For additional information regarding risk adjustment, visit:

- Provider Quick Reference Guide – Risk Adjustment:  
[http://www.bcbst.com/providers/medicare-advantage/quick\\_reference\\_guide.pdf](http://www.bcbst.com/providers/medicare-advantage/quick_reference_guide.pdf)
- Guide to Documentation – Risk Adjustment  
[http://www.bcbst.com/providers/guide\\_to\\_documentation.pdf](http://www.bcbst.com/providers/guide_to_documentation.pdf)

### Provider Assessment Forms

In 2018 Physicians will again be eligible to receive payments for completing and submitting a *Provider Assessment Form (PAF)* for their attributed BlueAdvantage Members. A paper version of this form is available and an electronic one is located in the Quality Care Rewards web tool located on Availity. If you are not registered as an Availity user, go to [www.Availity.com](http://www.Availity.com) and click on “Register” in the upper right corner of the home page, select “Let’s get started” and follow the instructions in the Availity registration wizard.

Effective January 1, 2017, BlueCross will reimburse the service as E/M Code 96160 and the reimbursement will be tiered with the highest earning potential in the first quarter and descending reimbursement in each quarter thereafter. Reimbursement is limited to one PAF per Calendar Year per Member. If multiple Providers bill a PAF for the same Member in a Calendar Year, only the first claim will be considered for payment. Subsequent claim submissions will be disallowed.

The PAF incentive schedule is located on the Financial Summary landing page in the Quality Care Rewards web tool located in Availity and on the Quality Care Rewards website at <http://www.bcbst.com/providers/quality-initiatives/Provider-Assessment-Form-Resources.page>.

To receive reimbursement, you must complete the form in its entirety and submit electronically at [https://www.bcbst.com/ibi\\_apps/bip/portal/Provider%20Quality](https://www.bcbst.com/ibi_apps/bip/portal/Provider%20Quality) or complete the writable pdf found at <http://www.bcbst.com/docs/providers/quality-initiatives/Patient-Assessment-Form.pdf>. It should also be included in your patient’s chart as part of his or her permanent record.

### Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD) Patient Registration Form

In 2016 Physicians have access to a new case management program. This program is designed to identify when Members are in Stage 4 or Stage 5 of CKD.

Early detection of CKD and proper management to prevent or slow the progression of the disease improves the overall health and clinical outcomes of seniors while reducing health care costs. The case management program offers education and support for Members identified with CKD and End Stage Renal Disease (ESRD). It provides Members with tools and support to promote knowledge and self-management of their CKD along with other chronic conditions to resolve barriers to care.

The CMS-2728-U3 form (*End Stage Renal Disease Medical Evidence Report Medicare Entitlement and/or Patient Registration*) can be accessed on the Centers for Medicare & Medicaid website at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms2728.pdf>. Fax a completed copy of the Members’ CMS-2728-U3 form to us at **423-535-5498, Attn: Medicare Advantage Revenue Reconciliation.**

Ensure that you have submitted the CMS-2728-U3 form into the CROWNWeb Data Management system and mail a hard copy of the form to the Social Security Administration.

Forms must be submitted within forty-five (45) days for:

- All patients who initially receive a kidney transplant instead of a course of dialysis
- Patients for whom a regular course of dialysis has been prescribed because they have reached that stage of renal impairment that a kidney transplant or regular course of dialysis is necessary to maintain life.
- Beneficiaries who have already been entitled to ESRD Medicare benefits and those benefits were terminated because their coverage stopped 3 years post-transplant but now are again applying for Medicare ESRD benefits because they returned to dialysis or received another kidney transplant.

- Beneficiaries who stopped dialysis for more than 12 months and have had their Medicare ESRD benefits terminated and now returned to dialysis or received a kidney transplant.
- A patient that has received a transplant or trained for self-care dialysis within the first 3 months of the first date of dialysis and initial form was submitted.

**Please note:** You must complete all the mandatory fields for your form to be considered “Complete.” Failure to do so will result in an “Incomplete” form. If your form is “Incomplete,” we will contact you to gather any missing information.

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## E. Claims Information

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**Effective July 1, 2013, all network providers are required to submit claims electronically rather than by paper format.** Submitting claims electronically will ensure compliance with the terms of the Minimum Practitioner Network Participation Criteria as well as lower costs and streamline adjudication. This effort is consistent with the health care industry's movement toward more standardized and efficient electronic processes.

Key advantages to submitting electronically are:

- Earlier payments;
- More secure submission process
- Reduced administrative costs; and
- Less paper storage.

More information regarding submitting electronic claims can be found on the company website at <http://www.bcbst.com/providers/ebusiness/electronic-claims-electronic-funds-transfer.page>. For assistance with Availity, please contact eBusiness Service at 423-535-5717, Option 2, Monday through Thursday, 8 a.m. to 6 p.m., Friday 9 a.m. to 6 p.m. (ET), or via e-mail at [eBusiness\\_Service@bcbst.com](mailto:eBusiness_Service@bcbst.com).

Tennessee Providers should submit claims on a CMS-1500 or CMS-1450 (UB-04) claim form for all BlueAdvantage Members directly to BlueCross BlueShield of Tennessee, using their National Provider Identifier (NPI) number.

- If a Provider currently submits claims electronically to BlueCross, the Provider may submit BlueAdvantage claims using the same process.
- PPO paper claims may be mailed to:

BlueCross BlueShield of Tennessee  
Attn: BlueAdvantage  
1 Cameron Hill Cr, Ste 0002  
Chattanooga, TN 37402-0002

Providers outside of Tennessee should file claims to their local Blue Plan in their normal manner.

**Note:** *Claims for all BlueAdvantage products should be filed using **the same Centers for Medicare & Medicaid Services (CMS) billing guidelines, forms and codes as Original Medicare.***

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## F. Electronic Funds Transfer (EFT)

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Beginning January 1, 2015, BlueCross began executing the July 2013 electronic claims filing requirement pursuant to the BlueCross BlueShield of Tennessee Minimum Practitioner Network Participation Criteria, which requires all network Providers to enroll in the Electronic Funds Transfer (EFT) process. EFT is a free service that sends payments directly to the Provider's financial institution and increases the speed at which they receive payment.

- Key advantages to receiving payments electronically are:
  - Earlier payments;
  - More secure payment process;
  - Reduced administrative costs; and
  - Less paper storage.

BlueCross accepts electronic funds transfer (EFT) enrollment through CAQH Solutions, who offers a universal enrollment tool for providers that provides a single point of entry for adopting EFT and Electronic Remittance Advice (ERA). The CAQH process facilitates compliance with the 2014 EFT/ERA Administrative Simplification mandate under the Affordable Care Act, eliminates administrative redundancies and creates significant time and cost savings. Enrollment information is available on the CAQH Solutions website at <https://solutions.caqh.org>.

To view/print a copy of your remittance advices, ensure you have access to Availity, BlueCross's secure area on its website, [www.bcbst.com](http://www.bcbst.com). If you are not registered, go to <http://www.Availity.com> and click on "Register" in the upper right corner of the home page, select "Let's get started" and follow the instructions in the Availity registration wizard.

For more information regarding the EFT Program Process, or for assistance with Availity, please call eBusiness Service at 423-535-5717, Option 2, Monday through Thursday, 8 a.m. to 6 p.m., Friday 9 a.m. to 6 p.m. (ET), or e-mail [eBusiness\\_Service@bcbst.com](mailto:eBusiness_Service@bcbst.com).

**EnrollHub™** is the new name for the CAQH EFT and ERA enrollment tool.

**Phone:** 1-844-815-9763 available Monday through Thursday 7 a.m. to 9 p.m. (ET)

Friday 7 a.m. to 7 p.m. (ET)

**e-mail:** [eftenrollhub@caqh.org](mailto:eftenrollhub@caqh.org)

**Website:** [http://www.caqh.org/eft\\_enrollment.php](http://www.caqh.org/eft_enrollment.php)

**CAQH ProView™** is now the provider data collection tool formerly the Universal Provider Datasource®.

**Phone:** 1-844-259-5347 available Monday through Thursday 7 a.m. to 9 p.m. (ET)

Friday 7 a.m. to 7 p.m. (ET)

**e-mail:** [proview@caqh.org](mailto:proview@caqh.org)

**Website:** <https://proview.caqh.org>

**Note:** Vendor and BlueCross shall be bound by the National Automated Clearing House Association rules relating to corporate trade payment entries (the "Rules") in the administration of these ACH Credits.

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## G. CMS Star Ratings

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The Centers for Medicare & Medicaid Services (CMS) uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the health care system. This rating system applies to all Medicare Advantage (MA) lines of business: Preferred Provider Organization (PPO). It also applies to Medicare Advantage plans that cover both health services and prescription drugs (MA-PD).



The program is a key component in financing health care benefits for MA and MA-PD plan enrollees. In addition, the ratings are posted on the CMS consumer website, [www.medicare.gov](http://www.medicare.gov), to give beneficiaries help in choosing among the MA and MA-PD plans offered in their area.

Physicians should understand the metrics included in the CMS rating system as some of them are part of BlueCross BlueShield of Tennessee Physician Quality program, in which you may be eligible to participate. This program is designed to promote improvement in quality and recognize primary care Providers for demonstrating an increase in performance measures over a defined period of time.

### **CMS Goals for the Five-star Rating System**

- Implement provisions of the Affordable Care Act
- Clarify program requirements
- Strengthen beneficiary protections
- Strengthen CMS' ability to distinguish stronger health plans for participation in Medicare Parts C and D and to remove consistently poor performers

### **How Are Star Ratings Derived?**

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

- Staying healthy, screenings, tests and vaccines
- Managing chronic (long-term) conditions
- Member experience with the health plan
- Member complaints, problems getting services and improvement in the health plan's performance
- Health plan customer service

A Medicare drug plan's rating is based on measures in four categories:

- Drug plan customer service
- Member complaints, problems getting services and improvement in the health plan's services
- Member experience with the drug plan
- Patient safety and accuracy of drug pricing

Measures in both groups of these categories are used to rate MA health plans. Annually, CMS sets the thresholds for each measure.

### **Benefits to Providers**

- Improved patient relations
- Improved health plan relations
- Increased awareness of patient safety issues
- Greater focus on preventive medicine and early disease detection
- Strong benefits to support chronic condition management
- Supports value-based contracting efforts

### **Benefits to Members**

- Improved relations with their doctors
- Greater health plan focus on access to care
- Increased levels of customer satisfaction
- Greater focus on preventive services for peace of mind, early detection and health care that matches their individual needs

### **BlueCross BlueShield of Tennessee's Commitment**

BlueCross is strongly committed to providing high-quality Medicare health plans that meet or exceed all CMS quality benchmarks. The structure and operations of the CMS star rating system ensures that funding is used to protect or, in some cases, to increase benefits and to keep member premiums low.

BlueCross encourages Members to become engaged in their preventive and chronic-care management through outreach, screening opportunities, and Member rewards.

### Tips for Providers

- Encourage patients to obtain preventive screenings annually or when recommended by the U.S. Preventive Services Task Force (USPSTF).
- Create office practices to identify and intervene with noncompliant patients at the time of their appointment.
- Submit complete and correct encounters/claims with appropriate codes via our Provider Quality Care Rewards web tool located in Availity.
- Submit clinical data such as lab results to BlueCross.
- Communicate clearly and thoroughly; ask, "Do you have any questions?"
- Understand each measure you impact.
- Incorporate Health Outcomes Survey (HOS) questions into each visit. Find out more about HOS at <http://www.hosonline.org/Content/SurveyInstruments.aspx>.
- Review the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey to identify opportunities for you or your office to have an impact: <http://www.madpcahps.org/en/survey-instruments/>.
- BlueCross will make the data available to you of services each patient has not yet received via the Provider Quality Care Rewards web tool located in Availity. Review this information and the patient's medical record to determine if the services have been completed or scheduled.
- If a service is not completed, flag or contact the Member to schedule the service.
- If a service is completed, submit an electronic attestation via the Provider Quality Care Rewards web tool in BlueAccess; or complete, sign and return the Paper Attestation Form to BlueCross with information and/or any exclusion(s).

### Questions?

#### For Program-Related Support

Contact a member of our Provider Quality Team or your Provider Relations Consultant (see Section II. BlueCross BlueShield of Tennessee Quick Reference Guide in this Manual for appropriate phone numbers).

#### Online Resources

[www.bcbst.com/providers/quality-initiatives.page](http://www.bcbst.com/providers/quality-initiatives.page)

#### For Technical Support with Availity

Contact our eBusiness team at (423) 535-5717, Option 2 or at [ebusiness\\_services@bcbst.com](mailto:ebusiness_services@bcbst.com)

#### Helpful Websites

To learn more about the CMS quality rating measures, visit:

<http://www.cms.gov>

<http://www.hosonline.org>

<http://www.ma-pdpcahps.org/en/survey-instruments/>

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## H. Health Management

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### Population Health

Our Population Health Programs are managed by the Population Health Department, which provides the following services:

- Complex/Catastrophic
- Chronic Care Management
- Transplant Case Management
- Social Work
- Nutritional Management/Dietitian

### **Referrals and Triage**

Population Health utilizes referrals from internal (MR area, SPD medical director, Customer Service, Operations, Appeals and Grievance Department, Clinical Quality, provider representative, Identification and Stratification (IDSTRAT), etc.) and external (Member, Practitioner, home health Provider, etc.) sources. PH referrals may originate from any internal BCBST department, any agency or Practitioner in the provider community, a designated representative for an Account, any Member or member representative. Referrals can be received both internally and externally via fax, telephone or e-mail. Members, family and/or caregivers, Practitioners and Providers are encouraged to initiate referrals for any of the above listed programs. A Population Health team member, such as a registered nurse, dietitian, or social worker will contact the designated person upon receipt of the program referral.

