Healthy Blue + Medicare℠ (HMO D-SNP)

Provider Manual

Medicare

Provider Services: 833-540-2106
https://www.bluecrossnc.com/providers/blue-medicare-providers/healthy-blue-medicare

BlueCross BlueShield of North Carolina MEDICARE

NCBCBS-CR-PM-037964-23

Contents

Introduction

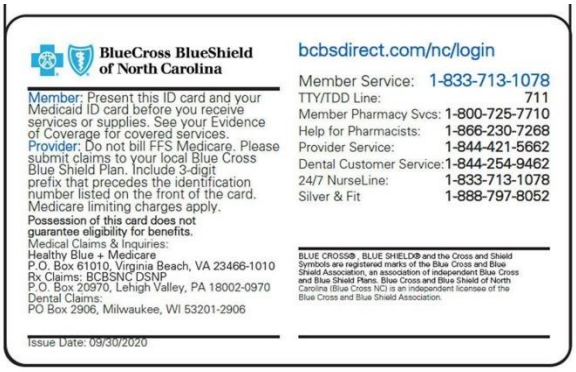
Healthy Blue + Medicare[SM] (HMO D-SNP) is offered pursuant to a contract between CMS and Blue Cross and Blue Shield of North Carolina Senior Health, a wholly-owned subsidiary of Blue Cross and Blue Shield of North Carolina (Blue Cross NC). Healthy Blue + Medicare is an included MA plan for all Blue Cross NC Medicare Provider Agreements, and its members are served by the same network that serves all other MA plans offered by Blue Cross NC. The amounts due, bundling edits, policies and procedures may differ based on the specific product as a result of different benefit designs and claims adjudication methodologies. Claims will be paid consistent with current contract provisions, and Blue Cross NC will use its best efforts to apply bundling logic that is consistent with industry AMA HCPCS (Level I and Level II) or CMS CCI standards in effect at the time of the date of service.

To view the member benefits guide for Healthy Blue + Medicare, visit **medicare.bluecrossnc.com/medicare**.

Contacts

Point of contacts	Telephone	Fax	Address	Hours of operation
Customer Care (Medical & Drug)	**833-713-1078**	**855-358-1226**	Healthy Blue + Medicare Customer Service P.O. Box 62947 Virginia Beach, VA 23466-2947	8 a.m. to 8 p.m. seven days per week, except Thanksgiving & Christmas
Grievances and Appeals (Medical & Drug)	**833-713-1078**	**888-458-1406**	Medicare Complaints, Appeals, Grievances 4361 Irwin Simpson Rd Mail Stop: OH0205-A537 Mason, OH 45040	8 a.m. to 8 p.m. seven days per week, except Thanksgiving & Christmas
Provider Services (Medical & Drug)	**844-895-8160**	**877-799-4129**	Healthy Blue + Medicare P.O. Box 60007 Los Angeles, CA 90060-0008	8 a.m. to 8 p.m. seven days per week, except Thanksgiving & Christmas
Case Management (Medical & Drug)	**866-611-4287**	**855-443-7821**	Healthy Blue + Medicare 3350 Peachtree Rd NE Mail Stop: GAG006-0012 Atlanta, GA 30326	8 a.m. to 5 p.m. M-F, except holidays

Sample ID card



Vision care

Providers in the Community Eye Care Blue Medicare network will be in-network for the Healthy Blue + Medicare medical vision benefits. Routine vision services are not covered through the Healthy Blue + Medicare medical vision network. All medical claims for vision care for Healthy Blue + Medicare members should be submitted to the address on the back of the member's ID card.

Please refer to the member benefits guide for routine vision care on the *More Healthy Benefits* page.

Diabetic supplies

Members requiring diabetic test strips and lancets (diabetic supplies) will only be covered through their pharmacy benefit and network. These supplies will not be covered as in-network when supplied by durable medical equipment providers. This does not apply to our Medicare Advantage HMO and PPO benefits.

Hospice Election

Members may elect Medicare hospice coverage if they have a terminal illness and meet the appropriate guidelines. Hospice care emphasizes supportive services, such as home care and pain control, rather than cure-oriented services. It also includes physical care and counseling.

When a Medicare Advantage (MA) member elects to enroll in the Medicare Hospice Program, Original Medicare assumes responsibility for payment of all hospice-related and all non-hospice related services rendered during the election period. The Medicare Advantage plan is responsible for supplemental services covered under the member's MA plan and coordinates benefits for the original Medicare deductible and coinsurance amounts applied so that it does not exceed the MA plan cost-share amount. CMS released CR6778 to clarify that this change in financial responsibility begins on the day of Hospice Election. Some members may have hospice coverage through their Medicare Advantage plan. Please verify the member's benefits.

The following are submission guidelines for Hospice claims:

Hospice-related Services

- Submit the claim directly to CMS

Nonhospice-related Services

- For Part A services not related to the member's terminal condition, submit the claim to the Medicare Fiscal Intermediary using the condition code 07.
- For Part B services not related to the member's terminal condition, submit the claim to the Medicare Carrier with a "GW" modifier.
- For services rendered for the treatment and management of the terminal illness by an attending physician that is not employed or paid by the hospice provider, submit the claim to the Fiscal Intermediary/Medicare Carrier with a "GV" modifier.

Coordination of Member Cost-Share Amount and Supplemental Benefits

- Submit the claim to the Medicare Advantage Plan with the Original Medicare Explanation of Medicare Benefits (EOMB).

