Provider Administration Manual

For Commercial and Medicare Advantage Networks

of Tennessee

Effective July 1, 2026

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I. INTRODUCTION

BlueCross BlueShield of Tennessee, Inc. ("BlueCross") is an independent licensee of the BlueCross BlueShield Association consisting of 34 BlueCross and/or BlueShield Plans throughout the United States.

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

The following pages contain comprehensive information regarding operating policies and procedures established by BlueCross and are incorporated by reference in our Provider Participation Agreements.

This Manual is designed to provide information and guidelines for facilities, practitioners and other providers who participate in one or more of our Commercial Provider Networks listed below:

- Blue Network P℠
- Blue Network S℠
- Blue Network L℠
- Blue Network E℠
- Medicare Advantage – (See Section XXIV)
- Behavioral Health Network (Commercial and Medicare Advantage)

A. Our Statement of Purpose

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

Code of Conduct

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

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

We encourage suppliers and third parties that we do business with to adopt and follow a Code of Conduct particular to their own organization that reflects a commitment to prevent, detect and correct any occurrences of unethical behavior. In addition, we embrace fraud prevention and awareness as essential tools in preserving affordable quality health care and actively work with our business partners and law enforcement agencies to combat health care fraud. More information regarding fraud, waste and abuse education and training can be found on the Centers for Medicare & Medicaid website at Fraud & abuse | CMS.

Included in our Code of Conduct are two sections about "Conflicts of Interest" and "Dealing with Customers, Suppliers, and Third Parties". The primary focus of these sections is to help make sure business decisions are based on the merit of the business factors involved and not on the offering or acceptance of favors. Additionally, any activity that conflicts or is incompatible with our professional responsibilities should be

avoided. You can review the Code of Conduct online at https://www.bcbst.com/docs/about/our-company/corporate-governance/code-of-conduct/Code-of-Conduct.pdf

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

B. Descriptions of Networks

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

Network	Characteristics
Blue Network P℠	The Blue Network P provider network offers a wide variety of credentialed practitioners, hospitals and other health care providers, as well as all participating pharmacies.
Blue Network S℠	Like Blue Network P, the Blue Network S provider network is based on a variety of credentialed practitioners, hospitals and other health care providers as well as all participating pharmacies. It's available for plans purchased on and off the Health Insurance Marketplace and focuses more on affordability. This is achieved in most Tennessee markets with a smaller network of providers than Blue Network P.
Blue Network L℠	The Blue Network L provider network focuses on providing more affordable care by limiting the number of participating providers in the network. This network will include fewer providers than Blue Network S and is available only in Memphis, Nashville, and Knoxville.
Blue Network E℠	The Blue Network E provider network focuses on providing the most affordable care by limiting the number of participating providers in the network. This network will include fewer providers than Blue Network S and is available only for plans purchased on and off the Health Insurance Marketplace.
Nationwide	Benefits vary. For more information on benefits, see Section III in this manual (*How to Identify a BlueCross Member).*

C. Individual Product and Plan Options

We offer a variety of health benefit plans to meet the needs of individuals who aren't covered under an employer-sponsored health plan.

This section is intended to assist you in identifying our individual products and their supporting networks. Although members' ID cards reflect network information, providers are required to log in to Availity® to verify benefits, deductible/copay amounts, and encouraged to check for prior authorization requirements. Providers can also view a member's ID card on Availity.

Individual plans don't cover out-of-network services, except for emergencies. All services that aren't emergency services obtained from any provider not contracted with BlueCross BlueShield of Tennessee in the network of the benefit plan in which the member is enrolled will not be covered. The member will be responsible for the full cost of care.

Marketplace Plans – Group number 127600

Marketplace plans began on Jan. 1, 2014. In order to apply and receive financial assistance from Advance Premium Tax Credits or Cost Sharing Reductions, individuals must purchase coverage through the Marketplace.

Plans on the Marketplace are offered in all eight regions across the state on Blue Network S and Blue Network E. These regions include:

Region 1- East
Region 2 - Knoxville
Region 3 - Greater Chattanooga
Region 4 - Greater Nashville
Region 5 - West
Region 6 - Greater Memphis
Region 7 - East Central
Region 8 - West Central

These plans are compliant with the Affordable Care Act (ACA) and out-of-pocket maximums can't be greater than $10,600 in 2026. Under the ACA, pre-existing conditions can't be excluded.

All plans cover the Essential Health Benefits package required by the law. These include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Treatment and services for mental illness and substance use disorders
- Prescription medications
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

All plans must meet one of the required metallic levels: bronze, silver, gold or platinum.

- Deductibles range from $0 to $10,600
- Out-of-pocket maximums range from $900 to $10,600
- Plans with office copays as low as $0 for primary care and $10 for specialist visits/urgent care center are available. Other plans cover office visits under the plan's deductible/coinsurance.

Off-Marketplace Plans – Group number 129800

Off-marketplace plans began Jan. 1, 2014. Consumers who enroll in one of the off-marketplace plans don't receive a subsidy.

Plans are offered in all eight regions across the state of Tennessee on Blue Network S and Blue Network E. These regions include:

Region 1- East
Region 2 - Knoxville
Region 3 - Greater Chattanooga
Region 4 - Greater Nashville
Region 5 - West
Region 6 - Greater Memphis
Region 7 - East Central
Region 8 - West Central

These plans are Affordable Care Act (ACA) compliant and out-of-pocket maximums can't be greater than $10,600 in 2026. Under ACA, pre-existing conditions can't be excluded.

All plans cover the Essential Health Benefits package required by the law. These include:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Treatment and services for mental illness and substance use disorders
- Prescription medications
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

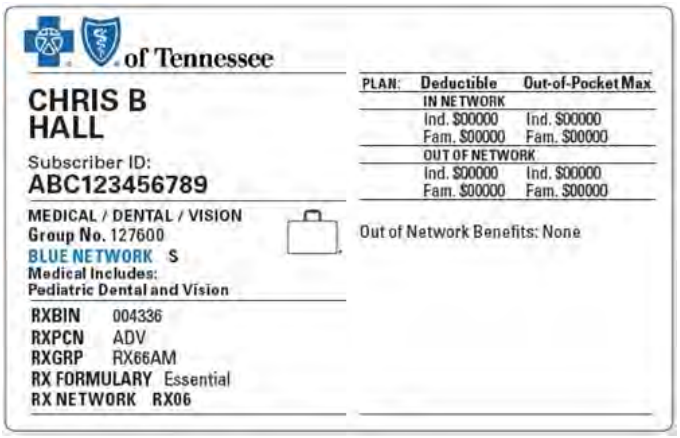
All plans must meet one of the required metallic levels: bronze, silver, gold or platinum.

- Deductibles range from $0 to $10,600
- Out-of-pocket maximums range from $7,400 to $10,600

- Plans with office copays as low as $30 for primary care and $60 for specialist visits/urgent care centers are available. Other plans cover office visits at deductible/coinsurance.
- On and Off-Marketplace Plans sample ID card

The ID card sample is for Network S, ID cards for Network E will have the appropriate letter for the Network.

Blue Network S:



Marketplace Regional Map

D. Health Insurance Portability and Accountability Act of 1996

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

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

1. Health Information Privacy Policies and Procedures

Our Privacy Policies and Procedures implement our obligations to protect the privacy of individually identifiable health information that's created, received or maintained. A major component of protecting health information is to adhere to the necessary data safeguards set forth in the Enterprise Information Technology policies and procedures.

We'll promptly change these policies and procedures as necessary to comply with changes in federal and state law. Any material changes in the policies and procedures will generate a revision to the Notice of Privacy Practices (NOPP), which must be distributed to members within 60 days of the effective date of change via mail unless the member has opted-in to electronic communications. Changes to the NOPP

that aren't considered to be material are updated on our website only. The revised notice will be available to anyone upon request on the effective date of the change.

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

Our Privacy Office will review and update the protected health information use and disclosure assessment every two years.

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

You can view the privacy policies on our website at https://www.bcbst.com/about/our-company/corporate-governance/privacy-security.

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

2. Allowable Disclosures about Protected Health Information (PHI) under HIPAA

The HIPAA Privacy Rule establishes national standards to protect an individual's medical records and other PHI and is applicable to health plans, healthcare clearinghouses, and providers that conduct certain health care transactions electronically. The rule requires appropriate safeguards to protect privacy of PHI, and sets limits and conditions on the uses and disclosures of information without patient authorization. The rule also gives rights to patients over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

Members have the right to access their health information and to know how it's being protected. So, we ask providers to maintain a notice of privacy practices and encourage them to publish these notices on their websites.

Federal regulations under HIPAA may require some changes in the way we operate; however, it won't prevent us from exchanging the information we need for treatment, payment, and health care operations (TPO).

We'll continue to conduct business as usual in most circumstances. HIPAA regulations allow the disclosure and contractually, providers (subject to all applicable privacy and confidentiality requirements) are obligated to make medical records of our members available, at no charge, to each provider treating our members and to us, our agents, or representatives.

Privacy regulations shouldn't impact patient treatment and quality of care. It's vital for the benefit of our members and your patients that quality of care isn't negatively impacted due to misconceptions about allowable exchanges of information for TPO. Examples of TPO include:

- Treatment - rendering medical services, coordinating medical care for an individual, or even referring a patient for healthcare.
- Payment: The money paid to a covered entity for services performed, whether it's a health plan collecting premiums, fulfilling its responsibility for coverage, or paying a provider for services rendered to a patient.
- Health care operations: Conducting quality assessment and improvement activities, underwriting, premium rating, auditing functions, business planning and development, and business management and general administrative activities.

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

If you have any questions or concerns about privacy matters, call the Privacy Office at **1-888-455-3824** or send an e-mail to privacy_office@bcbst.com.

3. Interoperability Standards and the HITECH Act

Providers are encouraged to comply with applicable Interoperability Standards and to demonstrate meaningful use of health information technology in accordance with with Public Law 115-5, The Health Information Technology for Economic and Clinical HeFalth (HITECH) Act.

E. General Information

1. Fraud and Abuse Hotline

A special hotline is available to report possible fraudulent activities involving the delivery or financing of health care. Anyone, whether they're a BlueCross provider or member, can report suspected fraud by calling our Fraud and Abuse Hotline at **423-535-7900** or **1- 888-343-4221**, or e-mailing us at ComplianceHotline@bcbst.com.

2. Interpretation Services

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

The entity that provides the requested language assistance service is financially responsible. Providers shouldn't charge our members, including a BlueCare or TennCare*Select* member, for these services. Full text of Title VI of the Civil Rights Act of 1964 can be found online at https://www.justice.gov/crt.

Providers can use the "I Speak" Language Identification Flash Card to identify the primary language of a member. The flash card, published by the Department of Commerce Bureau of Census, contains 38 languages and can be found online at http://www.lep.gov/ISpeakCards2004.pdf.

Additionally, the National Health Law Program and Access Project is an organization that assists providers who have patients with language issues by providing a Language Services Action Kit. The kit can be purchased by e-mailing lepactionkit@accessproject.org.

The Department of Health and Human Services can recommend resources for use when LEP services are needed. Providers can also locate interpreters specializing in meeting needs of LEP clients by calling:

- Language Line: 1-800-874-9426
- Institute of Foreign Language: 1-615-741-7579
- AVAZA Language Services: 1-800-482-8292

Providers may also consider:

- Training bilingual staff
- Utilizing telephone and video services
- Hearing impaired – written supports as well as alternative formats
- Video remote interpreting, including American Sign Language
- Using qualified translators and interpreters
- Using qualified bilingual volunteers

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

3. Provider Communications

We publish the *BlueAlert* newsletter monthly to communicate important policy and benefit-related news to providers. The newsletter also includes helpful tips and reminders on how to file claims and conduct other BlueCross business more efficiently. Newsletters are posted on our provider.bcbst.com website the first business day of each month.

4. Pre-existing Condition

Group Health Coverage – Employer-funded or sponsored

A pre-existing condition is defined as:

- Any physical or mental condition that began prior to the enrollment date* of the member's coverage.

- Any physical or mental condition, present during a variable look back.
- Any period immediately before the member's enrollment date* that, medical advice, diagnosis, care or treatment was recommended or should've reasonably been received.
- **Treatment** driven.

*The enrollment date could be the effective date of contract, but can be the hire date, if a policy waiting period exists.

5. Non-Discrimination

Our providers, through their contracts with us and in compliance with existing federal and state laws, rules and regulations, agree not to discriminate against members in the provision of services on the basis of race, color, national origin, religion, sexual orientation, gender identity, age or disability.

We don't discriminate the participation, reimbursement, or indemnification of any provider who's acting within the scope of their license or certification under applicable state law, solely based on that license or certification. Our ability to credential providers, as well as maintain a separate network and not include any willing provider, isn't considered discrimination.

We won't differentiate or discriminate in the treatment of providers and entities/organizations seeking participation in our networks on the basis of race, ethnic/national identity, gender, age, sexual orientation, gender identity, religion, patient type (e.g. Medicaid) that the provider specializes in, and in accordance with Section 2706(a) of the Public Health Service Act as added by the Affordable Care Act (ACA).

Section 1557 of the ACA and its implementing regulations prohibits "*covered entities*" from discriminating against individuals on the basis of race, color, ethnic/national identity, gender, age, sexual orientation, gender identity, religion, patient type (e.g., Medicaid) or disability in any health program or activity. "*Covered entities*" include health insurance issuers and health care providers that receive federal financial assistance.

Participating providers who are "*covered entities"* have identified compliance obligations and must meet those compliance obligations when providing services to our members. These obligations include, informing members about non-discrimination and the availability of translation services and information in their own language for members with limited English proficiency.

Participating providers should review their obligations and the requirements of Section 1557 to make sure they're compliant. Information about Section 1557 of the ACA and is available from the Department of Health and Human Services at https://www.hhs.gov/civil-rights/for-providers/index.html.

Providers agree to cooperate with reasonable requests from us and/or the applicable payor in the investigation of any member complaints.

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II. BLUECROSS BLUESHIELD OF TENNESSEE QUICK REFERENCE GUIDES

A. BCBST Telephone Quick Reference Guide

Contact	Location/Description	Telephone Number	Address/Description
BlueCross BlueShield of Tennessee	Provider Service Line	1-800-924-7141	General inquiries: Monday - Thursday 8 a.m. to 6 p.m. ET, and Friday, 9 a.m. to 6 p.m. ET Or mail to: BlueCross BlueShield of TN Claims Service Center 1 Cameron Hill Circle, Ste 0002 Chattanooga, TN 37402
eBusiness Solutions	Technical Support	423-535-5717 Option 2	BlueCross BlueShield of TN eBusiness Solutions 1 Cameron Hill Circle Chattanooga, TN 37402
Provider Networks & Contracting/Provider Relations (Toll Free Number)	Statewide (with the exception of Memphis)	1-800-924-7141 Option 2	BlueCare Tennessee/BCBST ATTN: Provider Networks & Contracting/Provider Relations 1 Cameron Hill Circle, CH 1.5 Chattanooga, TN 37402
	Memphis	1-800-924-7141 Option 2	BlueCross BlueShield of TN ATTN: Provider Networks & Contracting/Provider Relations 85 N. Danny Thomas Blvd- Memphis, TN 38103
Fraud & Abuse Hotline	Provider Service Line	1-888-343-4221	To report suspected fraudulent activity
Credentialing	Provider Service Line	1-800-924-7141	BlueCross BlueShield of TN/ Credentialing Dept. Email: credentials@bcbst.com
Paper Claims Submission **Note**: *Paper claims will only be an accepted method of submission when technical difficulties or temporary circumstances exist and can be demonstrated.*	Blue Networks E, L, P, & S BlueAdvantage BlueCross65℠ Federal Employee Program (FEP) Postal Service Health Benefits (PSHB)		Submit paper claims to: BlueCross BlueShield of TN Claims Service Center 1 Cameron Hill Circle, Ste 0002 Chattanooga, TN 37402-0002
BlueCard® **Benefits & Eligibility** **All other inquiries**	 Provider Service Line Provider Service Line	 1-800-676-2583 1-800-705-0391	 Available Monday through Friday, 8 a.m. to 6 p.m. ET

Contact	Location/Description	Telephone Number	Address/Description
BlueAdvantage	Provider Service Line	1-800-841-7434	Available Monday through Friday, 8 a.m. to 6 p.m. ET
Provider Audit Inquiries	Provider Audit Line	1-888-423-9493	Mail inquiries to: BlueCross BlueShield of TN Provider Audit Department 1 Cameron Hill Circle, Ste 0018 Chattanooga, TN 37402-0018
Utilization Management (UM)	Electronic Provider Service Line UM Forms can be found at: https://provider.bcbst.com/tools-resources/documents-forms For Provider Administered drugs, fax forms can be found at: Commercial Medicare	Availity.com 1-800-924-7141	Selected services require prior authorization. (View online at: https://provider.bcbst.com/tools-resources/authorizations-appeals) Prior authorization is required for all inpatient admissions and may be obtained Monday through Thursday, 8 a.m. to 6 p.m. ET, and Friday, 9 a.m. to 6 p.m. ET. (See Section VIII for information on emergency and after-hours admissions.)
Preservice Reconsideration	Provider Service Line	1-800-924-7141	
UM Standard Appeal	Written Only Fax	 423-591-9451	BlueCross BlueShield of TN Clinical Review Supervisor 1 Cameron Hill Circle, Ste 0017 Chattanooga, TN 37402 UM Appeal form can be found at: Commercial-Utilization-Management-Appeal.pdf (bcbst.com)
Case Management/ **Disease Management/** **Transplant Case Management**	Provider Service Line Provider Service Line Provider Service Line Fax	1-800-225-8698 1-800-818-8581 Ext. 4885 1-888-207-2421 Ext 4042 423-535-5260	To arrange coordination of care for Members with complicated needs (e.g., chronic illnesses and/or catastrophic illnesses or injuries) Available Monday-Thursday 8 a.m. to 6 p.m. ET, and Friday, 9 a.m. to 6 p.m. ET
Pharmacy Program	Provider Service Line	1-800-924-7141	To submit electronic coverage reviews, visit CoverMyMeds at https://account.covermymeds.com You can also request coverage reviews through SureScripts at: https://surescripts.com/. Both are also accessible through Availity.

Contact	Location/Description	Telephone Number	Address/Description
BlueCross BlueShield of Tennessee	Fax	1-888-343-4232	To submit comments or suggestions about our drug list, please fax the request with supporting documentation to 1-888-343-4232 (Attn: Formulary Management) To request a prior authorization, call the Provider Service Line, submit it digitally online at covermymeds.com or fax the request. To submit a reconsideration of a previously denied case, please send a fax or call the Provider Service Line.
CVS Caremark Help Desk	Provider Service Line	1-866-693-4620	Claims processing and technical assistance
Enrollment	Provider Service Line	1-800-314-8457	Pharmacy network contract inquiries

To access real time information, logon to Availity. If you're not registered, go to http://www.Availity.com and click on "Register" in the upper right corner of the home page. Then select "Providers", click "Register" and follow the instructions in the registration wizard.

On this site you can:

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

B. BCBST Contract Quick Reference Guide

Providers should send notice(s) to their Network Manager with a copy, not constituting notice, to BCBST's Legal Department, as outlined in the table below. To find out who your Network Manager is, please use the online self-service look up tool located at https://provider.bcbst.com/contact-us/my-contact or call the Provider Service Line at **1-800-924-7141**.

For purposes of notice under your Agreement, electronic notification, i.e, Docusign©, or other method of email, satisfies the requirements of written notification. Any notice required to be given pursuant to the terms and provisions of your Agreement will be transmitted electronically to the Contract Address on file (see table below) at the time of notice.

Contact	Contract Address*	Description
Provider Contract Management	Network Manager	All notices should be sent in accordance with this section.
Legal Department	GM_LegalProviderContracts@bcbst.com	Copies of all notices must be sent to our Legal Department.
Provider	Contract Address listed in BCBST's electronic enrollment tool, i.e., Availity©	When there is not a Contract address listed in Availity, we will default to the Primary Mailing Address currently on file. If Contract Email Address is not updated in Availity, your

Contact	Contract Address*	Description
		agreement with BCBST will be at risk of being terminated.

The Parties acknowledge that BCBST may specify different email address(es) for different purposes under the Agreement. Please see table above for details on the current BCBST Contract Addresses and information below on how to create and update your Contract Addresses.

**Contract Address(es)" means the current email address(es) specified for notifications between the Parties related to the Agreement.

C. Registering or Updating Your Provider Contract Address

If you haven't registered to receive real-time information about your contract, log on to Availity and provide us with your contract address:

1. Go to **http://www.Availity.com**
2. Click on "Register" in the upper right corner of the home page
3. Select "Providers"
4. Click "Register"
5. Follow the instructions in the registration wizard.

If you have already registered and need to update your contract address:

Please follow the step-by-step instructions outlined below.

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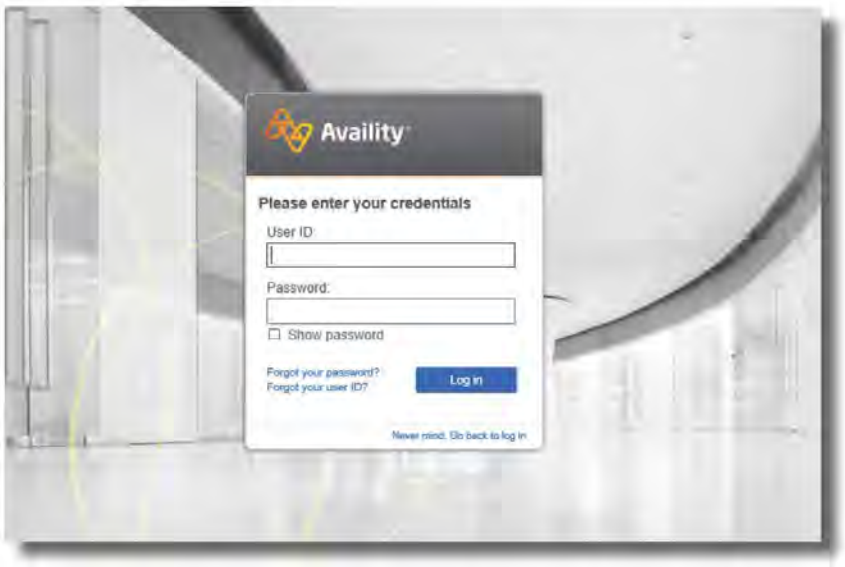
How To Update Your Contact Preference in Availity

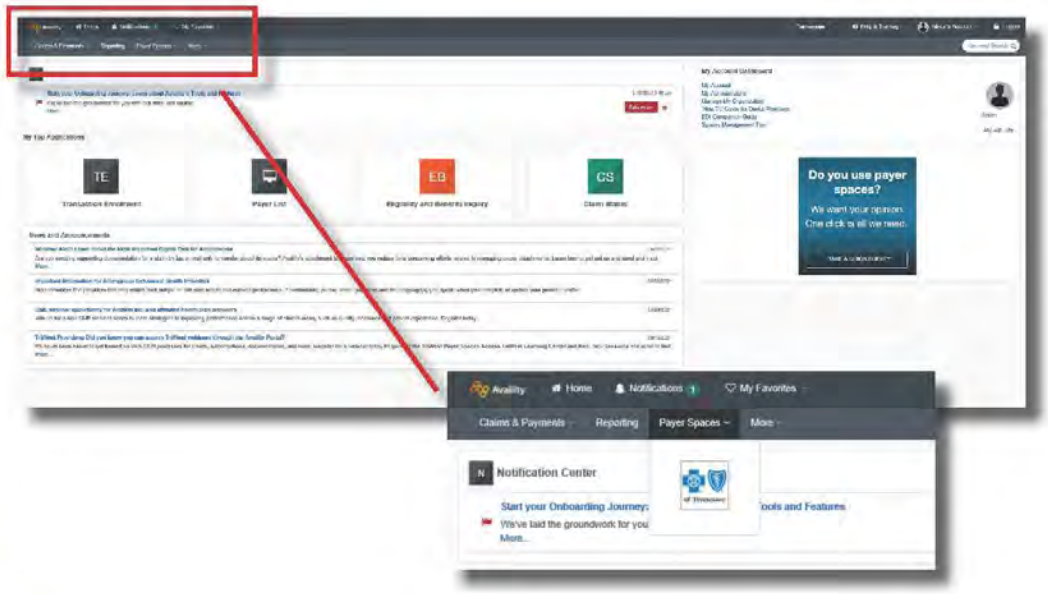
As you work hard to care for our members, we're also working hard to make sure you get important information quickly and efficiently. That's why we're expanding provider access to electronic communications. Users must request permission from their Availity administrator for access to view and update communication types.