### **Complex/Catastrophic Case Management**

Complex/Catastrophic Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a Member's health needs through communication and available resources to promote quality cost-effective outcomes.

Members with complex health care needs, unstable multi-disease states, and conditions where a longer period of management will be required are managed through Complex Case Management. Complex and catastrophic conditions such as multiple chronic conditions, trauma, End Stage Renal Disease, AIDS, extensive burns, Guillain-Barre' syndrome, severe depression and mood disorders, frequent emergency department utilization, and frequent inpatient admissions are intensively managed by continually assessing, planning, coordinating, implementing and evaluating care. By using this approach, multiple health and psychosocial needs of the Member are met.

The Complex/Catastrophic Case Management team works with the Member, treating Practitioners, family members, and other members of the health care team to coordinate and facilitate an individualized plan of treatment, evaluate the Member's progress and facilitate referrals to a less intensive health management program.

### **Chronic Care Management Programs**

Chronic Care Management is designed to provide education, resources, and support to Members with chronic conditions. Programs available to assist Members' care givers include:

- Chronic Condition Management
- Discharge Care Coordination
- Care Coordination

### **Chronic Condition Management**

The chronic conditions being managed within this program (subject to change based on analysis of "at risk" Members) are:

- Diabetes
- Congestive heart failure
- Coronary artery disease
- Chronic obstructive pulmonary disease
- Chronic kidney disease
- Hypertension
- Depression
- Anxiety

The primary goal of the Chronic Care Management Program is to stabilize the Member's health condition and assist them with tools, education and care necessary for self-management. The program promotes the Member and caregiver's active participation in management of their chronic condition resulting in an increased knowledge of the disease process, prevention and treatment.

Additionally, the Member increases his/her knowledge of healthy lifestyle changes and co-morbid management. The treating Physician's involvement is an integral part of the program and development of an individualized plan of care and desired outcomes. The program supports the Physician by reinforcing education, monitoring and reporting. Providers identifying Members with these diagnoses are requested to contact Population Health for referral into the program

### **Discharge Care Coordination**

The Discharge Care Coordination Program is a post hospital discharge program. Registered nurses call Members dismissed from acute care or post-acute care facilities within 48 -72 hours after discharge.

Members are called to verify:

- Understanding of discharge instructions
- Appointments have been made with the Member's Physician for post discharge follow-up
- Transportation is available in order to get to the appointment.
- Post discharge medications have been obtained and the Member understands their prescriptions; what the medication is for, and whether or not to continue previous prescribed medications
- Understanding of dietary instructions and needs
- Available food on hand in order to meet dietary needs
- Caregiver availability
- Safety concerns or needs

If needed, an additional call will be made within one week to help ensure all needs are met.

### **Care Coordination**

Care Coordination services involve the full spectrum of care coordination. Care Coordination is intended to stabilize Members' health condition/disease, promote self-management by providing tools and education to allow them to make informed decisions about their health care, encourage and provide tools for active participation in managing their condition(s), and assist with arranging for care in the most appropriate setting and care that is necessary for self-management. Providers are encouraged to make referrals to the program.

The Care Coordination team helps to identify the Member's needs, assist them to find solutions to those needs, and to reduce barriers to health care. Care Coordination interventions can improve quality of life, make effective use of available health care and community-based resources, and improve health outcomes.

### **Transplant Case Management**

Transplant Management focuses on the entire spectrum of transplant care. The coordination of transplant-related care is managed from the time the Member is identified as a possible transplant candidate and can continue up to twelve (12) months post-transplant based on the Member's status. Transplants must be performed in a Medicare approved facility. Attention is given to assisting and educating the Members about acquisition and use of needed drugs prescribed by their Physician, with special emphasis on the Part B benefit for anti-rejection drugs.

It is critically important, to both the Practitioner and Member, that Population Health be contacted as soon as the provider identifies the Member may need an evaluation for a transplant.

### **Social Worker**

The Social Worker Case Manager assists Members and or caregivers with financial and community resources available to assist with health care needs collaborating with other health care disciplines to improve health outcomes and Member experience.

### **Nutritional Management/Dietitian**

Nutritional counseling is a critical part of case management activities. The Registered Dietitian Case Manager will educate Members about diet, nutrition and the relationship between eating habits and preventing/managing chronic conditions. Nutritional assessments, care plans, and diet education will be provided for Members and or caregivers to evaluate nutritional needs and address any barriers to meeting those needs.

### **Contact/Referrals to Above Population Health Program Information**

Practitioners/Providers are encouraged to initiate referrals for any of the population health programs available for BlueAdvantage Members.

Phone: 1-800-611-3489  
Fax: 1-800-727-0841

### **Referral requests should include the following information:**

- Requesting Provider's name and telephone number;
- Contact person and telephone number (if different from Requesting Provider);
- Member name;
- Member ID number and telephone number;
- Diagnosis and current clinical information;
- Current treatment setting (e.g., hospital, home health, rehabilitation, etc.);
- Reason for referral; and
- Level of urgency.

A Case Manager will contact the requesting Provider upon receipt of the program referral.

## **1. Care Management**

BlueAdvantage Health Management programs adhere to CMS' Medicare Advantage rules and regulations promulgated in 42 CFR § 422 and CMS' *Internet Only Medicare Managed Care Manual*. CMS' requirements for Medicare Advantage vary from the requirements for Original Medicare. Chapter 13 of the *Medicare Managed Care Manual* is a significant resource utilized to implement our Care Management programs.

Care management includes services that require prior authorization, notification, advance determinations and retrospective review that may be requested by a Member, Practitioner or Provider. CMS' Medicare Advantage reconsideration process is available in cases of dissatisfaction with the review decision. Provider reimbursement appeals are handled through the CMS mandated Provider Payment Dispute Process. Additional Provider appeals are handled through the BlueCross Provider Dispute Resolution Procedure. (Refer to Section XIII. in this Manual for these processes).

These utilization management strategies are additional effective mechanisms for identifying Members who may benefit from Health Management programs outlined above.

### **Criteria Hierarchy**

Medical Necessity is described in CMS' hierarchy for determining Medical Necessity prospectively or retrospectively. Medical Necessity reviews are performed without regard to age, gender, creed, religion or race/nationality.

### ***The hierarchy of decision – the service must:***

- be a covered benefit in the Member's EOC;
- be a benefit that is not otherwise excluded; and
- be appropriate and Medically Necessary.

### ***The hierarchy of references includes:***

- The law (Title 18 of the SSA);

***The hierarchy of references includes (cont'd):***

- The Regulations (Title 42 Code of Federal Regulations (CFR) parts 422 and 476);
- National Coverage Determinations (Pub 100-03 of the Internet Only <http://www.cms.gov/mcd/search.asp>;
- MA Benefit Policy Manual (IOM 100-02);
- Local Coverage Determinations <http://www.cms.gov/mcd/search.asp>;
- Coverage guidelines in Interpretive Manuals (Internet Only Manual (IOM), sub manuals Pub 100-04 Claims Processing, Pub 100-08 Program Integrity Manual, Pub 100-10 QIO manual, Pub 100-16 Medicare Managed Care Manual; and
- Durable Medical Equipment Medicare Administrative Contractor (DMEMAC) (<https://www.cms.gov/medicare-coverage-database/indexes/contacts-durable-medical-equipment-medicare-administrative-contractor-index.aspx?bc=AgAAAAAAAAAAAA%3d%3d&>)
- Program Safeguard Contractor (PSC) local coverage determinations;
- MCG criteria;
- BlueCross Utilization Guidelines ([http://www.bcbst.com/providers/UM\\_Guidelines/](http://www.bcbst.com/providers/UM_Guidelines/))
- U.S.F.D.A Approved Indications for Medications;
- Supplemental Benefits and Limitations as outlined in the Member's Evidence of Coverage;
- BlueCross Medical Policy; and
- Other major payer policy and peer reviewed literature.

**a. Advance Determination**

A Member or Provider has the opportunity to seek a determination of coverage before receiving or providing services by requesting an Advance Determination. Providers can obtain an Advance Determination for select services from BlueCross for BlueAdvantage Members. Advance Determinations are performed to render coverage, Medical Necessity and Appropriateness determinations before services are rendered rather than during claims processing. However, claims submitted for services that were not reviewed prospectively will be reviewed retrospectively for Medical Appropriateness to determine coverage and reimbursement. Providers can obtain an Advance Determination by phone, fax, or online (see "Contact Information" at end of this section).

A reference number is issued when care and treatment are determined to be Medically Necessary and Medically Appropriate. Advance Determinations are also made available to Members when the service does not require a prior authorization.

**b. Prior Authorization**

Prior authorization is **required** before services are provided to BlueAdvantage PPO Members.

Prior authorization for coverage and Medical Necessity is required for:

- All acute care facility, skilled nursing facility (including non-routine supplies), rehabilitation, and long-term acute care
- Behavioral health facility inpatient stays, partial hospitalization, psychiatric residential, electroconvulsive treatment, and transcranial magnetic stimulation
- Certain Part B Pharmacy Medications
- Chiropractic manipulation
- Durable Medical Equipment for purchase greater than \$500
- Oxygen equipment
- All Durable Medical Equipment Rentals
- Orthotics and prosthetics greater than \$200
- Speech therapy, occupational therapy and physical therapy (after the initial evaluation)
- Home Health Service to include all therapies, nursing visits (including non-routine supplies), and psychiatric visits (**Note:** authorization is **not** required for routine supplies, or social worker visits.)
- Advanced Imaging and some cardiac diagnostic services

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An authorization number is issued when care and treatment are determined to be Medically Necessary and Medically Appropriate. A case reference number is issued regardless of the decision (either approved or denied) and Providers will be notified via letter of the determination.

### **High Tech Imaging Authorization Vendor**

BlueCross' Medicare Advantage and BlueCare Plus HMO DSNP products use NIA-Magellan for high-tech imaging and some cardiac diagnostics authorizations.

Authorization requests can be initiated by phone at 1-888-258-3864 or online through Availity. NIA Magellan does not accept authorization requests via fax.

Access BlueCross' secure portal, Availity, on its website, [www.bcbst.com](http://www.bcbst.com) and click on "Submission" link next to the section for MedAdvantage or BlueCare Plus (DSNP). (Note: Clicking on the BCBST Hi-Tech Imaging Program link or the Submission link next to the section for Commercial and BlueCare will direct you to the eviCore website. eviCore high-tech imaging is utilized for BlueCross Commercial or BlueCare lines of business.)

In addition to Medicare Medical Policies for some services, Providers can review NIA medical criteria through their website, <http://www.niahealthcare.com/our-difference/clinical-expertise/clinical-guidelines.aspx>.

### **c. Peer-to-Peer and Re-Evaluation Processes**

In accordance with guidance from the Centers for Medicare & Medicaid Services (CMS) the following Peer-to-Peer and Appeal processes are applicable for our Medicare Advantage products.

- When there is insufficient clinical documentation to support an organizational determination, clinical information is requested a minimum of three (3) times using at least two (2) different notification methods and if insufficient clinical documentation exists, an intent to deny fax will follow. The Plan Medical Director may make an additional outreach directly to the requesting Physician to perform a peer-to-peer. If we still do not receive the needed clinical information within one (1) business day, we will issue the adverse determination for insufficient clinical documentation. There are no additional peer-to-peer options for the requesting Physician. Documents submitted after the organizational determination will be treated as a Member appeal (reconsideration) according to CMS regulations.
- Concurrent Inpatient Review – An adverse determination for inpatient days from the current date forward will be treated as a **Member appeal**. An adverse determination for dates which have already occurred and the Member is still inpatient OR the Member has discharged, will be treated as a **Provider appeal**.
- When an adverse determination was rendered and there was sufficient clinical information, the requesting Provider can submit additional clinical documentation which will be treated as a Member appeal if the services have not yet been rendered.
- An adverse determination for Ancillary Services (Home Health, DME, outpatient/HH therapies), Pre-Service or from current date forward requesting an organizational determination will be treated as a Member appeal. An adverse determination for dates, which have already occurred, will be treated as a Provider appeal.
- When requests are treated as Member appeals, only the Member and rendering Provider have appeal rights per CMS regulations. Everyone else needs to have an Appointment of Representative (AOR) form on file before the appeal can be processed. ***This includes third-party companies acting on behalf of a facility for adverse determinations appealed while the Member is still in the hospital.***

When services were already rendered and there was no additional Member financial responsibility, these will be processed as Provider appeals. One (1) peer-to-peer conversation and one (1) level

of Provider appeal are permitted during this process, followed by binding arbitration. This process includes inpatient services with adverse determinations and the Member was discharged from the hospital. A peer-to-peer will not be scheduled if a written appeal has been submitted.