Note: The Anthem MA plan will coordinate based on the EOMB in the situation where the MA plan liability if the member cost sharing is less than the MA plan cost-share amount. Please submit the claim with the EOMB for consideration.

For additional detail on hospice coverage and payment guidelines, please refer to 42 CFR 422.320 — Special Rules for Hospice Care. Section (C) outlines the Medicare payment rules for members who have elected hospice coverage. The Medicare Benefit Policy Manual Publication 100-02 Chapter 9 Coverage of Hospice Service Section 20.4 Election by Managed Care Enrollee; Medicare Managed Care Manual Publication 100-16 Chapter 4 Benefits and beneficiary Protections Sections 10.22 – 10.4 and the CMS Change Request 8727 dated May 1, 2014, all-outline payment responsibility and billing requirements for services rendered during a hospice election period. This documentation is available online at the CMS website: **cms.gov**.

Provider training and attestation requirements

The Centers for Medicare & Medicaid Services (CMS) requires all contracted providers and staff receive basic training about the D-SNP Model of Care. This training and completion of an attestation are required for new providers and annually thereafter. Additional information regarding training will be provided at a later date.

Managed care plan enrollment

Most Medicare beneficiaries are eligible for enrollment in a managed care plan. To enroll, an individual must:

- Have Medicare Parts A and B and continue paying Part B premiums.
- Live in the plan's service area.

The plan must enroll Medicare beneficiaries, including younger disabled Medicare beneficiaries, in the order of application, without health screening. Medicare Advantage plans are required to have an open enrollment period from October 15 through December 7 each year, with a January 1 plan effective date.

Medicare Dual Eligible Special Needs Plans

Dual Eligible Special Needs Plans (D-SNPs) enroll beneficiaries who are entitled to both Medicare (Title XVIII) and Medical Assistance from a State Health Plan under Title XIX (Medicaid). D-SNPs offer the opportunity of enhanced benefits by combining those available through Medicare and Medicaid. D-The following Medicaid eligibility categories are presently eligible for Healthy Blue + Medicare:

- Qualified Medicare Beneficiary without other Medicaid (QMB only),
- QMB+,
- Specified Low-Income Medicare Beneficiary with full Medicaid SLMB+,

- Other full benefit dual eligible (FBDE)

Although D-SNPs are available to beneficiaries in all Medicaid eligibility categories, D-SNPs may further restrict enrollment to beneficiaries that belong to certain Medicaid eligibility categories. CMS divides D-SNPs into the following two categories according to the types of beneficiaries that the SNP enrolls:

- Medicare zero-cost-sharing D-SNPs
- Medicare non-zero cost-sharing D-SNPs

Cost-sharing and billing

Cost-sharing responsibility for special needs plan members

Members that are dually eligible for Medicare and for full Medicaid coverage of their Medicare Part A and Part B premiums and other cost sharing (such as deductibles, coinsurance, and copayments) through a Medicare Savings Program, are protected from liability for payment of Medicare premiums, deductible, coinsurance and copayment amounts. Some Medicare Savings Programs cover some but not all of the premiums and/or cost sharing amounts. Medicare members who do not receive full Medicare cost sharing assistance under Medicaid may be required to pay some cost sharing amounts for services. In addition, members in the QMB (Qualified Medicare Beneficiary) program have no liability to pay Medicare providers for Medicare Part A or Part B cost sharing. Federal law prohibits providers from charging dually eligible members with full cost sharing coverage and QMBs for Medicare cost sharing for covered Part A and Part B services – even when Medicaid does not fully pay the Medicare cost sharing amount. Providers who balance bill a full eligible dual member or a QMB member are in violation of Federal law and are subject to sanctions. Providers also may not accept dual eligible beneficiaries as 'private pay' in order to bill the patient directly and providers identified as continuing to bill dual eligible beneficiaries inappropriately will be reported to CMS for further action/investigation.

Blue Cross NC and/or its designee processes the claim for reimbursement when there is an arrangement with state Medicaid to pay Medicare cost sharing for dual-eligible members in its Special Needs Plans (SNP). The state retains responsibility for cost sharing when Blue Cross NC and/or its designee does not have an arrangement with the state Medicaid agency.

Note: Under Original Medicare rules, an Original Medicare participating provider (hereinafter referred to as a participating provider) is a provider that signs an agreement with Medicare to always accept assignment. Participating providers may never balance bill because they have agreed to always accept the Medicare allowed amount as payment in full. An Original Medicare nonparticipating provider (hereinafter referred to as a nonparticipating, or non-par, provider) may accept assignment on a case-by-case basis and indicates this by checking affirmatively field 27 on the *CMS-5010* claims form; in such a case, no balance billing is permitted.

The rules governing balance billing as well as the rules governing the MA payment of MA plan, noncontracting and Original Medicare, nonparticipating providers are listed below by type of provider.

Contracted provider

There is no balance billing paid by either the plan or the enrollee.

Noncontracting, Original Medicare, participating provider

There is no balance billing paid by either the plan or the enrollee.

