BlueCross BlueShield of South Carolina and
BlueChoice® HealthPlan of South Carolina

Independent licensees of the Blue Cross and Blue Shield Association

Medicare Advantage

Office Manual

BlueCross Total℠, BlueCross Total Value℠ and BlueCross Blue Basic℠ PPO Edition

Published by Provider Relations and Education
Your Partners in Outstanding Quality, Satisfaction and Service

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In the event of any inconsistency between information contained in this handbook and the agreement(s) between you and BlueCross, the terms of such agreement(s) shall govern. The information included is general information and in no event should be deemed to be a promise or guarantee of payment. We do not assume and hereby disclaim any liability for loss caused by errors or omissions in preparation and editing of this publication.

Introduction

BlueCross Total Upstate, BlueCross Total Midlands/Coastal, BlueCross Total Lowcountry, BlueCross Total Value Upstate, BlueCross Total Value Midlands/Coastal, BlueCross Total Value Lowcountry and BlueCross Blue Basic are products offered by BlueCross BlueShield of South Carolina. These plans offer a network of preferred providers, and members can receive benefits both in and out of network.

Purpose of This Guide

This manual serves as a reference for providers participating in the network for BlueCross Total, BlueCross Total Value and BlueCross Blue Basic plans.

The information in this manual is only general benefit information and does not guarantee payment. Benefits are always subject to the terms and limitations of the plan. No employee of BlueCross BlueShield of South Carolina has authority to enlarge or expand the terms of the plan. The availability of benefits depends on the patient's coverage and the existence of a contract for plan benefits as of the date of service. A loss of coverage, as well as contract termination, can occur automatically under certain circumstances. There will be no benefits available if such circumstances occur.

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Chapter One: General Information

Section 1: Provider Relations and Education Contacts

Our Provider Relations and Education staff focuses on providing training and support to health care professionals. It serves as liaisons between BlueCross and the health care community to promote positive relationships through continued education and problem resolution. The staff is available for on- site training and participation in regional practice manager meetings.

Our provider advocates cover the state of South Carolina and contiguous counties in Georgia and North Carolina. If you have a question about a topic — such as compliance requirements, electronic claim filing updates, or problem identification/resolution — submit the Provider Education Contact Form. If you have a training request, please contact your county's designated provider advocate by using the Provider Advocate Training Request form. These forms are located on the Contact Us/Provider Advocates page on our website www.SouthCarolinaBlues.com. You can also reach our Provider Education department by emailing provider.education@bcbssc.com or by calling 803-264-4730.

Section 2: Website

Visit the Provider page of www.SouthCarolinaBlues.com for educational information, news, updates, resources and forms. All information is real-time and confidential. To protect privacy and comply with HIPAA standards, we use the latest encryption technology to ensure that no unauthorized person can access protected health information (PHI).

Section 2.1: News and Updates

We have many informational publications for providers, including this manual. These publications are available on our website at www.southcarolinablues.com/web/public/brands/sc/providers/. By placing our publications on the website, we can provide you with important information quickly and accurately.

- Frequently Asked Questions (FAQs) — FAQs can be viewed online. FAQs are created from inquiries received from the provider community or are developed by the plan(s) in anticipation of provider questions.
- Bulletins — View the latest BlueCross news announcements for providers online. Bulletins cover a range of important topics from all areas of our business. We alert you of new bulletins via email notification, through faxed responses, and by call campaigns.
- Newsletters — BlueNews℠ for Providers is a publication available online and emailed by request. It is for educational and research purposes only. While the articles in the newsletter are derived from sources believed reliable, BlueNews℠ is not intended to be professional health care advice.

Section 2.2: Resources

We have developed several resources to make your interactions with BlueCross easy and efficient. Document types available include instructional manuals, user guides, managed care magazines, quick reference guides, and educational handouts. Resources are available to view online or to print. You can find these documents:

- BlueCard Program Manual
- Dental Providers Administrative Office Manual
- Provider Office Administrative Manuals
- Medicare Advantage Manuals
- BlueNews℠ for Providers newsletter
- Provider News Bulletins
- My Insurance Manager℠ User Guide
- My Remit Manager User Guide
- Medical Forms Center
- Identification (ID) Card Guides

- Reference Guide for Provider Information and Contacts
- Quick Reference Card for Provider Self-Help
- FAQs

Section 2.3: Forms

Forms are available to download and print from the Forms page of the website. Form headings include: Financial and Provider Reconsiderations, Prescription Drug Prior Authorization, Other Forms.

Section 2.4: Training Registration

As part of our service efforts, we provide training events for our providers and staff on our business objectives and processes.

From the Providers link of the website, select the News and Events link and then choose Upcoming Trainings. You can sign-up or register for upcoming training sessions based on your availability.

Section 3: Electronic Solutions and Provider Self-Help

Various tools are available to assist providers. Details on these tools follow.

Section 3.1: My Insurance Manager

My Insurance Manager is an online tool providers can use to access: Eligibility and Benefits in real time, request Prior Authorization, submit and track claims, get remittance information, send us a secure message, and more.

This valuable tool can be freely accessed after you have registered with a valid Tax ID number in our system as described below. Secure encryption technology ensures that any information you send or receive is completely confidential. My Insurance Manger can provide you with eligibility information and general benefits for members in Medicare Advantage, Preferred Blue, Federal Employee Program, State Health Plan, and Health Insurance Marketplaces. It can also give eligibility information and general benefits at the service-type level for BlueCard® members. Eligibility and benefits can be searched by Procedure Code to help you find a patient's benefits. The appropriate Medicare modifier must be entered when checking benefits for a procedure code. This system is not available while weekly maintenance is performed on Sunday evenings from 5 p.m. until midnight.

To register, select the My Insurance Manager tab on the www.SouthCarolinaBlues.com website. Choose Create Profile, and then enter your Tax ID number for BlueCross. Create a username and password. Your profile administrator and each authorized user must be registered with a unique username and password. Submit the information and you are now ready to access My Insurance Manager.

Section 3.2: My Remit Manager

My Remit Manager is also an online tool. Providers can use it to search remittances by patient, account number, and check number. It is free to all providers who receive EFT payments and ERAs. It accepts 835s from all commercial BlueCross lines of business, and it works independently of your practice management system or clearinghouse. My Remit Manager can be used to:

- View ERA information by file and see all details. Providers have the option of viewing the specific American National Standard Institute (ANSI) details the payer sends, or the standardized information in a conventional format.
- Instantly see patient errors and denials. The system highlights any claims that have errors or that BlueCross has denied.
- View information categorized by check numbers or by patient. It clearly lists the name of each patient whose EOB is associated with an individual check or EFT.
- Print individual remits for a single patient, eliminating the need to remove or black out other patient information on the remit.
- Print remits for selected patients.

- Print individual or group remits.
- Generate and analyze reports. Analyze claim, payment, subscriber, CPT code, etc., and specific data over a specific time period.

To register for My Remit Manager, complete a My Remit Manager Access Request Form by clicking on Providers from the main webpage and selecting Tools and Resources. You will then select the My Remit Manager link. You can also email EDI.Services@bcbssc.com, or call Provider Education at 803-264-4730.

Section 3.3: Voice Response Unit (VRU)

The VRU is available 24 hours a day, seven days a week. The VRU is a fully automated tool that provides quick and easy information to providers seeking benefits and eligibility, routine claims status, and refund statuses. If the requested information is available in the VRU, you will not have the option to speak to a provider services representative. For BlueCross member information, call 800-868-2510.

When using the VRU for a Medicare Advantage member and the provider opts out to speak to a representative, the provider is routed to Medicare Advantage Provider Services; Customer Service Representatives dedicated to providing customer service to Medicare Advantage members and providers.

For BlueCard member information (members who have coverage with another BlueCross plan outside of South Carolina) — 800-676-BLUE (2583).

Our Fax Back option is available through the VRU. Simply enter your fax number, and BlueCross will fax the member's benefits or claims status directly to you. You will usually receive the fax in less than five minutes. You can keep the document in the patient's file for future reference.

Section 3.4: STATchat

STATchat is a fast, free and simple way to talk with a provider services representative after you've searched online for the answer to a claim status or eligibility question. To use STATchat, log into My Insurance Manager. STATchat rewards you by allowing you to move to the front of the queue to ask additional questions on the member you have researched within our provider portal. Ask as many questions as you like related to one member's account. Only questions about that patient are permitted for each call.

Within My Insurance Manager, choose to talk to Provider Services online by selecting the Launch STATchat button. STATchat is available 8 a.m. to 8 p.m. Monday through Friday.

For more information on STATchat, go to My Insurance Manager/STATchat

Section 4: Health Insurance Portability and Accountability Act (HIPAA) Transactions and Electronic Data Interchange (EDI) Services

The BlueCross gateway processes the following ASC X12N Version 5010A1 transactions as required by HIPAA:

- 270 (Health Care Eligibility/Benefit Inquiry)
- 271 (Health Care Eligibility/Benefit Response)
- 276 (Health Care Claim Status Request)
- 277 (Health Care Claims Status Response)
- 278 (Health Care Services Review)
- 834 (Benefit Enrollment and Maintenance)
- 835 (Health Care Payment/Advice)
- 837 (Health Care Claim-Professional)
- 837 I (Health Care Claim-Institutional)

Section 4.1: Transaction Code Sets

The HIPAA Transactions and Code Sets regulation (45 CFR Parts 160 and 162) required the

implementation of specific standards for transactions and code sets by Oct. 16, 2003. We met this deadline and are fully HIPAA compliant.

Applicability - The regulation pertains to:

- All health plans (Medicare, Medicaid, BlueCross plans, employer-sponsored group health plans and other insurers).
- All vendors and clearinghouses (e.g., billing services, re-pricing companies and value-added networks that perform conversions between standard and non-standard transactions).
- All providers (physicians, hospitals and others) who conduct any of the HIPAA transactions electronically.

Purpose - The intent of HIPAA's Administrative Simplification regulation is to achieve a single standard for claims, eligibility verification, referral authorization, claims status, remittance advice (e.g., Explanation of Benefits) and other transactions. Adoption of standard transactions should streamline billing, enhance eligibility inquiries and referral authorizations, permit receipt of standard payment formats that can post automatically to your accounts receivable system, and automate claims status inquiries.

Your Responsibility - HIPAA requirements impact the majority of physicians and other providers, but not all. You should assign responsibility for ensuring compliance with the transactions and code sets to a specific person within your office who can work with the information systems vendors, payers and clearinghouses, as applicable. Also, you should establish a process to monitor the status of new regulations and changes to comply with them as they become effective.

Section 4.2: Trading Partner Agreements

In general, a trading partner is any organization that enters into a business arrangement with another organization and agrees to exchange information electronically. Typically, the two organizations develop a contract or agreement to describe this arrangement. BlueCross requires providers or their vendors to complete a Trading Partner Agreement (TPA). You can find the TPA application at www.SouthCarolinaBlues.com under Enrollments and Agreements.

Companion Guide — A companion guide clarifies the specifics about the data content a provider transmits electronically to a specified health plan. For example, it may clarify what identification number is needed for the Payer Identifier data element. We call our companion guides Supplemental Implementation Guides (SIGs), since they supplement the HIPAA Implementation Guides. These guides address the situational fields that HIPAA allows and explain how we use these fields. You can find all our guides at www.SouthCarolinaBlues.com.

Supplemental Implementation Guide (SIG) — There are data elements that we require in all cases (these are call "required"), and there are data elements we require only when the situation calls for them (these are called "situational"). Many situational data elements are related to the specialty of the physician. While you may choose to rely on your vendor to provide you with the necessary upgrade to capture the applicable data, it may be prudent to validate that the vendor has supplied all the necessary data for several reasons:

- It is the provider's responsibility to be compliant. If you are not compliant, you risk having us return claims or even fine you for non-compliance.
- Vendors are not covered entities under HIPAA. Most vendors will do the best they can to assist their clients in becoming HIPAA compliant, but it is critical for you to ensure that your software upgrade meets the HIPAA requirements.
- The capture of additional data usually means changes in business processes. You may need to change procedures or alter workflow. By understanding the new data you need to capture, you can plan where to make any necessary changes in your office.

Understanding the data requirements, however, is not easy. You may want to consider getting expert assistance, especially if you are a multi-specialty practice. If you decide to begin the task of validating your data requirements yourself, you should get a copy of the SIGs.

Section 4.3: Electronic Funds Transfer (EFT)

Complete the Electronic Funds Transfer and Electronic Remittance Advice (ERA) form to participate in the EFT program and if your practice does not currently receive an ERA. The authorized person who signs this form must also sign the EFT Terms and Conditions. You can fax the completed forms to 803-870-8065, Attn: EFT Coordinator, or email the forms to provider.eft@bcbssc.com. The EFT and ERA form is available on www.SouthCarolinaBlues.com. EFT deposits payments directly into your bank account, allowing you to receive funds before BlueCross mails checks.

Section 4.4: Electronic Remittance Advice (ERA)

Providers with electronic file transfer capabilities can choose to receive the 835 ERA containing their Provider Payment Registers. Once you download the remittance files at your office, you can upload the files into an automated posting system. This eliminates a number of manual procedures.

If you are adding or changing billing services or clearinghouses, please complete the ERA Addendum - Billing Services and Clearinghouse, or the ERA Addendum-Corporate Headquarters found on www.SouthCarolinaBlues.com. You will not need the BlueCross EDIG Trading Partner Enrollment form when only requesting 835 transactions for existing partners.

Remittance advices are available in My Insurance Manager and My Remit Manager.