**d. Inpatient DRG Day Outlier Management Program**

Consistent with the criteria in MCG, BlueCross will reimburse acute inpatient hospitalization days outside of the initial DRG initial day approval as follows:

- MCG will be used relative to the concurrent information provided from the acute care facility to determine if the care and services provided are consistent with acute inpatient service provision. This review is performed by a Plan Medical Director. If criteria are not met, then the hospital day may be denied for benefit coverage as not meeting acute inpatient level of care criteria per MCG. This review will occur during the time period after which the DRG days have elapsed, and are subject to the facility providing concurrent clinical information for review as contractually required.
- Clinical information is requested a minimum of three (3) times using at least two (2) different notification methods and if insufficient clinical documentation exists, an intent to deny fax will follow. The Plan Medical Director may make an additional outreach directly to the requesting Physician to perform a peer-to-peer followed by an "intent to deny" fax if unable to reach the Physician. If insufficient clinical is not provided after 24 hours, an adverse determination will be issued for a lack of clinical information necessary to establish Medical Necessity. In situations with a lack of clinical information, there will be no further peer-to-peer discussion option. If the Member is still confined to the facility, then any additional clinical information will be considered a Member appeal. If the Member has already been discharged, the additional information will be processed as a Provider appeal.

**Note:** The Member cannot be held liable for payment of services received when not authorized.

**Readmission Reimbursement**

Submitting a corrected bill or combining the services from the readmission with those of the initial admission will result in all services on the claim being disallowed. Also, billing with a "leave of absence" revenue code (018X) for the interval period and combining all the dates of service in a single claim will lead to a disallowed claim. Similarly, submitting a corrected bill or other alternate outpatient resubmission for these services is not appropriate, and services will be disallowed.

**Readmission Quality Program**

**31-Day Similar-Cause Readmission Quality Program**

Consistent with the Centers for Medicare & Medicaid Services (CMS) Hospital Readmissions Reduction Program, BlueCross will reimburse for a thirty-one (31) day readmission from an index admission as follows:

- For purposes of this program, a readmission is defined as an unplanned acute inpatient admission to the same or similar facility, or facility operating under the same contract, occurring within three (3) and thirty-one (31) days after a discharge from an acute care hospital (index admission) discharge for a complication of the original hospital stay or admission resulting from a modifiable cause relating to the index admission discharge diagnosis, as determined by a Plan Medical Director.
  - "Modifiable cause" is applicable only to readmissions occurring within three (3) days and thirty-one (31) days after a discharge from an acute care hospital. The modifiable cause can be related to any preventable issue which leads to a readmission, (such as not filling prescriptions or no post-discharge follow up) and is not limited to complications in the index hospitalization.



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- In this readmission scenario, the facility will be reimbursed only for a single inpatient DRG (the higher weighted of the two (2) admissions) and all other days will be reimbursed under DRG outlier methodology and subject to concurrent inpatient medical review for Medical Necessity.
- Readmissions that occur in an observational (outpatient) setting, are exempt from this program and are reimbursed as per the facility agreement.
- If there is a second (2nd) readmission that occurs, still within thirty-one (31) days from the index admission discharge, then this will likewise bundle into the original admission, if the above parameters are met.
- Standard facility appeal remedies are still applicable.

**Note:** The Member cannot be held liable for payment of services received when not authorized.

### **48 Hour Similar-Cause Readmission Quality Program**

Consistent with the Centers for Medicare & Medicaid Services (CMS) Readmissions Reduction Program, BlueCross will reimburse for a forty-eight (48) hour readmission from an index admission as follows:

- For purposes of this program, a readmission is defined as an unplanned acute inpatient admission to the same or similar facility, or facility operating under the same contract, occurring within forty-eight (48) hours after a discharge from an acute care hospital (index admission) discharge for a complication of the original hospital stay, as determined by a Plan Medical Director.
- In this readmission scenario, the facility will not be reimbursed for the readmission regardless of the readmission length of stay. This penalty is due to the fact that CMS considers a short-term readmission for the same or similar diagnosis to generally be due to a process failure in discharge planning or due to the Member not being clinically stable for discharge at the time of the original discharge.
- Readmissions that occur in an observational (outpatient) setting, are exempt from this program and are reimbursed as per the facility agreement.
- Standard facility appeal remedies are still applicable.

**Note:** *The Member cannot be held liable for payment of services received when not authorized.*

#### **e. Contact Method According to Type of Service**

The following grid is intended to assist Providers in determining the appropriate contact method according to type of service requested:

| Type of Service   | Submit via:  |
|---|--|
| Inpatient Rehabilitation<br>Long Term Acute Care<br>Skilled Nursing Facilities<br>(See Section VIII in this Manual for details) | BlueCross BlueShield of Tennessee<br>Phone 1-800-924-7141<br>Fax 1-888-535-5243      |
| Outpatient Therapies - Speech<br>(See Section VIII in this Manual for details)  | BlueCross BlueShield of Tennessee<br>Phone 1-800-924-7141                            |
| Outpatient Physical and Occupational Therapy -<br>Musculoskeletal Procedures  | Musculoskeletal Program Vendor<br>Phone 1-888-258-3864                               |
| Inpatient (Medical)<br>Observations Conversions<br>Home Health Services (excluding Home   | BlueCross BlueShield of Tennessee<br>Phone 1-800-924-7141<br>e-Health Web Submission |

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|   |   |
|---|---|
| Infusion Therapy<br>(See Section VIII in this Manual for details) | Fax 1-888-535-5243  |
| Advanced Imaging & Cardiology Diagnostic Testing                  | Advanced Imaging Vendor<br>Phone 1-888-258-3864<br>eHealth Web submission                 |
| Behavioral Health Services  | BlueCross BlueShield of Tennessee<br>Phone 1-800-924-7141<br>(After Hours) 1-800-836-1660 |
| Durable Medical Equipment (DME)<br>Orthotic/Prosthetic (O & P)    | BlueCross BlueShield of Tennessee<br>Phone 1-800-924-7141   Fax 1-888-535-5243            |
| Part B Pharmacy   | Part B Rx Vendor<br>Phone 1-888-258-3864  |

### f. Compliance with Prior Authorization Requirements

Prior authorization reviews can be initiated by the Member, designated Member advocate, Practitioner, or facility. However, it is ultimately the facility and Practitioner's responsibility to contact BlueCross to request an authorization and to provide the clinical and demographic information that is required to complete the authorization. Scheduled admissions/services must be authorized up to twenty-four (24) hours prior to admission. Notification of emergency admissions (unplanned) is required within twenty-four (24) hours or next business day after services have started. Behavioral health utilization review services are available 24-hours-a-day, 7-days-a-week. Prior authorization for all behavioral health services is required prior to admission.

When a request for an authorization of a procedure, an admission/service or a concurrent review of the days is denied, the penalty for not meeting authorization guidelines will apply to both the facility and the Practitioner rendering the care for the day(s) or service(s) that have been denied. BlueCross non-payment is applicable to both the facility and Practitioner rendering the care. The Member is held harmless if the Member is eligible at the time services are rendered and the Covered Services are received from a network Provider.

### g. Non-Compliance with Prior Authorization Requirements

Services provided without obtaining approval are considered "non-compliant" when prior authorization is required. Provider must obtain authorization prior to scheduled services. Non-compliance applies to initial as well as concurrent review for ongoing services beyond dates previously approved. Failure to comply within specified authorization timeframes will result in a contractual denial or reduced benefits due to non-compliance. BlueCross Providers cannot bill Members for Covered Services denied due to non-compliance by the Provider.

There is no reconsideration of a non-compliance denial. If a party is dissatisfied with a non-compliance denial, they may appeal through the Provider appeal process. Provider appeals of non-compliance denials must be submitted within sixty (60) days of the initial denial. The request should include a copy of any pertinent information, a copy of the medical records relevant to the admission or services, along with the face sheet, if applicable, and a statement from the Practitioner indicating the reasons for the appeal and a copy of the denial letter, to the Care Management Appeals Department. A determination will be sent to the Provider and/or Member within thirty (30) days of the receipt of the request for appeal. If the party is still dissatisfied with the decision, he/she may proceed to Arbitration as outlined within the Provider Appeal denial letter.

### h. Mandated Notices

- I. **Important Message from Medicare (IM):** Any facility providing care at an inpatient hospital level is responsible for delivering advance written notice of a Member's rights as a hospital inpatient including discharge appeal rights to the Member or the authorized Member representative in accordance with applicable CMS regulations. CMS requires the Important Message from Medicare (IM) be distributed no later than two (2) calendar days following the

Member's admission to the hospital and follow-up notice as far in advance of discharge as possible, but no more than two (2) calendar days before discharge.

- II. **Detailed Notice of Discharge (DN):** CMS requires a Detailed Notice of Discharge (DN) be distributed to a Member or authorized representative requesting an appeal of discharge from an inpatient facility or when BlueCross no longer intends to continue coverage of an authorized hospital inpatient admission. BlueCross delegates to Providers the responsibility for developing and delivering the DN for Provider discharge determinations and for delivery of DN for BlueCross discharge determinations. CMS requires the DN to be delivered as soon as possible, but no later than noon of the day after the QIO's notification or BlueCross's request for delivery. Providers are required to fax a signed copy of the DN to BlueCross UM Department at 1-888-535-5243 or 1-423-535-5243. Providers must be able to demonstrate compliance with the delivery of the DN in accordance with applicable CMS regulations.
- III. **Notice of Medicare Non-Coverage (NOMNC):** Home Health Agencies (HHA), Skilled Nursing Facilities (SNF), and Comprehensive Outpatient Rehabilitation Facilities (CORF) are responsible for delivering Medicare Notices of Non-Coverage (NOMNC) to the Member or the authorized Member representative in accordance with applicable CMS regulations.

CMS requires the NOMNC be delivered **at least two (2) days prior** to the Member's HHA, SNF, or CORF authorized services ending. Days will not be extended due to untimely delivery of the NOMNC by the facility. If the Member's services are expected to be fewer than two (2) days in duration, the HHA, SNF, or CORF must provide the NOMNC to the Member at the time of admission to the Provider.

The NOMNC must be faxed to BlueAdvantage no later than noon the day following receipt of the NOMNC. A model NOMNC form can be found on our website at <http://www.bcbst.com/providers/medicare-advantage/forms.shtml>. Providers are required to fax a signed copy of the NOMNC to BlueCross BlueShield of Tennessee Medicare Advantage Care Management Department at 1-888-535-5243.

- IV. **Detailed Explanation of Non-Coverage (DENC):** CMS requires a Detailed Explanation of Non-Coverage (DENC) be distributed to a Member or authorized representative requesting an appeal of discharge from a SNF, HHA, or CORF or when BlueCross no longer intends to continue coverage. BlueCross delegates to Providers the responsibility for developing and delivering the DENC for Provider discharge determinations and for delivery of the DENC for BlueCross discharge determinations. CMS requires the DENC to be delivered as soon as possible, but no later than close of business the day of the QIO's notification or BlueCross's request for delivery. Providers must be able to demonstrate compliance with the delivery of the DENC in accordance with the applicable CMS regulations. Providers are required to inform BlueCross Members that a request for denial notice must be submitted to BlueCross by the Member, in the event that the Member believes that he/she is being denied service.
- i. **Retrospective Claims and Clinical Record Review**  
Retrospective claims reviews are conducted to provide a determination of Medical Necessity, as well as verification of eligibility and benefits. Claims are targeted for review based on National Coverage Determinations, Local Coverage Determinations and BlueCross Medical Policy. Reviews are performed prior to claims payment using CMS' processing guidelines (i.e. post acute care transfer policy, low utilization payment adjustments, outlier payments, etc.).

Retrospective clinical record reviews may be conducted to meet our CMS contractual requirements. Record review results support CMS and other regulatory agencies audits, applicable accreditation audits, quality improvement activities, Quality Improvement Organization (QIO) and Independent Review Entity (IRE) review processes, and CMS' risk-adjusted payment processes.

**Care Management Contact Information:**

Phone: 1-800-924-7141  
Fax: 1-888-535-5243

Mailing Address:

BlueCross BlueShield of Tennessee  
Medicare Advantage Care Management Department  
1 Cameron Hill Circle, Ste 0005  
Chattanooga, TN 37402-0005

**j. Acute Care Facility**

In order for the services to be covered under BlueAdvantage, care and treatment must be Medically Necessary and Appropriate in an inpatient setting. Scheduled inpatient stays begin on the morning of a procedure in nearly all instances. Clinical information needed for processing an advance determination/prior authorization request:

- Procedure/Operation to be performed, if applicable;
- Diagnosis with supporting signs/symptoms;
- Treatment Plan;
- Vital signs and abnormal lab results;
- Elimination status;
- Ambulatory status;
- Hydration status;
- Comorbidities that impact patient's condition;
- Complications;
- Prognosis or expected length of stay;
- Current medications; and
- Discharge plans\*

\*Discharge information should be sent daily to BlueCross to help ensure appropriate follow-up and coordination of care for Members. Discharge dates may be entered for all lines of business via Availity, our secure area on the company website [www.bcbst.com](http://www.bcbst.com) or faxed to 423-591-9501. Providers may fax one Member listing for all lines of business as long as each Member listed reflects the line of business the Member belongs. Provider cover sheets should include the facility name and NPI number to help ensure appropriate and efficient processing.

**k. Skilled Nursing Facility (SNF)**

In order for SNF services to be covered under BlueAdvantage, care and treatment must be Medically Necessary and Appropriate in an inpatient setting. Skilled services are services requiring the skills of qualified technical or professional health personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, and/or audiologists. Skilled services must be provided directly by or under the general supervision of technical or professional health care personnel. SNFs are required to follow CMS guidelines regarding delivery of the Notice of Medicare Non-coverage (NOMNC). SNF days will not be extended due to untimely delivery of the NOMNC to the Member by the facility. The NOMNC must be faxed to BlueCross Medicare Advantage no later than noon the day following receipt of the NOMNC. (See details of Notice of Medicare Non-Coverage (NOMNC) in this Manual.)