Noncontracting, non-(Medicare)-participating provider

The MAO owes the noncontracting, nonparticipating (non-par) provider the difference between the members' cost-sharing and the Original Medicare limiting charge, which is the maximum amount that Original Medicare requires an MAO to reimburse a provider. The enrollee only pays plan-allowed

cost-sharing, which equals:

- The copay amount, if the MAO uses a copay for its cost-sharing; or
- The coinsurance percentage multiplied by the limiting charge, if the MAO uses a coinsurance method for its cost-sharing.
- MA-plan, noncontracting, nonparticipating DME supplier. The MAO owes the noncontracting nonparticipating (non-par) DME supplier the difference between the member's cost-sharing and the DME supplier's bill; the enrollee only pays plan allowed cost-sharing, which equals:
    - The copay amount, if the MAO uses a copay for its cost-sharing; or
    - The coinsurance percentage multiplied by the total provider bill, if the MAO uses a coinsurance method for its cost-sharing. Note that the total provider bill may include permitted balance billing.

Additional useful information on payment requirements by MAOs to non-network providers may be found in the *MA Payment Guide for Out of Network Payments*, at **cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/OONPayments.pdf.**

MA plans must clearly communicate to enrollees through the *Evidence of Coverage* (*EOC*) and *Summary of Benefi*ts (SOB) their cost-sharing obligations as well as their lack of obligation to pay more than the allowed plan cost-sharing as described above.

If you are a noncontracting, nonparticipating (Medicare) provider, who does not accept Medicare assignment, please contact us if there are any questions regarding your claim(s) payments.

Loss of Medicaid coverage for Special Needs Plan members

Blue Cross NC D-SNP (Dual Eligible Special Needs Plan) members are dual-eligible beneficiaries with both Medicare and Medicaid benefits, or they have Medicare and are considered Qualified Medicare Beneficiaries (QMB or QMB+). Medicare members who do not receive full Medicare cost share assistance under Medicaid may be required to pay cost sharing and copayments for services. Members are encouraged to be cognizant of their eligibility to ensure there is no loss or gap in coverage that would result in liability of cost share.

Note: If the Part A deductible and Part B deductible are not already met at the time of the beneficiary's loss of coverage, the member will be responsible for the extended Length Of Services (LOS) per diem cost share for inpatient facilities and/or any coinsurance on professional and outpatient services

Model of care

We have a model of care program in place for members of our Special Needs Plans (SNPs). Our model of care program is comprised of the following elements:

1. Perform an evaluation of our population and create measurable goals designed to address the needs identified. Goals are defined in our model of care and are specific to the population. The SNP model of care is designed to improve the care of our members in all of the following areas:
    - Improving access and affordability of the healthcare needs of the population.
    - Improvements made in coordination of care and appropriate delivery of services through the direct alignment of the health risk assessment (HRA), individualized care plan (ICP) and interdisciplinary care team (ICT).
    - Enhanced care transitions across all health care settings and providers.
    - Ensuring appropriate utilization of services for preventive health and chronic conditions.
2. Our staff structure and care management roles are designed to manage the special needs population. Each SNP member will have an individualized interdisciplinary care team which may include any of the following members: nurses, physicians, social workers, pharmacists, our member, behavioral health specialists, or other participants as determined by the member.

3. We work to complete a health risk assessment (HRA) on each member. For new members, the goal is to complete the initial HRA within 90 days of eligibility and then annually before the next anniversary of the last HRA. We perform outreach in multiple ways to attempt to reach all our members. As some individuals may be difficult to reach by phone, our team may contact your office for updated contact information. Our assessment covers physical, behavioral, cognitive, psychosocial, functional and environmental topics and serves as the basis for the member's individualized care plan (ICP). Providers have access to the HRA results and the individualized care plan (ICP) through the provider portal.
4. Based on the results of the HRA, an ICP will be developed by the case manager working directly with the member and the interdisciplinary care team (ICT) to address identified needs. The care plan includes interventions designed to educate, inform and serve as an advocate for our members. Use of community resources is facilitated for the member, and benefits are coordinated between Medicare and Medicaid for our dual special needs members. The member's care plan will coordinate with and support your medical plan of care
5. An ICT is assigned to each member and is responsible for reviewing the care plans, collaborating with you and other network providers and providing recommendations for management of care. You and/or your patient may be asked to participate in the care planning and management of the plan of care.
6. We have a contracted provider network having special expertise to manage the special needs population and monitor the use of clinical practice guidelines by the contracted providers. Roles of providers include advocating, informing and educating members, performing assessments, diagnosing and treating. If you believe our local network does not meet all of your members' specialized needs and would like to recommend possible additions to our network, please contact provider relations at the number on the members' identification card or discuss with the case manager.
7. We are committed to effective, efficient communication with you. We have developed a communication system to support effective information between you, our members and our care team. Information from our internal systems are available to you through the provider portal and may assist you in managing your patient's care. You can access claim information, the care plan, medication history, HRA results and see other providers involved in providing care to the member. Our case managers may reach out to you to discuss needs identified during our case management process. We may also reach out by phone or fax to provide important information or to assist in coordinating care. You may also receive a copy of the care plan or a phone call from the case manager asking you to review, make comments or recommendations about the care plan or the needs that have been identified during the care planning process. You may reach your patients' care team by calling the number provided to you on any correspondence from us or the number on the members' identification card. General information is available online through the provider portal on our website.
8. We support transitions in care for your patients. Special needs plan members typically have many providers and may transition into and out of health care institutions. Our care management team may contact you and your patient related to certain types of transitions. If you are aware of an upcoming care transition for your patient and would like our team to assist in the coordination, please notify us at the number provided on the members' identification card. Care transition protocols and your role in this process are communicated in this manual.
9. Performance and health outcome measurements are collected, analyzed and reported to measure health outcomes and quality measures and also to evaluate the effectiveness of the model of care. These measurements are used by our Quality Management Program and include any of the following measures:
    - HEDIS® — used to measure performance on dimensions of care and service
    - Consumer Assessment of Healthcare Providers and Systems (CAHPS) member satisfaction survey

- *Health Outcomes Survey* (*HOS*) member survey is multi-purpose and used to compute physician and mental component scores to measure the health status, while not limited to SNP members responses we use these results to assist us in the population assessment.
- CMS Part C Reporting Elements, including benefit utilization, adverse events, organizational determinations and procedure frequency
- Medication therapy measurement measures
- Clinical and administrative/service quality improvement projects

SNP model of care training is required annually and available to providers, employees and contractors. The training may be provided to you in your provider manual, through newsletters, provider orientation, or on our provider portal.