Chapter Two: Provider Role and Responsibilities

Section 1: Professional Agreement

The terms of the Medicare Advantage Participating Provider agreement, Preferred Blue Preferred Provider Agreement and this Medicare Advantage Office Administrative Manual outline the contractual responsibilities of both BlueCross and the network provider regarding the Center for Medicare and Medicaid Services (CMS) requirements to comply with all Medicare laws, regulations and CMS instructions, federal and state laws, and applicable authorities in the performance of delegated services. Here is a general summary of these requirements:

- The provider will file all claims for BlueCross Total, BlueCross Total Value and BlueCross Blue Basic members to the plan.
- The provider will accept BlueCross Total, BlueCross Total Value and BlueCross Blue Basic payment plus any patient copayments, coinsurance and deductibles as full reimbursement. The preferred provider will not bill the patient for more than his or her applicable patient liability amount (i.e. patient copay, coinsurance, deductible) as indicated on your BlueCross BlueShield of South Carolina remit.
- The provider will refrain from collecting Medicare cost sharing for covered Parts A and B services from individuals enrolled in the Qualified Medicare Beneficiary Program (QMB). The QMB program entitles a member to both Medicare and Medicaid. This dual eligible program exempts individuals from Medicare cost-sharing liability.
- The provider agrees to cooperate fully with Utilization Review Procedures.
- The provider will use other network providers for a member's care unless medically necessary services, supplies or equipment are not available from a network provider, or in cases of medical emergencies or urgently needed services.
- The provider will use other network providers for lab services.
- The provider agrees to bill promptly and in a manner approved by BlueCross Total, BlueCross Total Value and BlueCross Blue Basic for all services. Electronic Claims Submission (EMC) in the 837I or 837P HIPAA-compliant format is the required method of filing unless the provider has an exemption from Original Medicare (IOM 100-04, Chapter 24, Sections 90-90.6).

Unless otherwise prohibited by federal or state laws and regulations, BlueCross Total, BlueCross Total Value and

BlueCross Blue Basic network providers agree to refer members to other BlueCross Total Preferred Provider Organization (PPO) network providers to receive covered services. When a transfer is medically necessary, network hospitals agree to move patients to other BlueCross Total, BlueCross Total Value and BlueCross Blue Basic network hospitals, when possible.

If a member chooses to seek out-of-network services when in-network services are available, higher out-of-network cost sharing will apply. To find a BlueCross Total, BlueCross Total Value or BlueCross Blue Basic network provider, visit www.SouthCarolinaBlues.com and choose Find a Provider.

Section 2: Provider Anti-Discrimination

In selecting practitioners to participate in the BlueCross Total, BlueCross Total Value and BlueCross Blue Basic Medicare Advantage provider network, BlueCross may not discriminate, in terms of participation, reimbursement or indemnification, against any health care professional acting within the scope of his or her license or certification under state law, solely on the basis of the license or certification in terms of participation, reimbursement or indemnification.

This prohibition does not preclude:

- The refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of the plan's enrollees.
- The use of different reimbursement amounts for different specialties or for different practitioners in the same specialty.
- Implementation of measures designed to maintain quality and control costs consistent with BlueCross' responsibilities.

Section 3: Provider Enrollment

BlueCross Total, BlueCross Total Value or BlueCross Blue Basic cannot employ or contract with individuals excluded from participation in Original Medicare. All health care providers who submit bills to our BlueCross Total, BlueCross Total Value or BlueCross Blue Basic Plan for reimbursement, both in and/or out of network, must be Medicare-certified providers. Providers must have a Medicare provider number for the type of service rendered.

BlueCross Total, BlueCross Total Value and BlueCross Blue Basic verifies each provider's Medicare status during enrollment and re-credentialing processes, and periodically outside of the credentialing cycle. Credentialing is required for all practitioners who provide services to our BlueCross Total, BlueCross Total Value or BlueCross Blue Basic member, including providers of physician groups and all other health care professionals who are permitted to practice independently under state law.

Network applicants receive the Provider Enrollment Application, specific network contracts and professional agreements for network participation. Provider Enrollment Application is available in the Provider Enrollment area of the website. For contract or professional agreements, visit the New Provider/Initial Enrollment page and select the "Request Network Contracts" link.

BlueCross BlueShield of South Carolina implemented its new provider enrollment tool, My Provider Enrollment Portal (MyPEP). MyPEP offers a web-based solution for providers who are credentialed or are interested in credentialing with BlueCross to complete the enrollment process.
Use MyPEP to:

- Become a network provider
- Maintain enrollment (recredential)
- Receive automated status updates
- Make certain updates for the physician or practice (i.e. updates to location addresses, phone numbers, faxes, add new groups, new satellite locations, add and/or terminate practitioners from your locations, etc.)
- Receive notifications when you need to supply additional information

We have retired the historical processes (fax, email and phone) for provider enrollment. All provider enrollment business and communications will take place through the MyPEP portal. To sign up and begin

using the portal click the following link: MyPEP

As a reminder, you must upload all documents requiring a signature to complete a submission. The case cannot move forward through the enrollment process without the required signed documents. To locate the documents that require signature:

1. Select **My Forms**
2. Select the appropriate case number
3. Select **Form Information**
4. Under **Documents**, select the application or form requiring signature
5. Select **Download**
6. Sign the documents (applications can be electronically signed but all Contracts/Contracting Documents require 'wet/ink' signatures and dates by the practitioner/appropriate individual, depending on the document)
7. Follow steps 1 – 4 and select **Upload Files**
8. After you have uploaded ALL required and signed documents, click the 'confirm' button to Submit the case to our Enrollment Team for review

Once all required documents have been received, we can begin processing the request.
Online resources are available for quick assistance with MyPEP. View the manual or frequently asked questions for help.

If you have technical issues with MyPEP, please contact the provider education team at MyPEP.Portal@bcbssc.com. **Note:** This email address and phone number are not for questions related to eligibility and benefits, claims or authorizations. Please use MIM or call the number on the back of the member's ID card for those inquiries.

BlueCross Total, BlueCross Total Value and BlueCross Blue Basic is not required to credential health care professionals who are permitted to furnish services only under the direct supervision of another practitioner, or hospital-based health care professionals who provide services to members "incident to" hospital services. (IOM 100-16, Chapter 6, Section 60.3)

Section 3.1: Provider Credentialing — Mental Health Network

Credentialing for mental health practitioners is coordinated through Companion Benefit Alternatives, Inc. (CBA) and covers the BlueCross Total, BlueCross Total Value and BlueCross Blue Basic plan. CBA is a separate company that administers mental health and substance abuse benefits on behalf of BlueCross. Recredentialing for all contracted providers occurs every three years. Our credentialing staff will contact you when it is time for you to recredential.

CBA has an established behavioral health network that includes credentialed mental health and substance abuse providers. To be considered eligible for the CBA network, you must be licensed by the appropriate South Carolina state licensing board to practice independently without supervision. Any licensed provider with a qualifier "intern" is not eligible to join our network.

There is an open network of behavioral health specialties for BlueCross Total, BlueCross Total Value and BlueCross Blue Basic:

- Addictionologists
- Behavioral Health Pediatricians specializing in childhood behavioral health disorders
- Certified psychiatric clinical nurse specialists
- Licensed clinical psychologists
- Licensed independent social workers — clinical practice
- Licensed Marriage and Family Therapists
- Psychiatric nurse practitioners

- Qualified psychiatrists

CBA requires you to do these things as part of the credentialing process:

- My Provider Enrollment Portal (MyPEP) is the one-stop shop for all provider enrollment processes and is now available. Please access MyPEP to begin the enrollment process.
- Complete and sign the appropriate Behavioral Health Application.
- Read and sign the CBA Professional Agreement.
- Read and sign each Health Maintenance Organization (HMO) Hold Harmless Agreement (Appendix C of the abovementioned CBA Professional Agreement).
- Upload a copy of your S.C. State License(s).
- Upload a copy of your DEA License (if applicable).
- Upload a copy of the protocol (Nurse Practitioners only).
- Upload proof of current malpractice coverage.

Please make sure you include all information when submitting your information and allow at least 30 days before calling to check on the status of your application. CBA cannot process applications until it receives all information. Please keep a copy of all application materials for your records.

We recredential all contract providers every three years. Our credentialing staff will contact you when it is time for your recredentialing.

If you would like more information on joining the network, please email cba.provrep@companiongroup.com.

Section 3.2: Provider Recredentialing

BlueCross requires recredentialing every three years for BlueCross Total, BlueCross Total Value and BlueCross Blue Basic network providers. Our credentialing staff will contact you when it is time for your recredentialing.

We mail credentialing packages to health care practices. You must return the packages to us within the allotted time or you could lose your network participation. The re-credentialing package includes BlueCross Credentialing Update forms for each practitioner in the practice. When submitting, include these for each practitioner:

- Copy of State license(s)
- Current copy of Drug Enforcement Administration (DEA) registration, if applicable
- Current copy of malpractice coverage (Minimum of $1M/$3M)
- Copy of Clinical Laboratory Improvement Amendment (CLIA) certification

Please email Credentialing Update forms and requested documentation to Recred.App@bcbssc.com or fax to 803-870-9997.

Section 3.3: Provider File Updates

For our health plan to maintain accurate participating provider directories, and also for reimbursement purposes, providers are continually required to report all changes of address or other practice information electronically.

These changes can be updated any time by using the appropriate form found on our website. We'll also continue to reach out to you to verify that your office information is complete and accurate quarterly. Be sure you respond to requests from provider.directory@bcbssc.com or your provider advocate when contacted about provider file updates.

Section 3.4: Change of Ownership

You must promptly notify BlueCross if your organization changes ownership. Complete the Application for Clinic/Group/Institution/Location to File Claims or to Change Employer Identification Number (EIN) which can

be found in the Providers area of the website. Complete the Group Application which is located inside My Provider Enrollment Portal.

Section 3.5: Compliance Standards

CMS requires BlueCross Total, BlueCross Total Value and BlueCross Blue Basic providers and their staff to complete, on an annual basis, two refresher training modules for (1) compliance and (2) fraud, waste and abuse (FWA). All MA and PDP plans must accept certificates of completion of this CMS Compliance and FWA training (located on the Medicare Learning Network) from network providers. Providers should retain these certificates for 10 years and may be required to produce copies upon request by BlueCross or CMS for monitoring and audit purposes.

If you suspect fraud, we encourage you to let us know anonymously. Include as many details as possible. To report fraud, call the BlueCross Fraud Hotline at 800-763-0703 or fax to 803-264-4050. You can also complete an online form available on the Contact Us page at www.SouthCarolinaBlues.com.

Section 3.6: Preclusion List

CMS has a list of providers and prescribers who are precluded from receiving payment for Medicare Advantage (MA) items and services or Part D drugs furnished or prescribed to Medicare beneficiaries.

The Preclusion List is comprised of individuals who meet the following:

- Are currently revoked from Medicare, are under an active reenrollment bar and CMS has determined that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or
- Have engaged in behavior for which CMS could have revoked the individual or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare Program.

As a BlueCross Total, BlueCross Total Value and BlueCross Blue Basic provider, you must ensure that payments for healthcare services or items are not made to individuals or entities on the Preclusion List. You must also ensure that you do not refer a member to a precluded provider.

Section 3.7: Use of Offshore Subcontractors

CMS requires all BlueCross Total, BlueCross Total Value and BlueCross Blue Basic providers and subcontractors, including offshore subcontractors as defined by CMS, to safeguard Medicare beneficiaries' personally identifiable information, financial records, and payment and claims information. Therefore, any BlueCross Total, BlueCross Total Value and BlueCross Blue Basic provider who use an offshore subcontractor(s) to maintain, store or access confidential Medicare beneficiary information must submit an attestation to BlueCross for approval.

In addition, the provider must notify BlueCross of any change in the offshore vendors' contracting or operation status within 30 days. The attestation form and instructions are available on the Provider page at www.SouthCarolinaBlues.com. This attestation does not replace or alter the requirements that all providers, contractors, subcontractors and downstream entities comply with CMS rules and regulations, as well as the contractual provisions between the provider and BlueCross. BlueCross or CMS may change attestation requirements from time to time.

Section 4: Non-Acceptance and Termination

If BlueCross declines to include a provider or group of providers in the BlueCross Total, BlueCross Total Value and BlueCross Blue Basic network, BlueCross will furnish written notice to the affected provider(s) including the reason for the denial decision.

If you choose to terminate participation with BlueCross Total, BlueCross Total Value or BlueCross Blue Basic, you must follow contractual termination provisions. The Centers for Medicare and Medicaid Services (CMS) requires providers to give at least 60 days' notice to BlueCross BlueShield of South

Carolina when terminating participation without cause. We will notify all affected members of the termination of a provider contract within 30 days of receiving notice of termination. Thus, we request that providers adhere to termination notice requirements in provider contracts so that members can receive timely notice of network changes. We will notify you in writing of reasons for any suspension or termination from network participation.

If you have any questions about contracting, please submit a Contract Request Form from the Provider page on our website www.SouthCarolinaBlues.com.

Section 5: Member Discrimination Prohibited

Discrimination against BlueCross Total, BlueCross Total Value or BlueCross Blue Basic members based on health status is prohibited [42 CFR 422.110(a)]. We cannot deny or limit condition of coverage or benefits to individuals eligible to enroll in a BlueCross Total, BlueCross Total Value or BlueCross Blue Basic plan based on any factor related to the member's health status including, but not limited to:

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

BlueCross Total, BlueCross Total Value, and their contracted providers must comply with applicable state and federal laws, and rules and regulations, including Medicare requirements. This includes: the Civil Rights Act, the Age Discrimination Act, the Rehabilitation Act of 1973, and the Americans with Disabilities Act. BlueCross Total, BlueCross Total Value and BlueCross Blue Basic network providers cannot discriminate against a member with respect to the delivery of health care services consistent with the benefits covered in the member's policy based on race, ethnicity, national origin, religion, sex, age, mental or physical disability, sexual orientation, genetic information or source of payment. Applicable federal funds laws 42 CFR [422.504(h)(l)] include: The Health Insurance Portability & Accountability Act; The False Claims Act, The Anti-Kickback Statue, and The Sarbanes Oxley Act of 2002 (SOX). [§422.504(h)]

Section 6: Member Protections

Section 6.1: Marketing Materials/Health Fairs

Federal regulations establish protections for BlueCross Total, BlueCross Total Value and BlueCross Blue Basic members. You cannot distribute marketing or other member materials describing BlueCross Total, BlueCross Total Value and BlueCross Blue Basic plans unless CMS and BlueCross BlueShield of South Carolina approve the materials in advance (if CMS requires approval for the specific type of material). BlueCross employees or representatives and network providers must follow all CMS Medicare Advantage marketing guidelines, including those applicable to health fairs.