To facilitate an advance determination or prior authorization request please use the BlueCross BlueShield of Tennessee Skilled Nursing Fax form located online at <http://www.bcbst.com/providers/medicare-advantage/forms.shtml> and fax to 1-888-535-5243. BlueAdvantage has dedicated RN Nurse Clinicians available to assist you with necessary services for your BlueAdvantage patients. Our Health Management team can be contacted at 1-800-924-7141.

Basic information needed for processing an advance determination request:

- Member's identification number, name, and date of birth;
- Practitioner's name, provider number, NPI, Medicare number; address, and telephone number;
- Hospital/Facility's name, provider number and/or NPI, Medicare number, address and telephone number;
- Admission date; and
- Caller's name.

Clinical information required for review:

- Admitting diagnosis, symptoms, and treatment plan;
- Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care that would influence the Medical Necessity determination;
- A condition requiring skilled nursing services or skilled rehabilitation services on an inpatient basis at least daily;
- A Practitioner's order for skilled services;
- Ability and willingness to participate in ordered therapy;
- Medical Necessity for the treatment of illness or injury (this includes the treatment being consistent with the nature and severity of the illness or injury and consistent with accepted standards of medical practice);
- Expectation for significant reportable improvement within a predictable amount of time; and
- Discharge Plans.

***Evaluation and Plan of Care***

Evaluation of the Member must be submitted including the following as appropriate:

- Primary diagnosis;
- Circulation and sensation;
- Ordering Practitioner and date of last visit;
- Gait analysis;
- Date of diagnosis onset;
- Cooperation and comprehension;
- Baseline status;
- Developmental delays (pediatric patients);
- Prior level of functioning;
- Current functional abilities;
- Functional potential;
- Expected maximum level of functioning;
- Other therapies or treatments;
- Patient's goals;
- Strength;
- Medical compliance;
- Range of motion; and
- Support system/Caregiver.

Plan of care must be submitted including the following as appropriate:

- Short and long-term goals;
- Proposed admission date;
- Discharge goals;
- Frequency of treatment;
- Measurable objectives;
- Specific modalities, therapy, exercise;
- Functional objectives;
- Safety and preventive education;
- Home program; and
- Community resources.

***Information for billing Health Insurance Prospective Payment System (HIPPS) Codes***

The Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage plans to bill health insurance prospective payment system (HIPPS) codes for all skilled nursing facility (SNF) claims.

**Guidance:**

- SNF claims received for processing that do not include HIPPS coding with Revenue Code 0022 will be rejected and require re-submission with the appropriate HIPPS code;
- The HIPPS code should be billed indicating a quantity of one (1) \$0.00 charge and a date of service equal to the date of the earliest billable service on the claim; and
- The claim's "From" and "Through" dates should cover the assessment\* and services.

\*SNFs shall submit a HIPPS code from the admission assessment completed during the covered stay. If an assessment was not completed, refer to the following guidelines:

**Stays of more than fourteen (14) days** – If the admission assessment was completed **prior** to the covered portion of the stay, submit a HIPPS code:

- From another assessment completed during the covered portion of the stay;
- From the most recent assessment completed prior to the covered portion of the stay; or
- If no assessment was completed, submit a code from the most recent assessment.

**Stays of fourteen (14) days or less** – If no admission assessment was completed before discharge for a covered stay, submit a HIPPS code:

- From another assessment from the stay; or
- Use default code "AAA00"

Submit a default code **ONLY** if:

- Member was discharged prior to the completion of the initial assessment; or
- No other assessment was completed during the covered stay.

For additional HIPPS code information, refer to CMS Memo at <http://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Downloads/encounterdatahippsmemo.pdf>.

**Therapy Services**

Therapy services appropriate for skilled nursing facilities include occupational therapy, physical therapy and speech therapy not possible on an outpatient basis. Specific therapy services that may be appropriate for a SNF include, but are not limited to the following:

- Complex wound care requiring hydrotherapy; and
- Gait evaluation and training to restore function in a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality.

**Nursing Services**

Nursing services appropriate for skilled nursing facilities include skilled nursing services not possible on an outpatient basis. Specific nursing services that may be appropriate for a SNF include, but are not limited to the following:

- Intramuscular injections or intravenous injections or infusions;
- Initiation of and training for care of newly placed:
  - Tracheostomy
  - In-dwelling catheter with sterile irrigation and replacement
  - Colostomy
  - Levin tube
  - Gastrostomy tube and feedings;
- Complex wound care involving medication application and sterile technique; and
- Treatment of Grade 3 or higher decubitus ulcers or widespread skin disorder.

**Nursing and Therapy Services Not Requiring SNF Placement:**

Skilled nursing facility placement is not necessary for the services listed below. This list is not all-inclusive.

- Administration of routine oral, intradermal or transdermal medications, eye drops, and ointments;
- Custodial services, e.g., non-infected postoperative or chronic conditions;

- Activities or programs primarily social or diversional in nature;
- General supervision of exercises in paralyzed extremities, not related to a specific loss of function;
- Routine care of colostomy or ileostomy;
- Routine services to maintain functioning of in-dwelling catheters;
- Routine care of incontinent patients;
- Routine care in connection with braces and similar devices;
- Prophylactic and palliative skin care (i.e., bathing, application of creams, or treatment of minor skin problems);
- Duplicative services - Physical therapy services that are duplicative of occupational Therapy services being provided or vice versa;
- Invasive procedures;
- General supervision of aquatic exercise or water-based ambulation;
- Heat modalities (hot packs, diathermy or ultrasound) for pulmonary conditions or wound treatment, or as a palliative or comfort measure only (whirlpool and hydrocollator);
- Hot and cold packs applied in the absence of associated modalities;
- Diagnostic procedures performed by a Physical Therapist (i.e., nerve conduction studies); or
- Electrical stimulation for strokes when there is no potential for restoration of functional improvement. Nerve supply to the muscle must be intact.

## **I. Rehabilitation Facility**

In order for rehabilitation facility services to be covered under BlueAdvantage, care and treatment must be Medically Necessary and Appropriate. Inpatient Rehabilitation provides multidisciplinary, structured, intensive therapy for Members both requiring and able to participate in a minimum of three (3) hours of daily rehabilitation therapy services. Rehabilitation goals are to prevent further disability, to maintain existing ability, and to restore maximum levels of functioning within the limits of the Member's impairment. Potential inpatient rehabilitation admissions include Members with recent CVA, head trauma, multiple trauma, spinal cord injury or recent amputation.

BlueAdvantage has dedicated Nurse Clinicians available to assist you with necessary services for your BlueAdvantage patients. Our Care Management team can be contacted at 1-800-924-7141.

Basic information needed for processing an advance determination or prior authorization request:

- Member's identification number, name, and date of birth;
- Practitioner's name, provider number, NPI, Medicare number; address, and telephone number;
- Hospital/Facility's name, provider number, NPI, Medicare number, address, and telephone number;
- Admission date; and
- Caller's name.

Clinical Information required for review:

- Admitting diagnosis, symptoms, treatment, frequency of therapies, Member's ability to participate in treatment;
- Member is ventilator dependent or not; and
- Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care that would influence the Medical Necessity determination; and
- Discharge plans.

Evaluation of the Member must be submitted including the following as appropriate:

- Ordering Practitioner and date of last visit;
- Gait analysis;
- Primary diagnosis;
- Circulation and sensation;
- Date of diagnosis onset;

- Cooperation and comprehension;
- Baseline status;
- Prior level of functioning;
- Current functional abilities;
- Functional potential;
- Expected maximum level of functioning;
- Other therapies or treatments;
- Patient's goals;
- Strength;
- Medical compliance;
- Range of Motion; and
- Support system/Caregiver.

Plan of care must be submitted including the following as appropriate:

- Short and long-term goals;
- Proposed admission date;
- Discharge goals;
- Frequency of treatment;
- Measurable objectives;
- Specific modalities, therapy, exercise;
- Functional objectives;
- Safety and preventive education;
- Home program; and
- Community resources.

**m. Home Health Services and Billing Guidelines**

Effective October 1, 2017, the number of days spanned for **administrative** approvals on initial Home Health Care requests changed. Initial requests for Home Health authorization will be approved as an administrative approval of up to seven (7) visits over a timeframe of up to fourteen (14) days. Previously, approval was given for up to seven (7) visits for up to a thirty (30)-day timeframe.

The number of visits and timeframe given is sufficient to cover an initial evaluation and up to three (3) visits per week for two (2) weeks. **No clinical information is necessary for these administrative approvals other than a diagnosis.** Any additional requests after the initial approval of visits and/or timeframe outlined above are considered an **extension request** and **will require supporting clinical documentation** for a Medical Necessity review **at the point of the extension request.**

If Providers are requesting **more than seven (7) visits** within or beyond the fourteen (14)-day timeframe on initial request, all supporting documentation for Medical Necessity review should be submitted with the initial request

Home health services are hands-on, skilled care/services, provided by or under the supervision of a registered nurse that are needed to maintain the Member's health or to facilitate treatment of the Member's illness or injury. Services may include skilled nursing, physical therapy, occupational therapy and speech therapy. In order for the services to be covered under BlueAdvantage, the Member must have a medical condition that makes him/her unable to perform personal care and meet Medical Necessity and Medical Appropriateness criteria. Documentation must support the Member's limitations, homebound status, and the availability of a caregiver/family and degree of caregiver/families' participation/ability in Member's care.

Basic information needed for processing an advance determination request:

- Member's identification number, name, and date of birth;
- Practitioner's name, provider number, NPI, Medicare number; address, and telephone number;



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- Hospital/Facility's name, provider number, NPI, Medicare number, address, and telephone number;
- Date of service;
- Caller's name;
- Signed order from the ordering or treating Physician indicating primary reason for home health services in addition to the requested services; and
- Documentation supporting Certification Medical Necessity (CMN) requirements.

Billing of supplies including those provided by third party vendors such as medical supply companies that are used in conjunction with a Home Health visit are the responsibility of the Home Health Agency. Prior authorization will be required for skilled nurse visit(s) and any non-routine supplies used in conjunction with skilled nurse care rendered in the patient's home. Charges for non-routine supplies will not be reimbursed if they are not included and reviewed within the authorization.

Supplies not used in conjunction with a Home Health visit are not billable by the Home Health Agency.

See Reimbursement Guidelines at the beginning of the Medicare Advantage section.

|  |
|--|
| <b>Note:</b> Please fax a copy of the Home Health form to BlueAdvantage Care Management at 1-888-535-5243 or (423) 535-5243. |
|--|

The following is a sample of the BlueAdvantage (PPO)<sup>SM</sup> form. The form can be printed from this hyperlink: <http://www.bcbst.com/providers/medicare-advantage/forms.shtml>.



## BlueAdvantage (PPO)<sup>SM</sup> Services Authorization Request

Please type/print legibly. Upon completion of this form, please fax to 1-888-535-5243.

For a faster response submit online DRG authorization requests via BlueAccess<sup>SM</sup>

at [www.bcbst-medicare.com](http://www.bcbst-medicare.com) 24-hours-per-day/7-days-per-week.\*

Member Name: \_\_\_\_\_

Member Date of Birth: \_\_\_\_\_ Member ID Number: \_\_\_\_\_

Sender Name: \_\_\_\_\_

Sender Phone Number: \_\_\_\_\_ Sender Fax Number: \_\_\_\_\_

Facility Name: \_\_\_\_\_

Facility Address: \_\_\_\_\_

Date of Service/Admit Date: \_\_\_\_\_

Diagnosis Code(s): \_\_\_\_\_

Procedure with CPT®(s)/HCPS(s) Codes: \_\_\_\_\_

Ordering/Admitting Physician Name: \_\_\_\_\_ Provider ID and/or NPI#: \_\_\_\_\_

Physician Address: \_\_\_\_\_

# Sample

**Service Type:** (Select appropriate service type and include a list of all pertinent information such as)

☐ Initial DRG   ☐ Conversion to DRG   ☐ SNF   ☐ SNF Concurrent   ☐ Inpatient Rehabilitation   ☐ LTAC

1st and 2nd day of clinical for the an initial DRG admit, past medical history, provider's orders/treatment plan, IV meds, all pertinent lab values, all pertinent diagnostic testing, diet, activity, prior level of function, therapy notes/evaluation, discharge plans and any other supportive information.

☐ Home Health Services (SN/ST)   ☐ Outpatient Speech Therapy   ☐ Specialty Pharmacy

Past medical history, prior level of function, provider's orders/treatment plan, activity, therapy notes/evaluation, all pertinent lab values, short term/long term goals, number of visits/units, and any other supportive information.

☐ DME/Orthotics

CMN if applicable, specific clinical for needs per NCD/LCD, rental/purchase, and any other supportive information.

☐ Advance Determination   ☐ Retro Review

Past medical history and physical, provider's orders/treatment plan, office notes, all pertinent labs, diagnostic exams and/or photos if applicable.

BlueAdvantage<sup>SM</sup> Utilization Management Department can be contacted at 1-800-924-7141.

\*If you are not a registered user for BlueAccess contact eBusiness Technical Support:

Phone: 423-535-5717 (Option 2) • E-mail: [eBusiness\\_support@bcbst.com](mailto:eBusiness_support@bcbst.com)

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BlueCross BlueShield of Tennessee, Inc. is a PPO plan with a Medicare contract. Enrollment in

BlueCross BlueShield of Tennessee, Inc. depends on contract renewal.

Y0013\_14\_PPO Fax Form (02/2015)

**n. Durable Medical Equipment (DME)**

Basic information needed for processing an advance determination request:

- Member's identification number and name;
- Practitioner's name, provider number, NPI, Medicare number; address, and telephone number;
- Hospital/Facility's name, provider number, NPI, Medicare number, address, and telephone number;
- Date of service; and
- Caller's name.