1 Using your internet connected device open your web browser of choice. Navigate to the Availity web page using the web address **www.apps.availity.com**.

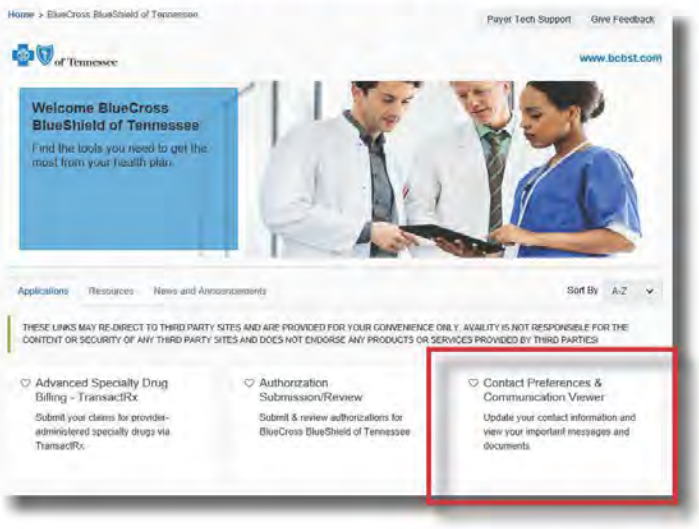
2 After successfully navigating to the web page listed above the user will be presented with a login page. Use your Availity login and password to proceed. If this is the first time logging into Availity from this device the user will receive a second authentication step. The user will be given a choice on how to enter a code that was previously supplied or one that is sent through text.



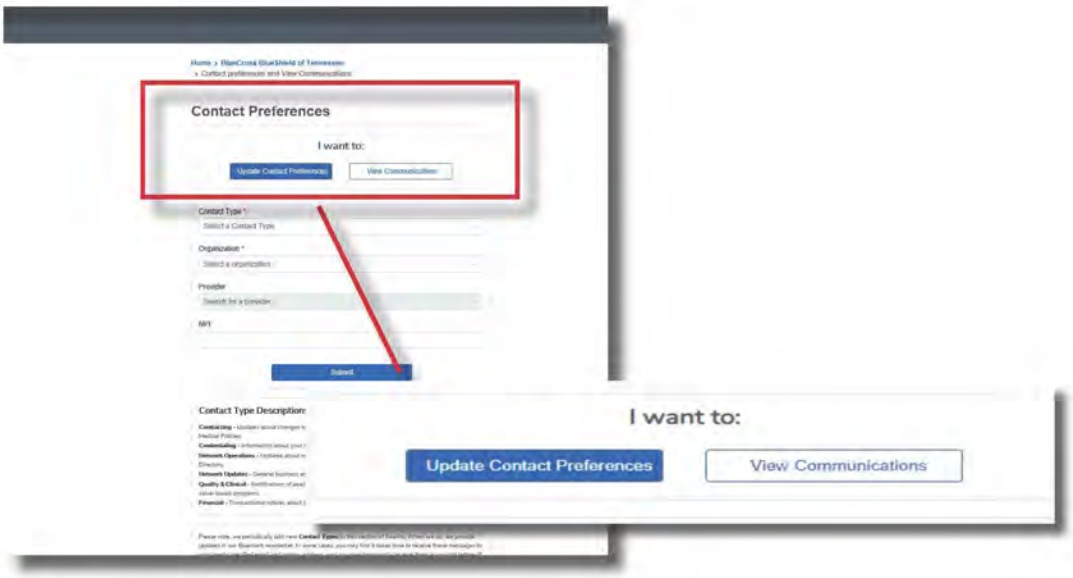
3 Once successfully logged into Availity the user will be presented with their Availity home page. The user will navigate to the **BCBST Payer Space**. To Navigate to the BCBST Payer Space the user will click the Payer Spaces Menu item and the BCBST icon.



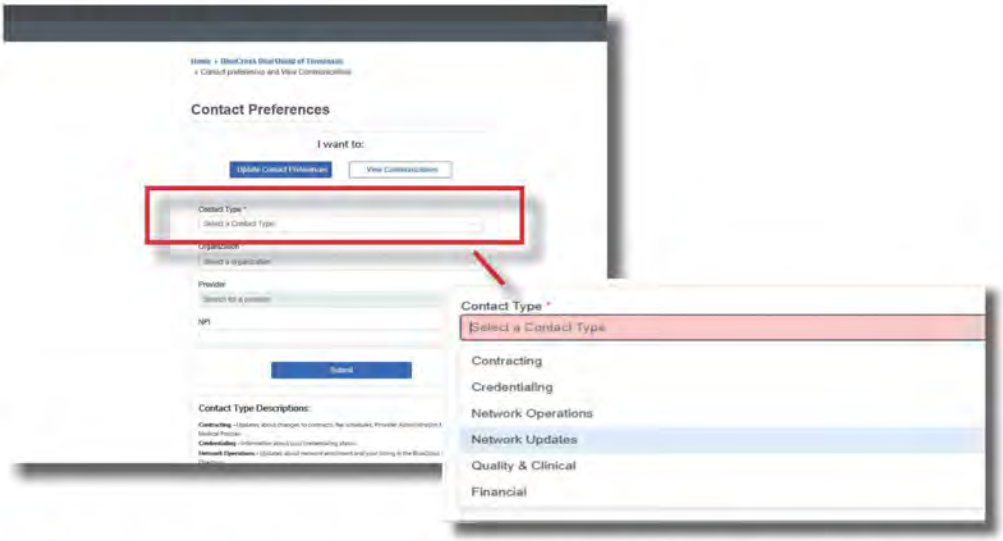
4 Select the **Contact Preferences & Communication Viewer** tile.



5 To update Contact Preferences choose **Update Contact Preferences.** The button will turn blue when selected.

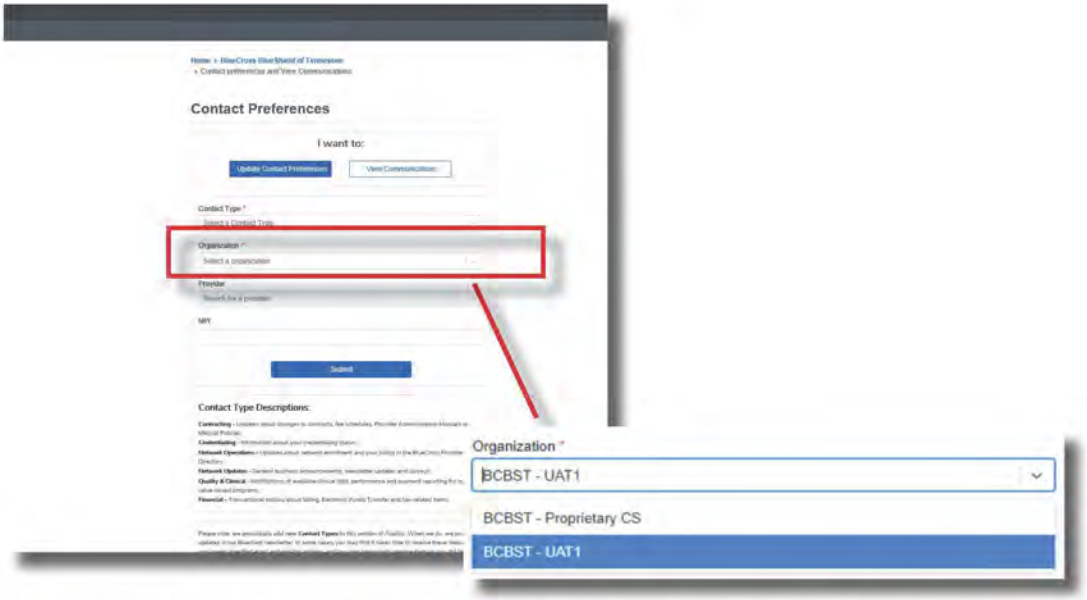


6 Select **Contact Type***.

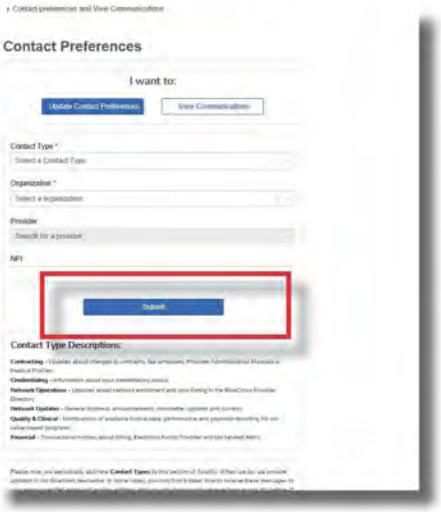


Contracting – Updates about changes to contracts, fee schedules, Provider Administration Manuals (PAMs) or medical policies | **Credentialing** – Information about your credentialing status | **Network Operations** – Updates about network enrollment and your listing in the BlueCross Provider Directory | **Network Updates** – General business announcements, newsletter updates and surveys | **Quality and Clinical Information** – Notifications of available clinical data, performance and payment reporting for our value-based programs | **Financial Updates** – Transactional notices about billing, Electronic Funds Transfer (EFT) and tax-related items

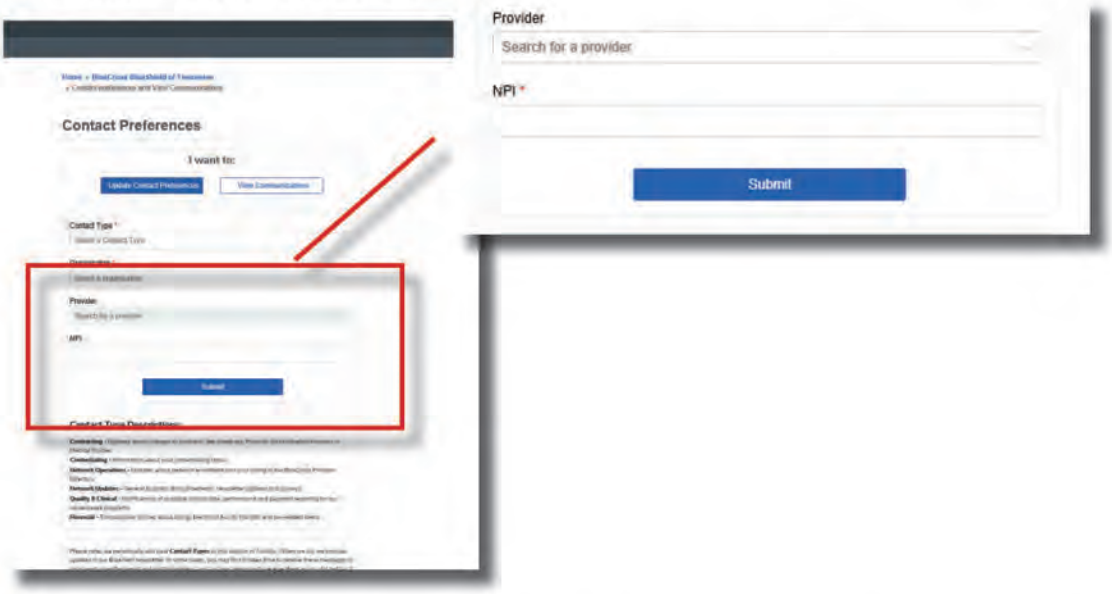
7 The user must then select the desired **Organization**.



8 If the contact type selected is **Contracting** the user may proceed to step 9 or skip to step 10 if they would prefer to see all contracts associated to the selected organization . **This step is for Contracting only. For all other Contact Types except for Contracting proceed to step 9.**



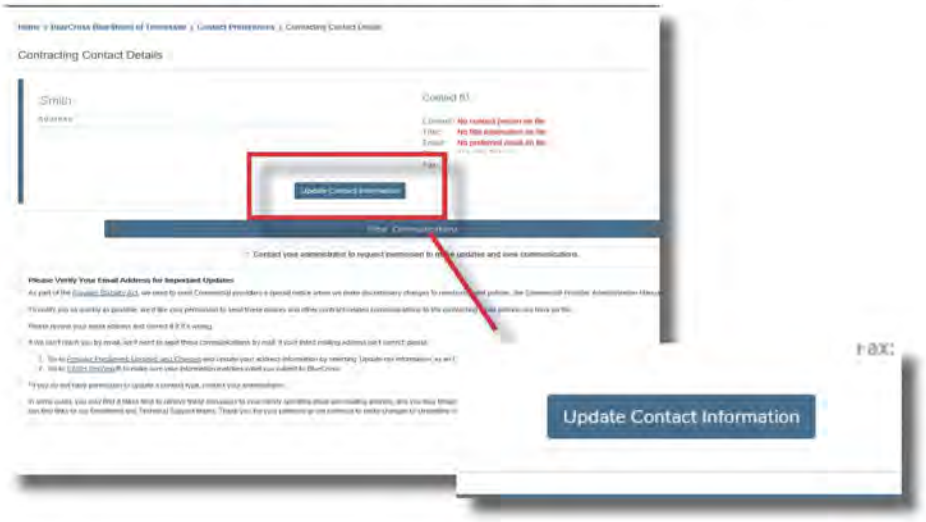
9 If the contact type is not Contracting the user is required to either select a provider from the provider drop down or manually enter an NPI. If contracting contact type is selected provider and NPI is not required but may be entered to narrow down the contracts retrieved. After the correct provider has been selected click “submit”.



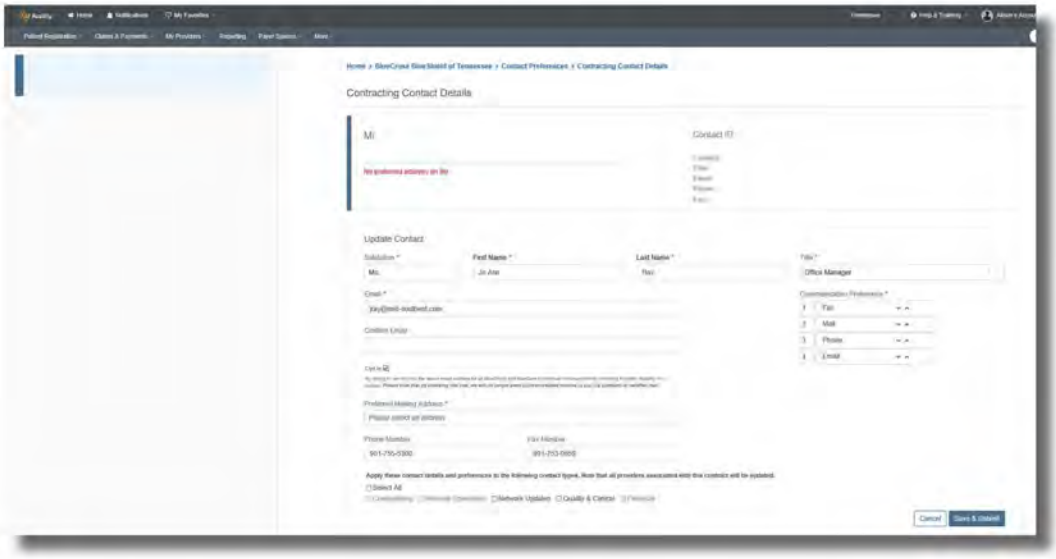
10 While the application retrieves information the user will be presented with a Fetching Contacts message on the screen. Please do not hit refresh or back button during this time.

11 On the left side of the page the user can select different tabs to view the contracts associated to their organization. By default the first contract is selected and displayed. The user may click on the desired contract to review, update, or insert the contact information for the selected contract.

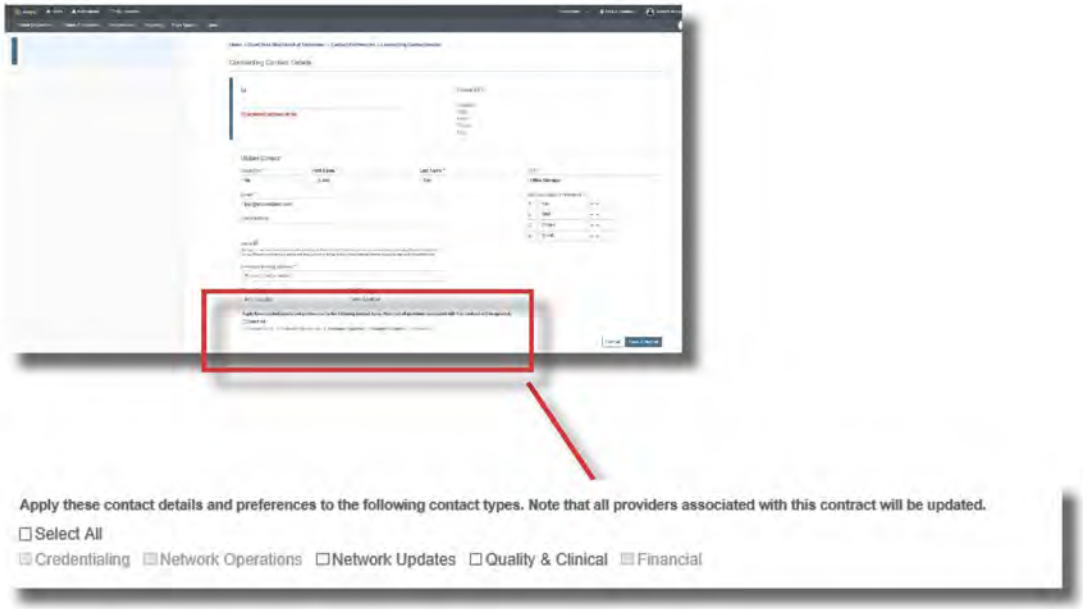
12 After reviewing the contract information the user can select the **Update Contact Information** button to update any information required for this contact. **Note:** The Provider Enrollment and Contracting role is required for the user to be able to update or insert contact information. Users may request this role from their Availity Administrator.



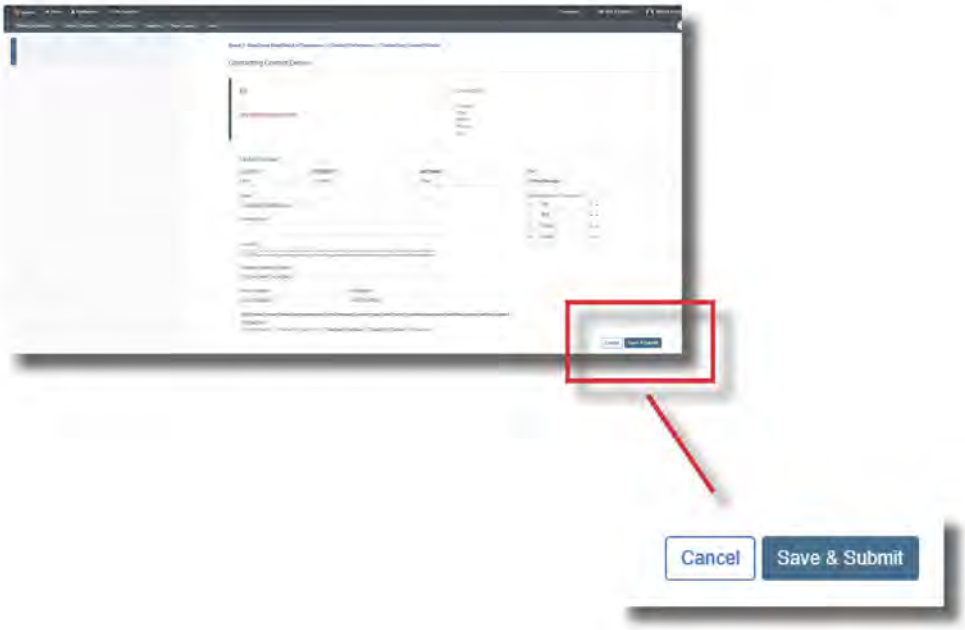
13 This will load a similar screen but with the added ability to update the specific contact information. The user can confirm which provider or contract they are updating information for by checking the tabs on the left side (the selected tab will be a light blue color) of the screen as well as the information before the update section.



14 Users can apply the same updated contact details to other Contact Types by **checking the Contact Type boxes** – or the **Select All box** (which automatically checks all Contact Types you have access to.)



15 Click “Save & Submit” when finished. Once the opt-in to email is selected this will need to be maintained to ensure providers receive all communications in a timely manner.



Need Help?

If you have questions or need help with Availity, please visit Availity.com or contact our eBusiness Service team at **(423) 535-5717 (option 2)** or to reach Provider Network Services call the Provider Service line at **1-800-924-7141 (Contracting & Credentialing Option).**

III. HOW TO IDENTIFY A BLUECROSS BLUESHIELD MEMBER

A. Identifying a Member's ID Card

Each of our members are issued an ID card. The ID card contains much of the information you will need to submit claims and coordinate your patient's care.

We provide standard ID cards to support our Commercial health care benefit plans. Some members have access to more than one Network, which will be indicated on the member's ID card. If a provider treats a member who has access to more than one Network in which the Provider participates, we'll reimburse the provider in accordance with the terms of the Network listed first on the member's ID card.

Note: If a member's ID card lists more than one Network, reimbursement will be paid in accordance with Section VI. Billing and Reimbursement in this manual.