Providers who want to display or distribute any information about BlueCross Total, BlueCross Total Value or BlueCross Blue Basic plans or benefits must first contact your Provider Services Representative to request approval.

Providers will remain neutral when assistance is requested by a beneficiary regarding an enrollment decision and ensure that any advice regarding plan selection is always in the best interest of the beneficiary.

If needed, providers shall cooperate with BlueCross to ensure that each member completes the required initial assessment of his or her health care needs within 90 days after the effective date of initial enrollment. Generally, members are able to complete the Health Risk Assessment required by CMS

without the assistance of a physician.

Section 6.2: Providing Non-Covered Services

Providers cannot bill or accept payment from members for any services BlueCross determines are not medically necessary according to BlueCross Total, BlueCross Total Value or BlueCross Blue Basic medical necessity guidelines unless:
(a) the provider specified prior to the service being rendered that the service was not medically necessary and (b) the member agreed, in writing, to pay for the service. The Advanced Beneficiary Notification (ABN) cannot be used for this agreement. The agreement needs to be a contract entered into by the member and provider in which the provider clearly outlines the service and charge. This contractual agreement between the provider and BlueCross Total, BlueCross Total Value and BlueCross Blue Basic member would allow the provider to pursue the member. BlueCross Total, BlueCross Total Value and BlueCross Blue Basic members cannot be billed for medical necessity denials.

Providers cannot hold any member liable for payment of any fee that is the legal obligation of a BlueCross Total, BlueCross Total Value or BlueCross Blue Basic plan or an amount that exceeds the contractually allowed amount.

Section 6.3: Billing for Covered Services

Providers shall provide covered services to members in a manner consistent with professionally recognized standards of health care.

Section 6.4: Notice of Medicare Non-Coverage (NOMNC)

Skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities must notify Medicare beneficiaries about their right to appeal a termination of benefits decision by complying with the requirements for providing Notice of Medicare Non-Coverage (NOMNC), including the time frames for delivery. Providers must use the revised NOMNC in link below beginning January 1, 2025. The NOMNC has been revised to reflect regulations that now afford Medicare Advantage enrollees the right to appeal untimely to the Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO), or to appeal after they end services on or before the planned termination date. (https://www.federalregister.gov/d/2024-07105/page-30827). Providers may be required to furnish a copy of any NOMNC to BlueCross upon request. For copies of the notice and the notice instructions, go to

FFS & MA NOMNC/DENC | CMS

Section 6.5: Hospital Discharge Appeal Notices

Providers must continue to provide covered services to members for the duration of the contract period for which CMS has made payments to a BlueCross Total, BlueCross Total Value or BlueCross Blue Basic plan. In the event that (a) BlueCross' contract with CMS terminates, or (b) BlueCross Total, BlueCross Total Value or BlueCross Blue Basic plans become insolvent, participating providers must continue to provide covered services to all hospitalized members through the date of discharge.

Hospitals must notify Medicare beneficiaries who are hospital inpatients about their discharge appeal rights by complying with the requirements for providing the Important Message from Medicare, including the time frames for delivery. For copies of the notice and additional information regarding this requirement, go to

https://www.cms.gov/medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im
BlueCross Total, BlueCross Total Value and BlueCross Blue Basic members can appeal a decision regarding a hospital discharge or termination of home health agency, comprehensive outpatient rehabilitation facility or skilled nursing facility benefits within the time frames specified by law.

Section 6.6: Medicare Outpatient Observation Notice (MOON)

All hospitals and critical access hospitals (CAHs) are required to provide the Medicare Outpatient Observation Notice (MOON), form CMS-10611, as well as an oral explanation of the written notice, to Medicare beneficiaries receiving observation services as outpatients for more than 24 hours. The notice must include

the reasons the individual is an outpatient receiving observation services and the implications of receiving outpatient services, such as required Medicare cost-sharing and post- hospitalization eligibility for Medicare coverage of skilled nursing facility services. Hospitals and CAHs must deliver the notice no later than 36 hours after observation services are initiated, or sooner if the individual is transferred, discharged, or admitted. The notice and accompanying instructions are available at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/index.html.

Chapter Three: Member Rights & Responsibilities

Section 1: Eligibility and Enrollment

While Medicare beneficiaries choose to enroll in a BlueCross Total, BlueCross Total Value or BlueCross Blue Basic plan, federal government regulations limit when and how beneficiaries can make plan elections. Requirements specify when beneficiaries can make plan elections and the limits on the number of elections they can make each year.

Medicare beneficiaries can enroll in a BlueCross Total, BlueCross Total Value or BlueCross Blue Basic plan when: (a) they are covered by both Medicare Parts A and B, (b) they continue to pay the Part B premium and, (c) they meet other eligibility requirements. An eligible Medicare beneficiary can also enroll during the Annual Election Period (AEP) from Oct. 15 through Dec. 7 or during the Medicare Advantage Open Enrollment Period from Jan. 1 through Mar. 31.

Section 2: Disenrollment

While Medicare beneficiaries choose to disenroll from a BlueCross Total, BlueCross Total Value or BlueCross Blue Basic plan, federal government regulations limit when and how beneficiaries can make plan elections. Medicare beneficiaries can disenroll from a BlueCross Total, BlueCross Total Value or BlueCross Blue Basic plan during: (a) the Annual Election Period (AEP) from Oct. 15 through Dec. 7 of every year or, (b) the Medicare Advantage Open Enrollment Period (MA OEP) from Jan. 1through Mar. 31 of every year.

Federal regulations permit BlueCross Total, BlueCross Total Value and BlueCross Blue Basic members to disenroll from BlueCross Total, BlueCross Total Value or BlueCross Blue Basic plans by:

- Submitting a signed letter requesting disenrollment to the BlueCross Total, BlueCross Total Value or BlueCross Blue Basic Operations department during a valid election period. Requests submitted outside of the Annual Enrollment Period should include the reason for the request.
- Contacting 1-800-MEDICARE.

BlueCross Total, BlueCross Total Value and BlueCross Blue Basic must disenroll members if they:

- Lose Part A or B of their Medicare benefits.
- Move outside the service area permanently.
- Temporarily reside outside the BlueCross Total, BlueCross Total Value or BlueCross Blue Basic service area for more than six consecutive months.
- Fail to pay monthly premiums.
- Plan termination.

In most cases, disenrollment requests received on or before the last business day of the month will be effective on the first day of the following month. Election period rules and limits apply.

BlueCross Total, BlueCross Total Value or BlueCross Blue Basic can also disenroll members for failure to fulfill member responsibilities, including the responsibility to be courteous and respectful to providers, staff and fellow patients.

Section 3: Provider Advice & Advocacy

BlueCross cannot prohibit or otherwise restrict a health care professional, acting within the lawful scope of practice, from advising or advocating on behalf of an individual who is a BlueCross Total, BlueCross Total Value or BlueCross Blue Basic patient.
Such advice may pertain to:

- The patient's health status, medical care or treatment options (including any alternative treatments that can be self-administered) and the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options.
- The risks, benefits and consequences of treatment or non-treatment options.
- The opportunity for an individual to refuse treatment and to express preferences about future treatment decisions.

You must provide information about treatment options in a culturally competent manner, including the option of no treatment. You must ensure that disabled BlueCross Total, BlueCross Total Value and BlueCross Blue Basic members have access to effective communications throughout the health system in making decisions about treatment options.

Section 4: Protecting Members' Health Information

Pursuant to regulations under HIPAA, BlueCross discloses only the minimum necessary PHI related to a member's treatment, for payment determination of claims and for the plan's health care operations.

Likewise, providers submitting information to BlueCross should send only minimum necessary information to complete the task. For example, you should remove or cover other patient information on a payment register that contains information not related to the inquiry.

We must verify the identity of all who request information concerning a member's PHI. Information used to verify identity for provider inquiries includes the provider's identification number, tax identification number and first name. The caller's department or position title assists us in accurately documenting each inquiry.

Chapter Four: Medicare Advantage PPO Plans

Section 1: Type of Medicare Advantage Plans

BlueCross offers seven individual Medicare Advantage PPO plans to Medicare-eligible recipients in select South Carolina counties. You should confirm the level of coverage for all BlueCross Total, BlueCross Total Value and BlueCross Blue Basic members before providing services. Level of benefits and coverage rules may vary.

Individual Plans:

1 BlueCross Total Upstate
   - Anderson, Cherokee, Greenville, Oconee, Pickens, Spartanburg, York

2 BlueCross Total Midlands/Coastal
   - Aiken, Calhoun, Chesterfield, Dillon, Fairfield, Florence, Horry, Kershaw, Lexington, Marion, Marlboro, Newberry, Orangeburg, Richland, Saluda, Sumter

3 BlueCross Total Lowcountry
   - Beaufort, Berkeley, Charleston, Dorchester, Georgetown

4 BlueCross Total Value Upstate
   - Anderson, Cherokee, Greenville, Oconee, Pickens, Spartanburg, York

5 BlueCross Total Value Midlands/Coastal
   - Aiken, Calhoun, Chesterfield, Dillon, Fairfield, Florence, Horry, Kershaw, Lexington, Marion, Marlboro, Newberry, Orangeburg, Richland, Saluda, Sumter

6 BlueCross Total Value Lowcountry

- Beaufort, Berkeley, Charleston, Dorchester, Georgetown

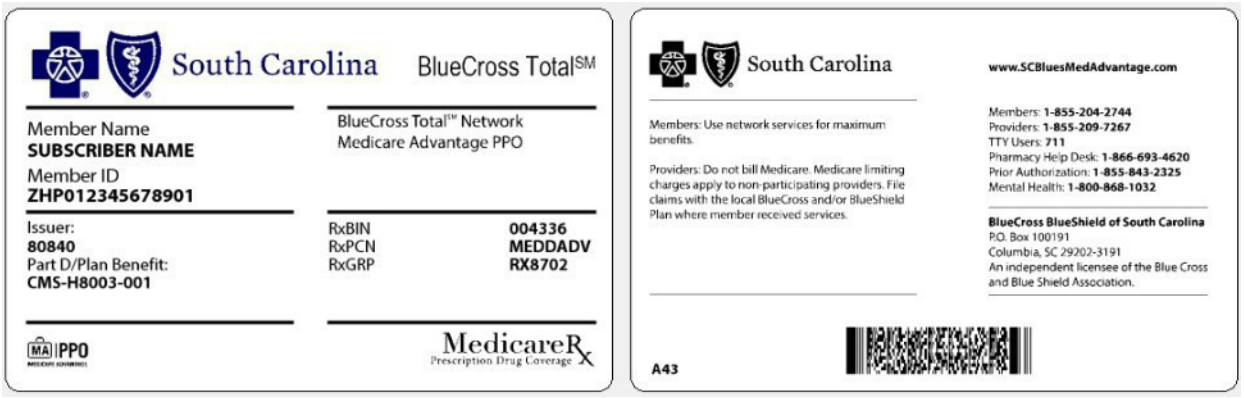
7 BlueCross Blue Basic

- Aiken, Anderson, Beaufort, Berkeley, Calhoun, Charleston, Cherokee, Chesterfield, Dillon, Dorchester, Fairfield, Florence, Georgetown, Greenville, Horry, Kershaw, Lexington, Marion, Marlboro, Newberry, Oconee, Orangeburg, Pickens, Richland, Saluda, Spartanburg, Sumter, York

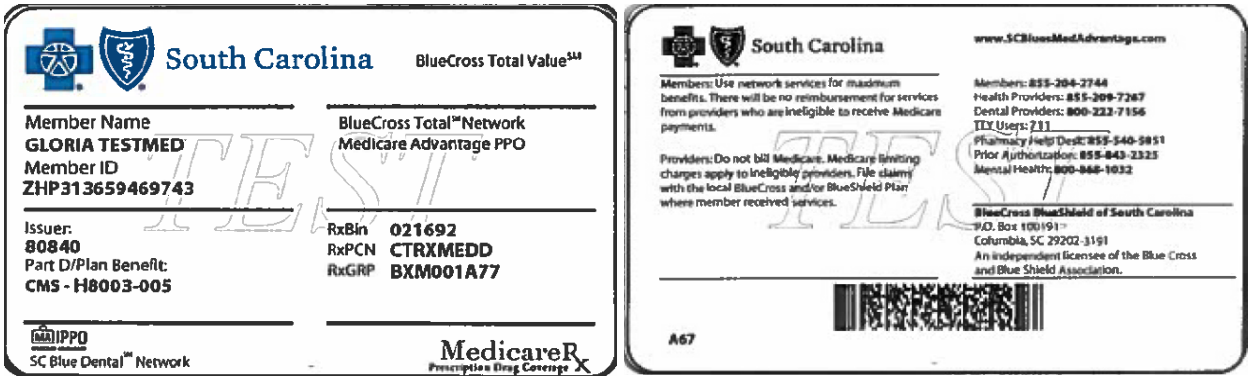
Section 1.1: BlueCross Total (PPO) and BlueCross Total Value (PPO)

BlueCross Total and BlueCross Total Value are a Medicare Advantage PPO plan that combines the benefits of traditional Medicare with Medicare Part D prescription drug coverage. Members can go to any network doctor, specialist or hospital for in-network benefits. A member can choose an out-of-network provider, but he or she may have to pay more for services.