Annual program evaluation
We conduct an annual evaluation of the model of care to identify any modifications that are needed and assess progress toward meeting the program goals. Throughout the year, we review our program to identify any issues. The results of our defined goals are included as part of the program evaluation. When necessary, we develop action plans for goals that are not trending toward our benchmarks. We compare our goals to the previous year to evaluate our progress toward our benchmarks. In most of our markets, we are meeting or exceeding in many areas. We are also showing an upward trend when we compare our year over year results. We continue to work on ways to improve our outreach to our members and improve our completion rates for the health risk assessments, individualized care plans and interdisciplinary care teams for each of our special needs plan members. We manage use of inpatient and emergency room services and have programs in place to address areas where we have opportunities for improvement. The goals related to managing transitions include access to the PCP and post discharge management which continue to improve in most markets. Preventive care goals are established for our programs and managed as a part of HEDIS. Multiple interventions are put in place to improve the HEDIS and STAR measures.

One of our desired outcomes as part of the model of care is to assist you in managing and coordinating care in order to improve the health status and outcomes of your patients. If you have any input regarding our model of care, we welcome your feedback.

Care transition protocols and management

Assisting with the management of transitions is an important part of our case management and model of care. Members are at risk of fragmented and unsafe care during transitions between care settings and levels of care. To help members and caregivers navigate transitions successfully, assistance is provided through many touch points and through educational materials. Transitions in care refer to the movement between health care providers and settings and include changes in a member's level of care. Examples of transitions include transitions to and from: acute care, skilled nursing facility, custodial nursing facility, rehabilitation facility, home, home health care, and outpatient or ambulatory care centers. A team approach is necessary to assist the member with a successful transition. Managing transitions includes protocols such as assisting with logistical arrangements, providing education to the member and caregiver, coordination between health care professionals and a provider network with appropriate specialists who can address the complex needs of the special needs population. Transitional care includes both the receiving and sending aspects of the transfer. Transitional care management assists in providing continuity of care by creating an environment where the member and the provider are cooperatively involved in ongoing health care management with goal of providing access to high-quality, cost-effective medical care.

Personnel responsible for coordinating care transition

Providers are essential members of the ICT and should assist members by coordinating care and communicating with members of the ICT. Members are connected to the appropriate provider to care for their individual needs including any complex medical conditions. The PCP is responsible for coordinating and arranging referrals to the appropriate care provider.

When services are not a covered benefit, coordination with community resources occurs to meet the needs of the population. For our dual population, you are required to coordinate between Medicare and Medicaid. Coordination with Medicaid services includes coordination of benefits and also working with Medicaid case managers/service coordinators and providers of long-term services and supports (LTSS) to close care gaps.

Protocols outlining the expectations for managing transitions may be communicated to the provider network through newsletters, published in the provider manual or on the provider portal. Below are protocols when managing transitions

- Participate in the interdisciplinary care team meetings.
- Notify the member in advance of a planned transition.
- Provide documentation to the provider or facility about the member to assist in providing continuity of care.
- Communicate and follow up with the member about the transition process.
- Communicate health status and plan of care to the member.
- Provide a treatment plan/discharge instructions to the member prior to being discharged from one level of care to another.
- Provide relevant patient history to the receiving provider.
- Forward pertinent diagnostic results to treating providers.
- Communicate any test results and the treatment plan back to the referring provider.

We assist our members and providers in the management of transitions in multiple ways within our care management programs. The actions below represent some of the ways our care team works with our providers and members to coordinate care and assist in the management of transitions:

- Communicate with the provider to discuss the member’s care needs as identified during case management or model of care activities.
- Assist the member in making appointments.
- Coordinate between Medicaid and Medicare benefits.
- Perform medication reconciliation.
- Arrange transportation.
- Refer the member to external or internal programs.
- Coordinate care with behavioral health services.
- Assist with arranging DME and home health services.
- Coordinate and facilitate transitions to the appropriate level of care.
- Provide the member with disease-specific education and self-management techniques.
- Contact high-risk members post-discharge to reduce unnecessary readmissions.
- During interactions with the member, communicate support is available from member services to serve as a central point of contact and assist during any transition.

Providing Noncovered Services Advanced Notification

For services that require prior authorization or are noncovered by the plan (in other words statutory exclusion), it becomes extremely important that Anthem authorization procedures are followed. If a

member elects to receive such care, the member cannot be held financially responsible unless notified in advance of the noncovered services. In such cases when the network physician fails to follow Anthem authorization protocols, Anthem may decline to pay the claim in which case the physicians will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

CMS issued guidance concerning the Advanced Beneficiary Notice of Noncoverage (ABN). The ABN is a Fee-for-Service document and cannot be used for Medicare Advantage denials or notifications. Per the ***CMS Medicare Claims Processing Manual*** (page 4), the ABN is given to beneficiaries enrolled in the Medicare Fee-For-Service program. It is not used for items or services provided under the Medicare Advantage (MA) Program or for prescription drugs provided under the Medicare Prescription Drug Program (Part D). CMS advised Medicare Advantage plans that contracted providers are required to provide a coverage determination for services that are not covered by the member's Medicare Advantage plan. This will ensure that the member will receive a denial of payment and accompanying appeal rights. If you have any doubt about whether a service is not covered, please seek a coverage determination from the plan.