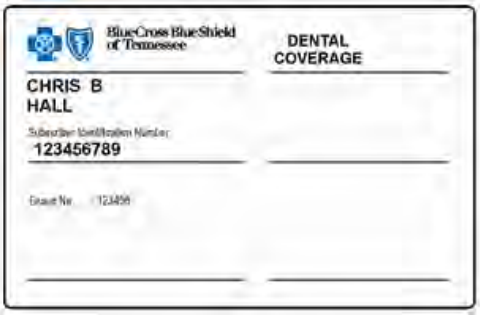
While our ID cards differ depending on the member's health care benefit plan, there are some standard elements common to most of our ID cards:

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

If a member presents without their ID card, providers should verify health care benefits or eligibility by:

- Calling the Provider Service Line at **1-800-924-7141**; or by logging on to Availity

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



Some member health care benefit plans may have customized ID cards* which differ slightly from those shown above. The BlueCross BlueShield of Tennessee logo appears on all of our member ID cards.

*The Federal Employee Program (FEP) and Postal Service Health Benefits (PSHB) ID cards are a nationally recognized ID card that will aid in admissions to hospitals without having to verify benefits with the member's employer. Members and providers can call FEP Customer Service at **1-800-572-1003** or **423-535-5707** and PSHB Customer Service at **1-866-780-7742** for claims filing procedures, requests for additional claim forms and/or benefit information.

All ID cards for federal and postal employees are issued by the FEP Operations Center in Washington, DC.

For services rendered in Tennessee, providers may submit claims to the following claims address for member carrying an FEP or PSHB ID card, regardless of the state in which the member resides.

Mail claims to:

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

B. Determining Eligibility

Providers can verify eligibility or member health care benefits information by:

- calling the Provider Service Line at **1-800-924-7141**
- Logging on to Availity

Note*:* Verification of BlueCross BlueShield of Tennessee health coverage isn't a guarantee of benefits or coverage (doesn't guarantee benefits will be paid for the provider's services). The member's health care benefit plan may have terminated. Self-insured or administrative services only (ASO) groups may not pay for services, or benefits may be limited by the terms of the member's contract or by pre-existing conditions. The provider's services and course of treatment must also be deemed medically necessary and medically appropriate. We reserve the right to determine whether, a service is medically necessary and medically appropriate for purposes of benefit determination. The fact that a practitioner has prescribed, performed, ordered, recommended or approved a service doesn't make it medically necessary and medically appropriate.

Availity

- Availity enables providers to view information in a secure online environment. In Availity, providers can:
  - Check claim status
  - Verify benefits, eligibility and coverage details
  - Submit claims (real-time claims adjudication)
  - View/print remittance advice
  - Submit/update prior authorizations

Retroactive Member Termination Recoveries

If we verify eligibility of an individual who's subsequently determined to have been ineligible at the time services were rendered, we'll recover payments made to providers for services rendered to that member no more than 90 days prior to the date that we were notified the individual member was ineligible. Such recovery will be based on the actual claim payment date. If the Member Benefit Agreement contains a lesser retroactive member termination clause (e.g. seven days), such clause will apply.

C. Member Fees

Members agree to pay certain cost-sharing fees for a covered service, depending on the health care benefit plan they're enrolled in. These cost-sharing fees are described below:

- **Co-insurance -** a pre-determined percentage of amount allowed
- **Copayment** - a specified dollar amount that a member pays each time they visit a provider's office. A provider can collect a copayment from the member at the time of the office visit
- **Deductible** - the amount of money the member is required to pay in a given time period before we start to pay benefits. The deductible is usually a set amount or percentage determined by the member's health care benefit plan

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IV. GROUP HEALTH CARE BENEFITS

Commercial Products

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

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

Visit bcbst.com for more information about our products in your area.

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

Member health care benefits may be verified by calling Provider Services at **1-800-924-7141**, the Member Services number listed on the member's ID card or accessing *e-Health Services*® via Availity.

The member's healthcare benefit plan will pay the Maximum Allowable Charge (MAC) for medically necessary and medically appropriate services and supplies provided in accordance with the reimbursement schedules. Charges higher than the reimbursement rates aren't eligible for reimbursement or payment.

To be eligible for reimbursement or payment, all services or supplies must be provided in accordance with our Medical Policies and Procedures. (See Section VIII. *Care Management* in this manual for specifics.)

Obtaining services not in accordance with our Medical Policies and Procedures may result in the denial of payment or a reduction in reimbursement for otherwise eligible covered services.

A. Eligible Providers of Service

1. Practitioner(s) - All services must be rendered by a practitioner type listed in our Referral Directory of Network Providers, or as otherwise required by Tennessee law. The services provided by a practitioner must be within their specialty or scope of practice.
2. Network Provider(s) - A provider who's contracted with us to provide covered services at specified rates. Some providers may have contracted with us to provide a limited set of covered services, like emergency services and are treated as Network Providers for this limited set of covered services.
3. Out-of-Network Provider(s) - A provider who doesn't have a contract with us to provide covered services, and who isn't a non-contracted provider.
4. Non-Contracted Provider(s) - A provider in a category or type that collectively doesn't hold a contract with us. A non-contracted provider is different from an out-of-network provider. A provider's status as a non-contracted provider, network provider or out-of-network provider can change.
5. Other Providers of Service - An individual or facility, other than a practitioner, duly licensed to provide covered services.
6. Assistant-at-Surgery - Benefits will be provided for surgery performed by a practitioner (see Section VI. for Assistant-at-Surgery specifics) who actively assists the operating surgical procedure when, no intern, resident or other staff practitioner is available.

B. Additional Services

Blue365 Program

Providers can help their patients save money on a number of non-covered services by informing them about the Blue365 Program. Our program is a value-added member discount program for health and wellness products and services available to our members located throughout the country. Members can receive

discounts on a wide variety of national and local products and services to help members and their families live a healthy balanced lifestyle.

Members are responsible for the entire cost of any services or products they receive through this program and the terms and conditions of the member's health plan don't apply to these services. The program discounts are subject to change. Discounts for products and services include:

- Apparel & Footwear
- Fitness
- Personal Care
- Hearing & Vision
- Home & Family
- Nutrition
- Travel

Members can take advantage of the Blue365 Program by logging on to bcbst.com and clicking on the "Manage Your Health" tab.

Note: Members of the Federal Employee Program (FEP),Postal Service Health Benefits (PSHB), BlueCare or TennCareSelect aren't eligible for the Blue365 Program.

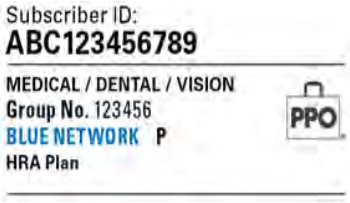
Health Reimbursement Arrangement (HRA)

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

Automatic reimbursement is a feature of our HRA that submits the eligible liability portion of an employee's health care claim and automatically processes it again available HRA funds (if funds are available), a reimbursement is then sent to the provider along with any applicable medical coverage payment.

Administration

- When the medical claim is submitted for processing, the HRA benefits will automatically process at the same time.
- The HRA payment is reimbursed directly to the provider on the same remit but on a separate line item as the medical reimbursement.
- Our Members with HRAs are identified by the "HRA Plan" reflected on their ID cards.



- HRA information can be found in the "Medical Plan Info" section on Availity. For more details on BlueCross HRA administration, refer to the Availity HRA Quick Reference Guide by following these steps":
  - Log on to Availity
  - Navigate to **Payer Spaces**
  - Select **BCBST**
  - Go to Resources
  - Scroll down to find the **HRA Reference Guide**

C. General Exclusions from Coverage

*Exclusions or non-covered services may vary between products and plans. Healthcare benefits for all members should be verified by calling Provider Services at **1-800-924-7141**, the Member Service number listed on the member's ID card, or accessing e-Health Services® on www.bcbst.com.

Non-covered services* include, but aren't limited to:

- Services or supplies not listed as a covered service under the member's health care benefit plan.
- Services or supplies that are determined to be not medically necessary and/or medically appropriate.
- Services or supplies that are investigational in nature including, but aren't limited to:
  - Drugs
  - Biologicals
  - Medications
  - Devices
  - Treatments
- Services or supplies provided by a provider that isn't accredited or licensed or are outside the scope of their license.
- Illness or injury resulting from war that occurred before the member's coverage began and that's covered by
  - Veteran's benefits
  - Other coverage the member is legally entitled to
- Self-treatment or training.
- Staff consultations required by hospital or other facility rules.
- Services rendered free of charge, except when rendered by a non-governmental, charitable research hospital that bills patients for services rendered but doesn't enforce collection from an individual patient.
- Services or supplies for the treatment of work-related illness or injury, regardless of the presence or absence of workers' compensation coverage. This exclusion doesn't apply to injuries or illnesses of an employee who's:
  - A sole proprietor of the Group, unless required by law to carry workers' compensation insurance
  - A partner of the Group, unless required by law to carry workers' compensation insurance
  - A corporate officer of the Group, provided the officer filed an election not to accept workers' compensation with the appropriate government department.
- Personal, physical fitness, recreational or convenience items, equipment and services, even if ordered by a licensed practitioner including but not limited to:
  - Weight loss programs and exercise programs
  - Air conditioners, humidifiers, air filters and heaters
  - Saunas, swimming pools and whirlpools
  - Water purifiers
  - Tanning beds
  - Televisions
  - Barber and beauty services
  - Self-help devices, programs or applications (including but not limited to, mobile medical applications) of any type, whether for medical, behavioral health or non-medical use, unless such mobile application is approved in advance to be used in connection with a wellness program offered.
- Services or supplies received before the effective date of the member's coverage.
- Services or supplies related to a hospital admission, received before the member's effective date of coverage.
- Services or supplies received after the member's coverage ceases for any reason. This is true even though the expenses relate to a condition that began while the member was covered. The only exception to this is described under *Extended Benefits* under the member's healthcare benefit plan.
- Services or supplies received in a dental or medical department maintained by or on behalf of the member's employer, mutual benefit association, labor union or similar group.
- Services or charges to complete a claim form or to provide medical records or other administrative functions. We don't charge the member or their legal representative for statutorily required copying charges.
- Charges for failure to keep a scheduled appointment.
- Charges for telephone consultations, email or web-based consultations, unless otherwise stated in the member's healthcare benefit plan.
- Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day.

- Charges over of the Maximum Allowable Charge for covered services.
- Any service stated in the member's healthcare benefit plan as a non-covered service or limitation.
- Charges for services performed by the member or their partner, or the member's / member's partner's parent, sister, brother or child.
- Any charges for handling fees.
- Safety items or items to affect performance primarily in sports-related activities.
- Services or supplies, including bariatric surgery, for weight loss or to treat obesity, even if the member has other health conditions that might be helped by weight loss or reduction of obesity. This exclusion applies whether the member is of normal weight, overweight, obese or morbidly obese.
- Services considered cosmetic. Services that are always excluded as cosmetic and not subject to Medical Necessity review include, but aren't limited to:
  - Removal of elective body art
  - Facelifts
  - Body contouring
  - Injections to smooth wrinkles
  - Piercing ears or other body parts
  - Rhytidectomy or rhytidoplasty
  - Brachioplasty
  - Keloid removal
  - Dermabrasion
  - Chemical peels
  - Laser resurfacing
  - Lipectomy for cosmetic purpose or for the treatment of variations in fat distribution
- Charges related to surrogate pregnancy when the surrogate mother isn't a covered member under the member's health benefit plan.
- Sperm preservation.
- Private duty nursing.
- Unless covered by the member's prescription drug coverage, services or supplies to treat sexual dysfunction, regardless of cause, including, but not limited to:
  - Erectile dysfunction
  - Delayed ejaculation
  - Anorgasmia and decreased libido

  *This exclusion doesn't apply to office visits.
- Charges for injuries due to chewing or biting or received other dental procedures.
- Services or supplies related to complications of cosmetic procedures.
- Services or supplies related directly to complications of bariatric surgery, re-operation of bariatric surgery or body contouring after weight loss. Body contouring is removing or rearranging tissues, generally on the external body surface, with the intention of achieving an improved cosmetic appearance.
- Intradiscal annuloplasty to treat discogenic back pain.
- Human growth hormones, unless covered by the member's prescription drug coverage.
- Prescription drugs that are illegal under state or federal law such as marijuana.
- Immunizations required for sports, camp, employment, insurance and marriage or legal proceedings.
- Travel immunizations not received through the pharmacy benefit.
- Compound drugs, unless medically necessary and/or medically appropriate.
- Intraoral devices for the treatment of headaches.
- Medical tourism or care received outside the United States when a member chooses to have an elective procedure in another country.
- Non-emergency and non-urgent medical services or supplies received while traveling outside of the United States when treatment could've been reasonably delayed.
- Home delivery of childbirth and any related services, unless the delivery is performed by a provider licensed by the state board of nursing as a registered nurse, duly certified as a nurse midwife by the American College of Nurse-Midwives.
- Devices and computers to assist in communication or speech (e.g. Dynavox).
- Wilderness treatment programs, boarding school programs or similar programs (whether or not the program is part of a residential treatment facility or otherwise licensed institution). This exclusion

applies to programs that treat medical conditions, surgical conditions, behavioral health conditions and substance use disorder.

- Services that do not require a licensed professional and may be provided by non-clinical personnel. This includes art therapy, music therapy, dance therapy, horseback therapy, and other forms of alternative treatment as defined by the National Center for Complementary and Integrative Health (NCCIH).
- Virtual reality therapy services, devices or software.
- Surgeries and related services, and prescription medications for puberty blockers or hormones performed or administered, on a member under age 18, for purposes of gender dysphoria, gender identity disorder, gender incongruence, or similar conditions, unless such services or medications are (1) permissive under applicable law; and (2) Medically Necessary and Medically Appropriate. We reserve the right to request that Providers submit an attestation certifying the services are in compliance with any and all applicable state and federal laws.

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V. MEMBER POLICY

A. Introduction

We're dedicated to the prevention and treatment of diseases by promoting access to quality medical services to our members. Our members and participating providers share a partnership for quality healthcare. Members have the right to receive covered medical services and have certain responsibilities to aid in receiving them.

B. Member Access-to-Care

To ensure quality and continuity of care for our members after regular clinic hours, practitioners will provide 24-hour-a-day, 7-days-a-week service. Practitioners must be able to respond to member calls or calls from an ER or hospital concerning their patients within the time limits described in the Member Access and Availability Standards for routine or urgent care.

Arrangements for 24-hour access to equally qualified practitioners participating in the same BlueCross network as the member's practitioner are the responsibility of all contracted practitioners who participate in our networks.

Standards for Telephone Access After Regular Clinic Hours:

- A telephone number or pager answered by a covering practitioner
- A non-automated, "live" answering service that directs members' calls to an "on-call" covering Practitioner
- An automated answering machine that directs the Member to the Practitioner or appropriate covering practitioner

Standards for Responding to Member Telephone Calls After Regular Hours:

- The member, or member's representative, must be able to speak directly with an appropriate practitioner
- It's acceptable for the answering service to take a message and have the practitioner return the call to the member
- At minimum, the live answering service should request the following from the member:
  - Reason for call
  - Name
  - Telephone number
  - Name of practitioner
- Practitioners providing on-call coverage after regular office hours must respond directly to members or a member's representative within the following time frames:
  - If urgent, in less than 30 minutes from when member calls and leaves a message.
  - If routine, in less than 90 minutes from when the member calls and leaves a message.

A survey of compliance with our call coverage policy is performed during office site visits. Noncompliance is addressed through our Medical Corrective Action Plan (See Section XII.). We'll use these guidelines when credentialing and recredentialing our practitioners.

Standards for Appointment Wait Times (Applies to Marketplace plans only – Group Numbers 127600 and 129800)

- The Appointment Wait Time Standards measure the number of business days between when an individual requests an appointment and when the first in-person appointment is available. These standards apply to appointments for both new and existing patients.

Provider/Facility Specialty Type	Appointment Must Be Available Within
Behavioral Health	10 business days
Primary Care (Routine)	15 business days
Specialty Care (Non-Urgent)	30 business days

Specific ambulatory encounters that we'll monitor are:

Appointment Type	Definition	Standard
Routine Adult Physical Examination	Routine exam of a patient who has no acute symptoms which includes medically necessary and medically appropriate health screenings and immunizations, if a covered benefit.	Annually: Within one year of last scheduled physical after coverage becomes effective, or if last physical is greater than one year, within three months
Children Preventive	Counseling, coordination, and treatment of an anticipatory nature to include guidance and risk reduction interventions. (e.g., vaccinations, immunizations) according to the American Academy of Pediatrics periodicity schedule.	According to the American Academy of Pediatrics periodicity schedule
Prenatal Care	Counseling, diagnosis, treatment and coordination of care for pregnancy for all member to prevent complications, and to decrease the incidence of maternal and prenatal mortality. • 1st Trimester • 2nd Trimester	< 6 weeks <15 weeks
Urgent Care for Adult and Child	• Urgent Examination: medically necessary and appropriate services and supplies to diagnose and treat acute symptoms of sufficient severity that can't wait until the next available appointment. These services may be provided by facility-based providers. • Urgent Specialty: Coordination of care which is diagnostic or confirmatory in nature and needed when an expert opinion is required to determine appropriate care for a patient with an acute condition that is moderate to severe in complexity. If not treated, this condition could lead to harmful outcomes and emergency care.	< 48 hours
Emergency Care	Medically necessary and medically appropriate services that are required to evaluate, treat and stabilize a patient's emergency condition. An emergency is defined as a sudden and unexpected medical condition that manifests itself by symptoms of sufficient severity, including: • Severe pain • Serious impairment of bodily functions • Serious dysfunction of any bodily organ or part that places a person's health in serious jeopardy These services may be provided by facility-based providers. It's understood that in those instances when a physician makes emergency care determinations, the physician will use the skill and judgment of a reasonable physician in making such determinations.	Immediate

Appointment Type	Definition	Standard
Specialty Care for both Adult and Child	Coordination of care, which is diagnostic or confirmatory in nature and needed when an expert is required to perform or determine appropriate follow-up care for a patient. (E.g., cardiology, orthopedics, urology, neurology)	As practitioner deems appropriate for condition or follow-up
Wait Times	1. Office wait time (including lab and X-ray) 2. Member telephone call (during office hours) • Urgent • Routine 3. Member telephone call (after office hours): • Urgent • Routine	< 45 minutes < 15 minutes < 24 hours < 30 minutes < 90 minutes

References: Thomas, Clayton L. MD(ED.) 1993 *Tabor's Cyclopedic Medical Dictionary.*

(Edition 17) Philadelphia: F.A. Davis Company. American Medical Association. (1998) *Practitioner s Current Procedural Terminology.*

C. Member Rights and Responsibilities

We educate our members on their rights and responsibilities. As a participating network provider, we want you to know what our members are being told to expect from you and what you have the right to expect from those members. To comply with regulatory and accrediting requirements, we periodically remind members of their rights and responsibilities. These reminders are intended to make it easier for Members to access quality medical care and to attain services.

- Member Rights
  - Members have the right to:
    - Receive information about the organization, its services, its practitioners and providers and members rights and responsibilities
    - Be treated with respect and recognition of their dignity and their right to privacy
    - Participate with practitioners in making decisions about their health care
    - Voice complaints or appeals about the organization or the care it provides
    - A candid discussion of medically appropriate or medically necessary treatment options for their conditions regardless of cost or benefit coverage
    - Make recommendations about the organization's member rights and responsibilities policy
- Member Responsibilities
  - Members are expected to:
    - Supply information, to the extent possible, that the organization and its practitioners and providers need in order to provide care.
    - Follow plans and instructions for care that they've agreed to with their practitioners.
    - Understand their health problems and participate in developing mutually agreed-upon treatment goals, whenever possible.

D. Member Grievance Process

We've incorporated formal mechanisms to address member concerns and complaints or grievances. Concerns raised by members and providers will be utilized to continuously improve product lines, processes and services. All employees are alert for and responsive to inquiries, complaints and concerns and address such issues promptly and professionally.

We document and maintain member concerns, complaints, and resolutions, if applicable, in accordance with our corporate policies. If a member has an inquiry, concern or complaint regarding any aspect of services received, the member may contact their designated Consumer Advisor to discuss the matter. If a member

feels that the Consumer Advisor hasn't resolved a problem, it is their right to submit a written grievance to the Grievance Committee.

E. Financial Responsibility for the Cost of Services

If a network provider renders a service which is Investigational or doesn't meet medically necessary and appropriate criteria, the provider must obtain a written statement from the member, prior to the service(s) being rendered, and acknowledging that the member understands that they may be responsible for the cost of the specific service(s) and any related services. Providers may also utilize this form in the event a member's requests non-emergency, cosmetic or elective services that are specifically excluded under the member's health benefits plan. It's essential the signed statement be kept on file, as it may be necessary to provide a copy of the signed statement to us so we can verify the member's agreement to the financial responsibility.

To help assist in this process, we've developed the Acknowledgement of Financial Responsibility for the Cost of Services form for provider use. This form meets the contractual obligations of our provider agreements. Providers are strongly encouraged to use this form. Providers using their own form must ensure that their form includes all of the following items or the form will not quality as an Acknowledgement of Financial Responsibility and the member will not have any responsibility for the cost of service:

- The name of the specific service/procedure the provider will perform
- The reason why the provider believes that we won't provide benefits for the service/procedure (i.e., BlueCross considers the service/procedure to be investigational, cosmetic or not medically necessary and appropriate
- The approximate cost of the service/procedure and associated costs
- A statement acknowledging the member understands that we won't provide benefits for the service/procedure
- A statement acknowledging the member has been advised why we won't cover the service/procedure and that they understand and agree that they will be responsible for all the costs and any associated costs
- A statement indicating the form is only valid for one service/procedure
- A specific expiration date

Some out-of-state plans have different coverage provisions. Please make sure that the out-of-state plan doesn't cover the service in question prior to the member signing the waiver agreement.

The Acknowledgement of Financial Responsibility for the Cost of Services form can only be used in the event the member doesn't have coverage for the service in question as determined by verification of the member's coverage. A copy of the Acknowledgement of Financial Responsibility for the Cost of Services form can be found at https://www.bcbst.com/docs/providers/Acknowledgement_Financial_Responsibility_Form.pdf.

Note: Please refer to Section VI. Billing and Reimbursement of this manual under Durable Medical Equipment for billing guidelines and a sample copy of the Acknowledgement of Financial Responsibility for the Cost of Equipment Upgrades and Supplies waiver form.

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VI. BILLING AND REIMBURSEMENT

A. How to File a Claim

Note: The reference to “Institutional” and “Professional” claims throughout this section of the manual is defined below:

Institutional Claims	Professional Claims
(Hospital or facility claims)	(Medical or practitioner claims)
CMS-1450	CMS-1500
UB-04	ANSI-837P
ANSI-837I	

We accept claims electronically in the ANSI 837 format or on paper; although the required method is electronically. An acceptable alternative for the Centers for Medicare & Medicaid Services (CMS) CMS-1500 or CMS-1450 claims is the Optical Character Recognition (OCR) scannable format. Electronic and OCR scannable claims promote effective processing and timely payment. When neither of the above methods are practical, paper claims will be accepted.