Sample BlueCross Total ID Card



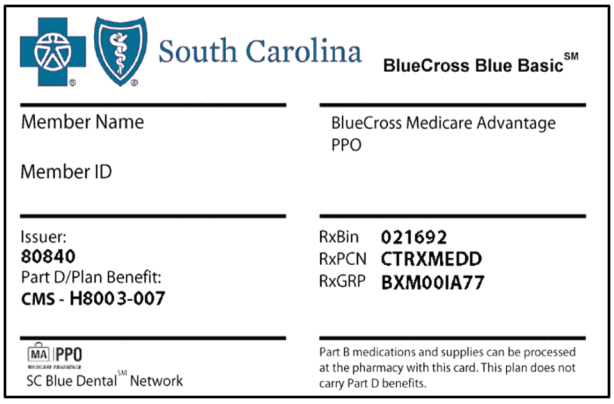
Sample BlueCross Total Value ID Card

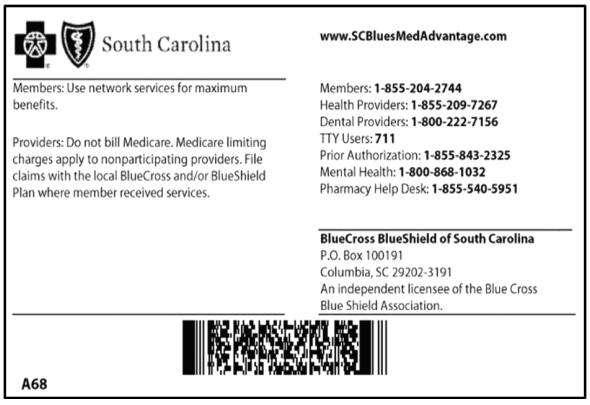


Section 1.2: BlueCross Blue Basic (PPO)

BlueCross Blue Basic is a Medicare Advantage PPO plan that provides the benefits of traditional Medicare as well as other value-added benefits. This plan does not include Part D prescription drug coverage. Members can go to any network doctor, specialist or hospital for in-network benefits. A member can choose an out-of-network provider, but he or she may have to pay more for services.

Sample BlueCross Blue Basic Card





Section 2: How to Identify BlueCross Total, BlueCross Total Value and BlueCross Blue Basic members

- The prefix is ZHP.
- The member's personal identification number follows the prefix. The ID number sequence must be included with each claim submission.
- The suitcase MA PPO on the front of the card indicates the network.
- The plan name (BlueCross Total Upstate, BlueCross Total Midlands/Coastal, BlueCross Total Lowcountry, BlueCross Total Value Upstate, BlueCross Total Value Midlands/Coastal, BlueCross Total Value Lowcountry or BlueCross Blue Basic) is located on the front of the card in the upper right quadrant.

Members should always show their BlueCross ID card, not their Medicare card. Make a copy of the front and back of each patient's ID card. Make sure that billing staff has access to the complete ID number shown on the card. If the entire ID number, including the three-digit prefix, is not captured and submitted correctly, you may experience a delay in claim processing.

An ID card does not guarantee coverage. You can verify benefits and eligibility by using My Insurance Manager, the Voice Response Unit (VRU) or by submitting a HIPAA-compliant electronic transaction request.

Section 3: General Coverage Information

CMS has established requirements applicable to BlueCross Total, BlueCross Total Value and BlueCross Blue Basic benefit plans. Find details on specific benefits and cost sharing included in the BlueCross Total, BlueCross Total Value and BlueCross Blue Basic plans by visiting the Providers page of www.SouthCarolinaBlues.com.

All BlueCross Total, BlueCross Total Value and BlueCross Blue Basic benefit plans offer benefits that:

- Provide beneficiaries with all Part A (except hospice care) and Part B services under Original Medicare if the beneficiary is entitled to benefits under both parts, and Part B services if the beneficiary is a grandfathered "Part B only" enrollee (CMS Internet-Only Manual (IOM)100-16, Chapter 4, Section 10.2).
- Cannot impose limitations, waiting periods or exclusions from coverage due to pre- existing

conditions that are not present in Original Medicare (IOM 100-16, Chapter 4, Section10.2).

- Cover ambulance services dispatched through 911 or a local equivalent for which other means of transportation would endanger the member's health (IOM 100-16, Chapter 4, Section20.1).
- Offer all Medicare preventive services performed at a network provider without copay. A copay will apply, however, if a beneficiary is being treated or monitored for an existing medical condition during the preventive visit.
- If a member receives services in a Specialist's office and is seen by a General Practitioner, Family Practitioner, OB-GYN, Internist, Geriatrician, Physician Assistant or Nurse Practitioner, a PCP copay for the plan will be accessed.
- Provide maintenance and post-stabilization care services. Benefits include covered services related to an emergency medical condition and which are provided after the member is stabilized either to maintain the member's stabilized condition or, under certain circumstances, to improve or resolve the member's condition.
- Cover renal dialysis services for members temporarily outside of the plan's service area.
- Offer a network of providers that allows sufficient access to covered services, according to CMS standards.
- Provide benefits in a manner consistent with professionally recognized standards of healthcare.
- Make covered services available to members through office hours or telephone service, 24 hours a day, seven days a week.

Section 4: Medical Policies and Guidelines

Medical policies consist of medical guidelines that are used when making clinical determinations in connection with a member's coverage under a health plan. The medical policies and associated medical guidelines are interpreted and applied at the sole discretion of the health plan fiduciary and may be subject to state or federal laws. CMS National and Local Coverage Determinations (NCD's and LCD's) provide the most authoritative guidance. If there are no NCD's or LCD's for a requested service, the CMS Internet-Only-Manuals (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs), MCG (formerly Milliman) guidelines, and peer-reviewed medical literature constitute the primary guideline sources.

Requests for medical services or equipment are evaluated based on the CMS guidelines based on medical necessity and whether they meet the guidance for "reasonable and necessary" services in the CMS manuals. Inclusion of a medical treatment in an NCD, LCD, MCG guidelines or peer-reviewed medical literature does not guarantee that the referenced service (or supply) is available to a specific member. For a determination of the benefits to which each member is entitled under his or her health plan, the specifics of that member's health plan must be reviewed. In the event of a conflict between the guidelines and the member's health plan, the express terms of the health plan (CMS guidance) will govern. The existence of a medical guideline is not an authorization, certification, explanation of benefits or a contract for the service (or supply) that is referenced in the medical guideline.

Guidelines only address frequently occurring clinical situations. Because of the variety of clinical circumstances, some services (or supplies) or conditions addressed in the medical guidelines may require additional review.

Guidelines ARE NOT medical advice and DO NOT guarantee any results or outcomes.

Section 5: Medical Management

The provider's participation agreement with BlueCross requires compliance with our medical management programs. BlueCross designed medical management programs to ensure that the treatment members receive is covered according to the medical necessity guidelines in their contracts. Medical management programs also encourage cost effective and appropriate use of the health care delivery system.

Medical management programs include:

1. Utilization management/prior authorizations.
2. Case management.
3. Disease management.
4. A discharge coordination program – Transitions of Care.

Objectives of the programs are to:

a. Ensure members receive medically necessary services at the most appropriate level of care.
b. Promote efficient use of health care resources.
c. Define and agree upon appropriate standards of care.
d. Ensure members receive appropriate care and follow-up hospital discharge.

The medical management process is a review for medical necessity only. Payment for services remains subject to all terms of the member's benefit plan as approved by CMS. Therefore, denials may occur because the benefit plan does not cover a service, or the member is not eligible at the time of service.

We recommend that you verify coverage, benefits, contract eligibility and limitations for all patients prior to providing services.

Section 5.1: Utilization Management/Prior Authorizations

The term "prior authorization", commonly referred to as precertification or preauthorization, is the process in which a network provider obtains approval from BlueCross Total, BlueCross Total Value or BlueCross Blue Basic prior to the services being rendered. The approval is determined based on medical necessity of services covered by the member's benefit that will be performed in the appropriate setting. Determination of medical necessity may require review of clinical documents.

The term "notification" refers to the process in which a provider or facility notifies BlueCross Total, BlueCross Total Value or BlueCross Blue Basic of a planned service to be provided. This notification requirement allows BlueCross Total, BlueCross Total Value and BlueCross Blue Basic the opportunity to enhance the member's care management. The list of items/services that require precertification and/or notification is posted on the web.

Please keep in mind that some services may require precertification through another managed care company such as:

- Companion Benefit Alternatives (CBA) (Behavioral Health)
- Avalon Healthcare Solutions (laboratory and pathology services)
- OptumRx (pharmacy drugs)

(Note: BlueCross Blue Basic only covers Medicare Part B prescription drugs.)

- Integrated Home Care Services (IHCS)

In the event precertification is not obtained by the rendering provider or facility, the claim will be denied. The member may **not** be held liable for any charges of the denied claim.

Services and items may be added or removed from the prior authorization list throughout the year. Please check the Provider web page for the most up to date items requiring prior authorization.

Section 5.2: Case Management

Licensed health care professionals (registered nurses and social workers) provide case management services by phone. These case managers coordinate health care services and manage benefits with members and providers. Case managers work with members who have chronic, complex and/or catastrophic injuries, illnesses, or diseases. They advocate for members who have medical and behavioral health conditions that require treatment by a variety of different specialists and ongoing or intermittent care.

Case managers coordinate services needed for home health and skilled nursing facilities to maximize contract benefits, improve patients' health and ability to function, and reduce the likelihood of complications. Case managers facilitate appropriate access to a variety of specialized health care providers.

Cases are often ongoing due to the nature of chronic conditions. Case management ensures coordination of benefits and health services across the continuum of care for members with a variety of health care conditions.

The goals of case management are to:

- Support and encourage individual accountability for health and wellness (self-care management).
- Promote the efficient use of health care benefits.
- Improve member satisfaction with the health plan and health care system.
- Maximize health and functional outcomes
- Help members coordinate services they need and navigate through the health care system.

Section 5.3: Disease Management

BlueCross offers disease management education to members with chronic conditions such as, but not limited to:

- Hypertension
- Hyperlipidemia
- Coronary artery disease (CAD)
- Diabetes
- Chronic obstructive pulmonary disease (COPD)
- Asthma

Some members who have any of these diagnoses may be candidates for home monitoring of weight and blood pressure. We will contact you to determine if this type of monitoring may benefit your patients.

We identify members for this program through health risk assessments or claims data analysis. Physician referrals into the program are welcome. The program's goal is to assist members in managing their conditions through education. Participation in the disease management program is voluntary and available at no charge to the member.

For high-risk members, registered nurses will:

- Talk with members about their conditions.
- Review members' medications and current treatments.
- Discuss best strategies, set goals, and create action plans.
- Help members understand their doctors' recommendations.
- Connect members to other helpful programs, as needed.
- Answer questions or address concerns.

Section 5.4: Discharge Coordination Program

BlueCross requires authorizations and continued stay reviews on all BlueCross Total, BlueCross Total Value and BlueCross Blue Basic inpatient admissions. This service ensures members receive appropriate care and follow-up when hospitalized, as well as identifies those beneficiaries who may need more case management upon discharge.

Our team of registered nurses coordinates with hospital staff on discharge coordination and transitional services to:

- Facilitate referrals to network providers, internal case managers and disease managers as necessary.
- Facilitate smooth transitions home by working with hospital case managers and discharge planners to ensure a plan of care is in place.
- Have an after-care conversation with members.
- Address any gaps in care as soon as possible.

Section 6: Quality Improvement

The BlueCross Total Quality Improvement (QI) program defines requirements for BlueCross Total, BlueCross Total Value and BlueCross Blue Basic network providers' practices, including, but not limited to, medical record keeping and documentation. The BlueCross Total QI program is customer-focused, data-driven and process- oriented; however, some requirements may not apply to every facility or practice.

BlueCross Total, BlueCross Total Value and BlueCross Blue Basic network providers must support a comprehensive quality improvement program which includes advising, supporting, and actively participating in the development and implementation of process improvements. BlueCross adheres to established QI standards that provider scan follow in pursuit of excellent care and service, including but not limited to:

- Screening and monitoring for health (i.e., Colorectal Cancer Screening, Adult BMI Assessment)
- Disease management (i.e., Medication Review; Diabetes Care, Controlling Hypertension)
- Member experience with the health plan (i.e., Care Coordination, Obtaining Appointments and Care Quickly)
- Member satisfaction (i.e., Access to Care, Rating of Physician)
- Providing customer service (i.e., Grievance and Appeals Process)

Section 6.1: Medicare Advantage and CMS STAR Rating

The BlueCross Total Quality Improvement (QI) program performance is based on the results of our CMS STAR Rating. This rating process utilizes a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the care they receive. This rating system applies to Medicare Advantage plans that cover both health services and prescription drugs (MAPD).

BlueCross Total, BlueCross Total Value and BlueCross Blue Basic are rated on 48 unique quality and performance measures. Each year, CMS conducts a comprehensive review of these measures considering the reliability of the measures, clinical recommendations, feedback received from stakeholders, and data analysis.

The STAR Rating measures span five broad categories:

1. Outcomes: measures reflecting improvements in a member's health and are integral to assessing quality of care.
2. Intermediate Outcomes: measures reflecting actions taken which can assist in improving a beneficiary's health status. For example, Controlling Blood Pressure is a measure where the related outcome of interest would be an improved health status for members with hypertension.
3. Patient Experience: measures reflecting members' perspectives of the care they received.
4. Access: measures reflecting processes and issues that could create barriers to receiving needed care. Timely decisions about grievances and appeals are an example of an access measure.
5. Process: measures capturing the health care services provided to members that can assist in maintaining, monitoring, or improving their health status.

CMS uses information from Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys, Health Outcomes Survey (HOS), Healthcare Effectiveness Data and Information Set (HEDIS®) data and feedback directly from health care providers to give an overall performance STAR rating to Medicare health plans.

CMS publishes the Part C and D STAR Ratings each year to incentivize quality improvement, assist beneficiaries in finding the best plan for them, and determine MA Quality Bonus Payments. Moreover, the ratings support the efforts of CMS to improve the level of accountability of the care provided by physicians, hospitals, and other ancillary providers.