Special Rules for Emergency and Urgently Needed Services, Post-Stabilization Care, and Ambulance Services

The Anthem MA plans are financially responsible for emergency services provided by contracted and noncontracted providers where services are immediately required because of an emergency medical condition. The plan is also financially responsible for urgently needed services, post-stabilization care, and ambulance services, including ambulance services dispatched through 911 or its local equivalent, where other means of transportation would endanger the beneficiary's health.

A Medicare Advantage organization is required to cover emergency services for its MA members regardless of whether the services were preauthorized or the organization has a contractual agreement with the provider of the services. Therefore, emergency services for members are covered without regard to prior authorization or whether services were provided in or out of the service area.

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- Serious jeopardy to the health of the individual
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part.

Urgently needed services are not emergency services as defined above, but are covered services which are medically necessary and immediately required as a result of unforeseen illness, injury or condition and it was not reasonable, given the circumstances, to obtain the services through the organization. For example, urgently needed services are covered when:

- An enrollee is temporarily absent from the MA plan's service area.
- When the enrollee is in the service area and there are extraordinary circumstances that cause the provider network to be temporarily unavailable or inaccessible.

Post-stabilization care is defined as covered services pertaining to an emergency medical condition provided after the member is stabilized. It is to be determined by the attending physician and under specific circumstances includes care to improve or resolve the enrollee's condition. The treating physician is responsible for determining when the member is considered stabilized for transfer or discharge. For the

purposes of this requirement, post-stabilization care and maintenance care are used synonymously. The plan's financial responsibility for post-stabilization care services includes:

- Any service administered, even though not preapproved by the plan or its representative, during the one-hour period following the request to the MA organization for preapproval of further post-stabilization care.
- Services administered to maintain, improve, or resolve the enrollee's stabilized condition if the MA organization does not respond to the request for preapproval within one hour.
- The MA organization's representative and the treating physician cannot reach an agreement concerning care decisions and a plan physician is not available for consultation.

The plan's financial responsibility for post-stabilization care ends when:

1. A plan physician with privileges at the treating hospital assumes responsibility for the member's care.
    - A plan physician assumes care through transfer.
    - The MA organization's representative and the treating physician reach an agreement on the member's care.
    - The member is discharged.

Distinguishing between Provider and Medicare Advantage Member Appeals

Anthem has separate and distinct processes for requests to reconsider an Anthem decision on an authorization or request for payment upon claims submission. Upon processing of each request, assignment of liability for the service is determined. All Medicare member liability denials are subject to the Medicare Complaints, Appeals and Grievances (MCAG) process as outlined in the *Medicare Member Liability Appeals* and *Medicare Member Grievance* sections of this Provider Manual. Disputes between the health plan and the provider that do not involve an adverse determination or liability for the Medicare member follow the Anthem Medicare Advantage participating provider appeals and dispute or nonparticipating provider payment dispute processes.

Providers must cooperate with Anthem and with members in providing necessary information to resolve the appeals within the required time frames. Providers must provide the pertinent medical records and any other relevant information upon request and when initiating an appeal. In some instances, providers must provide the records and information very quickly in order to allow Anthem to make an expedited decision. Your participation in and the member's election of the Medicare Advantage plan are an indication of consent to release those records as part of health care operations.

Medicare Member Liability

Anthem has determined that a Medicare member is responsible for payment as the service(s) are determined to be not covered under the plan to which they are enrolled or is considered Medicare member cost share. Any time a member liability denial letter is issued, the member appeals process must be followed and **not** the provider appeals process. Medicare member liability is assigned when:

- The *Integrated Denial Notice* (*IDN*) is issued as per the *CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance* with subsequent review by the Independent Review Entity (IRE).
- The *Notice of Denial of Medicare Prescription Drug Coverage* is issued as per the *CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.*
- A decision that inpatient hospital care is no longer necessary with delivery of the *Important Message from Medicare (IM)* as per the *CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance.*

- *Notice of Medicare Non-Coverage* (*NOMNC*) is delivered as per the *CMS Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance* with rights to pursue an appeal via the Quality Improvement Organization (QIO) or the plan directly.
- An *Explanation of Benefits* (*EOB*) indicates there is member responsibility assigned to a claim processed.
- An *Explanation of Payment* (*EOP*) indicates there is member responsibility assigned to a claim processed.

Participating Provider Liability
If Anthem has determined that the participating provider has failed to follow the terms and conditions of their contract either administratively or by not providing the clinical information needed to substantiate the services being requested for approval of payment, the participating provider is prohibited from billing a Medicare member for services unless the plan has determined member liability and issued the appropriate notices as above.

Nonparticipating Provider Liability
Anthem has determined that the nonparticipating provider failed to follow Medicare requirements unless the plan has determined member liability and issued the appropriate notices as above and has procedures for nonparticipating provider to follow.