Professional charges should be submitted on the CMS-1500/ANSI-837 professional transaction and institutional charges on the CMS-1450/ANSI-837 institutional transaction form. Complete claims data should be filed for all services regardless of whether those services are covered.

All services for the same patient, date of service, place of service, and provider must be billed on a single claim submission.

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

Our commercial timely filing period is six months from the date of service for individual providers, or within six months from the date of discharge for facilities. Failure to submit a claim within the timely filing period will result in the claim being denied.

If the provider has documented evidence that the member didn’t provide insurance information, the timely filing provision will begin when the insurance information was received, subject to the limitations of the member’s benefit agreement.

On paper claims that are returned to the provider for additional information, it’s important that providers send back the form that was attached as proof of timely filing. If BlueCross BlueShield of Tennessee is secondary, the timely filing period is 60 days from the date of service or, for facilities, within 60 days from the date of discharge or 60 days from the primary carrier’s notice of payment.

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

We generate the 277CA Health Care Information Status Notification as proof of timely filing for electronically submitted claims. The 277CA supplies providers with the assigned payer claim control number of each claim received electronically. This control number should be maintained by the provider for proof of timely filing. Providers submitting electronic claims either directly or through a billing service/clearinghouse will automatically receive the 277CA in their electronic mailbox.

To learn more about retrieving your electronic reports, call eBusiness Solutions at **423-535-5717 (Option 2)**, Monday through Thursday, 8 a.m. to 6 p.m. ET and Friday, 9 a.m. to 6 p.m. ET.

Note: Submission dates of claims filed electronically that aren't accepted due to transmission errors won't be accepted as proof of timely filing.

1. Filing Electronic Claims (Required Method)

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

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

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

Note: We follow the CMS guidelines for filing the National Provider Identifier (NPI) Number.

b. Electronic Enrollment and Support

Enrollment of new providers, changes to an existing provider's billing information (address, tax ID, provider number, NPI, name) or any changes of software vendor should be communicated to eBusiness Provider Solutions via the Provider Electronic Profile form. The Provider Electronic Profile form can be downloaded from bcbst.com or upon request. (See contact numbers listed below.)

Mail Provider Electronic Profile forms to:

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

Technical Support

Phone: 423-535-5717
E-mail: eBusiness_Service@bcbst.com

Enrollment

Phone: 1-800-924-7141
Fax: 423-535-7523
E-mail: eBusiness_SysConfig@bcbst.com

c. Electronic Data Interchange (EDI)

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

ANSI accredited a group called "X12" that defines EDI standards for many American industries, including health care insurance. Most electronic standards mandated or proposed under HIPAA are X12 standards.

d. Secure File Gateway (SFG)

The secure file gateway allows trading partners to submit electronic claims and download electronic reports using multiple securely-managed file transfer protocols. The SFG allows providers to transmit files using HTTPS, SFTP and FTP/SSL connections. This grid reflects a short description of each protocol:

Protocol	Description
HTTPS (server mftweb.bcbst.com/myfilegateway)	This secure website allows individuals to login with their credentials and submit electronic claims or download electronic reports.
SFTP (server mftsftp.bcbst.com)	The SFTP server allows trading partners to automate their processes to submit electronic claims or download electronic reports.
FTP/SSL (server mftsftp.bcbst.com)	The FTP/SSL server is an additional option to allow trading partners to automate their processes to submit electronic claims or download electronic reports.

e. ANSI 837 (Version 5010)

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

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

*Coordination of benefits (COB) is part of the ANSI 837, which provides the ability to transmit primary and secondary carrier information. The primary payer can report the primary payment to the secondary payer.

2. Filing Paper Claims

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

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

- CMS-1500 Practitioner's manual
- Tennessee Uniform Procedure Coding manual
- CMS-1450 Hospital manual
- ICD Code manual

To ensure precise control and timely and accurate payment of claims and to reduce the potential of fraud, we won't accept claims faxed, photocopied or altered; claims that don't meet exception criteria will be returned to the provider:

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

Altered claims are claims with whiteout or claims we've determined as suspicious.

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

Some tips that will help ensure claims are processed rapidly and accurately include:

a. General tips for submitting claims using OCR, electronic **or paper:**

- Use a red standard claim form
- Type all letters in upper case (capital letters)
- Align all print in the appropriate blocks
- Use a black font (if typed) or block letters (if handwritten) to reflect a clear impression
- Enter the insured's ID number including the three-letter alpha prefix, exactly as shown on ID card
- Review each claim to ensure all required fields have been provided
- Send only original claims and supporting documentation

- Securely staple any attachments or receipts
- Don't use correction tape or whiteout when submitting paper claims
- Date spans can be submitted unless stated otherwise in a special service section of this manual. However, each line must be specific and match the exact number of units billed. See Chapter 25 of the CMS manual that states how date spans should be used.
- Future dates shouldn't be submitted when filing claims for members. Failure to submit dates of service prior to the received date of the claim will result in the claim being returned for correction.

b. Billing requirements for faxed paperwork (PWK) attachments:

When paper documentation is necessary to support an electronically submitted claim, you can use the PWK06 (paperwork) segment (loop 2300) to indicate that documentation will be sent to us separately from the electronic claim. The actual supporting documentation would be faxed with a PWK fax cover sheet. We'll match the documentation to your electronic claim using the information supplied from the PWK06 segment and PWK fax cover sheet and utilize that documentation during claims processing and payment. To ensure that we match the documents to an electronic claim for processing, the documentation and fax sheet should be submitted no later than the day of claims submission.

Note: We'll only match on the first iteration of PWK06 (ACN) from the ANSI 837 data. Please ensure your first iteration at claim or line level matches the PWK06 (ACN)

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

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

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

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

c. Provider Assessment Forms

Beginning with dates of service 9/25/25 and after, certain physicians are eligible to receive payment for completing and submitting a Provider Assessment Form (PAF) for certain attributed BCBST ACA Marketplace members. This form is in the Quality Care Rewards application in Availity®. The form may be completed online within the application.

We'll reimburse the service as Evaluation and Management (E/M) Code 96161 for certain attributed ACA Marketplace members. Providers must bill for their full expected payment for the PAF; billing for a different amount will result in a standard contract reimbursement. Reimbursement is limited to one PAF per calendar year per member. If multiple providers bill a PAF for the same member in a calendar year, only the first claim will be considered for payment. Subsequent claim submissions will be disallowed.

The PAF is required to be included in your patient's chart as part of their permanent record. To receive reimbursement, you must complete the form in its entirety and submit electronically or upload in the Quality Care Rewards application in Availity within 90 days of the date of service or fax it to 1-877- 922-2963.

4. CMS-1500 Health Insurance Claim Form

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

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

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

- Professional outpatient services
- ER practitioner fees - must be filed with Location Code 23 (Emergency Room
- Hospital)
- Clinic visits (professional fees)

Note: We *follow CMS guidelines for filing the National Provider Identifier (NPI)* n*umber.* However, professional claims need a taxonomy code to be submitted for the billing and rendering providers. A taxonomy code is a unique 10-character code that designates your classification and specialization. It's important that both the billing and rendering provider taxonomy codes match the contracted provider. If you don't submit the appropriate taxonomy code, your claims may be rejected, denied, or result in reduced reimbursement.

A sample copy of the CMS-1500 (02/12) claim form and block descriptions can be viewed below:

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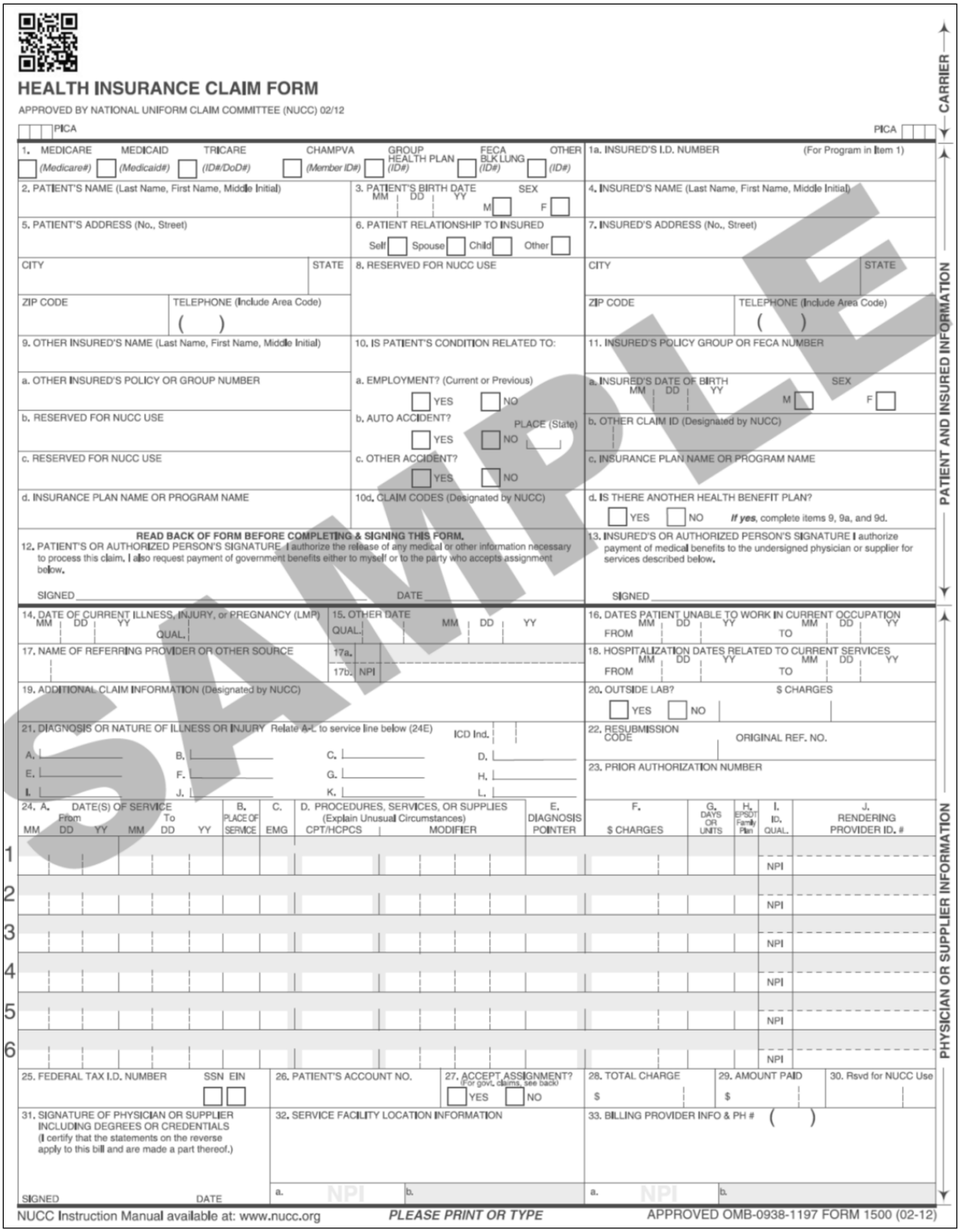

HEALTH INSURANCE CLAIM FORM

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

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE (Medicare#) MEDICAID (Medicaid#) TRICARE (ID#/DoD#) CHAMPVA (Member ID#) GROUP HEALTH PLAN (ID#) FECA BLK LUNG (ID#) OTHER (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other

7. INSURED'S ADDRESS (No., Street)

CITY STATE

8. RESERVED FOR NUCC USE

CITY STATE

ZIP CODE TELEPHONE (Include Area Code) ( )

ZIP CODE TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M F

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

SIGNED

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? YES NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

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

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.

NUCC Instruction Manual available at: www.nucc.org *PLEASE PRINT OR TYPE* APPROVED OMB-0938-1197 FORM 1500 (02-12)

SAMPLE

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

Block 1	Type of Plan
Block 1a	Insured's ID Number (include three-letter alpha prefix)
Block 2	Patient's Name
Block 3	Patient's Date of Birth
Block 4	Insured's Name
Block 5	Patient's Address and Telephone Number
Block 6	Patient's Relationship to Insured
Block 7	Insured's Address
Block 8	Reserved for NUCC Use
Block 9	Other Insured's Name
Block 9a	Other Insured's Policy or Group Number
Block 9b	Reserved for NUCC Use
Block 9c	Reserved for NUCC Use
Block 10abc	Is Patient's Condition Related To
Block 10d	Claim Codes
Block 11	Insured's Policy Group or FECA Number
Block 11a	Insured's Date of Birth
Block 11b	Other Claim ID
Block 11c	Insurance Plan Name or Program Name
Block 11d	Is There Another Health Benefit Plan
Block 12	Patient's or Authorized Person's Signature (Information Release/Government Assignment)
Block 13	Insured's or Authorized Person's Signature (Payment Authorization)
Block 14	Date of Current Illness, Injury, or Pregnancy (LMP)
Block 15	Other Date
Block 16	Dates Patient Unable to Work in Current Occupation
Block 17	Name of Referring Provider or Other Source
Block 17a	ID Number of Referring Provider or Other Source
Block 17b	NPI (National Provider Identifier) of Referring Provider
Block 18	Hospitalization Dates Related to Current Services
Block 19	Additional Claim Information

Block 20	Outside Lab?
Block 21A-L	Diagnosis or Nature of Illness or Injury; ICD Ind
Block 22	Resubmission Code/Original Reference Number (Identifies Corrected Bill)
Block 23	Prior Authorization Number (If Applicable)
Block 24A	Dates of Service
Block 24B	Place of Service
Block 24C	EMG (if emergency indicator required, enter “Y” for yes; leave blank if No)
Block 24D	CPT® or HCPCS code, modifiers
Block 24E	Diagnosis Pointer
Block 24F	Charges
Block 24G	Days or Units
Block 24H	EPSDT/Family Plan (TennCare Kids)
Block 24I	ID Qualifier
Block 24J	Rendering Provider ID Number
Block 25	Federal Tax ID Number or SSN
Block 26	Patient’s Account Number
Block 27	Accept Assignment
Block 28	Total Charge
Block 29	Amount Paid
Block 30	Reserved for NUCC Use
Block 31	Signature of Physician or Supplier
Block 32	Service Facility Location Information (address where service provided)
Block 32a	NPI (National Provider Identifier) of Service Facility
Block 32b	Non-NPI ID Number (unique identifier of the facility)
Block 33	Billing Provider Info and Telephone Number
Block 33a	NPI (National Provider Identifier) of Billing Provider in Block 33)
Block 33b	Non-NPI Number (unique identifier number of professional)

b. Data Elements Required for Submitting CMS-1500 Claims

To avoid delays in receiving payments and unnecessary claim denials, all required information must be provided. The following lists data required when filing a CMS-1500 claim form.

Note: (+) indicates if the format or data isn’t valid. If this happens, the claim will be rejected and returned to the provider for correction and resubmission.

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

5. Completing CMS-1500 Claim Form

This section incorporates information from the NUCC 1500 Health Insurance Claim Form Reference Instruction Manual for the 08/05 Version into our Provider Administration Manual to help provide information on how to complete claim forms in compliance with CMS regulations.

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

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

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

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

The following general instructions are intended to be a guide only for completing the CMS-1500 claim form. Providers should refer to the most current federal, state, or other payor instructions for specific requirements applicable to the 1500 claim form. The 1500 Health Insurance Claim Form Reference Instruction Manual for the 02/12 version can be found at nucc.org.

a. General Instructions

We've approved the CMS-1500 form, along with CMS and TRICARE/CHAMPUS on medical services.

Suggestions and requirements needed to complete the CMS-1500 claim form include:

- Only one line item of service per claim line (block #24) can be reported. If more than six lines per claim are needed, additional claim forms will be required.
- "Super bills," statements, computer printout pages, or other sheets listing dates, services, and/or charges can't be attached to the CMS-1500 claim form.
- The form is aligned to a standard typing format of 10 pitch (PICA) or standard computer-generated print of 10 characters per inch. Vertical spacing is six lines per inch.
- The form is designated for double spacing except for blocks #31, 32 and 33, which may be single-spaced.
- Use standard fonts: don't intermix font styles on the same claim form.
- Don't use italics and script on the form.
- When completing all claim information, the ink color should be:
  - Computer generated black
- Use upper case (CAPITAL) letters for all alpha characters.
- Don't use dollar signs ($), decimals (.), or commas (,) in any dollar amount blocks.
- Enter information on the same horizontal plane.
- Enter all information within the boundaries of the designated block.
- Extraneous data (handwritten or stamped) may not be printed on the form except to mark as "Corrected Bill".

1. Form Alignment

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

2. Entering All Dates

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

Unless otherwise indicated, all date information should be shown:

For blocks 3, 9B, and 11A

MMblankDDblankCCYY

MM=month (01-12)

One blank space

DD=day (01-31)

One blank space

CC=century (20, 21)

YY=year (00-99)

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

b. Physical Claim Form Specifications

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

PAPER

OCR bon - JCP25

20 pound

217 mm x 281mm (+ or - 2mm)

Cut square, corners 90 degrees (+ or -.025)

INK

Standard is Sinclair and Valentine J6983

Same ink front and back of form

Multipart forms must have same ink on all copies

MARGIN

Top to typewriter alignment bar is 34mm

Right to left margin is 9mm

ASKEWITY

No greater than .15mm in 100mm

X and Y OFFSET for MARGINS must not vary by more than + or - 0.010 inches from page to page

(x= horizontal distance form left margin to print, y= vertical distance from top to print).

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

Form Content and Description

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

BLOCK 1 - TYPE COVERAGE

1. MEDICARE	MEDICAID	TRICARE CHAMPUS	CHAMPVA	GROUP HEALTH PLAN	FECA BLK LUNG	OTHER
□ (Medicare #)	□(Medicaid #)	□ (Sponsor's (SSN)	□ (VA File #)	□ (SSN or ID)	□ (SSN)	□ (ID)

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

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

1a. INSURED'S I.D. NUMBER	(For Program in Item 1)
AAA123456789	

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

BLOCK 2 - PATIENT'S NAME

2. PATIENT'S (Last Name, First Name, Middle Initial)
ONEAL TIM L

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

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

BLOCK 3 - PATIENT'S BIRTH DATE AND SEX

3. PATIENT'S BIRTH DATE			SEX
MM	DD	YY	
01	03	2015	M □ F □

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

Examples:

January 3, 2015 = 01032015

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

BLOCK 4 - INSURED'S NAME

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

Description: For patients with coverage through private insurance (BlueCross BlueShield of Tennessee, etc.) or Medicaid, FEP, PSHB, TRICARE/CHAMPUS, etc., the patient's name may be different from the "insured". Because the payor also needs the insured's name, place the full name of the "insured", "subscriber," or "contract holder" in this block (see block 2). If the subscriber's name on the identification card is the same as the patient's name, you may use the word SAME or SELF.
Use all capital letters, no special characters, no titles and no imbedded spaces except to separate last and first names, and middle initial. Be sure to list the name as last name, first name, middle initial.

BLOCK 5 - PATIENT'S ADDRESS (multiple fields)

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

Description: Enter the patient's permanent mailing address and telephone number:
Line 7 = street address, including apt #
Line 9 = city and state
Line 11 = zip code and telephone #
The special character "-" (dash) may be used, but no imbedded spaces may be used except to separate the street number/name, and to separate city/state.

BLOCK 6 - PATIENT'S RELATIONSHIP TO INSURED

6. PATIENT RELATIONSHIP TO INSURED
Self □ Spouse □ Child □ Other □

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

BLOCK 7 - INSURED'S ADDRESS (multiple fields)

7. INSURED'S ADDRESS (No., Street) **SAME**	
CITY	STATE
ZIP CODE	TELEPHONE (Include Area Code) ( )

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

Please use all capital letters. No special characters can be used, except "-" (dash). No imbedded blanks will be accepted unless used to separate street number/name and city/state.

BLOCK 8 – RESERVED FOR NUCC USE (02/12)

8. RESERVED FOR NUCC USE

BLOCK 9 - OTHER INSURED'S NAME

Description: Enter the name of the insured individual who's enrolled in any other policy if the name is different from that shown in block 2. Enter the word "SAME" if the name is the same for block 2. If no other policy benefits are assigned, leave this block blank. The name of the insured individual is entered in the order of the last name, first name and middle initial. If the "insured" under the additional coverage is the same as the person listed in block 4, enter "SAME". Please use all capital letters. No imbedded spaces should be used except to separate last and first names, and middle initial.

BLOCKS 9a-9d - COORDINATION OF BENEFITS

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

Description: Coordination of benefits is a very important cost containment feature for payors. Providing complete and accurate information about a patient's health care coverage will help your office receive prompt and accurate claim payments. Blocks 9a-9d pertain to the coverage not shown in block 1a. For the company receiving the original claim (the company whose identification data is included in block 1a), this information pertains to the "other" coverage.

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

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

Description: Enter the policy or group number of the other insurance coverage for the patient. If the patient doesn't have other coverage, leave this block blank. Payor organizations may use different wording to signify the policy or group number (e.g., "insured's identification number," "contract number" or "certificate number").
(Don't repeat the same number listed in block 1a.)

BLOCK 9b - RESERVED FOR NUCC USE

BLOCK 9c - RESERVED FOR NUCC USE

BLOCK 9d - INSURANCE PLAN NAME OR PROGRAM NAME

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

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

BLOCK 10 – IS PATIENT'S CONDITION RELATED TO

10. IS PATIENT'S CONDITION RELATED TO:

a. EMPLOYMENT? (CURRENT OR PREVIOUS)

YES □ NO □

b. AUTO ACCIDENT? PLACE (State)

YES □ NO □

c. OTHER ACCIDENT?

YES □ NO □

Description: Indicate whether the patient's condition is related to their employment and is applicable to one or more of the services described in block 24. If the patient's condition is related to employment, put an "X" in the "YES" box and indicate whether it's related to the patient's "current" or "previous" employment by circling the appropriate term. If the injury or illness is related to an automobile accident, place an "X" in the "YES" box. Enter the date of the accident in block 14 in an eight-digit format. If the patient's condition is related to an "other accident", place an "X" in the "YES" box. Enter the date of the accident in block 14.

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

BLOCK 10d – CLAIM CODES (DESIGNATED BY NUCC)

10d. CLAIM CODES (Designated by NUCC)

BLOCK 11 - INSURED'S POLICY GROUP OR FECA NUMBER

11. INSURED'S POLICY GROUP OR FECA NUMBER

G12345

a. INSURED'S DATE OF BIRTH

MM	DD	YY	SEX
01	**03**	**2015**	M □ F □

b. OTHER CLAIM ID (Designated by NUCC)

c. INSURANCE PLAN NAME OR PROGRAM NAME

RETIRED

d. IS THERE ANOTHER HEALTH BENEFIT PLAN?