Providers can help improve the plan's performance by:

- Encouraging Medicare Advantage patients to participate in an annual wellness visit to review all care gaps and health needs.

- Within 30 days, follow-up with patient after hospital discharge to review medications and care plan.
- Documenting all care in the patient's medical record to include patient demographic data; medication allergies and adverse reactions; current medications and problem list; past medical, surgical, and immunization history; and clinical findings and appropriate treatments.
- Calculating and notating values of tests and screenings including A1C values, microalbumin levels, blood pressure values and results of screenings (e.g. colon screening, mammography, etc.).
- Coding and billing appropriately for all services rendered (e.g. use appropriate CPT and CPT II codes).
- Promoting medication adherence and participation in medication management programs.
- Recommending formulary alternatives or assessing pharmacy benefits.
- Timely responses to requests for medical records (within five business days).
- Recommending participation in Disease Management at BlueCross Total, BlueCross Total Value or BlueCross Blue Basic and/or within the practice.

Section 6.2: Healthcare Effectiveness Data and Information Set (HEDIS)

HEDIS is a tool developed by NCQA measuring the delivery of quality medical care and preventive health services. It provides a consistent way to evaluate the quality of care our members receive from BlueCross Total, BlueCross Total Value, BlueCross Blue Basic and their contracted providers. BlueCross uses HEDIS to identify and acknowledge areas of excellence and opportunities for improvement. HEDIS data is utilized to develop quality initiatives and educational programs for members and providers.

Reference guides are available to providers as an overview of the HEDIS measures that BlueCross focuses on. These materials provide measure-specific information on what services are needed and how to help prevent or close our members' gaps in care. If you have relevant information indicating the member has already received the service, or has a condition excluding him/her from the measure, gaps can be closed by:

- Submitting an appropriately coded claim for the service. You can submit up to 25 procedure codes with any claim to help transmit this information to us.
- Submitting the appropriately documented medical record of the service.

Section 6.3: Consumer Assessment of Healthcare Providers & Systems (CAHPS)

CAHPS is a standardized national survey that measures members' experiences with health plan services and the care and services that network professionals offer. Medicare beneficiaries answer questions about how quickly they obtain needed care and drugs, how satisfied they are with their physician and health plan as well as other satisfaction-based questions. Each year, BlueCross Total, BlueCross Total Value and BlueCross Blue Basic contracts with a vendor to send the survey to a randomly selected sample of members. Feedback is requested on issues related to getting the care they need, the quality of care received, customer service, and claims processing. The results of these surveys can be distributed to providers annually. For information regarding the most recent survey, please contact ma.opsrequest@bcbssc.com.

Section 6.4: Health Outcomes Survey (HOS)

BlueCross MAPD participates with the Medicare HOS program which was the first patient-recorded outcomes measure used in Medicare managed care. BlueCross Total, BlueCross Total Value and BlueCross Blue Basic analyzes data collected from the HOS to assess quality improvement activities and resources; monitor health plan performance; and promote the science of functional health outcomes measurement.

Section 6.5: Risk Adjustment Data Validation (RADV)

BlueCross conducts annual medical record reviews of randomly selected providers for RADV as required by CMS and the U.S. Department of Health & Human Services to validate the accuracy of risk adjustment data submitted by health plans. Selected providers are requested to respond timely to medical record requests if their members are identified as part of the random sample. Members' progress notes, hospital notes and correspondence from services provided during the measurement year will be reviewed and submitted to

CMS by BlueCross Total, BlueCross Total Value and BlueCross Blue Basic as deemed appropriate.

Section 6.6: Incentives for Providers

BlueCross Total, BlueCross Total Value and BlueCross Blue Basic may create an incentive program that provides rewards incentives/or rewards to providers in connection with participation in activities that focus on promoting improved health in members. The health plan determines the specific services, activities or behaviors that are subject to rewards or incentives (i.e., reporting adult BMI). Providers are notified of incentive programs through direct mail and announcements shared on the provider website.

Section 7: Accessibility Requirements

Providers shall provide or arrange for the provision of medical advice to members on a timely basis. Advice must be available 24 hours a day, seven days a week via a telephone response. You are not obligated to provide any health service not normally provided to others, or services for which you are not authorized by law to provide.

Section 7.1: Timeliness Requirements

All providers will give appointments and covered services to BlueCross Total, BlueCross Total Value and BlueCross Blue Basic members within a reasonable amount of time.

Category	Time Standard
Preventive Care Appointment or Immunization	Within eight weeks of a member's request
Routine Appointment	Within 14 days of a member's request
Urgent Appointment	Within 48 hours of a member's request
Emergency Care	Immediate
After-Hours Care	24 hours a day, seven days a week

Section 7.2: Telephone Responsiveness

During office hours, a physician or designee will assess the member according to his or her health condition.

- Providers should give a timely response to incoming phone calls.
- Providers must answer calls in six rings or less.
- Providers can only put members on hold for two minutes or less.

Section 8: Medical Record Keeping Practices

The patient medical record serves as legal documentation of services received and allows for evaluation of continuity and coordination of care. BlueCross requires providers to maintain timely and accurate medical, financial, and administrative records related to services rendered to BlueCross Total, BlueCross Total Value or BlueCross Blue Basic members.

Section 8.1: Minimum Requirements

- Maintain medical records for at least 10 years from the date of service unless a longer time period is required.
- Store medical records in a secure location using an efficient tracking process for ease of retrieval.
- Show either a patient's name or ID on each page.
- Ensure medical records are dated, legible and signed.
- Maintain current problem lists.
- Prominently display allergies/adverse reactions.
- Prominently note current medications and dosage.

- Describe recommended immunizations and preventive healthcare.
- Include initials and date that the primary care physician received and reviewed consultation report and labs/radiology results.
- Include a statement as to whether the member executed an advance directive and have in a prominent place within the medical record.

Chapter Five: Claims Process

Section 1: Claims Submission

This section provides information about claims submission, processing, and payment. Providers should submit all claims for BlueCross Total, BlueCross Total Value and BlueCross Blue Basic members, except for certain services that must be billed to Original Medicare (e.g., certain clinical trial services CMS determines and hospice care). If you submit a claim to us but should have sent it to Original Medicare, we will return the claim to you for submission to the local carrier or fiscal intermediary.

Section 1.1: General Information

Providers should always submit BlueCross Total, BlueCross Total Value and BlueCross Blue Basic claims electronically using Medicare billing guidelines and format (CMS-1500 or UB-04), and the National Provider Identifier (NPI). Note: Although not a fiscal intermediary or a Part B Carrier, we process claims for our BlueCross Total, BlueCross Total Value and BlueCross Blue Basic members. Additional information is available from CMS on its website.

You should include the member's complete and accurate identification number when submitting a claim. The complete identification number includes the three-character prefix and subsequent numbers as they appear on the member's ID card. We cannot process claims with incorrect or missing prefixes and member identification numbers. We will return (paper submission) or deny (electronic submission) claims you submit without all required information.

We must submit encounter data and medical records to certify completeness and truthfulness of information submitted to CMS. In turn, you must submit completely and accurately coded claims and assist us in correcting any identified errors or omissions.

Section 2: How to File Claims

BlueCross encourages providers to submit all claims within 12 months of the date of service to facilitate prompt payment and avoid delays that may result from expiration of timely filing requirements. Exceptions may be made to the timely filing requirements of a claim when situations arise concerning other payer primary liability such as Original Medicare, Medicaid or third-party insurers, or legal action and/or an error by BlueCross.

Please remember to submit claims electronically to BlueCross using Medicare billing guidelines. We will process all claims for BlueCross Total, BlueCross Total Value and BlueCross Blue Basic plans. Payments will not come from a fiscal intermediary or Part B carrier. For complete information regarding the mandatory electronic claim filing requirement and exceptions to the requirement, refer to the CMS Medicare Claims Processing Manual (Pub. 100-04), Chapter 24, Section 90.

Do not use a member's Social Security Number for filing claims. For prompt payment, providers should transmit claims in the HIPAA 837 format using the appropriate payer code C63.

The mailing address for BlueCross Total, BlueCross Total Value and BlueCross Blue Basic products:

Medicare Advantage
P.O. Box 100191
Columbia, SC 29202-191

Section 3: BlueCard and Medicare Advantage

BlueCard is a national program that enables members of one Blue Plan to get health care service benefits while traveling or living in another Blue Plan's service area. The program links participating health care providers with the independent Blue Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for claims processing and reimbursement.

The program lets you submit claims for patients from other Blue Plans, domestic and international, to your local Blue Plan. Your local Blue Plan is your sole contact for claims payment, adjustments, and issue resolution. BlueCross Total, BlueCross Total Value and BlueCross Blue Basic are a separate program from BlueCard. Because you can see members of other Blue Plans who have BlueCross Total, BlueCross Total Value and BlueCross Blue Basic coverage, this section addresses how to identify members and process these claims.

Section 3.1: Providing Services to Out of Area Blue Plans' Medicare Advantage members

BlueCross Total, BlueCross Total Value and BlueCross Blue Basic offer a continuation of enrollment to a member when the member temporarily resides in a "continuation area" designated by BlueCross Total, BlueCross Total Value and BlueCross Blue Basic for up to six months. Reasonable access through either network or non-network providers is given; and member cost sharing liability remains the same as the service area he or she has temporarily located from.

If you are a contracted BlueCross Total, BlueCross Total Value or BlueCross Blue Basic provider with BlueCross, you must give members of other Medicare Advantage Blue plans the same access to care as you do for our beneficiaries. You can expect to receive the same contracted rates for such services.

If you are not a BlueCross Total, BlueCross Total Value or BlueCross Blue Basic contracted provider, you may see Medicare Advantage members from other Blue Plans, but you are not required to do so. Should you decide to provide services to Blue Medicare Advantage members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member's out-of-network benefits. For urgent or emergency care, you will be reimbursed at the in-network benefit level.

If your practice is not accepting new Medicare Advantage patients, you do not have to provide care for out-of-area Medicare Advantage members. The same contractual arrangements apply to these out-of- area network-sharing members as your local Medicare Advantage members.

Section 3.2: Medicare Advantage PPO Network Sharing

A Medicare Advantage Preferred Provider Organization (PPO) plan allows members who enroll access to services provided outside the contracted network of providers. Required member cost sharing may be greater when covered services are received out of network. Medicare Advantage PPO plans may be offered on a local or regional (frequently multi-state) basis. Special payment and other rules apply to regional PPOs.

Medicare Advantage PPO members have in-network access to Blue MA PPO providers. Network sharing allows MA PPO members from other Blue Plans to get in-network benefits when traveling or living in the service areas of the MA PPO Plans if the member sees a contracted Medicare Advantage PPO provider. Medicare Advantage PPO shared networks are available in 48 states, the District of Columbia and one territory. For some of the states listed, Medicare Advantage PPO networks are only available in portions of the state.

Alabama	Arizona	Arkansas	California
Colorado	Connecticut	Delaware	District of Columbia
Florida	Georgia	Hawaii	Idaho
Illinois	Indiana	Iowa	Kansas
Kentucky	Louisiana	Maine	Maryland
Massachusetts	Michigan	Minnesota	Mississippi
Missouri	Montana	Nebraska	Nevada
New Hampshire	New Jersey	New Mexico	New York
North Carolina	North Dakota	Ohio	Oklahoma
Oregon	Pennsylvania	Puerto Rico	Rhode Island
South Carolina	South Dakota	Tennessee	Texas
Utah	Vermont	Virginia	Washington
Wisconsin	West Virginia		

BlueCross Total, BlueCross Total Value and BlueCross Blue Basic PPO network sharing does not change your current practice. You should continue to verify eligibility and bill for services as you currently do for any out-of-area Blue Medicare Advantage member you agree to treat. Benefits will be based on the Medicare-allowed amount for covered services and be paid under the member's out-of-network benefits unless for urgent or emergency care. Once you submit the MA claim, BlueCross will send you the payment. For questions about the Medicare Advantage PPO network-sharing program, contact Provider Education at provider.education@bcbssc.com.

Section 3.3: How to Identify Other Blue Plans' Medicare Advantage Members

The "MA" in the suitcase on the member's BlueCross identification card indicates coverage under the network-sharing program. Members should not show their Original Medicare identification card when receiving services.

Section 3.4: BlueCard Eligibility

Call the BlueCard Eligibility Line at 800-676-BLUE (2583) and provide the member's three-digit prefix located on the ID card.

You may also submit electronic eligibility requests for Blue members by:

1. Logging in to My Insurance Manager
2. Entering the required data
3. Submitting your request

If you experience difficulty getting eligibility information, please record the prefix and report it to provider.education@bcbssc.com.

Section 3.5: Member Cost Share under BlueCard

A MA PPO member cost-sharing level and co-payment is based on the member's health plan. You can collect the copayment amounts from the member at the time of service. You should confirm the level of coverage and cost-sharing/copayment amounts, by calling 800-676-BLUE (2583) or submitting an electronic inquiry, for all MA members prior to providing service, since benefits and coverage levels may vary depending on the MA plan.

Other than the applicable member cost-sharing amounts, a Blue Plan or its branded affiliate makes reimbursement directly. In general, you can collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service, and cannot otherwise charge or balance bill the member.

NOTE: Enrollee payment responsibilities can include more than copayments (e.g., deductible). Please review the remittance notice concerning MA plan payment, member's payment responsibility, and balance billing limitations.

Section 3.6: BlueCard Claims

You should submit the claim to BlueCross under your current billing practices. Providers in our BlueCross Total, BlueCross Total Value and BlueCross Blue Basic network are required to file claims electronically to BlueCross BlueShield of South Carolina unless they have an exemption from Medicare. To facilitate prompt payment when transmitting claims in the HIPAA 837 form, you should use payer (carrier) code C63. Do not bill Medicare directly for any services rendered to a BlueCross Total, BlueCross Total Value or BlueCross Blue Basic member.