Clinical information/documentation required for review:

- Member's diagnosis and expected prognosis;
- Copy of Certificate of Medical Necessity (CMN) and signed prescription;
- Estimated duration of use;
- Supporting face-to-face documentation that occurred no more than ninety (90) days prior to services or no more than thirty (30) days after the initiation of services;
- In addition to the certifying Physician, the following can perform the face-to-face:
  - A Nurse Practitioner or Clinical Nurse Specialist who is working in collaboration with the Physician in accordance with State law.
  - A Certified Nurse Midwife as authorized by State law.
  - A Physician Assistant under the supervision of the Physician.
- Limitations and capability of the Member to use the equipment;
- Itemization of the equipment components, if applicable;
- Appropriate HCPCS codes for equipment being requested; and
- Member's weight and/or dimensions (needed to determine coverage of manual or power wheelchairs), if available.

**o. Chiropractic Manipulation and Outpatient Occupational and Physical Therapy**

In order for therapy services to be considered for benefits, the services must be Medically Necessary and Medically Appropriate for the treatment of the Member's illness or injury. Occupational and Physical Therapy, and Chiropractic Manipulation reviews are performed by our Musculoskeletal Program vendor. You can request an advance determination by calling 1-888-258-3864.

Basic information needed for processing an advance determination request:

- Member's identification number, name, and date of birth;
- Practitioner's name, provider number, NPI, Medicare number; address, and telephone number;
- Hospital/Facility's name, provider number, NPI, Medicare number, address, and telephone number;
- Date of service; and
- Caller's name.

Clinical information/documentation required for review:

- Assessment Requirements (Evaluation and Plan of Care) Evaluation;
- Ordering Practitioner and date of last visit;
- Primary diagnosis;
- Date of diagnosis onset;
- Baseline status/current abilities;
- Functional potential;
- Prior level of functioning;
- Current functional abilities;
- Functional potential;
- Expected maximum level of functioning;
- Strength, ROM, if applicable;
- Circulation and sensation;
- Cooperation and comprehension;

Clinical information/documentation required for review (cont'd):

- Diagnostic and assessment services used to ascertain the type, causal factors, and severity of speech and language disorders;
- Support system/caregiver;
- Other therapies or treatments;
- Patient's goals; and
- Therapy compliance.

Plan of Care

- Long and short-term goals;
- Discharge goals;
- Measurable objectives;
- Functional objectives;
- Home program, if applicable;
  - Duration of therapy;
  - Frequency of therapy;
  - Date therapy is to begin;
  - Specific therapy techniques;
- Safety and preventive education; and
- Community resources.

**p. Orthotics/Prosthetics**

Basic information needed for processing an advance determination or prior authorization request:

- Member's identification number, name, and date of birth;
- Practitioner's name, provider number, NPI, Medicare number; address, and telephone number;
- Hospital/Facility's name, provider number, NPI, Medicare number, address, and telephone number;
- Date of service; and
- Caller's name.

Clinical information/documentation required for review:

- Member's diagnosis and expected prognosis;
- Limitations and capability of the Member to use the equipment;
- Itemization of the equipment components, if applicable; and
- Appropriate HCPCS codes for equipment being requested.

**q. Laboratory Services**

Providers need to utilize in-network options for all laboratory services requested, unless the specific laboratory test is not available from a participating lab provider. This includes genetic testing that is covered by Medicare. If the Provider refers testing to a non-participating lab and the test was available through a participating Provider, then this cost may be the Provider's and not the Member's responsibility through an off-set reconciliation.

**r. Retrospective Review**

BlueCross will conduct Retrospective Review within two (2) years of the original claim receipt date to provide a decision based on benefit eligibility, exclusion(s), and Appropriateness and Medical Necessity of services. Specific reasons as to why the service was not requested timely apply to retrospective reviews. References used to determine Appropriateness and Medical Necessity include Title 18 of the Social Security Act, Title 42 Code of Federal Regulations Parts 422 and 476, National Coverage Determinations, Local Coverage Determinations, coverage in CMS' Interpretive Manuals (Claims Processing Manual, Benefit Policy Manual, Program Integrity Manual, Quality Improvement Organization Manual, and Medical Managed Care Manual), MCG, BlueCross adopted guidelines, the BlueCross claims payment system, DMEMAC associated PSC local coverage determinations and other major payer policy and peer reviewed literature.

**s. Pharmacy (Part B Drugs)**

In order for Part B drugs to be considered for benefits, the service must be Medically Necessary and Medically Appropriate to the treatment of the Member's illness or injury according to National Coverage Determinations and/or Local Coverage Determinations.

Certain formulary drugs may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make a determination.

BlueCross' Medicare Advantage uses Magellan for Part B Specialty Pharmacy medication authorizations. Authorization requests can be initiated by phone at 1-888-258-3864, or online through Availity, BlueCross' secure portal on its website, [www.bcbst.com](http://www.bcbst.com).

The list of drugs requiring prior authorization can be found at:

<http://www.bcbst.com/docs/providers/Medicare-Advantage-Specialty-Pharmacy-List.pdf>

**Note:** New drugs may be periodically added to the Specialty Pharmacy list and those products requiring authorization are subject to change. Changes will be communicated via BlueAlert newsletter or updates to this Manual. Current and archived BlueAlert issues can be viewed on the company website at <http://www.bcbst.com/providers/newsletters/index.page>.

**t. Organization Determinations**

An organization determination is a determination of Medical Necessity and Appropriateness related to payment of services. Organization determinations include both advance determinations and retrospective reviews. An organization determination for an advance determination request will be reviewed as expeditiously as the Member's health condition requires, but no later than fourteen (14) Calendar days after the date of receipt of request for a Standard Organization Determination.

An expedited organization determination will be performed when requested or supported by a Physician indicating that applying the standard time for making a determination could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function. Additionally, the Physician does not need to be appointed as the Member's authorized representative in order to make this request. A decision will be rendered as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours after receiving the request for expedited review. The time frame will be extended by up to fourteen (14) Calendar days if the Member requests the extension or if the need for additional information and documents are delayed and is in the best interest of the Member. Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that the Member has already received.

Retrospective reviews are completed within thirty (30) Calendar days of receipt of the request for a Standard Organization Determination.

**u. Reconsideration Process**

The reconsideration process applies to Members or Member's representatives. More information is provided for Members in their Evidence of Coverage.

A Standard Reconsideration of an adverse organization determination or termination of services decision may be requested by a Member or Member's authorized representative. A Standard Reconsideration of the denial of a request for service will be determined no later than thirty (30) calendar days from the date the request of a Standard Reconsideration is received. The timeframe may be extended up to fourteen (14) calendar days at the Member's request.

A Member or Member's authorized representative may submit a verbal or written request for an Expedited Reconsideration in situations where applying the standard of procedure could seriously jeopardize the Member's life, health, or ability to regain maximum function. If BlueCross approves a request for an Expedited Reconsideration, the review will be completed no later than seventy-two (72) hours after receiving the request. The seventy-two (72)-hour timeframe may be extended up to fourteen (14) calendar days at the Member's request for an extension.

A request for payment of a service already provided to the Member is not eligible to be reviewed as an Expedited Reconsideration.

**v. Advanced Imaging**

Prior authorization\* is required for select advanced imaging radiology procedures performed in an outpatient setting. Prior authorization is not required for imaging procedures performed during an inpatient admission, observation, or emergency room visit. Procedures requiring prior authorization include, but are not limited to:

- Computed tomography (CT)
- Computed tomography angiography (CTA)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Positron emission tomography (PET)
- Nuclear and diagnostic cardiology

The Centers for Medicare & Medicaid Services (CMS) created “C” codes for its outpatient facility PPS payment logic to augment reimbursement when paying under a per diem basis. Accordingly, the codes were not created by CMS to represent “base” procedure codes like CPT® or “G” or “S” HCPCS codes.

Authorizations are not performed based on C codes, but use CPT® or possibly G or S HCPCS codes. Refer to High Tech Imaging C Code Crosswalk Reference Guide on our [provider website](#). The list can be found at: [C Code Crosswalk reference Guide](#).

**Bone Density/CT Bone Density Exclusions from Advanced Imaging Program**

\*Bone Mass Measurements are for the purpose of establishing the diagnosis of osteoporosis and to assess the individual's risk for subsequent fracture and **are excluded from this requirement**. These measurements are considered part of Medicare's Preventive Services.

To request prior authorization for any of the above listed radiology procedures, you can call the Advanced Imaging vendor at 1-888-258-3864 or complete the request online through Availity, BlueCross' secure portal on its website, [www.bcbst.com](http://www.bcbst.com).

**2. Oxygen Authorizations**

BlueAdvantage Members no longer receive lifetime, or multi-year approval for oxygen equipment rentals. Authorizations will be reviewed on a twelve (12) month rolling calendar.

A *Certification of Medical Necessity* is required for the initial authorization. Annual recertification requires updated clinical documentation denoting the use of the equipment and ongoing Medical Necessity within the last two (2) months of the request. Oxygen equipment rental is only covered for thirty-six (36) months, in accordance with CMS regulations.

**3. Reimbursement for Oxygen Equipment**

As required by CMS, Tennessee Local Coverage Determination L11446 and the supporting policy article A33750 released in October 2014, reimbursement for oxygen equipment is limited to thirty-six (36) monthly rental payments. Payment for accessories, delivery, back-up equipment, maintenance and repairs is included in the rental allowance.

The supplier who provides oxygen equipment for the first month must continue to provide any necessary oxygen equipment and all related items and services through the 36-month period. Contents only will continue to be reimbursed beyond thirty-six (36) months.

After thirty-six (36) monthly rental payments have been made there is no further payment for oxygen equipment during the five (5)-year reasonable use lifetime of the equipment. The supplier who provided the equipment during the 36-month rental is required to continue providing the equipment during the five (5)-year reasonable use lifetime of the equipment.

Exceptions and additional information can be found on the Centers for Medicare & Medicaid services (CMS) website at  
[http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=33750&ver=36&ContrId=140&ContrVer=2&LCDId=11446&CntrctrSelected=140\\*2&Cntrctr=140&name=CGS+Administrators%2c+LLC+\(18003%2c+DME+MAC\)&DocType=Active&LCntrctr=140\\*2&IsPopup=y&](http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=33750&ver=36&ContrId=140&ContrVer=2&LCDId=11446&CntrctrSelected=140*2&Cntrctr=140&name=CGS+Administrators%2c+LLC+(18003%2c+DME+MAC)&DocType=Active&LCntrctr=140*2&IsPopup=y&)

#### 4. Fusion for Degenerative Joint Disease of the Lumbar Spine

The following documentation is required to request authorization for Fusion for Degenerative Joint Disease of the Lumbar Spine:

- Continued pain and difficulty maintaining ADLs despite activity modification
- A documented home exercise program or supervised physical therapy
- Anti-inflammatory medication
- Results of pertinent imaging studies, full motor and sensory examination of lower extremities
- Response to conservative treatment, such as injection therapy
- Levels planned for instrumentation

**Note:** Both Tennessee specific Local Coverage Determination criteria and MCG criteria are used to make Medical Necessity determinations for these services.

#### 5. Hemodialysis

Nephrologists and Dialysis Providers are required to provide a copy of CMS form 2728 once per year for each Member receiving hemodialysis services. This form should be faxed to BlueCross Medicare Advantage Care Management at 1-888-535-5243.