YES □ NO □ If yes, complete items 9, 9a. and 9d

BLOCK 11a - INSURED'S DATE OF BIRTH, SEX

Description: Enter the eight-digit date of birth of the insured (if insured isn't the patient) and the sex of the insured. Place an "X" in the appropriate box to indicate the insured's sex.
(See previous example under BLOCK 11 - INSURED'S POLICY GROUP OR FECA NUMBER)

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

BLOCK 11c — INSURANCE PLAN NAME OR PROGRAM NAME

Description: Enter the complete name of the insurance plan or program that provides health care benefits for the person listed in block 4. Please use all capital letters.

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

BLOCK 11d — IS THERE ANOTHER HEALTH BENEFIT PLAN?

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

BLOCK 12 — PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

(INFORMATION RELEASE/GOVERNMENT ASSIGNMENT)

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED DATE

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

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

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

SIGNED _____

Description: For non-governmental programs, an assignment of benefits that's separate from the information release (block 12) is required if benefits should be sent to the provider. The patient must sign in this block if payment to the provider is desired, or the patient/insured's signature on a separate document must be maintained in the patient's file (enter "ON FILE"). Some provider agreements (PPOs, HMOs, etc.) specifically address how payments are handled, in which case, leave this block blank. However, it's still advisable to obtain an assignment of benefits from the patient or patient's representative if payment is supposed to go to your office. Don't make any notation in this space if payment goes to the patient. Signature on file will also be accepted here. Please use all capital letters.

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

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)			
MM	DD	YY	
01	**03**	**2015**	QUAL

Description: If an accident date is provided, complete block 10b or 10c. For chiropractic services, enter the date of the initiation of the course of treatment and the eight-digit X-ray date in Item 19.
Enter the six-digit (MM│DD│YY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported. Enter the qualifier to the right of the vertical, dotted line.
Example: January 1, 2015 = 01012015

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

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

BLOCK 15 — OTHER DATE

15. OTHER DATE.			
QUAL	MM	DD	YY

BLOCK 16 — DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION							
	MM	DD	YY		MM	DD	YY
FROM	02	15	2015	TO	02	22	2015

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

BLOCK 17 — NAME OF REFERRING PROVIDER OR OTHER SOURCE

BLOCK 17a — OTHER ID NUMBER

BLOCK 17b – NPI NUMBER

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a.	1B	ABC1234567890
RALPH SMITH MD	17b.	NPI	0123456789

Description: The name of the referring provider, ordering Provider, or other source who referred, ordered, or supervised the service(s) or supply (ies) on the claim. Avoid using periods or commas within the name. A hyphen can be used for hyphenated names.
The other ID number of the referring provider, ordering provider, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. The non-NPI ID number of the referring provider, ordering provider, or supervising provider refers to the payor assigned unique identifier of the professional. The NUCC defines the applicable qualifiers, found on their website at nucc.org.
Enter the NPI number of the referring provider, ordering provider, or supervising provider in block 17b.
Provider should be entered to the right of the vertical, dotted line. If multiple Providers are involved, enter one provider using the following priority order:

- DN Referring Provider
- DK Ordering Provider
- DQ Supervising Provider

Note: Please refer to Provider Categories/Billing and Supervision Requirements for the member co-pay information.

BLOCK 18 — HOSPITALIZATION DATES RELATED TO CURRENT SERVICES

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES							
	MM	DD	YY		MM	DD	YY
FROM	02	15	2015	TO	02	22	2015

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

BLOCK 19 — ADDITIONAL CLAIM INFORMATION (DESIGNATED BY NUCC)

19. ADDITIONAL CLAIM INFORMATION (DESIGNATED BY NUCC)

BLOCK 20 — OUTSIDE LAB? $ CHARGES

20.	OUTSIDE LAB?	$ CHARGES
	□ YES □ NO	

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

BLOCK 21 — DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

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

BLOCK 22 —RESUBMISSION CODE/ORIGINAL REFERENCE NUMBER

22. RESUBMISSION CODE	
CODE	ORIGINAL REF. NO.

Description: This block should be used when submitting a corrected claim. "Resubmission" means the code and original reference (claim) number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter.
A resubmission code should be filed in the first portion of block 22. The valid values for this field are "7" Replacement of prior claim and "8" Void/Cancel of prior claim. These codes should be left-justified in the box so that they'll be processed correctly.

- The original claim number issued to the claim being corrected should be filed in the Original Ref. No. portion of block 22.
- This block isn't intended for use for original claim submissions.
- Failure to include the proper "Resubmission Code" and "Original Ref. No." may result in a claim rejection or denial.

BLOCK 23 — PRIOR AUTHORIZATION NUMBER

23. PRIOR AUTHORIZATION NUMBER
009876

Description: The "prior authorization number" is the payer-assigned number authorizing the services(s) for plans that require them.

Note – For ground and air ambulance services submitted on the CMS1500 claim form, the pick-up location zip code should be submitted in block 23. Multiple zip codes shouldn't be submitted in this block. If the points of pick-up are located in different zip codes, a separate claim form should be submitted for each trip. The correct zip code is five numeric digits, if a nine-digit zip code is submitted the last four digits are ignored. block 32 can be used to document the drop off location's zip code. **If the pick-up location zip code is missing, invalid, or submitted in an incorrect format the claim will be returned unprocessed.**

BLOCK 24A. – 24J. – SUPPLEMENTAL INFORMATION

These qualifier codes and description of supplemental information that can be entered in the **shaded** lines of block 24:

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

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

The following qualifiers should be used when reporting NDC units:

- F2 international unit
- ME milligram
- ML milliliter
- GR gram
- UN unit

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

The following qualifiers should be used when reporting these services:

ZZ Narrative description of unspecified code

N4 National Drug Codes (NDC)

Example: N450242006101 ME1.25 ZZAvastin

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

These examples define how to enter different types of supplemental information in block 24. They demonstrate how the data should be entered into the fields and aren't meant to provide direction on how to code for certain services:

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

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
7 Begin 1245 End 1415														1B	12345678901
10	01	05	10	01	05	22		00770	P2	134	875 00	90	N	NPI	0123456789

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

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
7 Begin 1245 End 1415 Time 90 minutes														1B	12345678901
10	01	05	10	01	05	22		00770	P2	134	875 00	6	N	NPI	0123456789

Example 3: Unspecified Code

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
ZZKaye Walker														1B	12345678901
10	01	05	10	01	05	12		E1399		12	165 00	1	N	NPI	0123456789

Example 4: NDC Code

24. A. DATE(S) OF SERVICE From MM	DD	YY	To MM	DD	YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
N450242006001 ME1.25 ZZ Avastin														1B	12345678901
10	01	05	10	01	05	11		J1563		13	500 00	20	N	NPI	0123456789

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

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

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

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

BLOCK 24A — DATE(S) OF SERVICE

Description: This block indicates the beginning and ending dates of service for the entire period reflected by the procedure code, using six-digit formats and excluding all punctuation. Don't use slashes between dates. If the date or month is a single digit, precede it with a zero. Make sure the dates shown are no earlier than the

date of the current illness shown in block 14. If the same service is furnished on different dates, each date should be listed on the claim. For services performed on a single day, the “from” and “to” dates are the same.
Up to six services (line items) may be reported on any one document. If more than six services (line items) need to be reported, additional forms must be completed.
The six service lines in block 24 have been divided horizontally to accommodate submission of both the NPI and another/proprietary identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service.
The top area of the six service lines is shaded and is the location for reporting supplemental information. It isn’t intended to allow the billing of 12 lines of service. Supplemental information can only be entered with a corresponding, completed line and should be placed in the shaded section of blocks 24A through 24G.

Example March 6, 2015 = 03062015

BLOCK 24B — PLACE OF SERVICE

Description: Enter the appropriate two-digit place of service code for each item used or service performed. If services were provided in the ER, use code 23. If services were provided in an urgent care center, use code 20. If services were rendered in a hospital, clinic, lab or other facility, show the name and the address of the facility in block 32. To see all POS codes and descriptions, go to https://www.cms.gov/Medicare/Coding/place-of-service-codes/Place_of_Service_Code_Set.html.

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

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

BLOCK 24D — PROCEDURES, SERVICES, OR SUPPLIES

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

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

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

BLOCK 24E — DIAGNOSIS POINTER

Description: Indicate reference numbers linking the ICD codes listed in block 21 (alpha A- L) to the dates of service and CPT® codes listed in bocks 24A and 24D. This information is used to document that the patient's diagnosis warranted the physician's services. Don't enter 01, 02, 03 or 04. When multiple services are performed, the primary reference letter (A-L) for each service should be listed first and other applicable services should follow. (Note: ICD diagnosis codes must be entered in block 21 only. Don't enter them in 24E.) Numeric entries in block 24E are no longer valid for this block. A minimum of three alpha characters is required.

Enter each applicable diagnosis at the line item level. If the service is for three diagnosis codes, it should be keyed as ABC. Don't enter a span such as A-C. (Note: Per NUCC guidelines, only submit a diagnosis pointer. If more than a diagnosis pointer is entered, your claim will be returned unprocessed).

BLOCK 24F — CHARGES

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

BLOCK 24G — DAYS OR UNITS

Description: This block shows the number of days or units of procedures, services or supplies listed in block 24D. This block is used to report multiple visits, units of supplies, minutes of anesthesia and oxygen volume. The number "1" must be entered if only one service is performed. For some services (e.g., hospital visits, tests, treatments, doses of an injectable drug, etc.), indicate the actual quantity provided. When the number of days is reported, it's compared with the inclusive dates of service listed in block 24A. Days are usually reported when the patient has been hospitalized. When billing for radiology services, don't provide the number of X-ray views.

However, when the same radiology procedure is performed more than once on the same day, the amount should be shown in this block. Please use numeric characters only. Anesthesia claims must be reported in minutes. (Refer to Anesthesia Specifics for billing procedures.)

Whole units should be reported for all services except ambulance mileage.

BLOCK 24H — EPSDT

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

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

Description: If the provider doesn't have an NPI number, enter the appropriate qualifier and identifying number in the shaded area. (See the National Uniform Claim Committee (NUCC) website, www.nucc.org for this information.)
The rendering provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where a substitute provider (Locum Tenens) was used, enter that provider's information here. Report the identification number in blocks 24I and 24J only when different from data recorded in blocks 33a and 33b.

BLOCK 24J —RENDERING PROVIDER ID #

Description: The individual rendering the service is reported in block 24J. Enter the non-NPI number in the shaded area of the field and enter the NPI number in the unshaded area of the field. The rendering Provider is the person or company (lab or other facility) who rendered the care. In the case where a substitute or delegated provider (locum tenens) was used, enter that provider's information there. Report the identification number in blocks 24I and 24J only when different from the data recorded in blocks 33a and 33b.
Note: When line-item rendering provider is used in block 24J:

- It should be an individual, never a group identity
- It must be the individual who performed the service(s)
- It must be an identity that we recognize as a valid provider of health care services
- Multiple rendering providers can't be submitted on the same claim
- Blocks 24J and 33a don't have to match
- Refer to Provider Categories/Billing and Supervision Requirements for the member co-pay information.

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

25.	FEDERAL TAX I.D. NUMBER	SSN	EIN
	612123456	☐	☐

Description: Enter the federal tax I.D. number or social security number (SSN) of the provider identified in block 33. Designate whether the number listed is an SSN or an employer identification number (EIN) by placing an "X" in the appropriate box.

BLOCK 26 — PATIENT'S ACCOUNT NUMBER

26.	PATIENT'S ACCOUNT NO
	M123456

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

BLOCK 27 — ACCEPT ASSIGNMENT?

27.	ACCEPT ASSIGNMENT?
	(For govt. claims, see back)
	YES ☐ NO ☐

Private and Federal Programs

Description: Place an "X" in the box indicating if you're accepting assignment.

BLOCK 28 — TOTAL CHARGE

28. TOTAL CHARGE	
$ 1150	00

Description: Enter the total of all charges for services listed in block 24.
The total amount should be the sum of the individual amounts shown in block 24F. Don't use dollar signs ($) or decimals (.) because both are reflected on the printed document.
Always print two positions in the cents field.

BLOCK 29 — AMOUNT PAID

29. AMOUNT PAID	
$ 50	00

Description: Enter the amount that's been paid on the charges listed in block 24

BLOCK 30 — RESERVED FOR NUCC USE

30. RESERVED FOR NUCC USE

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

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

Description: The form should be signed by the practitioner or supplier (or an authorized representative for the supplier). See the Special CMS-1500 Billing Guidelines Section.
Enter the current date when signing the form.

BLOCK 32 — SERVICE FACILITY LOCATION INFORMATION

32. SERVICE FACILITY LOCATION INFORMATION **GENERAL HOSPITAL** **123 EAST STREET** **THIS TOWN, TN 37000**	
a. NPI	b.

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

BLOCK 32a — NPI #

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

BLOCK 32b — OTHER ID #

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

BLOCK 33 — BILLING PROVIDER INFOR & PH #

33. BILLING PROVIDER INFO & PH # ( ) **RALPH S SMITH MD** **124 EAST STREET** **THIS TOWN, TN 37000**	
a. NPI	b.

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

BLOCK 33a — NPI #

Description: Enter the NPI number of the service facility location.
Note: When block 33, billing provider is used:

- Submit the Individual NPI for the billing provider in block 33a only when the provider is an individual, unincorporated entity
- The group NPI should always be filed as the billing provider if the provider is not an individual unincorporated entity

BLOCK 33b — OTHER ID #

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

c. CMS-1500 Specific

- Multi-page claims:
  - List diagnosis code(s) for all conditions related to the patient's illness on each page
  - Place the total amount only on the last page of the claim. The total on the last page should reflect the sum of the line items for all pages
  - Use the words "Continued on next page" or "Page X of X" in block 28 on each page (except on the last page, which reflects the total charge in block 28)
  - Staple each page of the multi-page claim together (this will help us identify multi-page claims)
  - Staple only the pages of the individual claim together as one. Don't staple several multi-page claims together as one
- Donor/recipient information when filing transplant claims
  - Block 2 should contain the patient information of the person that received the service. In this case it would be the donor
  - Block 19 should be marked "Donor" and contain the recipient's name

NUCC maintains the CMS 1500 form. Review the NUCC 1500 Health Insurance Claim Form Reference Instruction Manual at nucc.org for additional information. From the top of the website, select "1500 Claim Form," then "1500 Instructions."

Note: The National Drug Code (NDC) is required on all CMS-1500 claims for provider-administered medications for all members, including commercial members. This requirement for provider-administered

medications applies to all lines of business. If the NDC code isn't provided, it may result in the claim being denied.

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

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

1. Physician

Practitioners should use their individually assigned provider number. Some practitioners may have multiple provider numbers. Practitioners should use the appropriate provider number based on a unique tax, "pay to" or physical location.

Block 31 Signature of practitioner or supplier including degrees and credentials

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

33a NPI # of the billing provider. **This number should represent the** p**ractitioner's signature in** b**lock 31 unless billing** through the d**elegated** s**ervices** p**olicy.**

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

Note: Professional claims need a taxonomy code to be submitted for the billing and rendering providers. A taxonomy code is a unique 10-character code that designates your classification and specialization. It's important that both the billing and rendering provider taxonomy codes match the contracted provider. If you don't submit the appropriate taxonomy code, your claims may be rejected, denied, or result in reduced reimbursement.

1. **Health Care Professional**

All contract-eligible health care professionals should follow the practitioner previously noted guidelines.

2. Medical Service Provider

Durable medical equipment (DME) suppliers, home infusion therapy services, and labs should bill on the CMS-1500/ANSI-837P for all commercial business using these billing requirements:

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

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

33a NPI # of the billing provider.

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

Note: *Home health agencies and hospice providers should bill charges on the CMS-1450/ANSI-837I.*

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

6. Staff Supervision Requirements for Delegated Services

This policy defines our requirements for supervision by eligible professional Providers of their associate and assistant practitioners. For specific information on behavioral services and any supervision or billing requirements applicable to behavioral health practitioners, please see the full Behavioral Health Services section of this Manual.

Supervision alone doesn't create eligibility for the services of associate and assistant practitioners. Such practitioners must be supervised as specified in the categories below for a service to be eligible for reimbursement.

This policy, together with the Incident To Services & Supplies policy, also describes requirements for billing delegated services. To the extent state or federal law or regulation exceeds these internal requirements, those laws or regulations will control.

Autonomous Providers

Autonomous providers are Providers who by their state license are qualified to diagnose and initiate treatment independently, and who do not require supervision. Providers in this autonomous category are required to complete our full credentialing process and bill us directly under their own provider NPI.

Licensed Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Chiropractic (DC), Doctor of Podiatric Medicine (DPM), Licensed Genetic Counselor, Licensed Pharmacist, Licensed Physical Therapists, Certified Occupational Therapists, Registered Dietitians / Registered Nutritionists, Lactation Consultants (IBCLC), Speech and Language Pathologists, and Certified Audiologists are all examples of autonomous providers. Their services don't require supervision or orders from another professional.

For specific information on providers of Lactation Services (other than Lactation Consultant (IBCLC) credentialed by BCBST), including supervision and billing requirements, please see "Lactation Services Billing Guidelines" later in this section.

Specific Billing Requirements:

Block 24J – Practitioner rendering the service

A specific modifier explaining the NPI listed in this block may be required. Please see the specific billing requirements set forth in the Billing and Reimbursement Guidelines section of this Provider Manual.

Delegated Services

An eligible Provider may delegate services to be performed by other practitioners. Such services must be covered under the benefit contract, performed under appropriate supervision, and billed according to the policies set forth by BCBST. Services performed by an APHCP, as that term is defined later in this section, must be billed according to the APHCP policy, in conjunction with the Incident To Services and Supplies policy.

Practitioners not specifically mentioned in this policy aren't eligible to have services delegated to them.

Practitioner services can be delegated to:

- Certified Anesthesiologist Assistant*
- Certified Athletic Trainer
- Certified Chiropractic Therapy Assistant
- Certified Medical Assistant
- Certified Nurse Midwife*
- Certified Nursing Assistant
- Certified Occupational Therapy Assistant
- Certified Podiatric Assistant
- Certified Registered Nurse Anesthetist*
- Chiropractic Radiology Technician
- Licensed Physical Therapy Assistant
- Licensed Practical Nurse
- Licensed Resident Physician
- Medical Laboratory Technician
- Medical Laboratory Technologist
- Nurse Practitioner*
- Physician Assistant*
- Radiologic Technologist
- Registered Nurse
- Registered Respiratory Therapist
- Speech Language Pathology Assistant

While classified as Delegates because they do not fall within the "autonomous" definition, professional practitioners listed above with an (*) must be individually enrolled with BlueCross and bill their services under their own NPI. The supervising practitioner may not bill for services delegated to these practitioners unless rendered by an APHCP and the services fall within the requirements of the Incident To Services & Supplies policy. More details on billing requirements for these Delegates, depending on the level of supervision required, are listed below or in the Billing and Reimbursement Guidelines of this Provider Manual for specific services.

Delegate Categories for Billing and Supervision Requirements

Licensed or Certified Practitioners Requiring Supervision by Retrospective Review

Retrospective review refers to supervision conducted after a service has been rendered, rather than during its performance. It may occur days or weeks later and typically involves reviewing a patient's medical record (e.g., complaints, signs, symptoms, diagnostics, and treatments). The supervising practitioner is typically not present at the site of service when the delegated service is performed.

Licensed providers requiring supervision by retrospective review include, but are not limited to, Certified Nurse Midwives, Certified Registered Nurse Anesthetists, Licensed Resident Physicians, Nurse Practitioners, and Physician Assistants. Supervising practitioners must review delegated services and comply with all requirements and regulations of the applicable licensing or certification board.

Delegate Providers in this category must complete the full BlueCross credentialing and contracting process and submit claims with their own NPI as the rendering provider. This requirement doesn't apply to:

- Practitioners rendering services at health departments,
- Licensed residents when performing services that are a part of their residency program, or
- Services performed by APHCPs that fall within the requirements of the BCBST Incident To Services & Supplies policy.

Specific Billing Requirements:

Block 17 – Supervising Practitioner

To indicate the role of the Provider being reported, enter the appropriate qualifier (DQ for Supervising Provider) to the left of the vertical, dotted line. The name of the Provider being reported should be entered to the right of the vertical, dotted line.

Block 24J - Practitioner rendering the service

Note: Claims not submitted according to the above billing guidelines are subject to denial unless submitted according to BCBST's Incident To Services & Supplies policy.

Additional Note: For nurse practitioners and physician assistants, Member copays for all lines of business (excluding Federal Employee Program members, Postal Service Health Benefits members, and BlueCard) will be based on whether the supervising physician reported in Block 17 is a primary care or specialist provider. Please note, our implementation of this guideline has been postponed to a later date to allow additional time for providers to adopt these billing requirements. The effective date will be communicated in a BlueAlert publication.

Licensed or Certified Practitioners Requiring Minimal Supervision

Supervising practitioners must perform all requirements and follow all regulations set forth by the applicable medical licensing or certification board for each provider type falling under this subsection. At a minimum, this level of supervision requires the supervising practitioner to:

- Evaluate the patient at some reasonable time before the delegated service;
- Issue a specific written order for the service prior to the service being performed; and
- Document the results of the delegated service.

The supervising practitioner doesn't have to be within the place of service (e.g., facility, office) when the delegated service is rendered.

Licensed Providers requiring minimal supervision include Certified Athletic Trainers, Chiropractic Radiology Technicians, Licensed Physical Therapy Assistants, Licensed Practical Nurses, Medical

Laboratory Technologists, Certified Occupational Therapy Assistants, Radiologic Technicians, Registered Nurses, and Registered Respiratory Therapists. These practitioners are not independently credentialed or contracted by BCBST or eligible to bill separately for their services.

Supervising practitioners must also:

- Annually review and document the licensure or certification of any practitioner to whom they delegate medical services
- Delegate only services within the delegate practitioner's legal scope of practice, as defined by certification or license, and that don't require independent professional judgement.
- Maintain documentation including:
  - Patient evaluation prior to delegating or ordering any services;
  - A specific order for the delegated service;
  - Results of the service ordered; and
- Use treatment protocols from nationally recognized professional sources, available on-site for review.

Specific Billing Requirements:

Supervising practitioners are required to supervise the provision of delegated services for this category of providers. If the actual provider of the service needs the direction or supervision of a licensed practitioner to legally perform a service and is ineligible to bill under their own NPI pursuant to the terms and conditions of their license or certification, then such supervising practitioner will be allowed to bill those services under their name and NPI.

Certified Practitioners Requiring Direct and Close Supervision

Direct and close supervision requires the supervising practitioner to be onsite and readily available, with face-to-face contact with the patient immediately before and after a delegated service. The supervising practitioner must materially participate by evaluating the patient prior to the service, issuing a detailed written order, and performing a final evaluation before the patient leaves the facility or office. Being available via telephone doesn't constitute direct and close supervision. (**Note**: See *Extenuating Circumstances* below.)