If you are an in-network provider with BlueCross, benefits will be based on your contracted Medicare Advantage rate for providing covered services to Medicare Advantage members from any MA PPO Plan. Once you submit the MA claim, we will work with the other Plan to determine benefits and send you the payment.

When you provide covered services to other Blue Medicare Advantage out-of-area members, benefits will be based on the Medicare-allowed amount. Once you submit the MA claim, BlueCross will send you the payment. These services will be paid under the member's out-of-network benefits, however, unless for urgent or emergency care.

Section 3.7: Provider Reimbursement

We reimburse you for covered services in accordance with your contracted BlueCross Total, BlueCross Total Value or BlueCross Blue Basic rate with BlueCross. You cannot balance bill members for the difference in their charges and the allowance. You can bill members for any deductibles, coinsurance and/or copayments.

For information concerning the reimbursement amount, contact BlueCross via My Insurance Manager from our website or call 800-868-2510.

Section 3.8: Confidentiality and Data Use

1. **Comingling**: The combination of data sets from multiple sources, including, but not limited to, the combination of Inter-Plan Data and/or Blue Cross Blue Shield Association data with non-Inter-Plan Data and/or non-Blue Cross Blue Shield Association data.

2. **Confidential Information:** Non-public information that includes strategic and/or competitively sensitive information including, but not limited to, the Blue Cross Blue Shield Association or Licensee trade secrets, policies, procedures, data and processes.

3. **Inter-Plan Data**: Information that relates to 1) another Licensee, 2) another Licensee's Member(s), or 3) activity of a Licensee's Member(s) in another Licensee's Service Area.

4. **Licensee**: A Blue Cross and/or Blue Shield Plan or other entity that holds a license to use the brands owned by the Blue Cross Blue Shield Association.

5. **Member**: Any person entitled to receive benefits under a product issued or administered by a Licensee.

6. **National Account**: An entity with employee and/or retiree locations in more than one Licensee's Service Area.

7. **Service Area**: The geographic area in which a Licensee is authorized to use the BCBSA-owned brands.

Your use of Confidential Information and/or Inter-Plan Data shall be strictly for the purpose for which it was disclosed. This use must be consistent with our data use and display requirements.

You are not permitted to re-sell Confidential Information and/or Inter-Plan Data.

You are not permitted to de-aggregate Inter-Plan Data to identify a Licensee, National Account and/or Member information.

You shall limit the use of Confidential Information and/or Inter-Plan Data to the minimum amount necessary to fulfill the purpose for which it was disclosed.

You may not Comingle Inter-Plan Data without our prior written consent.

You agree that we shall be able to audit your compliance with this Section relative to the use and disclosure of Confidential Information and/or Inter-Plan Data, provided that we will give you reasonable notice of the audit and shall make reasonable efforts to perform the audit in a way that minimizes disruption to your business.

You agree to return or destroy all copies of Confidential Information and/or Inter-Plan Data, upon conclusion of the purpose(s) for which it was disclosed. Should you be unable to completely return or destroy the Confidential Information and/or Inter-Plan Data because of legal or licensure requirements, you must maintain the confidentiality of the Confidential Information and/or Inter-Plan Data pursuant to the terms of this Section until the expiration of the applicable legal or licensure requirement. Upon expiration of that requirement, the Confidential Information and/or Inter-Plan Data must be returned or destroyed.

You agree that you shall notify us within thirty (30) days of any change in your ownership interests.

Section 4: Claim Status

You can submit claim status inquiries by visiting www.SouthCarolinaBlues.com and logging into My Insurance Manager. You can also access claim status through the VRU by calling 800-868-2510.

Section 5: Claim Payment

If you do not receive payment for a claim, it is not necessary to resubmit the claim. This confuses members because they receive multiple Explanations of Benefits.

In some cases, a claim may pend because medical review or additional information is necessary. When resolution of a pended claim requires additional information from you, we will notify you in writing (via your remittance or a letter) requesting the additional information.

Section 6: Corrected Claims

If an adjustment for charges is required, resubmit a corrected claim with the correct charges. Please do your best to bill correctly the first time and limit the number of corrected claims that you file to us.
Corrected claims require manual intervention and may decrease your claim adjudication times.

Section 7: Electronic Format

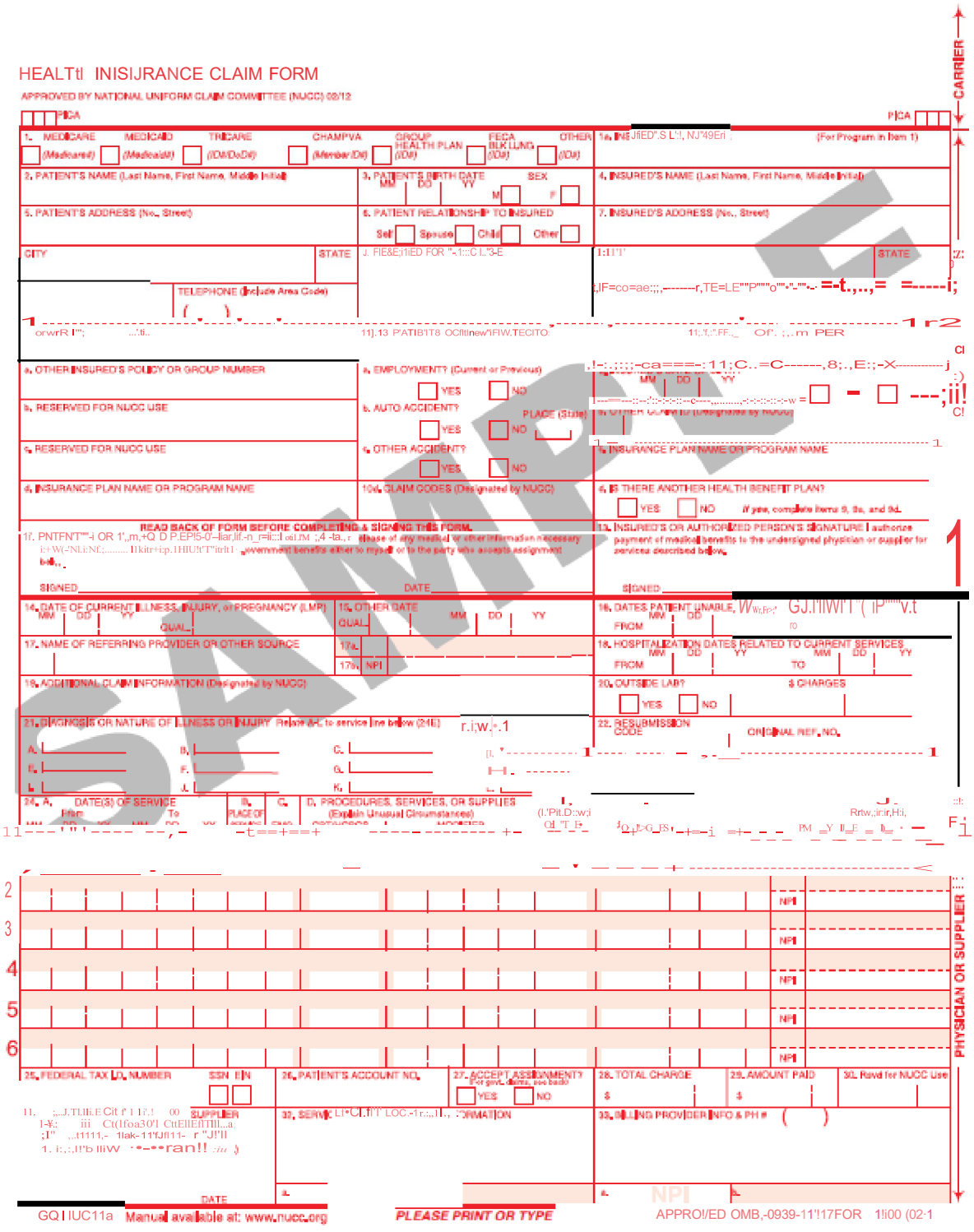
Filing claims electronically is the most effective way to submit claims for processing and receive payment. The Health Insurance Portability and Accountability Act-Administrative Simplification (HIPAA- AS) passed by Congress in 1996 sets standards for the electronic transmission of health care data.
Electronic submitters must submit claims using the ANSI 837x5010A1 format. The HIPAA-AS TR3 (Technical Report 3) provides comprehensive information providers need to create an ANSI 837 transaction.

Section 8: CMS-1500 Claim Form

The National Uniform Claim Committee (NUCC) has approved a new CMS-1500 health insurance claim form, version 02/12. This claim form is used for professional claims.

The CMS-1500 form is the standard paper claim form used by providers or suppliers to bill Medicare Fee-For-Service (FFS) contractors. You can only use this form if you have received an exception from the Administrative Simplification Compliance Act (ASCA). ASCA requires that claims be sent electronically to BlueCross Total, BlueCross Total Value or BlueCross Blue Basic unless a provider qualifies for an exception waiver.

Sample CMS-1500 Health Insurance Claim Form, version 02/12



If you qualify to submit paper claims, follow these instructions when completing your CMS-1500 claim forms. A crosswalk to the electronic transaction is included as reference for those who do not qualify to submit paper claims.

Item	CMS-1500 Form	837P
1a	**Insured's ID Number:** Enter the patient's identification number, including the three-character prefix.	**Loop ID: 2010BA** **Segment/Data Element:** NM109
2	**Patient's Name:** Enter the patient's last name, first name and middle initial, if any, as shown on the patient's BlueCross Total, BlueCross Total Value or BlueCross Blue Basic identification card.	**Loop ID: 2010CA, 2010BA** **Segment/Data Element:** NM103, NM104, NM105, NM107
3	**Patient's Birthdate:** Enter the patient's eight-digit birth date (MM/DD/YYYY) and sex.	**Loop ID: 2010CA, 2010BA** **Segment/Data Element:** DMG02, DMG03
4	**Insured's Name:** List the name of the policyholder here. When the policyholder and the patient are the same, enter the word "Same." If Medicare is primary, leave blank.	**Loop ID: 2010BA** **Segment/Data Element:** NM103, NM104, NM105, NM107
5	**Patient's Address:** Enter the patient's mailing address and telephone number.	**Loop ID: 2010CA** **Segment/Data Element:** N302, N401, N402, N403
6	**Patient's Relationship to Insured:** Check the appropriate box for patient's relationship to insured when item 4 is completed.	**Loop ID: 2000B, 2000C** **Segment/Data Element:** SBR02, PAT01
7	**Insured's Address:** Enter the insured's address and telephone number. When the address is the same as the patient's, enter the word SAME. Complete this item only when items 4, 6, and 11 are completed.	**Loop ID: 2010BA** **Segment/Data Element:** N301, N302, N401, N402, N403
8	**Patient Status:** Check the appropriate box for the patient's marital status and whether employed or a student.	**Loop ID: N/A** **Segment/Data Element:** N/A
9	**Other Insured's Name:** If applicable, enter the last name, first name and middle initial of the other insured enrollee.	**Loop ID: 2330A** **Segment/Data Element:** NM103, NM104, NM105, NM107
9a	**Other Insured's Policy or Group Number:** **Enter the policy and/or group number** **Note**: Complete Item 9d if you enter a policy and/or group number in Item 9a.	**Loop ID: 2320** **Segment/Data Element:** SBR03
9b	**Other Insured's Date of Birth:** Enter the other insured's eight-digit birth date (MM/DD/YYYY) and sex.	**Loop ID: N/A** **Segment/Data Element:** N/A
9c	**Employer's Name or School Name:** Enter the employer's or school's name.	**Loop ID: N/A** **Segment/Data Element:** N/A

9d	**Insurance Plan Name or Program Name:** Enter the insurance plan name or program name.	**Loop ID: 2320** **Segment/Data Element:** SBR04
10a-10c	**Is the Patient's Condition Related to:** Check "Yes" or "No" to indicate whether employment, auto liability or other accident involvement applies to one or more of the services described in this item.	**Loop ID: 2300** **Segment/Data Element:** CLM11
10d	**Reserved for Local Use:** Use this item exclusively for Medicaid (MCD) information. If the patient is entitled to Medicaid, enter the patient's Medicaid number preceded by MCD.	**Loop ID: 2300** **Segment/Data Element:** HI
11	**Insured's Policy Group or FECA Number:** You must complete this item. We will reject it if it is blank.	**Loop ID: 2000B** **Segment/Data Element:** SBR03
11a	**Insured's Date of Birth:** Enter the insured's eight-digit birth date (MM/DD/YYYY) and sex if different from Item 3.	**Loop ID: 2010BA** **Segment/Data Element:** DMG02, DMG03
11b	**Employer's Name or School Name:** Enter the employer's name, if applicable. If there is a change in the insured's insurance status, e.g., retired, enter either a six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY) retirement date preceded by the word "Retired."	**Loop ID: 2010BA** **Segment/Data Element:** REF01, REF02
11c	**Insurance Plan Name or Program Name:** Enter the nine-digit Payer ID number for the primary insurer. This is required if there is insurance primary to Medicare that is indicated in Item 11.	**Loop ID: 2000B** **Segment/Data Element:** SBR04
11d	**Is There Another Health Benefit Plan?:** Leave blank. Not required by Medicare.	**Loop ID: 2320** **Segment/Data Element:**
12	**Patient's or Authorized Person's Signature:** The patient or authorized representative must sign and enter a six-digit date (MM/DD/YY), eight-digit date (MM/DD/YYYY) or an alphanumeric date (e.g., Jan. 1, 2009) unless the signature is on file.	**Loop ID: 2300** **Segment/Data Element:** CLM09
13	**Insured's or Authorized Person's Signature:** The patient or his/her authorized representative signs this item or the signature must be on file as a separate Medigap authorization.	**Loop ID: 2300** **Segment/Data Element:** CLM08
14	**Date of Current:** Enter either an eight-digit (MM/DD/YYYY) or six-digit (MM/DD/YY) date of current illness, injury or pregnancy.	**Loop ID: 2300** **Segment/Data Element:** DTP01, DTP03
15	**If the Patient Has Had Same or Similar Services/Illness, Give First Date:** Leave blank. Not required by Medicare.	**Loop ID: 2300** **Segment/Data Element:** DTP01, DTP03
16	**Dates Patient Unable to Work in Current Occupation:** If the patient is employed and is unable to work in his/her current occupation, enter an eight-digit (MM/DD/YYYY) or six-digit (MM/DD/YY) date.	**Loop ID: 2300** **Segment/Data Element:** DTP03