Provider Claim Payment Disputes and Administrative Plea Processes

Provider Claim Payment Dispute process
If you disagree with the outcome of a claim, you may begin the provider payment dispute process. Provider Payment Disputes and Provider Administrative Pleas are different processes:

- **Provider Payment Dispute**: The claim has been finalized but you disagree with the amount that you were paid;
- **Provider Administrative Plea**: The claim has been finalized, but you disagree with the administrative denial that has been applied. An administrative denial is applied within the claims process when it is determined that the provider failed to follow the terms and conditions of their contract. Examples of administrative denials are as follows: denials such as no prior authorization or late notification.

Please be aware, there are two common claim-related issues that are **not** considered claim payment disputes. To avoid confusion with claim payment disputes, these are briefly defined below. They are:

- Claim Inquiry: A question about a claim, but not a request to change a claim payment.
- Claims Correspondence: When Anthem requests further information to finalize a claim. Typically, these requests include medical records, itemized bills, or information about other insurance a member may have. A full list of correspondence related materials are in the correspondence section of this provider manual.

Claims that were denied for lack of medical necessity should follow the participating provider standard appeal process. A Medicare participating provider standard appeal is a formal request for review of a previous Anthem decision where medical necessity was not established where provider liability was assigned (see original decision letter) for services already rendered. An example of this appeal scenario would be as follows:

- On clinical review, the services related to the prior authorization request were deemed not medically necessary but services were rendered and claim payment was denied.

For more information on each of these claim-related processes, please refer to the appropriate section in this provider manual.

The Anthem provider payment dispute process consists of two internal steps. You will **not** be penalized for filing a claim payment dispute and no action is required by the member.

1. Claim Payment Reconsideration: This is first step in the provider payment dispute process. The reconsideration represents your initial request for an investigation into the outcome of the claim. Most issues are resolved at the claim payment reconsideration step.
2. Claim Payment Appeal: The second step in the provider payment dispute process. If you disagree with the outcome of the reconsideration, you may request an additional review as a claim payment appeal. Claim Payment Appeals must be submitted in writing or via the web and should explain the basis for disputing the outcome of the Claim Payment Reconsideration.

A claim payment dispute may be submitted for multiple reason(s) including:

- Contractual payment issues.
- Disagreements over reduced claims or zero-paid claims not related to medical necessity.
- Post-service authorization issues.
- Other health insurance denial issues.
- Claim code editing issues.
- Duplicate claim issues.
- Retro-eligibility issues.
- Experimental/investigational procedure issues.
- Claim data issues.
- Timely filing issues.*

*Timely filing issues: Anthem will consider reimbursement of a claim which has been denied due to failure to meet timely filing if you can: 1) provide documentation the claim was submitted within the timely filing requirements or 2) demonstrate good cause exists.

The first step in the Anthem claim payment dispute process is called the reconsideration. It is your initial request to investigate the outcome of a finalized claim. Please note, we cannot process a reconsideration without a finalized claim on file.

We accept reconsideration requests in writing, verbally and through our provider web portal within 120 calendar days from the date on the *Explanation of Payment* (*EOP*) (see below for further details on how to submit). Reconsiderations filed more than 120 days from the *EOP* will considered to be untimely and denied unless good cause can be established.

When submitting reconsiderations, please include as much information as you can to help us understand why you think the claim was not paid as you would expect.

The plan encourages providers to use our claims payment reconsideration process if you feel a claim was not processed correctly, however, this optional step is not required prior to filing a claim payment appeal**.**

If a reconsideration requires clinical expertise, it will be reviewed by appropriate clinical professionals.

The plan will make every effort to resolve the claims payment reconsideration within 45 calendar days of receipt.

We will send you our decision in a determination letter when upholding our decision, which will include:

1. A statement of the provider's reconsideration request.
2. A statement of what action the plan intends to take or has taken.

3. The reason for the action.
4. Support for the action including applicable statutes, regulations, policies, claims, codes or provider manual references.
5. An explanation of the provider's right to request a claim payment appeal within 63 calendar days of the date of the reconsideration determination letter.
6. An address to submit the claim payment appeal.
7. A statement that the completion of the claim payment appeal process is a necessary requirement before requesting a state fair hearing (where applicable).

If the decision results in a claim adjustment, the payment and *Explanation of Payment* (*EOP*) will be sent separately. Overturned decisions will result in an adjustment and EPOs.

Claim Payment Appeal

If you are dissatisfied with the outcome of a Reconsideration determination, you may submit a claim payment appeal.

We accept claim payment appeals through our provider website or in writing within 63 calendar days of the date on the reconsideration determination letter. Claim payment appeals received more than 63 calendar days after the explanation of payment or the claims reconsideration determination letter will be considered untimely and will be upheld unless good cause can be established.

When submitting a claim payment appeal, please include as much information as you can to help us understand why you think the reconsideration determination was in error. Please note, we cannot process a claim payment appeal without a reconsideration on file.

If a claim payment appeal requires clinical expertise, it will be reviewed by appropriate clinical professionals.

The plan will make every effort to resolve the claim payment appeal within 30 calendar days of receipt.

If the decision results in a claim adjustment, the payment and *EOP* will be sent separately.

How to submit a Claim Payment Dispute

We have several options when filing a claim payment dispute. They are described below.