With the exception of the Certified Anesthesiologist Assistant, the following health care practitioners aren't independently credentialed or contracted by BCBST and are ineligible to bill directly for services:

- Certified Anesthesiologist Assistant
- Certified Chiropractic Therapy Assistant
- Certified Medical Assistant
- Certified Nursing Assistant
- Certified Podiatric Assistant
- Medical Laboratory Technician
- Speech Language Pathology Assistant

Supervising practitioners must meet all requirements and regulations set forth by the applicable medical licensing or certification board for each provider type falling under this type of supervision. At a minimum, supervising practitioners must:

- Annually review and document the licensure or certification of any delegated staff or practitioners;
- Delegate only services in which they materially participate – this means evaluating the patient immediately prior to the service, preparing a detailed written order, and performing a final evaluation of the patient and the service performed prior to the patient leaving the facility or office that ensures the service was delivered appropriately and was clinically effective;
- Remain on site and available at all times while the service is rendered;
- Document in the patient medical record that these supervision steps occurred;
- Follow nationally-recognized treatment protocols, which must be kept onsite and available for review; and
- Only delegate services that don't require independent clinical judgement or couldn't be construed as services requiring the expertise of practitioners in either of the above supervision categories.

Extenuating Circumstances

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

Specific Billing Requirements:

For Certified Anesthesiology Assistants:

Block 17 – Supervising Practitioner

To indicate the role of the Provider being reported, enter the appropriate qualifier (DQ for Supervising Provider) to the left of the vertical, dotted line. The name of the Provider being reported should be entered to the right of the vertical, dotted line.

Block 24J – Practitioner rendering the service

7. Locum Tenens Policy

A "locum tenens" is only allowed to serve as the substitute practitioner for the participating practitioner for up to 90 days. A practitioner who is a permanent member of a practice or who performs services for over 90 days doesn't meet the definitions of a "locum tenens". To become a permanent member of the practice or continue performing services to members, the locum tenens must initiate contracting and credentialing with us. Any practitioner that's been denied credentials with us and hasn't successfully appealed that denial can't serve as a locum tenens and treat our members as an in-network provider or bill under an in-network provider's ID number.

The locum tenens generally doesn't have a practice of their own and moves from area to area as needed. The participating practitioner generally pays the locum tenens or an agency a fixed amount per diem, giving the locum tenens the status of independent contractor rather than an employee.

A participating practitioner may submit a claim for a member's covered services (including emergency visits and related services) of a "locum tenens" practitioner who isn't an employee of the practice, and whose services for members of the participating practitioner aren't restricted to the participating practitioner's office, if:

- The member has arranged or seeks to receive services from the participating practitioner
- The participating practitioner is unavailable to provide services due to leave of absence for illness, vacation, pregnancy, continuing medical education, etc.
- The participating practitioner has left a group practice and the group has engaged a "locum tenens" practitioner as a temporary replacement until a permanent replacement practitioner is obtained. In this case, a member of the group must be selected as an oversight practitioner
- The participating practitioner, or group practice acting on their behalf, sends a non-participating form available at: https://www.bcbst.com/providers/forms/Out_of_Network_Provider_Request.pdf and letter to provider network mailbox, PNS_GM@bcbst.com stating the reason for "locum tenens". The letter should state the date the services will begin and the estimated end date. To expedite your request, add "Locum Tenens" in the subject line of your e-mail
- The participating practitioner or group practice acting on their behalf must notify us of the date they return to work via email to mailto:PNS_GM@bcbst.com
- The participating practitioner, or group practice acting on their behalf, has verified that the "locum tenens" is qualified by training and experience to temporarily maintain the participating practitioners' practice
- The participating practitioner pays the "locum tenens" for their services on a per diem or similar fee-for-time basis; Compensation paid by a group to the "locum tenens" practitioner is considered paid by the participating practitioner for purposes of this policy
- Services may not be provided by the locum tenens for a continuous period of more than 90 days. Any claims for the date of service after day 90 will be processed as out of network
- The participating practitioner, or group practice acting on their behalf, must keep a record of each service provided by the locum tenens and make the records available to us upon request

- Professional claims should be submitted with the participating practitioner's name, individual provider number, and/or NPI number in block 33 and the "locum tenens" name in block 31 as the servicing provider. In case the participating practitioner has left group practice, claims should be submitted with the participating oversight practitioner name, individual provider number, and/or NPI number in block 33 and "locum tenens" name in block 31 as the servicing provider

8. CMS-1450 Facility Claim Form

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

The UB-04 contains several improvements and enhancements that include better alignment with the electronic HIPAA ASC X 12N 837-Institutional Transaction Standard. The UB-04 paper billing form accommodates the reporting of the NPI number. The NPI number, which is required by HIPAA and must be used by all HIPAA covered entities, such as health plans, health care clearinghouses, and health care providers.

Note: We follow CMS guidelines for filing the NPI number.

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

Balance this Page
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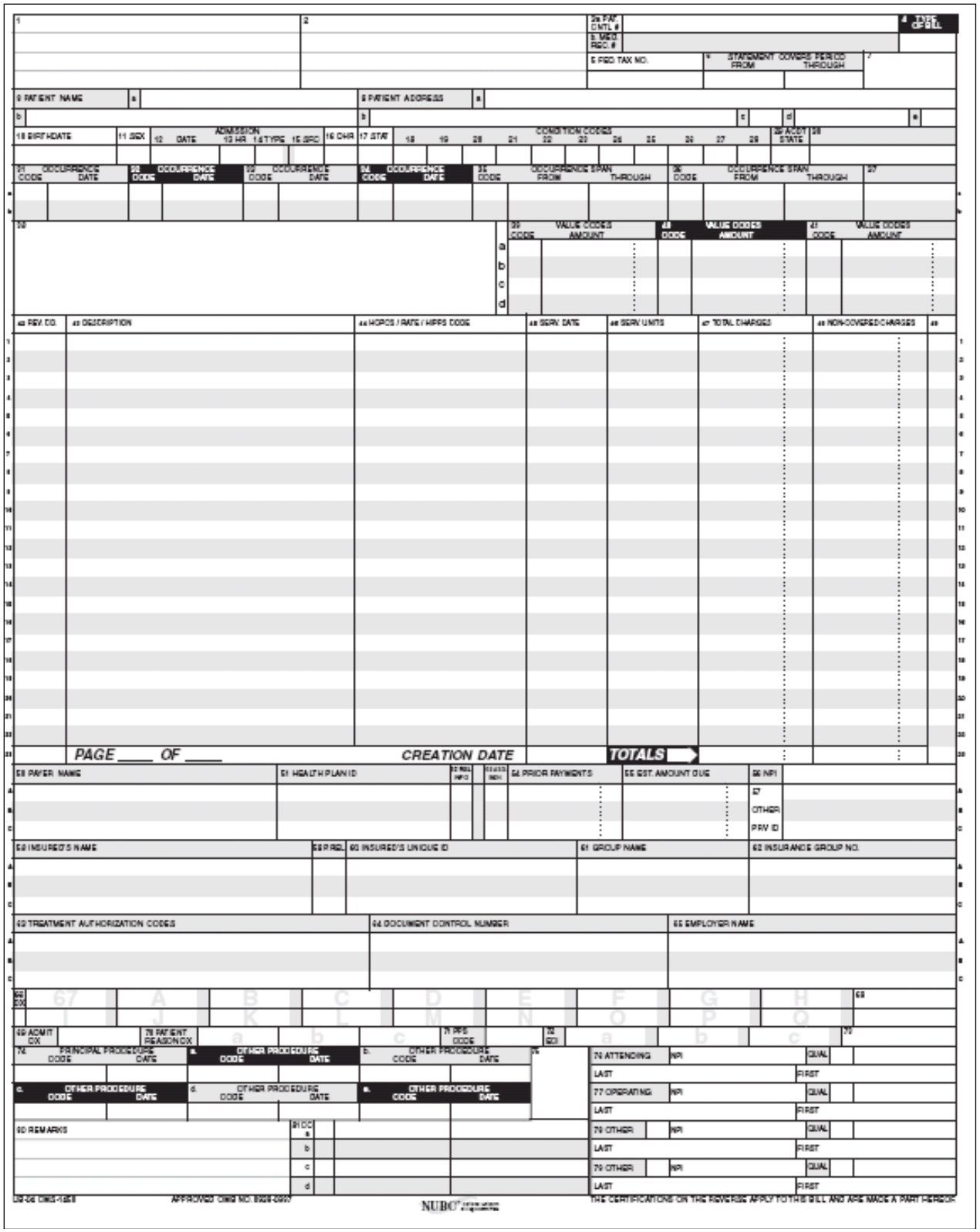
1
2
2a PAT. CNTL #
3 MED. REC. #
4 TYPE OF BILL
5 FED. TAX NO.
6 STATEMENT COVERS PERIOD FROM THROUGH
7
8 PATIENT NAME
9 PATIENT ADDRESS
10 BIRTHDATE
11 SEX
12 DATE
13 HR
14 TYPE
15 SRC
16 DHR
17 STAT
CONDITION CODES
24 ACDT STATE
28
31 OCCURRENCE CODE DATE
32 OCCURRENCE CODE DATE
33 OCCURRENCE CODE DATE
34 OCCURRENCE CODE DATE
35 OCCURRENCE SPAN CODE FROM THROUGH
36 OCCURRENCE SPAN CODE FROM THROUGH
37
39 VALUE CODES CODE AMOUNT
40 VALUE CODES CODE AMOUNT
41 VALUE CODES CODE AMOUNT
42 REV. CD.
43 DESCRIPTION
44 HCPCS / RATE / HIPPS CODE
45 SERV. DATE
46 SERV. UNITS
47 TOTAL CHARGES
48 NON-COVERED CHARGES
49
PAGE ____ OF ____
CREATION DATE
TOTALS
50 PAYER NAME
51 HEALTH PLAN ID
52 REL. INFO
53 ASSIGN. BEN.
54 PRIOR PAYMENTS
55 EST. AMOUNT DUE
56 NPI
57 OTHER PRV ID
58 INSURED'S NAME
59 P REL
60 INSURED'S UNIQUE ID
61 GROUP NAME
62 INSURANCE GROUP NO.
63 TREATMENT AUTHORIZATION CODES
64 DOCUMENT CONTROL NUMBER
65 EMPLOYER NAME
66 DX
67
68
69 ADMIT DX
70 PATIENT REASON DX
71 PPS CODE
72 ECI
73
74 PRINCIPAL PROCEDURE CODE DATE
74a OTHER PROCEDURE CODE DATE
74b OTHER PROCEDURE CODE DATE
74c OTHER PROCEDURE CODE DATE
74d OTHER PROCEDURE CODE DATE
74e OTHER PROCEDURE CODE DATE
75
76 ATTENDING NPI QUAL LAST FIRST
77 OPERATING NPI QUAL LAST FIRST
78 OTHER NPI QUAL LAST FIRST
79 OTHER NPI QUAL LAST FIRST
80 REMARKS
81 CC
APPROVED OMB NO. 0938-0997
NUBC
THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

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

Form Locator 1	Provider Name, Address, Telephone Number***
Form Locator 2	Pay-to Name, Address, City, State, and ID
Form Locator 3	3a>Patient Control Number*** 3b>Medical Record Number***
Form Locator 4	Type of Bill***
Form Locator 5	Federal Tax Number***
Form Locator 6	Statement Covers Period***
Form Locator 7	Unlabeled Field
Form Locator 8	8a>Patient Name-ID 8b>Patient Name***
Form Locator 9	9a>Patient Address-Street 9b>Patient Address-Other 9b>Patient Address-City 9c>Patient Address-State 9d>Patient Address-Zip 9e>Patient Address-Country Code***
Form Locator 10	Patient Birthdate***
Form Locator 11	Patient Sex***
Form Locator 12	Admission Date*** (Inpatient)
Form Locator 13	Admission Hour*** (except for Bill Type 02X)
Form Locator 14	Type of Admission/Visit***
Form Locator 15	Source of Admission***
Form Locator 16	Discharge Hour*** (final inpatient claim only)
Form Locator 17	Patient Discharge Status***
Form Locator 18	Condition Codes
Form Locator 19	Condition Codes
Form Locator 20	Condition Codes
Form Locator 21	Condition Codes
Form Locator 22	Condition Codes
Form Locator 23	Condition Codes
Form Locator 24-28	Condition Codes
Form Locator 29	Accident State
Form Locator 30	Unlabeled Field
Form Locator 31	a-b Occurrence Code/Date
Form Locator 32-34	a-b Occurrence Codes and Dates
Form Locator 35	a-b Occurrence Span Code/From//Through
Form Locator 36	a-b Occurrence Span Code/From/Through
Form Locator 37	a-b Unlabeled Fields
Form Locator 38	1-5 Responsible Party Name/Address
Form Locator 39	a-d Value Code-Code
Form Locator 39	a-d Value Code-Amount
Form Locator 40	a-d Value Code-Code
Form Locator 40	a-d Value Code –Amount

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

Form Locator 41	a-d Value Code-Code
Form Locator 41	a-d lines Value Code-Amount
Form Locator 42	Revenue Code***
Form Locator 43	1-22 Revenue Code Description***
Form Locator 43-44	Line 23 Page_of_Creation_Date
Form Locator 44	HCPCS/Rates/HIPPS/Rate Codes***
Form Locator 45	1-22 Service Date
Form Locator 45	Line 23 Creation Date
Form Locator 46	Units of Service***
Form Locator 47	Total Charges***
Form Locator 48	Non-Covered Charges
Form Locator 49	Unlabeled Field
Form Locator 50	Payer Identification***
Form Locator 51	Health Plan ID
Form Locator 52	Release of Information Certification Indicator
Form Locator 53	Assignment of Benefits Certification Indicator
Form Locator 54	Prior Payments – Payer
Form Locator 55	Estimated Amount Due
Form Locator 56	NPI
Form Locator 57	Other Provider ID-Primary/Secondary***
Form Locator 58	Insured's Name***
Form Locator 59	Patient's Relationship to Insured
Form Locator 60	Certificate/Social Security Number/Health Insurance Claim/Identification Number***
Form Locator 61	Insured Group Name
Form Locator 62	Insurance Group Number
Form Locator 63	Primary/Secondary/Third
Form Locator 64	Document Control Number
Form Locator 65	Employer Name
Form Locator 66	DX Version Qualifier
Form Locator 67	Principal Diagnosis Code***
Form Locator 67	A-Q Other Diagnosis Codes
Form Locator 68	Unlabeled Field
Form Locator 69	Admitting Diagnosis Code*** (Inpatient)
Form Locator 70	Patient's Reason for Visit Code
Form Locator 71	PPS Code*** (if in Provider contract with payor)
Form Locator 72	A-C External Cause of Injury Code

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

Form Locator 73	Unlabeled
Form Locator 74	ICD Code/Date*** (if surgical procedure performed)
Form Locator 74	a-e Other Procedure Code/Date
Form Locator 75	Unlabeled Field
Form Locator 76	1- Attending –NPI/QUAL/ID
Form Locator 76	2-Attending-Last/First
Form Locator 77	1-Operating-NPI/QUAL/ID
Form Locator 77	2-Operating-Last/First
Form Locator 78	1-Other ID-QUAL/NPI/ID
Form Locator 78	2-Other ID-Last/First
Form Locator 79	1-Other ID- QUAL/NPI/QUAL/ID
Form Locator 79	2-Other ID-Last/First
Form Locator 80	1-4 Remarks
Form Locator 81	a-d Code-Code-QUAL/CODE/VALUE

** Required Fields by Pre-Adjudication Edits

*** Required Fields by Electronic Billing

b. Revenue Code (FL42)

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

- **Billing guidelines (form locator 42) field definitions**

  Each field contains specific billing information critical to understanding how to file a claim. These guidelines will help maximize reimbursement

- **Revenue code –** The revenue code is the initial indicator to the claims administration system as to what type of services were performed. Revenue codes for inpatient and outpatient services are included in the billing guidelines.
- **Category** – The category defines a general description of the type of service provided under the revenue code. Some revenue codes fall into several categories such as revenue code 110. revenue code 110 is generally used to file services under medical, surgical, orthopedic, trauma, trauma medical and trauma surgical, among others. The participating provider contract outlines which revenue codes can be filed under each category.
- **Reimbursement rule –** The reimbursement rule explains what type of reimbursement the facility should expect if billed properly. It's extremely important to have the facility's contract on hand when reviewing how a claim should be reimbursed. Our claims administration system in some cases will default to another category if there's no specifically-contracted rate for a service. In addition, some services are ineligible as "not medically necessary," or there's no negotiated fee.
- **Principal diagnosis** – The principal diagnosis determines the category for reimbursement. The principal diagnosis should always be billed in form locator 67 on the CMS-1450 claim form. This field indicates to our system the primary reason for the services rendered to the patient.
- **Principal procedure code** – The principal procedure code is an ICD procedure code. This code will help determine the category of service. The facility should bill the correct principal procedure code in form locator 74 of the CMS-1450.
- **CPT®/HCPCS required** – CPT® codes should always be billed on the CMS-1450 in Form locator 44. This field indicates when a revenue code must be filed with a CPT®/HCPCS code. If a required CPT® /HCPCS code is missing, the claim may be denied and returned to the facility for proper coding.

c. HCPCS Codes/Rates (FL44)

Complete this field with the CPT®/HCPCS code related to the service being provided. To determine which CPT®/HCPCS codes should be filed with a related revenue code, refer to our FL44 – CPT®/HCPCS code requirement.

Note: For the related contract, we only accept valid CPT®/HCPCS codes that can be billed in a hospital acute care setting. Prior to payment, unlisted procedures must be filed as a hard copy with the supporting medical record(s).

- **Billing guidelines (form locator 44) field definitions**

  Each field contains specific billing information critical to understanding how to file a claim. By following these guidelines, the facility will maximize reimbursement. These guidelines only apply to revenue codes stated in the billing guidelines (form locator 42) as requiring a CPT®/HCPCS code:

- **CPT®** – The CPT® field lists the CPT®/HCPCS code or range of codes eligible to be filed in form locator 44 of the CMS-1450
  - Codes ranging from 10000-69999 are generally surgical codes and require individual negotiated rates for outpatient services. Please refer to the correct network attachment for reimbursement schedules.
  - Codes ranging from 70000-79999 are generally radiology codes. Please refer to the provider network attachment for any procedure codes that have individual negotiated rates.
  - Codes ranging from 80000-89999 are generally lab or pathology codes. Please refer to your provider network attachment for any procedure codes that have individual negotiated rates.
- **MOD** – The modifier (MOD) field contains any code that must be filed with a modifier in addition to a CPT®/HCPCS code:
  - **Required revenue code(s)** – The required revenue code(s) field is provided so the facility will know exactly what revenue codes are eligible to bill us for each CPT®/HCPCS code. Without the correct revenue code and CPT®/HCPCS codes, we won't accept the claim for consideration of benefits. Incorrectly filed claims may be returned to the provider for correction.
  - **Billing instructions** – The billing instruction field explains the requirements to bill the selected CPT®/HCPCS code. This field also provides an insight about how we adjudicate the claim.

d. Service units (FL46)

In general, report the quantitative measure of service, by revenue category, to or for the patient; such as, the number of accommodation days, visits, miles, pints of blood, units or treatments.

Units for related CPT®/HCPCS codes are to be based on the number of times the service or procedure was performed, as defined by the CPT®/HCPCS code. Visit codes shouldn't be reported as units.

e. Principal diagnosis code (FL67)

Depending on your contract, the principal diagnosis code may be required for proper adjudication of an inpatient claim. For specific instructions, see billing guidelines (form locator 42). If applicable, report the full ICD code that describes the principal diagnosis.

f. Principal procedure code and date (FL74)

Depending on your contract, the principal procedure code may be required for proper adjudication of an inpatient claim. For specific instructions refer to Billing Guidelines (form locator 42). If applicable, report the ICD code for the principal procedure performed during the period covered by the bill and the date that the principal procedure was performed.

g. Attending physician (FL76)

Report the name and unique physician identification number (UPIN) of the licensed physician who is expected to certify the medical necessity of the services rendered and who is primarily responsible for the patient's care. (If the UPIN isn't available, enter "OTH000" in this field.)

h. CMS-1450 specific

- All date information should be shown in the following format (except Form Locator 10 – Birth Date):

MMDDYY
MM=month (01-12)
DD=day (01-31)
YY=year (00-99)
Example: January 1, 2004 = 010404
Form Locator 10 must be a continuous 8-digit number (Correct: January 1, 2004 = 01042004)

- Don't exclude leading zeros in the date fields
- Multi-page claims:
  - All diagnosis code(s) listed on the first page must be listed on each page
  - Place the total amount and 0001 total revenue code only on the last page of the claim. The 0001 total revenue code line on the last page of the claim should reflect the sum of the line items for all pages.
  - Use the words "continued on next page" or "page X of X" on line 23 of each page (except on the last page, which reflects the total charge on the 0001 total revenue code line).
  - Staple only the pages of the individual claim together as one. Don't staple several multi-page claims together as one.
- Donor/recipient information when filing transplant claims:
  - Block 8 should contain the name of the patient that received the service. "In this case it would be the donor".
  - Block 58 should contain the subscriber, the recipient "if different from the subscriber" and the donor (the donor should only be listed if there's other insurance coverage for the donor charges making the recipient's plan with us secondary).
  - Block 59 on the subscriber/recipient lines should contain the patient relationship code 39 which equals "organ donor".

We updated the OCR scanning processes for CMS-1500 and CMS-1450 paper claims. Following the 2012 Official UB-04 Data Specifications Manual guidelines, this update didn't require any changes related to the CMS-1500 claim form. However, these changes will be required when submitting CMS-1450 paper claims:

- **Form locator 12 – admit date:** The admit date should only be populated for inpatient, home health, and hospice claims. A rejection will occur for any other claim type.
- **Form locator 13 – admit hour:** The admit hour should only be populated for inpatient claims, excluding bill type 021x. A rejection will occur for any other claim type.
- **Form locator 15 – admission source:** The admission source should be populated for ALL institutional claims except those with bill type 014X. Any UB-04 (or its successor) claim form submitted without an admission source will be rejected and returned for correction.
- **Form locator 69 – admitting diagnosis code:** The admitting diagnosis code is only required for inpatient claims. A rejection will occur for any other claim type.
- **Form locator 74 – principal procedure code:** The principal procedure code should only be submitted for inpatient claims. A rejection will occur for any other claim type.
- **Form locator 74a-e – other procedure code:** The other procedure codes should only be submitted for inpatient claims. A rejection will occur for any other claim type.

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

Element	Description
1. NDC qualifier	N4
2. NDC number	11 digit number

3. NDC quantity qualifier	F2 – international unit GR – gram ME – milligram ML – milliliter UN – unit
4. NDC quantity	Numeric value
5. NDC unit price	(ANSI-837 only)

To help ensure compliance with National Uniform Billing Committee (NUBC) guidelines, claims submitted with discharge status 20, 40, 41 or 42 must also include occurrence code 55 and date of death.