17	**Name of Referring Physician or Other Source:** Enter the name of the referring or ordering physician if the service or item was ordered or referred by a physician.	**Loop ID: 2310A (Referring), 2310D (Supervising), 2420E (Ordering)** **Segment/Data Element:** NM101, NM103, NM104, NM105, NM107
17a	**ID Number of Referring Physician:** Leave blank.	**Loop ID: 2310A (Referring), 2310D (Supervising), 2420E (Ordering)** **Segment/Data Element:** REF01, REF02
17b	**NPI Number of Referring Physician:** **Enter the NPI of the referring/ordering physician listed in Item 17.** **Note:** Field 17b is required when a service was ordered or referred by a physician.	**Loop ID: 2310A (Referring), 2310D (Supervising), 2420E (Ordering)** **Segment/Data Element:** NM109
18	**Hospitalization Dates Related to Current Services:** Enter either an eight-digit (MM/DD/YYYY) or a six-digit (MM/DD/YY) date when a medical service is furnished as a result of, or subsequent to, a related hospitalization.	**Loop ID: 2300** **Segment/Data Element:** DTP03
19	**Reserved for Local Use:** Unless indicated, do not enter any other documentation in Item 19 of the CMS- 1500 claim form.	**Loop ID: 2300** **Segment/Data Element:** NTE, PWK
20	**Outside Lab Charges:** Complete this item when billing for diagnostic tests subject to the anti-markup payment limitation. Note: This is a required field when billing for diagnostic tests subject to purchase price limitations.	**Loop ID: 2400** **Segment/Data Element:** PS102
21	**Diagnosis or Nature of Illness or Injury:** Enter the patient's diagnosis/condition. Use an ICD-9-CM code number and code to the highest level of specificity for the date of service. Enter up to four diagnosis codes. For form version 02/12, it may be appropriate to use either ICD-9-CM or ICD-10- CM codes depending upon the dates of service. The "ICD Indicator" identifies the ICD code set being reported. Enter the applicable ICD indicator according to these: **Indicator Code Set** 9 ICD-9-CMdiagnosis 10 ICD-10-CMdiagnosis	**Loop ID: 2300** **Segment/Data Element:** HI01-2, HI02-2, HI03-2, HI04-2, HI05-2, HI06-2, HI07-2, HI08- 2, HI09-2, HI10-2, HI11-2, HI12-2
22	**Medicaid Resubmission Code:** Leave blank. Not required by Medicare.	**Loop ID: 2300** **Segment/Data Element:** CLM05-3, REF02
23	**Prior Authorization Number, CLIA, or Ambulance POP:** Enter the prior authorization number for those procedures requiring	**Loop ID: 2300**

	prior approval. Enter the 10-digit Clinical Laboratory Improvement Act (CLIA) certification number for laboratory services billed by an entity performing CLIA covered procedures. For ambulance claims, enter the ZIP code of the loaded ambulance trip's point-of-pickup.	**Segment/Data Element:** REF02
24a	**Date(s) of Service:** Enter a six-digit (MM/DD/YY) or eight-digit (MM/DD/YYYY) date for each procedure, service or supply. When "from" and "to" dates are shown for a series of identical services, enter the number of days or units in column 24G.	**Loop ID: 2400** **Segment/Data Element:** DTP03
24b	**Place of Service:** Enter the appropriate place of service code(s) from the list provided in IOM 100- 04, Chapter 26, Section 10.5. Note: When a service is rendered to a hospital inpatient, use the "inpatient hospital" code.	**Loop ID: 2300, 2400** **Segment/Data Element:** CLM05-1, SV105
24c	**Type of Service:** Medicare providers are not required to complete this item.	**Loop ID: 2400** **Segment/Data Element:** SV109
24d	**Procedures, Services or Supplies:** Enter the procedures, services or supplies using the CMS Health Care Procedure Coding System (HCPCS) code. When applicable, show HCPCS code modifiers with the HCPCS code.	**Loop ID: 2400** **Segment/Data Element:** SV101 (2-6)
24e	**Diagnosis Code:** Enter the diagnosis code reference number or letter as shown in item 21 to relate the date of service and the procedures performed to the primary diagnosis. If a situation arises where two or more diagnoses are required for a procedure code (e.g., Pap smears), reference only one of the diagnoses in item 21.	**Loop ID: 2400** **Segment/Data Element:** SV107 (1-4)
24f	**Charges:** Enter the charge for each listed service.	**Loop ID: 2400** **Segment/Data Element:** SV102
24g	**Days or Units:** Enter the number of days or units.	**Loop ID: 2400** **Segment/Data Element:** SV104
24h	**EPSDT Family Plan:** Leave blank. Not required by Medicare.	**Loop ID: 2400** **Segment/Data Element:** SV111, SV112
24i Shaded Line	**Legacy Qualifier Rendering Provider:** Leave blank.	**Loop ID: 2310B, 2420A** **Segment/Data Element:** PRV02-REF01, PRV02- REF01
24j Shaded Line	**NPI Rendering Provider:** Enter the rendering provider's NPI number in the lower portion.	**Loop ID: 2310B, 2420A** **Segment/Data Element:** PRV03-REF02, PRV03-REF02

24j	**NPI Rendering Provider:** Enter the rendering provider's NPI number in the lower portion.	**Loop ID: 2310B, 2420A** **Segment/Data Element:** NM109, NM109
25	**Federal Tax ID Number:** Enter the provider of service or supplier Federal Tax ID (Employer Identification Number) or Social Security Number.	**Loop ID: 2010AA** **Segment/Data Element:** REF01-REF02
26	**Patient's Account Number:** Enter the patient's account number assigned by the provider of service or supplier's accounting system. This field is optional to assist you in patient identification.	**Loop ID: 2300** **Segment/Data Element:** CLM01
27	**Accept Assignment:** Check the appropriate block to indicate whether the provider of service or supplier accepts assignment of Medicare benefits.	**Loop ID: 2300** **Segment/Data Element:** CLM07
28	**Total Charges:** Enter total charges for the services (i.e., total of all charges in item 24f).	**Loop ID: 2300** **Segment/Data Element:** CLM02
29	**Amount Paid:** Enter the total amount the patient paid on the covered services only. Note: This is not the amount the primary insurance paid.	**Loop ID: 2300, 2320** **Segment/Data Element:** AMT02
30	**Balance Due:** Leave blank. Not required by Medicare.	**Loop ID: N/A** **Segment/Data Element:** N/A
31	**Signature of Physician or Supplier:** Enter the signature of provider of service or supplier, or his/her representative and the six-digit date (MM/DD/YY), eight-digit date (MM/DD/YYYY) or alpha-numeric date (e.g., Jan. 1, 2009) the form was signed.	**Loop ID: 2300** **Segment/Data Element:** CLM06
32	**Name and Complete Address of Facility (Including ZIP Code) Where Services Were Rendered:** For services payable under the physician fee schedule and anesthesia services, enter the name and address, and ZIP code of the facility if the services were furnished in a hospital, clinic, laboratory, or facility other than the patient's home or physician's office. Enter the name, address, and ZIP code of the service location for all services other than those furnished in place of service home -12.	**Loop ID: 2310C** **Segment/Data Element:** NM103, N301, N401, N402, N403
32a	**Facility NPI Number** Enter the NPI of the service facility.	**Loop ID: 2310C** **Segment/Data Element:** NM109
32b	**Facility Qualifier and Legacy** Leave blank.	**Loop ID: 2310C** **Segment/Data Element:** REF01, REF02
33	**Physician's Supplier's Billing Name, Address, ZIP Code and Phone Number:** Enter the provider of service/supplier's billing name, address, ZIP code, and telephone number. This is a required field.	**Loop ID: 2010AA** **Segment/Data Element:** NM103, NM104, NM105, NM107, N301, N401, N402, N403, PER04

33a	**Billing Provider NPI Number** Enter the NPI of the billing provider or group. This is a required field.	**Loop ID: 2010AA** **Segment/Data Element:** NM109
33b	**Billing Provider Qualifier and Legacy Number** Leave blank.	**Loop ID: 2000A, 2010AA** **Segment/Data Element:** PRV03, REF01, REF02

Section 9: Uniform Bill (UB-04) Claim Form

The Uniform Bill (UB-04) is the standardized form for institutional services. The National Uniform Billing Committee (NUBC) offers a UB-04 billing guide published by the American Hospital Association, called the National Uniform Billing Guide. Hospital billing departments should refer to the 2019 UB-04 Data Specifications Manual for a crosswalk to the electronic transactions.

Section 10: Common Claims Filing Errors

Proper payment of BlueCross Total, BlueCross Total Value and BlueCross Blue Basic claims is a result of efforts of the provider, employee clinicians and billing personnel, and of adherence to national and local payment policy requirements. This section: (a) describes common claim filing errors that can result in claim rejections or claim denials, (b) includes general requirements for properly resubmitting rejected claims and (c) discusses the process for appealing a denied claim.

Generally, there are three common types of errors that result in claim denials:

1. Billing/data entry errors
2. Noncompliance with coverage policy
3. Billing for services that are not medically necessary

In some cases, additional documentation may be required in order for the claim to complete adjudication. After BlueCross receives the additional information, we will adjust or correct the claim.

Section 10.1: Billing/Claim Filing Error

A common billing or data entry error involves omission of required data (either on the CMS-1500 claim form or the electronic claim record). An example is entering improper bill types. This includes submitting the claim without a discharge bill type when the status code indicates that the patient was still in the facility.

These claim errors can result in claim rejections or denials:

- Incorrect member prefix and/or ID number
- Invalid/missing diagnosis code
- Past timely filing requirements
- Incorrect provider number
- Missing, incorrect or invalid modifier
- Invalid/missing HCPCS code
- Missing or incorrect quantity

Section 10.2: Compliance Issues Resulting in Claim Denials

We may deny coverage or reject a claim for these reasons:

- The patient is not eligible for BlueCross Total, BlueCross Total Value or BlueCross Blue Basic benefits.
- The provider is not qualified to furnish the Medicare services billed.
- BlueCross Total, BlueCross Total Value or BlueCross Blue Basic is the secondary payer to other insurance and the primary plan has not processed the claim.
- Services are excluded by national or local coverage policy because:
  - The service is not covered.
  - A limited benefit is exhausted.
  - Claim/services do not meet technical requirements for payment, e.g., non-compliance with Correct Coding Initiative (CCI) edits (including national and local requirements).

Section 11: Improper Payments

Section 11.1: Unbundling

Unbundling occurs when a provider bills in multiple parts for a procedure that would typically be reported under a single comprehensive code. This unethical act reflects improper procedure reporting under CCI coding requirements. CMS has identified specific code pairs that BlueCross will reject if a provider bills for them for the same patient on the same day. In most unbundling cases, providers cannot bill beneficiaries for amounts Medicare denies due to unbundling.

Section 11.2: NCCI Edits

CMS developed the National Correct Coding Initiatives (NCCI) program to promote national correct coding methods and to control improper coding that leads to inappropriate payment in Medicare Part B claims. NCCI edits prevent improper payments when incorrect code combinations are reported. The coding policies are based on coding conventions defined in the American Medical Association's "Current Procedural Terminology (CPT) Manual," national and local Medicare policies and edits, coding guidelines developed by national societies, standard medical and surgical practice, and/or current coding practice. NCCI edits are handled systematically for BlueCross Total, BlueCross Total Value and BlueCross Blue Basic member claims.

Section 11.3: MPFS

The Medicare physician fee schedule provides extensive information about more than 10,000 services that doctors perform and that Medicare covers. The fee schedule provides a complete list of all covered services, adjustment policies based on geographical region and practice setting, and calculations for the role the physician plays in the procedure. The MPFS is the basis for reimbursement by BCBSSC Medicare Advantage. BlueCross BlueShield of South Carolina Medicare Advantage will follow the 2025 MPFS and the 2025 Final Rule.

Section 12: Provider Not Qualified to Furnish the Services Billed

A provider’s billing office must be aware of the status of not only its billing provider number but also whether all physicians and clinicians furnishing and billing for Medicare-covered services through the provider PIN are legally permitted to participate in the Medicare program. We may not pay for services furnished by excluded providers, providers who have opted out of the Medicare program or providers who are not authorized to bill Medicare. In addition, we may prohibit facilities from submitting claims in some situations for services they furnished if an excluded employee was indirectly involved in the care of a BlueCross Total, BlueCross Total Value or BlueCross Blue Basic member (e.g., an excluded medical director). Providers need to ensure that they do not bill BlueCross Total, BlueCross Total Value or BlueCross Blue Basic for services furnished by individuals excluded from Medicare participation.

Depending on the specialty of the provider there are additional and special considerations a biller must be aware of when submitting claims. These considerations include:

- Determining whether claims should be submitted to Medicare
- Providing Notice of Exclusions of Medical Benefits (NEMBs)

Section 13: Non-Covered Items and Services

Physicians and other providers are responsible for understanding whether specific items and services are covered under Original Medicare and, therefore, also covered by BlueCross Total, BlueCross Total Value and BlueCross Blue Basic. If the provider is ordering or the member wants a service that is not covered by Medicare, the provider must inform the member that the service is not covered and the member will be responsible for all of the charges related to the service.

If there is uncertainty regarding whether a particular service requested by the member is covered under Medicare, the provider or the member may request a pre-service "Organization Determination" from BlueCross Total or BlueCross Total Value. You may also request a pre-service "Organization Determination" for issues related to referrals. If the patient is asking for a service which is not clearly stated as non-covered or is covered in some circumstances but not others, the proper avenue to notify the member of non-coverage is through a pre-service Organization Determination.