### I. Valuable Health Tools for Your BlueAdvantage Patients

| Tool                           | Description  | For more information...   |
|--------------------------------|--|---|
| <b>Personal Health Manager</b> | An on-line personal health record. This tool is customizable and provides patients with condition-specific information and recommendations. It also has trackers available to assist them with documenting lab tests, exercise achievements and medications among other many other things. | To access the Personal Health Manager, Members must use their Internet browser and go to <a href="http://www.bcbst-medicare.com">www.bcbst-medicare.com</a> . To register, go to <a href="http://www.Availity.com">www.Availity.com</a> and click on "Register" in the upper right corner of the home page, select "Let's get started" and follow the instructions in the Availity registration wizard.   |
| <b>Blue365</b>                 | Offers savings on nutrition programs, fitness accessories, and medical supplies and services like hearing aids and LASIK eye surgery. It is included with the Member's health plan at no additional charge.  | To sign up for Blue365, Members need to register through Blue365 via the internet. Members can sign up through <a href="http://bcbstmedicare.com">bcbstmedicare.com</a> or <a href="http://www.Blue365Deals.com/bcbstn">www.Blue365Deals.com/bcbstn</a> .<br>1. To submit an inquiry via email, the Member should click on "Contact Us" (link located in footer of website) to fill out a form or send an email directly to <a href="mailto:support@blue365deals.com">support@blue365deals.com</a><br>2. To submit an inquiry via phone, the Member should call 1-855-511-2583 (BLUE) |



## BlueCross BlueShield of Tennessee Provider Administration Manual

| Tool  | Description   | For more information...   |
|---|---|---|
| <b><i>Health Guide for Seniors</i></b>                    | A tool that offers health tips and tools to record things such as the date and results of important health screenings, immunizations and current medications, among other things.   | To obtain a copy of this tool, direct your patients to call Care Management at 1-800-611-3489, Monday through Friday 9 a.m. to 6 p.m. (ET) or visit <a href="http://bluecareplus.bcbst.com/docs/2018/Health_Guide_for_Seniors.pdf">http://bluecareplus.bcbst.com/docs/2018/Health_Guide_for_Seniors.pdf</a> to download a printable copy. |
| <b><i>24/7 Nurse Line</i></b>                             | A nurse line is available 24-hours-a-day, 7-days-a-week to help answer your patient's health concerns. This important resource can also help your patients know when to go to the emergency room if they are unsure.  | To access the nurse line, direct your patients to call 1-866 275-1660.  |
| <b><i>Care Campaigns</i></b>                              | To assist you in your efforts to close your patient's preventive gaps in care, BlueAdvantage reviews claims data and provides your patients with periodic reminders to get important preventive health services. Gaps in care measures include, but are not limited to: flu/pneumonia shots, annual wellness exams, and diabetic, glaucoma, breast/colorectal cancer screenings, etc.   | Outreach conducted by BlueAdvantage will consist of either directing Members to contact their primary care Physician to schedule an appointment or calling the primary care Physician's office to schedule an appointment on the Member's behalf.   |
| <b><i>Silver Sneakers®</i></b>                            | A fun, energizing program that helps older adults take greater control of their health by encouraging physical activity and offering social events. Members who join Silver Sneakers have access to a wide variety of benefits.   | For more information or to join the program, direct your patients to visit <a href="http://www.silversneakers.com/">http://www.silversneakers.com/</a> or call 1-888-423-4632.  |
| <b><i>Medication Therapy Management Program</i></b>       | BlueAdvantage offers a Medication Therapy Management program to Members that meet the enrollment requirements. This program provides them with a comprehensive medication therapy review, personal medication record, and tools to assist them with managing their prescription medications, over-the-counter medications and/or herbal therapies.  | Members that meet the qualifying criteria are automatically enrolled and sent a letter explaining the program.  |
| <b><i>My HealthPath® Wellness and Rewards Program</i></b> | We are committed to ensuring our Members get the care they need, so we reward them for making healthy choices. My HealthPath® is a program that partners with Members as they take steps toward a healthier lifestyle. Members must opt-in and have an annual wellness exam claim on file* to participate in this program. After they are actively enrolled, Members are educated about the importance and completion of preventive screenings while being rewarded for receiving the screenings that apply to them.<br>*To be eligible, the AWE claim on file must be filed using the following codes: G0402, G0438, G0439, 96160, 96161, 99385, 99386, 99387, 99395, 99396, 99397 | For more information on the Member Incentive Program, please visit our Quality Care Rewards website at <a href="http://www.bcbst.com/providers/quality-initiatives.page">www.bcbst.com/providers/quality-initiatives.page</a>   |



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| Tool  | Description   | For more information...  |
|---|---|--|
| <b>Medicare Diabetes Prevention Program(MDPP)</b> | Starting April 1, 2018, MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle. There is no coinsurance, copayment, or deductible for the MDPP benefit.  | <p>MDPP Provider Referral Form available</p> <p>Referrals to MDPP program should be sent to MA Population Health at 800-611-3489 or by fax 800-727-0841</p> <p><b>Eligibility requirements:</b><br/>The Member eligibility/referral criteria includes the following:</p> <ul style="list-style-type: none"> <li>• Be at least 18 years old and</li> <li>• Be overweight (body mass index <math>\geq 24</math>; <math>\geq 22</math> if Asian) and</li> <li>• Have no previous diagnosis of type 1 or type 2 diabetes and</li> <li>• Have a blood test result in the prediabetes range within the past year: <ul style="list-style-type: none"> <li>- Hemoglobin A1C: 5.7%–6.4% or</li> <li>- Fasting plasma glucose: 100–125 mg/dL or</li> <li>- Two-hour plasma glucose (after a 75 gm glucose load): 140–199 mg/dL or</li> </ul> </li> <li>• Be previously diagnosed with gestational diabetes</li> </ul> <p>Note: Prediabetes can be diagnosed via oral glucose tolerance tests, fasting blood glucose tests, or an A1C test. Blood-based testing is the most accurate way to determine if a patient has prediabetes.</p> |
| <b>Telehealth</b>                                 | <ul style="list-style-type: none"> <li>• Telehealth services are provided by MDLive. Members can access telehealth services for non-emergency medical issues 24-hours-a-day, 7-days-a-week.</li> <li>• Consults limited to the following conditions: <ul style="list-style-type: none"> <li>- Allergies</li> <li>- Cold and Flu</li> <li>- Fever</li> <li>- Sinus Infections</li> <li>- Respiratory Issues</li> <li>- Skin conditions (rashes or insect bites)</li> <li>- Sore Throats</li> <li>- Urinary Tract Infections</li> </ul> </li> </ul> | <p>Members can enroll at:</p> <p><a href="http://bcbst.com/member">bcbst.com/member</a> website and download a link on their mobile telephones.</p>  |

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## J. Pharmacy

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### 1. Formulary

The BlueAdvantage formulary is located on the company website,  
<http://www.bcbst.com/providers/medicare-advantage/BAPPO-pharmacy.shtml>.

### 2. Prior Authorization

Certain drugs with special indications require authorization. These drugs are noted on the formulary. For the BlueAdvantage plan, the prescribing Practitioner is responsible for obtaining the necessary authorization from Express Scripts. Prior authorization must be obtained **before** the drug is dispensed.

**Note:** *Only Home Infusion Compounds are currently covered. Compound ingredients are subject to Formulary rules and Medicare requirements. If one ingredient requires prior authorization, the prescribing Practitioner must obtain the necessary authorization before the Compound is dispensed.*

You may request prior authorization by contacting the following:

**BlueAdvantage  
Express Scripts**

Phone 1-844-648-9628  
Fax 1-877-251-5896

Website:

[https://www.bcbst-medicare.com/docs/BlueAdvantage\\_Request\\_for\\_Medicare\\_Prescription\\_Drug\\_Coverage\\_Determination.pdf](https://www.bcbst-medicare.com/docs/BlueAdvantage_Request_for_Medicare_Prescription_Drug_Coverage_Determination.pdf)

### 3. Quantity Limits or Maximum Drug Limitation

Some medications have a quantity limit for a given time period. These drugs are noted on the formulary. Greater quantities require Practitioner request for Medical Necessity. You may request prior authorization by contacting:

**BlueAdvantage  
Express Scripts**

Phone 1-844-648-9628  
Fax 1-877-251-5896

Websites:

[https://www.bcbst-medicare.com/docs/BlueAdvantage\\_Request\\_for\\_Medicare\\_Prescription\\_Drug\\_Coverage\\_Determination.pdf](https://www.bcbst-medicare.com/docs/BlueAdvantage_Request_for_Medicare_Prescription_Drug_Coverage_Determination.pdf)

#### 4. Exceptions

An exception is a type of coverage determination that is unique to the Part D benefit. A Member, Member's authorized representative or Member's prescribing Physician may request a Tiering Exception or a Formulary Exception.

- **Tiering Exception:** Permits Member to obtain a non-preferred drug at the cost-sharing amount applicable to drugs on preferred tiers.
- **Formulary Exception:** Ensures that Member has access to Medically Necessary Part D drugs that are not included on the BlueAdvantage formulary. Also permits Members to request an exception to a quantity or dose limit, or a Step Therapy requirement that the Member try another drug before BlueCross's Medicare Advantage Plan will pay for the requested drug.

The Physician's supporting statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be effective because:

1. All covered Part D drugs on any tier of the BlueAdvantage formulary would not be as effective for the Member as the non-formulary drug, and/or would have adverse effects;
2. The number of doses available under a dose restriction for the prescription drug:
  - a. Has been ineffective in the treatment of the Member's disease or medical condition or,
  - b. Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the Member, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
3. The prescription drug alternative(s) listed on the BlueAdvantage formulary:
  - a. Has been ineffective in the treatment of the Member's disease or medical condition or,
  - b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
  - c. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the Member.

The review process for a tiering exception or formulary exception request will not begin until BlueAdvantage receives the Physician's supporting statement.

The Physician's supporting statement will be evaluated based on:

- Comparisons of quality of the particular medication therapy, including safety, efficacy, effectiveness and cost, as well as, comparison of the drug product within the specific therapeutic class, and
- Medical evidence, such as, peer reviewed medical references, primary research, standards of practice, or relevant findings of government agencies, medical associations, and national commissions.

To request a formulary exception, complete a Medicare Part D Prescription Drug Authorization Request form. This form may be accessed on the following websites:

**BlueAdvantage**

[https://www.bcbst-medicare.com/docs/BlueAdvantage\\_Request\\_for\\_Medicare\\_Prescription\\_Drug\\_Coverage\\_Determination.pdf](https://www.bcbst-medicare.com/docs/BlueAdvantage_Request_for_Medicare_Prescription_Drug_Coverage_Determination.pdf)

Formulary exception requests can be made either in writing or by phone:

Phone 1-800-935-6103  
Fax 1-877-852-4070

If an exception is granted, BlueAdvantage cannot require the Member to request approval for a refill or new prescription from the Prescriber in order to continue using the Part D drug that was approved. The exception will be approved until the specified expiration date so long as the Member remains enrolled in the Plan, the Physician continues to prescribe the drug and it continues to be safe for treating the Member's condition.

For formulary changes during the benefit year that result in a Member's drug no longer being covered, the affected Members will be notified by letter at least sixty (60) days prior to the effective date of such changes. Members may request an appeal of any formulary change and BlueAdvantage will review the request according to the tiering exception and formulary exception process.

**5. Redetermination**

If Express Scripts has made an adverse determination for a medication or pharmaceutical product, the Member or the Member's Physician may initiate a pharmacy redetermination. This must be in writing, by phone, or be faxed.

**BlueAdvantage** (for Reconsideration and Expedited Requests)  
***Express Scripts***

Phone 1-800-935-6103  
Fax 1-877-852-4070  
Website:

<https://www.bcbst-medicare.com/docs/Request-for-Redetermination-ppo.pdf>

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**K. Provider Appeal Process**

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**Provider Claim Payment Dispute Resolution Procedure**

A. Inquiry/Reconsideration Level (Written or verbal)

B. Appeal Level (Formal, Written request)

- If not satisfied, submit a written appeal within sixty (60) days of receipt of the reconsideration response
- The request should state the following:
  - Reason for the appeal
  - Why dissatisfied with the reconsideration
  - Any additional information the Provider would like considered in support of the appeal

C. Binding Arbitration

- If dispute is not resolved to Provider's satisfaction, this is the final step in the process

A **Reconsideration** allows Providers dissatisfied with a claims outcome/denial to ask us questions. Reconsiderations must be requested and completed before filing a formal appeal.

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Provider Reconsiderations may be requested for, but not limited to the following:

- Corrected claims
- Coordination of benefits
- Diagnoses codes
- Procedure or revenue codes
- Recoupment disputes

If you disagree or have questions about payment, you can submit a request for a Provider reconsideration within eighteen (18) months of the initial claim denial by submitting the **Provider Reconsideration Form** along with any supporting documentation related to your reconsideration request. For faster review and processing information can be faxed to (423) 535-1959 or mail to:

BlueCross BlueShield of Tennessee  
1 Cameron Hill Circle, Ste 0039  
Chattanooga, TN 37402-0039

Additional information on Reconsideration processes and the fillable Provider Reconsideration Form is located on BlueCross' website at:

<http://www.bcbst.com/providers/forms/ProviderReconsiderationForm16PED988.pdf>

**Note:** Only one (1) reconsideration is allowed per claim. You **cannot** use the Provider Reconsideration Form to request an appeal.

If you are dissatisfied with our response to your request for Reconsideration, you may submit a **Formal Appeal**. Request must be submitted within sixty (60) days after receiving the response for a Reconsideration using the **Provider Appeal Form** and including any supporting documentation. For faster review and processing information fax the Appeal to (423) 535-1959 or you may mail to:

BlueCross BlueShield of Tennessee  
1 Cameron Hill Circle, Ste 0039  
Chattanooga, TN 37402-0039

Additional information on Appeal processes and the fillable Provider Appeal Form is located on BlueCross' website at:

<http://www.bcbst.com/providers/forms/ProviderAppealForm16PED987.pdf>

To avoid delays in reviewing your request, it is imperative that the Provider Reconsideration form or the Provider Appeal form, whichever is appropriate, be completed accurately. When supplying records or documentation as part of a Reconsideration or Reopening, or an Appeal, please attach the appropriate form with your submission. The absence of the form may necessitate the records/documentation being returned to you for clarification of your request.

### **Formal Care Management Provider Appeal**

Per CMS guidelines, contract Providers do not have appeal rights. However, BlueCross has a contractual Provider Appeals process if a Provider disagrees with a determination post-service or payment. Typically pre-service scenarios are defined as Member appeals.

- Post-Service Appeal Options (services have already been received)  
You have the right to ask for a Provider appeal from BlueAdvantage by sending the supporting documentation to:

BlueCross BlueShield of Tennessee  
Attn: BlueAdvantage Care Management  
1 Cameron Hill Circle, Ste 0005  
Chattanooga, TN 37402-0005

BlueAdvantage must receive this information within sixty (60) days of receiving the initial decision. If you initiate a written appeal, BlueAdvantage will review the request and provide a decision within thirty (30) days from receiving your appeals request. After the appeal review has been completed, we will inform you and/or the Member in writing of the decision. If you disagree with that decision, then you can request binding arbitration. (See Section XIII. Provider Dispute Resolution Procedure in this Manual for information on binding arbitration.)

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## L. Website Related Links

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Links to the Centers for Medicare & Medicaid Services (CMS) website, Quarterly Provider Update Site and the Medicare Coverage Home page follow. The Medicare Coverage Home page includes a search function for national and local coverage decisions.