NUBC is responsible for the design and printing of the UB-04. Additional information for the UB-04 is available to subscribers. If you're interested in additional information please visit the NUBC website at www.nubc.org.

Note: As of Oct. 1, 2018, all inpatient facilities are required to submit an itemized statement for services reimbursed at a discount off charge method. The itemized bill must be submitted through the faxed paperwork (PWK) attachment process. If we don't receive the required documents, your claims may be denied or returned.

9. Instructions for Returned Claims and Processed Claims Needing Correction

Note: Corrected bills must be submitted within two years of the end of the year the claim was originally submitted. For example, if a claim was filed on Feb. 15, 2020, any corrected bill must be submitted by Dec. 31, 2022.

a. Incomplete Claims

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

Providers should correct the error(s) and resubmit the claim as a new claim on a new claim form. Please refrain from writing or stamping "corrected claim" on the new claim. Correcting the error(s) and resubmitting on a new claim form will help ensure a quicker turnaround.

Incomplete electronic claims are reflected on the provider's 277CA health care information status notification report. Providers should correct the error and resubmit the claim electronically.

Note: Since incomplete returned claims haven't been processed (providers have not received a remittance advice for these claims), the claim won't be denied as "duplicate" when resubmitted. Images of all rejected and accepted claims will be maintained in our archives for future reference.

b. Corrected Bills

Claims that have been processed (providers receive a remittance advice that includes the claim) and were paid incorrectly because of an error or omission on the claim may be filed as a "corrected bill". A true corrected bill includes additional/changed dates of service, codes, units, and/or charges that were not filed on the original claim.

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

When a corrected bill is filed, we'll recover any payment previously made under the original claim submission from the provider's remittance advice (a refund request letter won't be sent). Any applicable new payment will be based on the services submitted on the corrected bill claim.

Corrected Electronic Claims (Required Method)

If a claim is rejected, it requires correction and resubmission electronically. Corrected Bills for facility and professional claims can be filed electronically in the ANSI-837, version 5010 format. The following guidelines are based on National Implementation

Guides found at http://www.wpc-edi.com and our companion documents found at http://www.bcbst.com/providers/ecomm/technical-information.shtml when filing these claims.

c. ANSI-837P – (Professional) and ANSI-837I – (Institutional)

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

- In the 2300 loop, the claim information (CLM) segment CLM05-3 (claim frequency type code) must indicate the third digit of the bill type being sent. The third digit of the bill type is the frequency and can indicate if the bill is an adjustment, a replacement or a voided claim:
  - "7" – REPLACEMENT (Replacement of Prior Claim)
  - "8" – VOID (Void/Cancel of Prior Claim)
- In the 2300 loop, the reference (REF) segment (claim information), must include the original claim number issued to the claim being corrected. The original claim number can be found on your electronic remittance advice.
  - REF01 must contain 'F8'
  - REF02 must contain the original claim number

Example: REF*F8*1234567890~

- In the 2300 Loop, the NTE (notes and comments) segment (freeform claim note), must include the explanation for the corrected/replacement claim.
  - NTE01 must contain 'ADD'
  - NTE02 must contain the free form notes indicating the reason for the corrected
  - replacement claim.

Example: NTE*ADD*CORRECTED PROCDURE CODE ON LINE 3

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

Method for Filing Corrected Paper Claims

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

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

Submit a new claim form with the correct data.

- Attach correspondence behind the claim form indicating what information was originally submitted and what was changed on the new claim form. Example: "Procedure code in block 24D of first line item was submitted as 99201; corrected to 99202 on new claim"
- Write (using pen with black ink) or type qualifier"**7**" (replacement of prior claim), or "**8**" (void/cancel of prior claim) in Block 22 on the CMS-1500 claim form. our optical character recognition (OCR) equipment won't recognize red ink. Refrain from using a thick marker or crayon that may cover other form fields.
- On the **CMS-1450 (UB-04)** claim form, if the third digit in the bill type field (form locator 4) ends in a "7" or "8", the claim is considered a corrected bill.

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

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

Alternate Method for Filing Corrected Paper Claims

- Draw a thin line through the original information and **clearly** list the new information above, below or beside the original information.
- Keep within the boundaries of the form field when adding the correct information. Refrain from using a thick marker or crayon that may cover other form fields.
- Do not use correction tape or fluid (White Out) – the original information must be visible.
- Write (using pen with black ink) or type qualifier "**7**" (replacement of prior claim), or "**8**" (void/cancel of prior claim) in block 22 on the CMS-1500 claim form.
- Use the appropriate bill type on the CMS-1450 claim form to identify the claim as a corrected bill. (See code definitions above.)
- If filing a corrected claim as a new claim submission, the claim number originally used to process the claim should be included in the Original Ref. No. field – FL64. This item number isn't intended for use for original claim submissions. Failure to include the proper indicator and original claim number may result in a claim denial.

10. Coordination of Benefits

Our provider contracts include the provision for coordination of benefits (COB), which applies when a member has coverage under more than one group contract or health care benefits plan. Claims should be submitted to the primary carrier prior to submission to us. Upon claim submission to us, please provide a copy of the remittance advice from the primary carrier. Coordination of benefits works in conjunction with the maintenance of benefits as set forth below.

11. Maintenance of Benefits

Maintenance of benefits (MOB) is a form of coordination of benefits (COB). When our health care coverage is secondary to another plan, maintenance of benefits ensures that the combined payments of the two health care plans don't exceed what we would've paid if it had been the only coverage. MOB is often referred to as "preservation" COB, because it preserves the secondary plan's deductibles, copayments and coinsurance amounts.

If the primary insurance carrier's payment amount is the same or more than what we would've paid, we won't make any additional payment. If the primary insurance carrier's payment is less than what we would've paid, we'll only pay the difference in what it would've paid and what the primary insurance carrier did pay. The provider cannot bill the member for any amount over the negotiated maximum allowable amount that applied from either the primary and/or secondary coverage. Even if we don't make a payment, and a participating provider rendered the services, the member isn't liable for any amount over the provider's negotiated reimbursement amount, from the applicable primary or secondary coverage, which is the maximum allowable charge. The provider can't bill the member for any amount over the maximum allowable charge.

Note: If the member is a Medicare beneficiary, routine waiver of deductible and copayments by the charge-based providers, practitioners or suppliers is unlawful because it results in:

- False claims
- Violations of the anti-kickback statute
- Excessive utilization of items and services paid for by Medicare.

12. Right of Reimbursement and Recovery (Subrogation)

The right of reimbursement and recovery (subrogation) is a provision in the member's health care benefits plan that permits us to pay the provider when a third party causes the member's condition. We handle subrogation cases on a "pay and pursue" basis. If a provider becomes aware that the services rendered result from the actions of a third party, they should contact us at the following address and telephone number:

BlueCross BlueShield of Tennessee
Subrogation Department

1 Cameron Hill Circle, Ste 0008
Chattanooga, TN 37402-0008
(423) 535-5847

If there's a payment from a third-party carrier that results in an overpayment, it's the responsibility of the provider to reimburse us the overpaid amount. If a provider receives more than they should have when benefits are provided by an auto insurance or a homeowner's plan, the provider will be expected to repay any overpayment to the appropriate insurer. The provider won't pursue any third-party recoveries or, accept any payments from other parties after payment. This doesn't apply to copayments, deductible or coinsurance amounts.

13. Balance Billing

Providers agree to accept reimbursement made in accordance with the terms of their provider contract with us, plus any applicable member copayment/deductible, and coinsurance amounts as the maximum amount payable to the provider for covered services rendered to members.

Providers **can't** seek payment from a member when:

- The provider failed to comply with our medical management policies and procedures or provided a service that doesn't meet our standards for medical necessity or doesn't comply with our medical policy
- The provider failed to submit or resubmit claims for payment within the time periods required by our timely filing guidelines
- Services rendered are considered Investigational and are therefore non-reimbursable, unless **prior** to rendering such services to the member, provider has entered into a **procedure-specific** written agreement with the member, which advised member of their payment responsibilities

Providers **can** bill the member for:

- Non-covered services*
- Any applicable deductible/copay amounts
- Any applicable co-insurance amounts.

*When billing members for non-covered services due to benefit limitations (e.g., dollar limits or service limits) network providers may bill the member the difference between the limit amount and the allowed amount. The difference between the billed amount and the allowed amount is considered a provider write-off.

When seeking payment from a member, please refer to the **Patient Owes** column on your provider remittance advice. This column includes the non-covered total, deductible/copay total and coinsurance total. It may also reflect the other insurance total, which is the amount paid by the patient's other insurance carrier.

Before billing the member, check both the deductible/copay and the other insurance columns to make sure that any applicable copayment or other insurance payments haven't already been received.

Example: Dollar Limit

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

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

Example: Service Limit

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

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

Note: Our members must be held harmless for any contractual difference between billed charges and member payment obligations unless noted above.

14. Provider Overpayment Recovery Policy/Process

If a provider identifies that a payment made results in an overpayment, it's the responsibility of the provider to reimburse us the overpaid amount. The provider should return the overpayment with a copy of the remittance advice and a cover letter explaining why the payment is being refunded. Member cost-share overcharges must be properly reimbursed to the member, regardless of the amount of overpayment, including but not limited to the Federal Employee Program (FEP) and Postal Service Health Benefits (PSHB).

Mail to:

BlueCross BlueShield of Tennessee
Receipts Department
1 Cameron Hill Circle, Ste.40
Chattanooga, TN 37402

If a provider receives an overpayment notification, no action is required unless records conflict with the findings. We'll recover the overpayment through an offset to the remittance advice within 30 days from the date of the notification. Please refrain from sending a check for the overpayment. Checks received for solicited overpayments will be returned to the payee.

a. Overpayment notifications

An overpayment notification is sent on all overpayments that are identified on claims submitted by physicians, non-participating facilities and participating facilities requiring notification. Requests for reimbursement of overpayment should be made no later than 18 months after the date that we paid the claim submitted by the provider, except in the case of Provider fraud, in which case no time limit will apply. In addition, the limited period won't apply to any federal governmental program, including the Federal Employee Program (FEP) and Postal Service Health Benefits (PSHB). With the exception for FEP and PSHB, the 18-month limitation does apply to Veterans Administration (VA) providers ONLY.

Unless stated otherwise, our review of relevant financial or medical records isn't limited to a time period of 18 months. Depending on the results of the review, we maintain the right to pursue legal or other equitable action.

The points below inform providers how to read remittance advice transactions when overpayment recovery activity is reflected:

b. Automatic overpayment recovery

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

Exception: If the overpayment was the result of a payment made to an incorrect provider, a duplicate payment, a claim billed in error, or a payment made on an incorrect member, the negative adjustment line will indicate the recovery and there won't be a second line entry.

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

Note: The **Amount Paid** column won't always equal the amount of the check when recovery amounts are carried from one remittance advice to the next.

It's important that providers post all negative adjustments to a "payables" account when posting from the remit. By posting to a payables account, the provider's records will show funds that are owed. This account can then be adjusted when the money is recovered.

- **Auto-recovery adjustment/credit balance remains:**
  - On the last page of the remittance advice, the columns are totaled, including any negative adjustments listed on the remit. A negative amount in the **Amount Paid** column indicates there were insufficient funds on the remit to recover all the funds owed. In this situation, the credit balance will be forwarded to the next remit and deduction will be made from the total payment due to the provider on that remit.

  Note: If there's a negative amount in the **Amount Paid** column, no check will be issued. However, the remittance advice detail should be used to post all member accounts listed on the remit.

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

c. Manual Overpayment Recovery

We use a manual recovery transaction to recover overpayment dollars from the provider's check and remittance advice when normal activities aren't successful in resolving an overpayment situation.

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

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

These manual overpayment recoveries will appear on the last page of the provider's remittance advice with a narrative description of Manual Reduction. Instructions on the remittance advice state Manual Recovery Detail Sent Separately. These claim details are mailed to the provider's office in advance of receiving a check and remittance advice from us.

An overpayment claim detail hotline number is listed on the provider's remit beside the "Manual Reduction Transaction" narrative. A provider's office staff can call this hotline telephone number to request claim details supporting the manual reduction. The additional information will assist providers when posting their member accounts.

15. Electronic Funds Transfer

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

Key advantages to receiving payments electronically include:

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

We're now using the **CAQH ProView**™ provider data collection tool (formerly Universal Provider Datasource®).

Phone: 1-844-259-5347 available Monday through Thursday 7 a.m. to 9 p.m. ET and Friday 7 a.m. to 7 p.m. ET
Email: proview@caqh.org
Website: https://proview.caqh.org

Note: Vendors and BlueCross BlueShield of Tennessee shall be bound by the National Automated Clearing House Association rules relating to corporate trade payment entries in the administration of these ACH credits.

Effective Dec. 2, 2021:

We accept electronic funds transfer (EFT) enrollment through Change Healthcare who offers a universal enrollment tool for providers that provides a single point of entry for adopting EFT and ERA. The Change Healthcare process facilitates compliance with CAQH Core III requirements, eliminates administrative redundancies and creates significant time and cost savings. Enrollment information is available on the Change Healthcare website at payerenrollservices.com.

To view/print a copy of your remittance advices, ensure you have access to Availity.

For more information about the EFT program process, or for assistance with Availity, please call the eBusiness Service line at **800-924-7141** and follow the prompts to eBusiness support or email ebusiness_service@bcbst.com.

Payer Enrollment Services is the name for the new Change Healthcare EFT and ERA enrollment tool.

Phone: 800-956-5190 Monday through Friday, 8 a.m. to 5 p.m. CT
Website: payerenrollservices.com

16. Federal Employee Program (FEP) and Postal Service Health Benefits (PSHB) Claims Filing Guidelines

Our commercial timely filing period is six months from the date of service or, for facilities, within six months from the date of discharge. If we're listed as secondary, the timely filing period is 60 days from the date of service or, for facilities, within 60 days from the date of discharge or 60 days from the primary carrier's notice of payment. As an exception, for claims filed by out-of-network providers, all claims must be submitted no later than Dec. 31 of the calendar year following the year during which the service or supply is received. For example, if a member receives covered services on May 8, 2021 a claim for

reimbursement must be submitted no later than Dec. 31, 2022. Claims for long hospital stays or other long-term care should be submitted every 30 days.

We're responsible for processing most claims for services rendered within their FEP/PSHB service area. Claims not meeting these criteria should be filed to the plan where the services were rendered. Claims for services provided to FEP/PSHB members are submitted by providers in the same manner as other local contracts.

OBRA Omnibus Budget Reconciliation Act

OBRA '90

OBRA '90 refers to the provisions of federal regulations that mandate Federal Employee Health Benefit Program (FEHBP) and Postal Service Health Benefits Program (PSHBP) benefit payment calculations for the types of services covered under "Medicare Part A". Members covered by the provisions of the OBRA '90 law are those who are:

- Age 65 or over; and
- Not enrolled in Medicare Part A; and
- Enrolled in our plan as annuitants (retirees) or former spouses or as family members of annuitants (retirees) or former spouses; and
- Not employed in jobs that provide FEHBP/PSHBP coverage.

Limits on Payments for Members without Medicare Part A:

OBRA '90 requires FEHBP plans to base payment for covered facility services on an amount equivalent to Medicare. This amount is referred to as the "equivalent Medicare amount." For Federal Employee Program (FEP) and Postal Service Health Benefits (PSHB) members, after FEP/PSHB pays, the law prohibits the hospital from charging the member for any additional amounts other than the member's usual FEP/PSHB cost-sharing expenses (e.g., deductible, coinsurance amounts, copayments, or costs for non-covered services).

OBRA '93

OBRA '93 refers to the provisions of federal regulations that mandate FEHBP/PSHBP benefit payment calculations for the types of services covered under Medicare Part B. Members covered by the provisions of the OBRA '93 law are those who are:

- Age 65 or over; and
- Not enrolled in Medicare Part B; and
- Enrolled in our plan as annuitants (retirees) or former spouses or as family members of annuitants (retirees) or former spouses; and
- Not employed in jobs that provide FEHBP/PSHBP coverage.

Limits on Payments for Members without Medicare Part B:

OBRA '93 requires FEHBP/PSHBP plans to base payment for covered professional services on the amount Medicare Part B would have paid if the member were covered by Part B. Because OBRA '93 requires FEHBP/PSHBP plans to limit their benefits to those that Medicare Part B would have provided, plans first need to determine the amount Medicare would have paid. Medicare Part B bases its payments on a standard allowance for each type of service it covers called the "Medicare approved amount." If the provider's actual charge is less than the Medicare approved amount, Medicare bases its payment on the provider's actual charge.

FEP Claims for Home Nursing Care, DME or Rehabilitation Therapy

FEP Claims for Home Nursing Care, DME or Rehabilitative Therapy Claims for the rental or purchase of durable medical equipment (DME), home nursing care, physical therapy, occupational therapy, or speech therapy must be accompanied by a written statement from the physician specifying the medical necessity form the service or supply and the length of time needed, or a Certificate of Medical Necessity (CMN) for DME.

Reimbursement

For FEP/PSHB claims, BCBST requests Medicare pricing (i.e., Medicare allowed amount) information from a central repository of Medicare pricing data. Charge line data is electronically transmitted to the repository for each affected claim submitted by BCBST. Each procedure is priced, and the Medicare-priced charge lines are transmitted back to BCBST. The claim then continues processing for payment.

B. General Billing and Reimbursement Guidelines

Unless otherwise indicated, the information in this section is common for both professional and institutional services. (See professional or institutional sections for more specific guidelines.)

These billing and reimbursement guidelines should apply to Medicare lines of business unless otherwise noted. Please refer to Section XXIV. MedAdvantage, in this manual where specific guidelines may also apply.

1. Medical Clinical Code Sets and Maintenance

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

a. Current Dental Terminology (CDT)

These codes should be reported in accordance with the American Dental Association guidelines (e.g., CDT Manual).

Addition/Deletion/Revision CDT Codes

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

We'll implement updates to CDT codes according to the following schedule:

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

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

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

b. Current Procedural Terminology (CPT®)

These codes should be reported in accordance with the American Medical Association guidelines including the CPT® Manual, CPT® Coding Changes, CPT® Assistant, CPT® Clinical Examples, CPT® Companion and other coding resources authorized by the American Medical Association.

Addition/Deletion/Revision CPT® Codes

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

CPT® codes are updated and maintained by the American Medical Association. CPT® codes are subject to quarterly updates each year as indicated below. CPT® updates include the addition, revision and/or deletion of codes.

We'll implement updates to CPT® codes according to the following schedule:

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

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

Due to the short American Medical Association publication schedule, it's not possible for us to notify providers of changes to CPT® codes. The provider is responsible for ensuring codes billed are valid for the date of service. CPT® codes and resources can be obtained from the American Medical Association and may also be located on the American Medical Association website at ama-assn.org.

c. HealthCare Common Procedural Coding System (HCPCS)

These codes should be reported in accordance with the guidelines established by the Centers for Medicare & Medicaid Services (CMS), the Department of Health and Human Services guidelines including, but not limited to, the HCPCS Manual, Federal Register, CMS program memorandums and transmittals, Medicare Part B bulletins, Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for Jurisdiction C guidelines (e.g., the DMEPOS Supplier Manual and Revisions, DME MAC Jurisdiction C fee schedule, pricing, data analysis and coding contractor (PDAC*) product classification lists and pricing, data analysis and coding contractor (PDAC*) coding bulletins.

*This document is located at https://www4.palmettogba.com/pdac_dmecs/.

Addition/Deletion/Revision HCPCS Codes

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

Medicare and other insurers cover a variety of services, procedures, supplies, and equipment that aren't identified by CPT® codes or have specific program or benefit rules, the level II HCPCS codes were established for submitting claims for these items.

HCPCS codes are updated and maintained by the CMS under the authority delegated by the Secretary of Health and Human Services (HHS) Department of Health and Human Services. CMS establishes uniform national definitions of services, codes to represent services, and payment modifiers to the codes. Currently, HCPCS codes are subject to updates effective Jan.1, April 1, July 1, and Oct.1 of each year. HCPCS updates include the addition, deletion, and/or revision of codes.

We'll **implement updates to HCPCS codes according to the following schedule**:

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

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

Due to the short Department of Health and Human Services' publication schedule, it's not possible for us to notify providers of changes to HCPCS codes. The provider is responsible for ensuring codes billed are valid for the date of service. HCPCS codes, code updates, and resources include, but aren't limited to:

- Federal Register
- CMS Program Memorandums and Transmittals
- Medicare Part B Educational Materials
- Durable Medical Equipment Medicare Administrative Contractor (DME MAC*) for Jurisdiction C guidelines including, but aren't limited to:
  - DMEPOS Supplier Manual and Revisions
  - DME MAC Jurisdiction C Fee Schedules
  - Pricing, Data Analysis and Coding Contractor (PDAC*) Product Classification Lists
  - Pricing, Data Analysis and Coding Contractor (PDAC*) Advisory Articles

*This document is located at https://www4.palmettogba.com/pdac_dmecs/.

d. International Classification of Diseases (ICD)

These codes should be reported in accordance with the Department of Health and Human Services guidelines (e.g., ICD Manual).

Note: Effective Oct. 1, 2015, ICD-10 codes should be filed in accordance with CMS guidance.

ICD-10 includes:

ICD 10-CM codes used to report diseases, injuries, impairments, their manifestations, and causes of injury, disease, impairment, or other health problems

ICD 10-PCS codes used to report prevention, diagnosis, treatment, and management.

Note: It is imperative that providers accurately report the appropriate diagnosis for patient encounters, services, procedures and medications on the claim form. This is also applicable to services, procedures and medications that require a prior authorization. Even though the supporting clinical information is provided when a prior authorization is requested, the supporting diagnosis must be reported on the claim form just as with any other services, procedures and medications that do not require a prior authorization. Claims that do not have supporting diagnosis reported will be subject to review.

ICD-10 codes are updated and maintained by the Department of Health and Human Services. Codes are subject to updates effective with discharges on or after April 1 and Oct.1 of each year. Updates include the addition, deletion, and/or revision of codes.

We'll **implement updates to ICD-10 codes according to the following schedule:**

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

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

Due to the short Department of Health and Human Services' publication schedule, it's not possible for us to notify providers of changes to ICD-10 codes. The Provider is responsible for ensuring codes billed are valid for the date of service. ICD-10 codes can be obtained from the Department of Health and Human Services.

An online educational tool is available to assist providers in utilizing ICD codes appropriately. The tool can be accessed from provider.bcbst.com.

NOTE: We use the following hierarchy for coding, billing, and reimbursement of claims.

1. Provider's contract
2. BCBST policies and procedures
3. CMS guidelines
4. Coding guidelines from CPT
5. Coding guidelines from coding organizations

2. Miscellaneous, Non-Specific and Not Otherwise Classified (NOC) Procedures/Services (Refer to "How to File a Claim" in this section for billing information)

Unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) procedures/services should only be used when a more specific CPT® or HCPCS code isn't available or appropriate. The maximum allowable amount for eligible procedures/services reported using an unlisted, miscellaneous, non-specific CDT, CPT® or HCPCS code will be based on "individual consideration". Services which have a specific CPT®/HCPCS code but are filed with unlisted or miscellaneous codes will be returned to the provider for corrected billing.