- **Verbal (Reconsideration only):** Verbal submissions may be submitted by calling Provider Services.
- **Web Portal (Reconsideration and Claim Payment Appeal)**: The plan can receive reconsiderations and claim payment appeals via the secure Availity Portal Payment Dispute/Appeal Tool at **availity.com**. Supporting documentation can be uploaded on the Portal.
  You will receive immediate acknowledgement of your web submission.
- **Written (Reconsideration and Claim Payment Appeal):** Written reconsiderations and claim payment appeals should be mailed, along with the *Claim Payment Appeal Form* or the *Reconsideration Form* to:

  Medicare Payment Dispute Unit
  Healthy Blue
  P.O. Box 61010
  Virginia Beach

Participating Provider Standard Appeals

Anthem participating providers may initiate provider appeals under the provider appeal procedures. Anthem typically determines provider appeals within 60 days) when sufficient information is received to make a decision.

Medicare Participating Provider Standard Appeal

A formal request for review of a previous Anthem decision where medical necessity was not established where provider liability was assigned (see original decision letter) for services already rendered.

Provider Medical Necessity Appeals Responsibility

All requests must be:

- Submitted in writing.
- Submitted within 180 days from the Anthem decision letter date.*
- Include a cover letter with:
    - Member identifiable information
    - Date(s) of service in question
    - Specific rationale as to why the services did in fact meet medical criteria and reference specifics within the medical record to refute Anthems original decision
- Include necessary attachments:
    - Copy of the original Anthem decision
    - All applicable medical records

N**ote**: Anthem will not request additional records to support the provider's argument and expects the provider to submit the necessary information to substantiate their request for payment.

Mail to:

Medicare Complaints, Appeals and Grievances (MCAG)
Attention: Medical Necessity Provider Appeals
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

Providing the above information will enable the Anthem Participating Provider Appeals team to properly and timely review requests within 60 days. Requests that do not follow the above may be delayed.

* Days from original denial date may differ, depending upon the contract and/or state requirements.

Nonparticipating Provider Payment Disputes

If, after a claim has been adjudicated, a nonparticipating provider contends that our decision to pay for a different service from the one originally billed or believe they would have received a different payment under Original Medicare, the nonparticipating provider payment dispute resolution process can be used. Notification will be provided to the nonparticipating provider at each step of the process. For more information regarding the disputes process, please see **Claims Dispute** section.

Nonparticipating Provider Appeals Rights

If a claim is partially or fully denied for payment with member liability (see original decision letter), the nonparticipating provider must request a reconsideration of the denial within 60 calendar days from the remittance notification. When submitting the reconsideration of the denial of payment on a claim, a signed *Waiver of Liability Statement* must be included. To obtain this form, please go to:

cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip.

Distinguishing Between Member Appeals and Member Grievances

Complaints are considered any expression of dissatisfaction to a Medicare health plan, provider, facility or Quality Improvement Organization (QIO) by an enrollee made orally or in writing. There are two procedures for resolving MA member complaints: the Medicare member **appeals** process and the Medicare member **grievance** process. All member concerns are resolved through one of these mechanisms. The member's specific concern dictates which process is used. Therefore, it is important for the physician to be aware of the difference between appeals and grievances.

The purpose of the *Waiver of Liability Statement* is to hold the enrollee harmless regardless of the outcome of the appeal.

With the appeal, the nonparticipating provider should include documentation such as a copy of the original claim, remittance notification showing the denial, and any clinical records and other documentation that supports the provider's argument for reimbursement. **The appeal must be in writing.**

Please mail the appeal to this address.
Medicare Complaints, Appeals & Grievances
Attention: Non-Contracted Provider Appeals
Mailstop: OH0205-A537
4361 Irwin Simpson Rd
Mason, Ohio 45040

Medicare Member Liability Appeals

A member appeal is the type of complaint a member (or authorized representative) makes when the member wants Anthem to reconsider and change an initial coverage/organization determination (by Anthem or a provider) about what services, benefits or prescription drugs are necessary or covered or whether Anthem will reimburse for a service, a benefit or a prescription drug.

An appeal refers to any of the procedures that deal with a request to review a denial of payment or services. If a member believes he or she is entitled to receive a certain service and Anthem denies it, the member has the right to appeal. It is important to follow the directions in the denial letter issued to ensure the proper appeals process is followed.

A member may appeal:

- An adverse initial organization determination by Anthem or a provider concerning authorization for or termination of coverage of a health care service
- An adverse initial organization determination by Anthem concerning reimbursement for a health care service
- An adverse initial organization determination by Anthem concerning a refusal to reimburse for a health service already received if the refusal would result in the member being financially liable for the service
- An adverse coverage determination by Anthem or a provider concerning authorization or payment for prescription drugs

Appeals should be sent to:

Medicare Complaints, Appeals and Grievances (MCAG)
Attention: Member Appeals

Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

All Medicare member concerns that do not involve an initial determination are considered grievances and are addressed through the grievance process.

Participating provider responsibilities in the Medicare member appeals process

- Physicians can request expedited or standard pre-service appeals on behalf of their members; however, if not requested specifically by the treating physician, an *Appointment of Representative Form* may be required. The *Appointment of Representative Form* can be found online and downloaded at **cms.gov/Medicare/CMS-Forms/CMS-Forms/CMS-Forms-Items/CMS012207**
- When submitting an appeal, provide all medical records and documentation to support the appeal at that time. If additional information is needed, the request for information will delay processing of the appeal.
- Expedited appeals should only be requested if the normal time period for an appeal could jeopardize the member's life, health or ability to regain maximum function.
- The CMS guidelines should be utilized when requesting services and initiating the appeals process.