**CMS website**

<http://www.cms.gov/>

**Quarterly Provider Update**

<https://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/index.html>

**Medicare Coverage Home page**

<http://www.cms.gov/center/coverage.asp>

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## M. Contact Us

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Learn more about BlueCross BlueShield of Tennessee Medicare Advantage plans:

|  |  |
|--|--|
| <b>Website:</b>  | <a href="http://www.bcbst.com">www.bcbst.com</a><br><a href="http://www.bcbstmedicare.com">www.bcbstmedicare.com</a>                         |
| <b>Provider Service</b>  | 1-800-841-7434<br>Monday through Friday, 8 a.m. to 5 p.m. (ET)   |
| <b>Advance Determinations/<br/>Prior Authorizations<br/>Phone</b>      | 1-800-924-7141<br>Monday through Friday 9 a.m. to 6 p.m. (ET)<br>1-888-535-5243 or 1-423-535-5243  |
| <b>Fax</b>   | Online Web Authorization also available via<br>Availity, the secure area on our website,<br><a href="http://www.bcbst.com">www.bcbst.com</a> |
| <b>Express Scripts</b><br>(BlueAdvantage Pharmacy<br>Benefits Manager) | 1-844-648-9628<br><br>24-hours-a-day, 7-days-a-week  |
| <b>BlueCard Host Services</b>  | 1-800-705-0391   |

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## XXV. CoverTennessee

The Cover Tennessee program, CoverKids, was developed by the State of Tennessee to provide free health care coverage for pregnant women and children who do not have insurance and who do not qualify for TennCare.

Information on the CoverKids program can be found in the *BlueCare Tennessee Provider Administration Manual* located on the BlueCare Tennessee website at <http://bluecare.bcbst.com/Providers/Provider-Administration-Manual.html>.



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## **Blue Network S State Employee Health Plan and Fully Insured Episodes of Care Provider Guide**

This Provider Guide includes important information about the design of the program and also offers resources to help health care Providers understand how the program impacts their organization.

In February 2013, the State of Tennessee launched the Tennessee Health Care Innovation Initiative, which seeks to pay for outcomes and quality care (i.e. value-based care), rather than for the amount of services provided (i.e. volume-based care). The state is working collaboratively with hospitals, medical Providers, and payers to achieve meaningful payment reform. By working together, the state believes we can make significant progress towards sustainable medical trends and improving care.

Episodes of Care is one of three strategies under the Tennessee Health Care Innovation Initiative implemented for Medicaid to focus on health care delivered in association with acute health care events such as a surgical procedure or an inpatient hospitalization. Episodes encompass care delivered by multiple Providers in relation to a specific health care event.

Effective January 1, 2017, BCBST expanded the Episode of Care program to our State Employee Health Plan (SEHP) and Fully Insured members who utilize Blue Network S<sup>SM</sup>. There are four areas where the SEHP and Fully Insured episodes of care program will differ from the Medicaid episodes of care program:

- Rewards Only Program
- The Principle Accountable Provider (PAP) a.k.a. Quarterback must have forty or more episodes in either SEHP or Fully Insured, or combination of both to be eligible for shared savings
- Only up to sixty of the seventy five episodes established under the Tennessee Health Care Innovation Initiative will be implemented through year 2019
- Both Acceptable and Commendable level thresholds will be determined by BCBST

Episodes of Care effective for 2017: In performance period:

- Perinatal
- Total Joint Replacement (hip and knee)
- Screening and Surveillance Colonoscopy
- Outpatient and Non-Acute Inpatient Cholecystectomy

- Acute Percutaneous Coronary Intervention (PCI)
- Non-acute Percutaneous Coronary Intervention (PCI)

Episodes of Care for 2018: These episodes will be in a preview period for all of 2018:

- Upper GI Endoscopy
- Bariatric Surgery
- CABG
- Valve Repair and Replacement

For additional detail regarding Episodes of Care design and requirements, visit the TennCare website:  
[Tennessee Health Care Innovation Initiative](#)

|   |   |   |
|---|---|---|
| <b><i>Program Introduction:</i></b>   | <b>Tennessee Health Care Innovation Initiative Program</b>  | <a href="#">Tennessee Health Care Innovation Initiative</a>   |
| BlueCross BlueShield of Tennessee produces quarterly reports for Principal Accountable Providers, a.k.a. “Quarterbacks”, with qualifying episodes that provide cost and quality performance information related to the episode(s). Reports from BlueCross can be accessed via the Availity® secure portal. Go to the BlueCross website at <a href="http://www.bcbst.com/">http://www.bcbst.com/</a> then select “Log In to Availity”; scroll down to Tennessee Health Care Innovation Initiative. Included with these reports are helpful resources to better understand the reports. Additionally, we developed a Frequently Asked Questions (FAQ) document that provides answers to many of the commonly asked questions to Episodes of Care. |   |   |
| <b><i>Reporting and Frequently Asked Questions</i></b>  | <b>How to Read Your Episode of Care Report</b><br><br><b>Episode of Care Waves Description and Code Summary</b> | Guide to Reading Your Episode of Care Report<br><a href="http://www.bcbst.com/docs/providers/SEHP-FI_ProviderReport_HowToGuide_FINAL_120916.pdf">http://www.bcbst.com/docs/providers/SEHP-FI_ProviderReport_HowToGuide_FINAL_120916.pdf</a><br><br><a href="#">Episodes By Wave</a> |

\* If you are not registered, go to <http://www.Availity.com> and click on “Register” in the upper right corner of the home page, select “Let’s get started” and follow the instructions in the Availity registration wizard.

|  |   |  |
|--|---|--|
|  | <b>State Employee Health Plan and Fully Insured Episode of Care BlueCross BlueShield of Tennessee – Blue Network S Frequently Asked Questions</b> | THCH State Employee Health Plan and Fully Insured – FAQs<br><a href="#">THCH   BlueCross BlueShield of Tennessee</a> |
| A detailed explanation of the risk adjustment methodology and Risk Factors and Weights used for the different episode of care waves is provided below.   |   |  |
| <b><i>BCBST Risk Adjustments</i></b>   | <b>Risk Adjustment Methodology</b>  | Episode of Care Risk Adjustment Methodology<br><a href="#">THCH   BlueCross BlueShield of Tennessee</a>              |
| <b><i>Risk Factors and Weights</i></b>   | <b>Risk Factors and Weights</b>   | Episode of Care Risk Adjustment Factors and Weights<br><a href="#">THCH   BlueCross BlueShield of Tennessee</a>      |
| Prior to the start of the performance period, BCBST will set for each episode the “Acceptable” and “Commendable” thresholds and gain-sharing limits. An explanation of the “Acceptable” and “Commendable” threshold levels and gain-sharing limits for each episode of care is provided below. Quality thresholds are defined by TennCare and will be defined in each of the episodes of care documents found on the BCBST website using the hyperlinks below. |   |  |
| <b><i>2017 Bundle Thresholds</i></b>   | <b>Threshold Level Methodology</b>  | 2017 Thresholds<br><a href="#">THCH   BlueCross BlueShield of Tennessee</a>  |
| <b><i>2017 Gain-sharing Limits</i></b>   | <b>Gain-sharing Limits</b>  | Gainsharing Limits for Episodes of Care<br><a href="#">THCH   BlueCross BlueShield of Tennessee</a>                  |

| <i>Quality Thresholds</i>  | Quality Thresholds  | <a href="#">Episodes By Wave</a> |
|--|---|----------------------------------|
| A BlueCross BlueShield of Tennessee episodes of care reporting and gain payment will be calculated based on a contract entity identifier as explained below: |   |                                  |
| <i>Contract Entity Identifier</i>  | <p>BlueCross BlueShield of Tennessee reporting is aggregated using a combination of the Provider’s Contract ID and Tax ID based on how a Provider is contracted (i.e., individual, group, facility, health system, IPA, etc.).</p> <p>Further, the combination of Contract ID and Tax ID impacts the episode of care gain share payments. Since reporting is run by the combination of Contract ID and Tax ID, Provider’s episodes are also aggregated using the combination. BCBST will payout gain share payments according to how the contracted entity/Provider is contracted as a whole under the Contract ID and Tax ID combination. BCBST does not split out payments to the entity, but will allow the contracted entity/Provider(s) to distribute as they determine.</p> |                                  |
| There are specific Lines of Business that were selected to participate in the Tennessee Health Care Innovation Initiative.                                   |   |                                  |
| <i>Lines of Business affected</i>  | Network S - State Employee Health Plan and Fully Insured  |                                  |
| <i>THCII Provider Dispute Resolution Procedure</i>   | <p>THCII Episode of Care Reports can be disputed with BlueCross BlueShield of Tennessee. It is important for participants review interim and performance reports quarterly. Please address any issues or concerns found in a preview or performance period report with your Network Manager and if escalation is necessary, through our Dispute Resolution process. Any questions related to claims data and quality measures should be directed first to the appropriate Network Manager. The Network Manager will engage a resolutions team that will work to reconcile issues. If these issues cannot be resolved, the Provider or Quarterback will be able to follow our Dispute Resolution process in order to reach a solution.</p>   |                                  |

*\*This Provider Guide is being included in the upcoming revisions to the Provider Administration Manual.*

## Glossary

These term definitions have been edited for this medium and are not as complete or detailed as some of the glossary definitions that come with BlueCross BlueShield of Tennessee contracts.

**Ambulance:** A specially designed and equipped vehicle used only for transporting the sick and injured.

**Ambulatory Surgical Facility:** An Institution which:

1. primarily performs surgical procedures on an outpatient basis;
2. does not provide inpatient care;
3. has an organized staff of Practitioners and permanent facilities and equipment;
4. may not be primarily used as an office or clinic for a Practitioner's or Other Professional's practice; and
5. is a licensed Institution.

**Benefit Period:** A calendar year during which benefits are available for Covered Services.

**BlueCard® Program:** A program established by BlueCross and/BlueShield organizations and the Blue Cross and BlueShield Association to process and pay claims for Covered Services received by a Member of a BlueCross and/or BlueShield organization from a Provider outside the organization's service area.

**Coinsurance:** The portion of an eligible medical bill a Member must pay out-of-pocket before BlueCross BlueShield of Tennessee begins paying insurance benefits. Coinsurance amounts are usually a percentage of the total medical bill, i.e., 20 percent. Coinsurance applies after the Member meets a required Deductible or Copay amount. Coinsurance is part of certain health plans.

**Concurrent Review:** A determination of whether continued inpatient care, or a given level of services being received, is Medically Necessary for the Member's medical condition. This review can be performed by the Provider's utilization review staff, BlueCross BlueShield of Tennessee's review coordinator or Medical Director, or any other entity or organization under contract with BlueCross BlueShield of Tennessee. Once the case is reviewed, BlueCross BlueShield of Tennessee will notify the Practitioner and the Member of the results.

**Copay or Copayment:** A copay is a fixed-dollar amount that a Plan Member pays to a participating network doctor, caregiver, or other medical Provider or pharmacy each time health care services are received. A Copay is paid before BlueCross BlueShield of Tennessee pays the covered benefit amount. Copays are part of certain health care plans.

**Contract:** The entire agreement between BlueCross BlueShield of Tennessee and the Member. It including a contract document, the signed application and any attached papers or riders. A rider is an extra provision that is added to the basic Contract. BlueCross BlueShield of Tennessee considers the statements an individual makes in the application to be representations, not warranties.

**Contract Date or Effective Date:** The date coverage begins.

**Covered Service:** A Medically Necessary service or supply shown in the Contract for which benefits may be available.

**Custodial Care:** Care provided primarily for maintenance designed to assist the Member in activities of daily living. It is not provided primarily for its therapeutic value in treatment of an illness or injury. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets, and supervision of self-administration of medication not requiring constant attention of medical personnel.

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**Deductible or Deductible Amount:** A Deductible is a fixed-dollar amount that a Member must pay for eligible services before BlueCross BlueShield of Tennessee begins applying insurance benefits. Usually Deductibles apply every calendar year. Deductibles are part of certain health care benefits plans.

**Dependent:** Another family member covered under a Member's health care benefits plan. May be a spouse and/or unmarried children who meet eligibility requirements of the Plan.

**Diagnostic Service:** A procedure ordered by a Practitioner or Other Provider to determine a specific condition or disease. Some common diagnostic procedures include:

1. X-rays and other radiology services;
2. laboratory and pathology services; and
3. cardiographic, encephalographic and radioisotope tests.

**Durable Medical Equipment (DME):** Equipment which:

1. can only be used to service the medical purpose for which it is prescribed;
2. is not useful to the Member or other person in the absence of illness or injury;
3. is able to withstand repeated use; and
4. is appropriate for use in an ambulatory or home setting.

Such equipment will not be considered a Covered Service, even if it is prescribed by a Practitioner or Other Provider simply because its use has an incidental health benefit.

**Effective Date:** The date on which coverage begins for a Member.

**Eligible Person:** A person entitled to make application for coverage.

**Emergency or Emergency Medical Condition:** An emergency is defined as a sudden and unexpected medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect to result in: serious impairment of bodily functions; serious dysfunction of any bodily organ or part; or placing the prudent layperson's health in serious jeopardy. These services may be provided by facility-based Providers. It is understood that in those instances where a Physician makes emergency care determinations, the Physician shall use the skill and judgment of a reasonable Physician in making such determination.