Once the provider or member has initiated an Organization Determination, the plan will issue an approval or denial for the services in question.

Sample Integrated Denial Notice (IDN) - CMS 10003-NDMCP (Expires: 11/30/2027)

Important: This notice explains your right to appeal our decision. Read this notice carefully. If you need help, you can call one of the numbers listed on the last page under "Get help & more information."

Medicare Advantage

Notice of Denial of Medical Coverage

Date: 08/10/2020 **Member Number: ZHP ID Number**

Member Name
Member Address
Member Address

Member Name: Name Name
Provider Name: Provider
Service Requested: Service

Your request was denied
We've *denied* the Pre-Service request of medical services/items listed below requested by you or your doctor:

Why did we deny your request?

Complete reason for denial (including clinical verbiage)

You should share a copy of this decision with your doctor so you and your doctor can discuss next steps. If your doctor requested coverage on your behalf, we have sent a copy of this decision to your doctor.

You have the right to appeal our decision
You have the right to ask BlueCross Total Value to review our decision by asking us for an appeal.

Plan Appeal: Ask BlueCross Total Value for an appeal within **60 days** of the date of this notice. We can give you more time if you have a good reason for missing the deadline. See section titled "How to ask for an appeal with BlueCross Total Value" for information on how to ask for a plan level appeal.

If the pre-service Organization Determination is denied and the provider still renders the service or item, the provider and member will need to have a private pay agreement. This agreement must include the service or item being rendered and the member's charge for the service. It must include the member's signature indicating they are aware that they will be responsible for the service or item. When these services are rendered, the claim must be billed using a -GA modifier (indicating a waiver of liability statement, known as an Integrated Denial Notice (IDN) for Medicare Advantage plans, was issued by the provider in advance, as required by plan guidelines).

The IDN is not to be used universally, but only for those services that the provider knows are not Medicare covered. The provider must discuss these services with the member and the member agrees to wanting these services. BlueCross BlueShield of South Carolina network providers should not be ordering non-covered Medicare services.

We may not pay for the referred services if it is outside of our contractual agreements, and the provider would be responsible for the payment and is not allowed to bill the patient, except for the applicable cost-sharing for that service as set forth in the member's Evidence of Coverage.

Also, under Medicare Advantage, unlike Original Medicare, providers are prohibited from using an Advanced Beneficiary Notice (ABN) (CMS Form CMS-R-131). Instead, the pre-service "Organization Determination" process described above must be followed, and the IDN used in place of an ABN. If a provider uses an ABN, the provider will be held liable for the services.

Section 14: Balance Billing

Providers can collect only applicable copayments or coinsurance amounts from BlueCross Total, BlueCross Total Value and BlueCross Blue Basic members and cannot otherwise charge or bill the members for covered services. BlueCross prohibits balance billing for covered services beyond the member's normal cost sharing amounts by network and deemed providers who provide covered services to BlueCross Total, BlueCross Total Value or BlueCross Blue Basic members.

You should collect copayments or coinsurance for covered services from the member at the time of service. If a provider (either deemed or not deemed) incorrectly collects more from a member than the designated copayment or coinsurance amount, you must refund the difference to the member.

Section 15: Payment Methodology

In general, BlueCross pays claims per Medicare reimbursement methodology, less any applicable member cost-sharing amount, which you can collect from the member.

Each provider contract, amendment or payment exhibit describes specific details regarding contracted payment amounts.

CMS applies a risk-adjusted payment methodology based on diagnostic and demographic information. BlueCross conducts ICD-10 coding validation reviews of all claims network physicians submit. These reviews help us comply with CMS.

This table shows the payment process and payment responsibility.

Role	Action
Member	Pays the cost-share amount as stated in the contract up to the allowable fees the plan has established.
Provider	Submits to the local BlueCross and/or BlueShield Plan.

	Bills members only the cost-share amount up to the allowable fees the plan has established. Providers can collect the cost share when they provide services.
BlueCross	Pays benefits directly to the provider.

As a Medicare contractor, BlueCross must ensure that it pays only for those services that comply with Medicare coverage and coding rules, including only reasonable and medically necessary services. For medically necessary services, BlueCross must ensure that services are rendered in the most cost- effective manner (i.e., consideration is given to the location of service and the complexity and level of care provided).

To ensure that payment is made only according to Medicare rules, BlueCross performs data analysis to identify potentially aberrant patterns of care and to apply the medical review process.

Section 16: Medical Review

Medicare contractors conduct the medical review process in accordance with both national and local policies that are the foundation of the review process. The primary authority for all coverage provisions and subsequent policies is the Social Security Act. Contractors apply Medicare policies from regulations, National Coverage Determinations (NCDs), coverage provisions in interpretive manuals and local coverage determinations (LCDs) to comply with the Social Security Act.

Some services may require Prior Authorization. The Prior Authorization process is a review of a requested item or service to assure that it meets the guidelines for a "reasonable and necessary" service by the definition provided in the Social Security Act. Specific items and services that require prior authorization are listed on the Provider section of the BlueCross Medicare Advantage web page (https://www.scbluesmedadvantage.com/). If a claim is submitted for a service that requires prior authorization, but no prior authorization has been obtained, the claim may not be able to be paid. The services and items (and specific codes for those services and items) that require prior authorization are updated monthly on the Provider tab of the web page.

BlueCross Medicare Advantage prior authorization policies follow the CMS guidelines and other nationally recognized guidelines for evidence-based practice.

Section 16.1: Medical Records

Providers should document and maintain legible and comprehensive medical records. The medical record chronologically documents the patient's medical history in sufficient detail and substantiates services as medically necessary.

Document in the patient's medical record precise descriptions of all aspects of patient care, including information regarding the need for and results of services provided. Dictated and transcribed descriptions and other related medical information must be legible and accurate. While you cannot alter initial descriptions of services provided, you can submit documentation in addition to that initially submitted to support a claim.

Network providers are responsible for voluntary disclosure of information that was omitted or incorrect in the initial claim submission. If submission of incorrect claim information results in an overpayment, the provider agrees to promptly return the overpaid amount to BlueCross.

Any documentation that we may need for medical review of provider services may include, but are not limited to, medical records, laboratory and radiology reports, and a current list of prescribed medications and/or progress notes.

Section 16.2: Medical Records Requests

You may receive requests from us or one of our business partners to review medical charts for one or several of your patients. We appreciate your cooperation in helping us meet our quality goals as we seek to improve the overall health of our members — your patients.

We know it's not an easy task to prepare charts for medical review. But we believe you are as committed to improving patients' health outcomes as we are. So that's why we are asking you to help us by complying with our requests for records.

We do NOT pay for fees for your practice to supply medical records to our health plans. If your practice contracts with a vendor that manages the release of patient information on your behalf, please work with your vendor to forward the data to us as a non-billable event. Ensure your vendor understands that you permit our health plans or our designated business partner to inspect, review and acquire copies of records upon request at no charge.

It is important to note that we are less likely to request medical records when you submit claims with suitable procedure and diagnosis codes.

Providers that do not send the requested information timely — or send an invoice for payment — will be contacted by a Provider Advocate to facilitate release of medical records.

Section 17: National Coverage Determinations (NCDs)

CMS developed NCDs to describe the circumstances for Medicare coverage for a specific medical service, procedure, or device. NCDs generally stipulate conditions under which a service is covered (or not covered) under Title XVIII, Section 1862(a) (1) of the Social Security Act or its applicable provisions. Providers can visit the Medicare Coverage Database (MCD Search (cms.gov)).

BlueCross Medicare Advantage follows all NCDs for claim adjudication.

Section 18: Local Coverage Determinations (LCDs)

An LCD is a decision by a Medicare Contractor to cover a particular service on a contractor-wide basis in accordance with Title XVIII, Section 1862(a)(1)(A) of the Social Security Act. As a Medicare contractor, BlueCross considers these coding descriptions in determining medical necessity. LCDs specify under what clinical circumstances a service is reasonable and necessary and serve as administrative and educational tools to assist providers with correctly submitting claims. You can search for LCDs using the Medicare Coverage Database found at MCD Search (cms.gov).

BlueCross Medicare Advantage follows all LCDs for claim adjudication.

Section 19: Local Coverage Articles (LCAs)

A Local Coverage Article is a detailed description by a Medicare Contractor of the specific Billing and Coding requirements in order for a claim for an item or service to be paid. As a Medicare Contractor, BlueCross follows these coding and billing requirements in processing all claims for services under its Medicare plans. LCAs contain important claims and billing directions to assist providers in submitting claims correctly. You can search for LCAs using the Medicare Coverage Database found at MCD Search (cms.gov).

BlueCross Medicare Advantage follows all SC LCAs for claims adjudication.

Chapter Six: Other Important Information

Section 1: Appeals and Grievances

An appeal is a request to review an adverse organization determination. Members have the right to make an appeal if they have concerns or problems related to their coverage or care. Please reference the following chart which identifies who may request an appeal:

Type of Request	Who May Request An Appeal
Standard Pre-Service Reconsideration	• An enrollee; • An enrollee's representative; • The enrollee's treating physician acting on behalf of the enrollee or staff of physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead or otherwise indicates staff is working under the direction of the provider); or • Any other provider or entity (other than the MA plan) determined to have an appealable interest in the proceeding.
Standard Payment Reconsideration	• An enrollee; • An enrollee's representative; • Non-contract provider (see §50.1.1 for non-contract provider payment appeals); • The legal representative of a deceased enrollee's estate; or • Any other provider or entity (other than the MA plan) determined to have an appealable interest in the proceeding
Expedited Reconsideration	• An enrollee; • An enrollee's representative; • Any physician or staff of physician's office acting on said physician's behalf (e.g., request is on said physician's letterhead or otherwise indicates staff is working under the direction of the provider) acting on behalf of the enrollee.

Source: *Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance*

If the member does sign over the rights to the provider, the provider will be held to the decision. A grievance is any expression of dissatisfaction about the plan that is NOT related to payment.

Per CMS regulation, contract providers (including subcontracted entities) may request an appeal for a Pre-service, but do not have appeal rights for claims.

Section 1.1: Levels of Appeals

There are five levels of appeals that apply only when a provider is requesting an appeal on behalf of a member. BlueCross MA network providers must cooperate in the appeals process for members.

Level 1: Reconsideration — Appealing the initial decision by BlueCross
If you disagree with our decision of how we processed a claim, you can request a redetermination. The

time limit for filing the appeal request is 65 calendar days from the date of receipt of the initial determination. After reviewing, we will decide whether the initial decision should be affirmed, dismissed or reversed.

Level 2: Independent Review — Request for a review by an independent review organization
If the claim has gone through the first level appeal process and the determination is upheld, the plan will automatically forward your case to the independent review entity (IRE). The time limit for filing the appeal request at this level is 180 calendar days from the date of receipt of the redetermination. The IRE will review the request and decide to affirm, dismiss or reverse the original decision.

Level 3: Administrative Law Judge (ALJ) Hearing
At this level of appeal request you can ask for an administrative law judge to consider the case and make a decision. The time limit for filing the appeal request is 60 days from the date of receipt of the reconsideration. For calendar year 2025, the monetary threshold to be met is at least $190 that remains in controversy.

Level 4: Medicare Appeals Council Review
At this level of appeal request the Departmental Appeals Board can review the case. The time limit for filing the appeal request is 60 days from the date of receipt of the ALJ hearing decision.

Level 5: Federal Court Review
If the provider disagrees with the decision the Medicare Appeals Council made in appeal level 4, the federal court can review the case. The time limit for filing the appeal request is 60 days from date of receipt of the DAB decision or declination of review by the DAB. For calendar year 2025, the dollar value of the contested benefit must be at least $1,900 in controversy.

Member appeals should be mailed or faxed to:

BlueCross BlueShield of South Carolina
Medicare Advantage
P.O. Box 100191
Columbia, SC 29202-3191
Fax: 803-264-9581

Section 1.2: Grievances

A grievance is a type of complaint that is made if a member is dissatisfied with any aspect of BlueCross or with service or quality of care rendered by a contracting provider. Only the member or his/her authorized representative may file a grievance. Members have the right to make a complaint in the form of a grievance if they have concerns or problems related to their coverage or care. BlueCross Medicare Advantage network providers must cooperate in the grievance process for members.

Complaints from members about contracting providers may relate to a provider's compliance with BlueCross Medicare Advantage procedures, personal relations between providers and members, access to medical care, service issues with the provider's office, or potential medical quality problems.

All complaints about providers are documented and placed in the provider's file for trending and review during credentialing. Every quality of care grievance is reviewed by a plan Medical Director who will decide if further investigation with the provider in question is indicated.

If a member has a grievance about BlueCross Total, BlueCross Total Value or BlueCross Blue Basic, their provider(s), or any other issue, you should instruct the member to contact the Member Services area by calling 855-207-2744.

Chapter Seven: National Plan and Provider Enumeration System (NPPES)

Section 1: Provider Directory Accuracy

Beginning January 2020, the National Plan and Provider Enumeration System (NPPES) will allow providers to certify their National Provider Identifier (NPI) data. As you may be aware, NPPES provides core directory data elements (provider name, specialty, address, and telephone number) in a machine-readable format for virtually every provider in the country.

BlueCross Medicare Advantage believes that Medicare beneficiaries' ability to identify and locate providers, including for purposes of accessing treatment and making health plan choices, demands Medicare Advantage organization (MAO) directory accuracy, as required under 42 CFR § 422.111(b)(3). NPPES data serves as an important resource to improve provider directory reliability and accuracy.

In order to keep provider directories up to date to ensure members can locate physicians, BlueCross Medicare Advantage strongly encourages providers to review information located on NPPES and update this information on a regular basis. BlueCross Medicare Advantage will continue to work with their contracted providers to review and update their NPPES data.

For a listing of frequently asked questions, please click here.