Appeal time frames

- Members or their authorized representatives have 60 days from the date of the initial adverse determination to file an appeal. The 60-day filing deadline may be extended where good cause can be shown.
- Standard Part C pre-service appeals that are not for a Part B drug, must be resolved within 30 calendar days from the date the request was received, unless it is in the member's interest to extend the timeframe
    - If the normal time period for an appeal could jeopardize the member's life, health or ability to regain maximum function, a request for an expedited appeal may be submitted orally or in writing. Such appeals are resolved within 72 hours, unless it is in the member's interest to extend this time period.
    - A standard pre-service appeal for the coverage of a Part B drug must be resolved in 7 days from the date the request was received. Part B drug appeals timeframes cannot be extended.
- Post-service payment appeals must be resolved within 60 calendar days from the date the request was received. All payment appeals must be submitted in writing.
- For Part D appeals:
    - Part D expedited pre-service appeals must be resolved within 72 hours from receipt. Part D standard pre-service appeals must be resolved within 7 days from the date the request was received.
    - Part D payment appeals must be resolved within 14 days from the date the request was received.
    - Part D appeals timeframes cannot be extended.

Further appeal rights

If Blue Cross NC is unable to reverse the original denial decision for a Part C item or service in whole or part, the following additional steps will be taken:

- Blue Cross NC will forward the appeal to an Independent Review Organization (IRO) contracted with the federal government. The IRO will review the appeal and make a decision:
  - Within 24 hours of the adverse decision, if expedited.
  - Within 30 days if the appeal is related to authorization for health care that is not a Part B drug.
  - Within 7 days if the appeal is related to authorization of a Part B drug.
  - Within 60 days if the appeal involves reimbursement for care. (or 30 days for integrated DSNP plans with unified grievance and appeal procedures)
  - Part D prescription drug appeals are not forwarded to the IRO by Blue Cross NC but may be requested by the member or representative; information will be provided on this process during the Blue Cross NC Medicare member appeals process.
- If the IRO issues an adverse decision (not in the member's favor) and the amount at issue meets a specified dollar threshold, the member may appeal to an Administrative Law Judge (ALJ).
- If the member is not satisfied with the ALJ's decision, the member may request review by the Medicare Appeals Council. If the Medicare Appeals Council refuses to hear the case or issues an adverse decision, the member may be able to appeal to a federal court.

Hospital discharge appeals and QIO review process
Hospital discharges are subject to an expedited member appeal process. CMS has determined that Medicare Advantage members wishing to appeal an inpatient hospital discharge must request an immediate review from the appropriate Quality Improvement Organization (QIO) authorized by Medicare to review the hospital care provided to Medicare patients.

When an MA member does not agree with the physician's decision of discharge from the inpatient hospital setting, the member must request an immediate review by the QIO. The member or their authorized representative, attorney, or court-appointed guardian must contact the QIO by telephone or in writing. This request must be made no later than midnight of the day of discharge.

The QIO will make a decision within one full day after it receives the member's request, the appropriate medical records, and any other information it needs to make a decision. While the member remains in the hospital, Blue Cross NC continues to be responsible for paying the costs of the stay until noon of the calendar day following the day the QIO notifies the member of its official Medicare coverage decision.

If the QIO agrees with the physician's discharge decision, the member will be responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO provides notification of its decision. If the QIO disagrees with the physician's discharge decision, the member is not responsible for paying the cost of additional hospital days. If an MA member misses the deadline to file for an immediate QIO review and is still in the hospital, then he/she may request an expedited pre-service appeal. In this case, the member does not have automatic financial protection during the course of the expedited appeal and may be financially liable for paying for the cost of the additional hospital days if the original decision to discharge is upheld upon appeal.

Medicare member grievances

A Medicare member grievance is the type of complaint a member makes regarding any other type of problem with Blue Cross NC or a provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room and the cleanliness of the provider's facilities are grievances.

Blue Cross NC must accept grievances from members orally or in writing within 60 days of the event.* Blue Cross NC must make a decision and respond to the grievance within 30 days. A member can request

an expedited grievance, in which case Blue Cross NC has 24 hours to respond. An expedited grievance can only be initiated if Blue Cross NC refuses to grant the member an expedited organization/coverage determination or an expedited reconsideration/redetermination or notifies the member that an extension will be taken in making an organization determination or deciding an appeal (when allowed). Blue Cross NC can request up to 14 additional days to respond to a grievance if it is in the member's best interest.

* Note: Some plans may not limit the time in which a member grievance is filed (for example, certain integrated DSNP plans and MMPs). These plans allow the member to file a grievance at any time.

Resolving Medicare Member Grievances

If a Medicare member has a grievance about Anthem, the Medicare Advantage plan, a provider or any other issue, providers should instruct the member to call Member Services at the number located on the back of their ID card or send a written grievance to:

Medicare Complaints, Appeals and Grievances (MCAG)
Attention: Member Grievance Unit
Mailstop: OH0205-A537
4361 Irwin Simpson Road
Mason, Ohio 45040

MEDICARE

Provider Services: 833-540-2106

https://www.bluecrossnc.com/providers/blue-medicare-providers/healthy-blue-medicare

Blue Cross and Blue Shield of North Carolina Senior Health, DBA Blue Cross and Blue Shield of North Carolina, is an HMO D-SNP plan with a Medicare contract and a NC State Medicaid Agency Contract (SMAC). Enrollment in Blue Cross and Blue Shield of North Carolina Senior Health depends upon contract renewal.