**Emergency Admission:** Admission as an Inpatient in connection with an Emergency.

**Emergency Services:** Health care services and supplies furnished in a hospital which are needed to determine, evaluate and/or treat an emergency medical condition until the condition is stabilized, as directed or ordered by a Practitioner or hospital protocol.

**Fee Schedule or Fee for Services:** The maximum fee that BlueCross BlueShield of Tennessee will pay for specified Covered Services.

**Freestanding Diagnostic Laboratory:** An Other Provider that provides laboratory analysis for other Providers.

**Freestanding Dialysis Facility:** A Facility Other Provider that provides dialysis treatment, maintenance, and training to Members on an outpatient or home health care basis.

**Freestanding Sleep Study Center:** A Facility Other Provider that provides sleep studies on an outpatient basis.

**Health Care Professional:** A Podiatrist, Dentist, Chiropractor, Nurse Midwife, Registered Nurse, Optometrist, or other person licensed or certified to practice a health care profession, other than medicine or osteopathy, by Tennessee or the state in which that health Care Professional practices.

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**Home Health Care Agency:** An Other Provider, which is primarily engaged in providing home health care services.

**Hospital:** A short-term, acute-care, general hospital which:

1. is a licensed institution;
2. provides inpatient services and is compensated by or on behalf of its patients;
3. provides surgical and medical facilities primarily to diagnose, treat, and care for the injured and sick; except that a psychiatric hospital will not be required to have surgical facilities;
4. has a staff of Practitioners licensed to practice medicine; and
5. provides 24-hour nursing care by registered graduate nurses.

A facility which serves, other than incidentally, as a nursing home, custodial care home, health resort, rest home, rehabilitative facility or place for the aged is not considered a hospital.

**In-Network:** Practitioners, caregivers and medical facilities are considered “in-network” if they participate in an agreement with BlueCross BlueShield of Tennessee to provide services according to specific terms and rates.

**Inpatient:** Inpatient medical care is when treatment is provided to a Member who is admitted as a bed patient in a hospital or other medical facility, and room and board charges are incurred. For behavioral health benefits, Inpatient care can refer to treatment received at a hospital, a behavioral health facility or a behavioral health program. Most benefit plans require prior authorization for Inpatient care before a Member is admitted to a hospital, skilled nursing facility or rehabilitation facility.

**Investigational:** A drug, device, treatment, therapy, procedure, or other services or supplies that do not meet the definition of Medical Necessity:

1. cannot be lawfully marketed without the approval of the Food and Drug Administration (FDA) when such approval has not been granted at the time of its use or proposed use;
2. is the subject of a current investigational new drug or new device application on file with the FDA;
3. is being provided according to a Phase I or Phase II clinical trial or the experimental or research portion of a Phase III clinical trial (participation in a clinical trial shall not be the sole basis for denial);
4. is being provided according to a written protocol which describes among its objectives, determining the safety, toxicity, efficacy or effectiveness of that service or supply in comparison with conventional alternatives;
5. is being delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS);
6. the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within HHS has determined that the service or supply is Investigational or that there is insufficient data to determine if it is clinically acceptable;
7. in the predominant opinion of experts, as expressed in the published authoritative literature, that usage should be substantially confined to research settings;
8. in the predominant opinion of experts, as expressed in the published authoritative literature, further research is necessary in order to define safety, toxicity, efficacy, or effectiveness of that service compared with conventional alternatives; and/or
9. the service or supply is required to treat a complication of an Investigational service.

The Medical Director shall have discretionary authority, in accordance with applicable ERISA standards, to make a determination concerning whether a service or supply is an Investigational service. If the Medical Director does not authorize the provision of a service or supply, it will not be a Covered Service. In making such determinations, the Medical Director shall rely upon any or all the following, at his or her discretion:

1. Member's medical records;
2. the protocol(s) under which proposed service or supply is to be delivered;



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3. any consent document that has been executed or the Member is asked to execute, in order to receive the proposed service or supply;
4. the published authoritative medical or scientific literature regarding the proposed service or supply in connection with the treatment of injuries or illnesses;
5. regulations or other official publications issued by the FDA and/or HHS;
6. the opinions of any entities that contract with the Plan to assess and coordinate the treatment of Members requiring non-Investigational Services; and/or
7. the findings of the BlueCross and BlueShield Association Technology Evaluation Center or other similar qualified evaluation entities.

**Maximum Allowable Charge:** The highest dollar amount of reimbursement by BlueCross BlueShield of Tennessee for a Covered Service. This amount is based on the rates or fees negotiated between BlueCross BlueShield of Tennessee and certain Practitioners, Health Care Professionals, or Other Providers, and whether Covered Services are received from a participating or non-participating Provider. Reimbursement for Out-of-Network services will be the stated percentage of the Maximum Allowable Charge or Billed Charges, whichever is less.

**Medical Care:** Professional services by a Practitioner or Professional Other Provider to treat an illness, injury, pregnancy, or other medical condition.

**Medically Appropriate:** Services, which have been determined by the Medical Director of BlueCross BlueShield of Tennessee to be of value in the care of a specific Member. To be Medically Appropriate, a service must:

1. Be Medically Necessary.
2. Be used to diagnose or treat a Member's condition caused by disease, injury or congenital malformation.
3. Be consistent with current standards of good medical practice for the Member's medical condition.
4. Be provided in the most appropriate site and at the most appropriate level of service of the Member's medical condition.
5. On an ongoing basis, have reasonable probability of:
  - correcting a significant congenital malformation or disfigurement caused by disease or injury;
  - preventing significant malformation or disease; or
  - substantially improving a life-sustaining bodily function impaired by disease or injury.
6. Not be provided solely to improve a Member's condition beyond normal variation in individual development and aging including:
  - Comfort measures in the absence of disease or injury; or
  - Improving physical appearance that is within normal individual variation.
7. Not be for the sole convenience of the Provider, Member or Member's family.
8. Not be an Investigational service.

### **Medically Necessary or Medical Necessity:**

"Medically Necessary" are procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical Practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and not primarily for the convenience of the patient, Physician or other health care Provider; and

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- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician specialty society recommendations, and the views of medical Practitioners practicing in relevant clinical areas and any other relevant factors.

**Medicare:** The program of health care for the aged and disabled established by Title XVIII of the Social Security Act as amended.

**Member:** Any person covered under a health plan from BlueCross BlueShield of Tennessee, including that person's eligible spouse and/or eligible, unmarried children.

**Nervous and Mental Disorder:** A condition characterized by abnormal functioning of the mind or emotions in which psychological, intellectual, emotional or behavioral disturbances are the dominant feature. Nervous and Mental Disorders include mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and psychiatric conditions, whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement. Nervous and Mental Disorders include alcohol, drug or chemical abuse or dependency, but do not include learning disabilities, attitudinal disorders, or disciplinary problems.

**Non-Participating Provider:** A Practitioner, hospital or ambulatory surgical facility that has not contracted with BlueCross BlueShield of Tennessee to furnish services and to accept specified levels of payment, plus applicable Deductibles and Copayment amounts, as payment in full for Covered Services.

**Other Provider:** An individual or facility, other than a Hospital or Practitioner, duly licensed to render Covered Services.

1. The following institutions are **Facility Other Providers** which may provide Covered Services:

- Freestanding Dialysis Facility;
- Ambulatory Surgical Facility;
- Skilled Nursing Facility;
- Substance Abuse Treatment Facility;
- Residential Treatment Facility; and/or
- Licensed Birthing Center.

2. The following **Professional Other Providers** may provide services covered by certain BlueCross BlueShield of Tennessee Contracts. In order to be covered, all services rendered must fall within a specialty (as defined below) and be those normally provided by a Practitioner within this specialty or degree. All services or supplies must be rendered by the Practitioner actually billing for them and be within the scope of his or her Licensure.

- Doctor of Osteopathy (OD);
- Doctor of Dental Surgery (DDS);
- Doctor of Dental Medicine (DDM);
- Doctor of Optometry (OD);
- Doctor of Podiatric Medicine (DPM);
- Doctor of Chiropractic (DC);
- Licensed Clinical Social Worker (LCSW);
- Licensed Independent Practitioners of Social Worker (LIPSW);
- Licensed Marriage and Family Therapist (LMFT);
- Licensed Practical Nurse (LPN);
- Licensed Professional Counselor (LPC)
- Licensed Psychological Examiner (LPE) supervised in accordance with Tennessee law
- Licensed Psychologist;

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- Nurse Midwife (NM), licensed as a RN and certified by the American College of Nurse Midwives);
  - Registered Nurse (RN), including an RN who is a nationally-certified Nurse Practitioner (NP), Nurse Anesthetist (NA), or Clinical Specialist (CS);
  - Registered Nurse Anesthetist (RNA);
  - Registered Physiotherapist (RPT);
  - Licensed Pharmacist (D. Pharm.);
  - Occupational Therapist (for services to restore functioning of the hand following trauma only); and/or
  - Registered Dietitian or Nutritionist approved by BlueCross BlueShield of Tennessee (for nutritional counseling in connection with the treatment of diabetes only)
3. The following **Other Providers** may also provide services covered by certain BlueCross BlueShield of Tennessee Contracts:
- Suppliers of durable medical equipment, appliances and prosthesis;
  - Suppliers of oxygen;
  - Certified ambulance service;
  - Hospice;
  - Pharmacy;
  - Freestanding Diagnostic Laboratory;
  - Freestanding Sleep Study Center; and/or
  - Home Health Care Agency.

**Out-of-Network Provider:** A Practitioner, caregiver or medical facility that does not participate in an agreement with BlueCross BlueShield of Tennessee to provide services according to specific terms and rates.

**Out-of-Pocket Maximum:** The dollar amount, which a Member must pay for Covered Services during a benefit period (does not apply to psychiatric care services).

**Outpatient:** Outpatient medical care is when treatment is provided to a Member in a facility or setting where room and board charges are not incurred. Outpatient medical services may be provided in a Practitioner's office, the Outpatient department of a hospital, or in some other medical setting. For behavioral health benefits, Outpatient care refers to routine visits to a behavioral health professional. Most benefit plans require prior authorization for certain Outpatient medical services.

**Outpatient Surgery:** Surgery performed in an Outpatient department of a hospital, Practitioner's office or Facility Other Provider.

**Physical Therapist:** A licensed Physical Therapist. (In states where there is no Licensure required, the Physical Therapist must be certified by the appropriate professional body or accrediting organization.)

**Participating Provider:** A Practitioner, Hospital, or Ambulatory Surgical Facility or Other Health Care Provider that has contracted with BlueCross BlueShield of Tennessee to furnish services and to accept BlueCross BlueShield of Tennessee payment for Covered Services after applicable Deductibles, Coinsurance or Copayment amounts have been paid by the Member.

**Practitioner:** A licensed Practitioner legally entitled to practice medicine and perform surgery. All Practitioners must be licensed in Tennessee or in the state in which Covered Services are rendered.

**Preferred Provider Organization (PPO):** A PPO plan offers a network of Practitioners, caregivers and medical facilities that agree to provide health care services to Members at less than the usual service fees. Members receive the highest level of benefits when network Providers are used. Members may seek medical care outside the network, but benefits are reduced substantially.

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**Primary Care Practitioner (PCP):** A Practitioner selected by the Member to coordinate all his or her health care, including routine checkups and treatment for medical conditions. A PCP is usually a Practitioner in general practice, family practice, internal medicine or pediatrics. Certain health plans require the Member to select a PCP.

**Prior Approval:** See "Prior Authorization".

**Prior Authorization:** Prior Authorization verifies the Medical Necessity of certain treatments, as well as the setting where medical services are provided. For pharmacy benefits, Prior Authorization helps determine cost-effective alternatives for certain prescription drugs.

**Provider:** A Provider is a Practitioner, other professional caregiver, medical facility, or medical supplier that supplies health care.

**Referral:** The process by which a PPO Member's Primary Care Practitioner authorizes treatment from a medical specialist.

**Skilled Nursing Facility (SNF):** A facility, which provides convalescent and rehabilitative care on an Inpatient basis. Skilled nursing care must be provided by or under the supervision of a Practitioner.

**Specialist:** A Specialist is a Practitioner highly trained in a specific area. Specialists may refer to a sub-Specialist in complex cases. Some examples of a Specialist include:

- Cardiologist
- Dermatologist
- Neurologist
- Obstetrician
- Podiatrist
- Psychiatrist

**Surgery:** Surgery is defined as follows:

1. operative and cutting procedures, including use of special instruments;
2. endoscopic examinations (the insertions of a tube to study internal organs) and other invasive procedures;
3. treatment of broken and dislocated bones;
4. usual and related pre-and post-operative care when billed as part of the charge for Surgery; and
5. other procedures that have been approved by BlueCross BlueShield of Tennessee.

**Termination Date:** The date a Contract ends and the date Benefits end.

**Therapy Services:** Services for treatment of illness or injury defined below:

1. Radiation Therapy – treatment of disease by X-ray, radium, or radioisotopes;
2. Chemotherapy – treatment of malignant disease by chemical or biological agents;
3. Dialysis – treatment of a kidney ailment, including the use of an artificial kidney machine;
4. Physical Therapy – treatment to relieve pain, restore bodily function, and prevent disability following illness, injury, or loss of a body part;
5. Respiratory Therapy – introduction of dry or moist gases into the lungs; and
6. Home Infusion Therapy (HIT) – therapy in which fluid or medication is given intravenously, subcutaneously, intramuscularly, or epidurally, at the patient's home, including total Parenteral Nutrition, Enteral Nutrition, Hydration Therapy, Chemotherapy, and Aerosol Therapy and Intravenous Drug Administration.

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