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

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

For radiopharmaceuticals and contrast materials:

- The name of the radiopharmaceutical and or contrast material, NDC, dosage and quantity

OR

- The manufacturer's invoice listing the name of the patient, name of the specific diagnostic radiopharmaceutical or contrast material, dosage and number of units. If multiple patients are listed on the manufacturer's/supplier's invoice, the diagnostic radiopharmaceutical imaging agent

or contrast material, dosage and number of units for the patient being billed should be clearly indicated.

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

3. Code Edits

We apply code editing rules to professional (including durable medical equipment, medical supplies, prosthetics, orthotics, home infusion therapy services) and institutional claims during processing and adjustment phases to evaluate the accuracy and adherence of medical claims to accepted national standards. These rules are based on editing guidelines such as:

- National Correct Coding Initiative (NCCI)
- The Outpatient Code Editor (OCE)
- American Medical Association (AMA) coding guidelines
- Centers for Medicare & Medicaid (CMS) guidelines
- Medical societies/associations such as:
  - American Academy of Orthopedic Surgeons (AAOS)
  - American College of Obstetricians and Gynecologists (ACOG)
  - Society of Interventional Radiologists
- Knowledge based editing software which includes clinical rationale/expertise edits
- Our reimbursement policies

Our provider audit department will continue the retrospective audit process, as well as necessary and periodic onsite review.

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

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

To facilitate correct claims handling the comprehensive code should be the first billed service on the claim.

Code editing can occur on multiple levels depending on the combination of codes reported, which could result in partial code service reimbursement or in certain cases, full claim denial. For example, when multiple codes are billed for one date of service, two codes could bundle into one code. That one code could then bundle into another code.

Editing software also allows for a historical look back for claims filed by different providers for same date of service, same provider on different claims and claims filed that have guidelines related to reporting limits.

If, after implementation of a software update, an edit or class of edits doesn't perform as expected, they'll be reviewed to determine if it's reasonable, appropriate and complies with provider contracts, state laws and recognized coding standards. Then, appropriate action will be taken.

Code pairs will be updated on a quarterly basis according to NCCI guidelines.

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

Retained NCCI Edits for Commercial Claims

Our edits are based on NCCI logic.

Example: Effective Jan. 1, 2010, CMS no longer recognizes CPT® codes 99241-99245 (office or outpatient consultations) and 99251-99255 (inpatient consultations) under the Medicare Physician's Fee Schedule.

As a result, CMS termed the edits for these CPT® codes. We continue to allow providers to bill these consultation codes for the commercial and Medicaid lines of business; therefore, the edits related to these CPT® codes were retained by BlueCross.

Note: Effective for claims with dates of service on or after **October 1, 2025,** BCBST will not reimburse services filed with consultation CPT® codes 99242-99245 and 99252-99255, including when reported with telehealth modifiers. (Refer to **Guidelines for Evaluation and Management (E&M) New or Established Patient Determinations** sub section of this Provider Administration Manual for billing of these services).

Medically Unlikely Edits (MUE)

An MUE for an HCPCS/CPT® code is the maximum units of service that a provider would report under most circumstances for a single member on a single date of service. Not all HCPCS/CPT® codes have an MUE.

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

NOTE: We follow the CMS MUE standard guidelines except for the BCBST Laboratory Code Testing Policies. See this policy located in this section of the Provider Administration Manual.

Maximum Units of Service

Edits are also applied for maximum units of service derived from several sources: CMS, AMA CPT® (American Medical Association Current Procedural Terminology), knowledge of anatomy, the standards of medical practice, FDA (U.S. Food and Drug Administration) and other nationally recognized drug references and outlier claims data from provider billing patterns.

4. Modifiers

Modifiers are two-digit indicators (alpha or numeric) that, when appended to a procedure code, indicate that a service or procedure has been altered by some specific circumstance, but not changed in its definition or code. They're designed to give additional information needed to process claims.

a. General Guidelines

- Consult the National Correct Coding Initiative (NCCI) Policy Manual on **CMS.gov** for information on correct use of modifiers such as when a modifier is allowed and when allowed, which modifiers are appropriate.
- Modifiers are required on both professional and institutional claim forms in accordance with the governing coding organizations.
- See additional modifier information in the Guidelines for Resource Based Relative Value Scale (RBRVS) Reimbursement Methodology in the Professional Claim Billing and Reimbursement Guidelines section of this manual.
- Order of modifiers impact how claim is handled.
- Applying modifiers to both the comprehensive and component code will result in incorrect claim processing.
- Use of a modifier without the required supporting documentation will be subject to recovery.
- Use of a modifier to bypass editing is inappropriate and will result in recoupment of erroneous reimbursement.
- All modifiers should be billed on the detail line, when appropriate, with procedure code(s) that are specific to the services being rendered. The provider needs to make sure they are using the appropriate modifier, if applicable. All benefit, policy, or authorization type requirements still apply.

b. Modifier 22 – Unusual Procedural Services

Modifier 22 should be utilized to identify when services provided are greater than what's usually required or was expected for the listed procedure. The increment of work represented by affixing modifier 22 shouldn't be frequently encountered when performing the base procedure, nor should it be reportable with another code.

To be considered for additional reimbursement, services submitted with modifier 22 must be accompanied by documentation that details the unusual or extraordinary work exceeding what's

typical, such as descriptive statements identifying the unusual circumstances, operative report, pathology report, progress notes, and/or office notes.

The operative report should clearly describe the difficult or complex nature of the procedure and what additional work was required.

Services billed with CPT® modifier 22 without the required supplemental documentation won't be considered for additional reimbursement.

Provider specialty or the BMI of the patient aren't automatic qualifiers for additional reimbursement.

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

c. Modifier 24 –Unrelated post-op evaluation and management

Modifier 24 should only be appended when the evaluation and management service rendered during a global period is unrelated to the surgical procedure.

d. Modifier 25 – Significant, separately identifiable evaluation and management service by the same Provider on the same day of the procedure or other service

Modifier 25 will only be recognized as valid to bypass edits when there's documentation of a significant, separately identifiable evaluation and management service which must contain the required number of key elements (history, examination, and medical decision making) for the evaluation and management service reported.

Modifier 25 won't be recognized for certain services, which includes, but isn't limited to:

- An evaluation and management service that resulted in a decision for surgery
- Ventilation management in addition to an evaluation and management service
- Use on the same day of a minor procedure

Documentation for the evaluation and management service must be able to stand alone.

The evaluation and management service may or may not require a different diagnosis.

(Refer to the Same Day Evaluation & Management and Preventative Medicine Exam Reimbursement Policy sub section of this Provider Administration Manual).

e. Modifier 52 – Reduced Services

Under certain circumstances a service or procedure is partially reduced or eliminated at the discretion of the physician or other qualified health care professional. Under these circumstances the service provided can be identified by its usual procedure number and the addition of modifier 52, signifying that the service is reduced. This provides a means of reporting reduced services without disturbing the identification of the basic service. **(Refer to the Discontinued and Reduced Services/Procedures Reimbursement Policy sub section of this Provider Administration Manual)**.

f. Modifier 53 – Discontinued Procedures

Under certain circumstances, the physician or other qualified health care professional may elect to terminate a surgical or diagnostic procedure. Due to extenuating circumstances or those that threaten the well-being of the patient, it may be necessary to indicate that a surgical or diagnostic procedure was started but discontinued. This circumstance may be reported by adding modifier 53 to the code reported by the physician for the discontinued procedure. **(Refer to the Discontinued and Reduced Services/Procedures Reimbursement Policy sub section of this Provider Administration Manual).**

g. Modifier 57- Decision for surgery

Modifier 57 may be recognized as valid when used appropriately and there is documentation that the evaluation and management service resulted in the initial decision to perform surgery with the exception of minor surgical procedures. Because the decision to perform a minor procedure is typically done immediately before the service, it is considered a routine preoperative service and therefore not separately reimbursable.

Modifier 57 isn't appropriate to report with the evaluation and management service when performed for the preoperative evaluation.

h. Modifiers for Distinct Procedural Services

59 – Distinct Procedural Service

- XE Separate Encounter – A Service That Is Distinct Because It Occurred During A Separate Encounter
- XS Separate Structure – A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure
- XP Separate Practitioner – A Service That Is Distinct Because It Was Performed By A Different Practitioner
- XU Unusual Non-Overlapping Service – The Use Of A Service That Is Distinct Because It Doesn't Overlap Usual Components Of The Main Service

Under certain circumstances, it may be necessary to indicate that a procedure or service was distinct or independent from other non-evaluation and management services performed on the same day. Distinct procedural modifiers are used to identify procedures/services, other than evaluation and management services, that aren't normally reported together, but are appropriate under the circumstances

Documentation must support a different session, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury (or area of injury in extensive injuries) not ordinarily encountered or performed on the same day by the same individual.

An established modifier should be used instead of modifiers 59, XE, XS, XP or XU when appropriate. Only use modifiers 59, XE, XS, XP or XU if they best explain the circumstances or if a more descriptive modifier isn't available.

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

Modifier 63 shouldn't be added to any CPT® codes listed in the Summary of Codes Exempt from Modifier 63 Appendix of the CPT® Manual

Documentation should include the procedure code, and the weight of the infant on the date of the surgery/procedure.

Reimbursement for eligible services will be based on the lesser of total covered charges or up to 130% of the contracted rate for that procedure.

Services billed with Modifier 63 without the required supplemental documentation won't be considered for additional reimbursement.

j. Modifier 73 – Discontinued outpatient hospital or ASC procedure before the administration of anesthesia. (Refer to the Discontinued and Reduced Services/Procedures Reimbursement Policy sub section of this Provider Administration Manual).

k. Modifier 74 – Discontinued outpatient hospital or ASC procedure after the administration of anesthesia. (Refer to the Discontinued and Reduced Services/Procedures Reimbursement Policy sub section of this Provider Administration Manual).

l. Modifier 79 Unrelated post-op procedure

Modifier 79 should only be added when the procedure rendered during a global period is unrelated to the surgical procedure.

m. Modifier KX

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

Description

The KX modifier is one example of a multipurpose modifier for professional claims and can be used to identify gender-specific services, CAR-T therapy, or signal on a claim that although the patient services have met the capped amount allowed, the provider deems continued care medically

necessary. (Also, refer to the **Use of Imaging Studies for Uncomplicated Low Back Pain** Policy sub section of this Provider Administration Manual for additional use of the KX Modifier).

5. Real Time Claim Adjudication

Real Time Claim Estimation/Adjudication (RTCA) provides a secure online environment to create estimates to confirm reimbursement amounts as well as identify member liability at the point of care. You may also submit claims for Tennessee members through the application.

You won't be able to generate an estimate of member liability or submit a claim for the following circumstances:

- If the Tennessee member has other insurance
- BlueCard (out-of-state members)
- Inpatient facility claims
- Dental claims
- Federal Employee Program (FEP) and Postal Service Health Benefits (PSHB) members can't have an estimate performed, but you can submit the claim for FEP/PSHB members as their primary carrier

Accessing the application is easy. Simply log into Availity® and go to the **Payer Spaces** title. Then, click on the **Real Time Claim Adjudication** application tile.

Note: You can also access this application while verifying member eligibility and benefits. Simply click the **Patient Cost Estimator** tab from the members benefit screen.

6. Qualitative Drug Screen Testing

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

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

For more information and a list of the G-codes, please refer to the CMS documentation "Clinical Laboratory Fee Schedule (CLFS)" located on the CMS website.

7. Sexually Transmitted Infections Testing

For professional providers submitting claims for sexually transmitted infection (STI) testing, there are single STI CPT® codes (87491, 87591, 87661) which are differentiated by the specific causative infectious agent. Separately, there is a comprehensive STI CPT® code (87801), which is for more than one organism tested.

Effective for claims with dates of service on or after October 1, 2025, BCBST will deny claims with two or more single STI testing CPT® codes performed by the same provider on the same date of service and ask provider to refile with the more comprehensive STI CPT® test code.

This policy applies to services billed on a professional claim form – CMS-1500 or electronic equivalent.

Note: This policy excludes the Federal Employee Program (FEP).

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

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

According to the National Quality Forum (NQF), never events are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients. These events indicate a real problem in the safety and credibility of a health care facility. Therefore, to reduce or eliminate the occurrence of never events, we won't provide reimbursement or allow hospitals to retain reimbursement for any care directly related to the never event. We've adopted the list of never events in accordance with CMS, as well as any additional events assigned by the Blue Cross Blue Shield Association. The list of never events can be located on the CMS website.

We require all participating providers to report never events by populating present on admission (POA) indicators on all acute care inpatient hospital claims. Otherwise, we'll follow CMS guidelines for the billing of never events. In the instance that the never event has not been reported, we'll use any means available to determine if any charges filed with us meet the criteria, as outlined by the NQF and adopted by CMS, as a never event. In the circumstance that a payment has been made for a never event, we reserve the right to re-coup the reimbursement as necessary. We require all participating acute care hospitals to hold members harmless for any services related to never events in any clinical setting.

9. Final Reimbursement

Presence of a fee on the maximum allowable fee schedule isn't a guarantee that the procedure, service or item will be eligible for reimbursement. Final reimbursement determinations are based on several factors, including but not limited to:

- Member eligibility on the date of service
- Medical appropriateness
- Code edits
- Applicable Member co-payments
- Coinsurance
- Deductibles
- Benefit plan exclusions/limitations
- Authorization/referral requirements
- Medical policy/coverage decisions

10. Policy for Quarterly Reimbursement Changes

(**Note**: Doesn't apply to Medicare lines of business)

This policy will be applicable when referenced in the provider agreement or reimbursement policy. Reimbursement changes applicable to this policy will be made according to the following schedule (unless otherwise contracted)*:

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

Notwithstanding any other provision in this manual (including the notes below) we reserve the right at our sole discretion not to implement one or more CMS changes to Resource-Based Relative Value Scale (RBRVS), Relative Value Units (RVUs), Geographic Practice Cost Index (GPCI), conversion factors, or other elements of the reimbursement method. We'll provide notice within 60 days of our decision not to implement such changes.

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

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

Note:

- This quarterly reimbursement change policy won't apply to providers contracted for the RBRVS reimbursement methodology amendment on or after July 23, 2011. The reimbursement changes applicable to this amendment will be updated per policy RBRVS reimbursement methodology amendment updates.

- The Banded RBRVS Reimbursement Methodology Amendment for providers contracted on or after Nov. 1, 2014, will be updated per guidelines in the provider's contract as indicated below:
  - For those procedure codes that fall into bands with a fee source of 2013 CMS RBRVS:
    - The established fee will be calculated based on the RVUs, conversion factors and Geographic Practice Cost Indices (GPCIs) effective Oct. 31, 2013. No updates will be made to these fee components, except for any new procedure code added after Oct. 31, 2013.
    - If the AMA modifies the code description, the underlying use of the code or the components that make up the code. We'll treat the code as a new code in order to remain consistent with recognized coding guidelines.
  - For those procedure codes that fall into bands with a fee source of 2017 CMS RBRVS, the established fee will be calculated based on the RVUs, conversion factors and GPCIs effective Oct. 31, 2017. No updates will be made to these fee components, except:
    - Any new procedure code added after Oct. 31, 2017, will be added as noted above
    - If the AMA modifies the code description, the underlying use of the code or the components that make up the code, we'll treat the code as a new code in order to remain consistent with recognized coding guidelines.
  - For those procedure codes that fall into bands with a fee source of 2021 CMS RBRVS, the established fee will be calculated based on the RVUs, conversion factors and GPCIs effective Oct. 31, 2021. No updates will be made to these fee components, except:
    - Any new procedure code added after Oct 31, 2021, will be added as noted above
    - If the AMA modifies the code description, the underlying use of the code or the components that make up the code, we'll treat the code as a new code in order to remain consistent with recognized coding guidelines.
  - For those procedure codes that fall into bands with a fee source of 2025 CMS RBRVS, the established fee will be calculated based on the RVUs, conversion factors and GPCIs effective Jan. 1, 2025. No updates will be made to these fee components, except:
    - Any new procedure code added after Jan. 1, 2025, will be added as noted above
    - If the AMA modifies the code description, the underlying use of the code or the components that make up the code, we'll treat the code as a new code in order to remain consistent with recognized coding guidelines.
  - Other fee components, which are listed in the Guidelines for RBRVS Reimbursement Method in this manual, may be updated to ensure that reimbursement is consistent with current usage of the code. Updates to these components may result in increases or decreases to the established fee at the individual code level.

11. Policy for Codes Priced on an Individual Consideration Basis

Code Sets

- Current Dental Terminology (CDT)
- Current Procedural Terminology (CPT®)
- Healthcare Common Procedure Coding System (HCPCS)
- Revenue Codes

Claim Types

- CMS-1500 / ANSI-837P
- CMS-1450 / ANSI-837I
- Paper dental claim forms / ANSI-837D

The maximum allowable amount for codes priced on individual consideration are based on an individual claim review.

The codes priced by this policy are identified and published on the provider fee schedules with one of these maximum allowable detail indicators:

- **BU:** Reimbursement is included in the reimbursement to which procedure or service is incidental.
- **BU-PO:** Reimbursement is included in the reimbursement to which procedure or service is incidental when the location of service is the physician's office.
- **BR:** By report/individual consideration.

- **IC:** Maximum allowable amount will be determined by individual consideration. An operative report may be required.
- **IC-DR:** Maximum allowable amount is determined by individual consideration. Name of drug, National Drug Code (NDC#), dosage, and number of units is required.
- **IC-SM:** Maximum allowable amount is determined by individual consideration. Manufacturer name, product name, product number and quantity are required.
- **IC-RP:** Maximum allowable amount is determined by individual consideration. Manufacturer/supplier's invoice listing name of patient, the date of service, acquisition cost for the radiopharmaceutical(s) or contrast material and number of doses/units is required.
- **RP:** Manufacturer/supplier's invoice listing name of patient, the date of service, acquisition cost for the radiopharmaceutical(s) or contrast material, and number of doses/units is required.
- **UL:** Unlisted service or procedure – Code should only be used for services or procedures not assigned a CPT® or HCPCS code. For consideration of reimbursement, description, radiology report, lab report, a manufacturer's/supplier's invoice, name of drug, NDC#, dosage and number of units is required.
- **UL-SM:** Unlisted service or procedure. Manufacturer name, product name, product number, and quantity are required.
- **UL-DR:** Unlisted service or procedure. Name of drug, National Drug Code (NDC#), dosage and number of units is required.

The maximum allowable amount for a code priced on individual consideration may vary by claim based on:

- Supplemental information provided with the claim or related claims
  - Supplemental information includes, but isn't limited to:
    - A description of the procedure or service provided
    - An operative report for surgical procedures
    - An anesthesia flow sheet for anesthesia procedures
    - The name of the drug, immune globulin, vaccine, toxoid, radiopharmaceuticals, contrast material, National Drug Code (NDC), dosage and number of units provided
    - The manufacturer's name, product name, product number, and quantity for durable medical equipment, medical supplies, orthotics, and prosthetics
    - A manufacturer/supplier's invoice listing the name of the patient, date of service, number of units provided, and acquisition cost for radiopharmaceuticals or contrast materials
    - Documentation of the time and effort necessary to perform the procedure or service.
    - Information published by governing coding organizations available at the time the claim is reviewed
    - Information published by established primary, secondary, or tertiary reimbursement sources as indicated on the Professional and Home Health Services Reimbursement Hierarchy at the time the claim is reviewed

Codes priced on an individual consideration basis are generally limited to new codes added by the governing coding organizations.

The objective is to establish maximum allowables and/or reimbursement policies for new codes added by the governing coding organizations as quickly as possible when feasible and appropriate.

Establishing maximum allowables and/or reimbursement policies for codes priced on individual consideration isn't always feasible or appropriate due to various reasons:

- Unlisted, miscellaneous, non-specific, or not otherwise classified (NOC) procedures/services
- Generic codes where different levels of reimbursement are warranted
- Codes that aren't used frequently
- Delays in publication of guidelines by governing coding organizations
- Delays in publication of benchmark data by established primary, secondary, or tertiary reimbursement sources as indicated on the Professional and Home Health Services Reimbursement Hierarchy

When maximum allowable amounts and/or reimbursement policies are developed, they'll be implemented based on the greater of the effective date of the code, the effective date of the network or the effective

date of the schedule (e.g., fee schedule, unit schedule) in order to facilitate automated claims adjudication. In the event the reimbursement for a code priced on an individual consideration basis is different than the established maximum allowable and/or reimbursement policy, claims processed during the interim period won't be adjusted unless claims are resubmitted by the provider or adjusted for an unrelated reason (e.g., member eligibility, member benefits, medical policy, utilization management, or through routine audit activities).

In some cases, it may be necessary to change pricing for a code that has an established maximum allowable amount and/or reimbursement policy to individual consideration for various reasons including, but not limited to:

- Codes revised by governing coding organizations that result in a significant change in reimbursement (e.g., code definition changes from 1 unit = 1 pair to 1 unit = box of 100; code definition changes from 1 unit = box of 100 to 1 unit = 1 pair).
- Codes where there's a conflict between guidelines published by governing coding organizations and information published by established primary, secondary or tertiary reimbursement sources as indicated on the Professional and Home Health Services Reimbursement Hierarchy.
- Pricing that's frequently overturned as the result of a Level I or Level II appeal.

In some cases, a code may be published externally as individual consideration, but an interim maximum allowable amount or reimbursement policy is configured on the adjudication system. This typically occurs when an interim maximum allowable amount or reimbursement policy is applied consistently to all claims for each standard network agreement, non-standard network agreement, and/or claim type. The purpose of configuring the interim maximum allowable amount or reimbursement policy is to:

- Monitor how pricing impacts us and/or the Provider without having to manually price claims
- Ensure more accurate and consistent pricing through automated mechanisms
- Improve turnaround time for claims processing

Note: This policy formally documents historical practice for administering codes priced on an individual consideration basis.

C. Professional Claim Billing and Reimbursement Guidelines

1. Lesser Of Calculation

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

2. Split Bills

We don't accept split billing unless requested to reflect covered charges allocated for approved and denied days. Split bills that we haven't requested are subject to denial or recovery. All services for the same patient, same date of service, same place of service and same provider must be billed on a single claim submission.

3. Reimbursement Hierarchy for Professional and Home Health Services

This policy applies to the code sets listed below and claim types for all lines of business.

Code Sets

- Current Dental Terminology (CDT)
- Current Procedural Terminology (CPT)
- Healthcare Common Procedure Coding System (HCPCS)
- Revenue Codes

Claim Types

- CMS-1500/ANSI-837P
- CMS-1450/ANSI-837I (Home Health only)
- Paper dental claim forms/ANSI-837D

Codes for professional and home health services priced on individual consideration will be priced based on the Reimbursement Methodology Hierarchy referenced in Exhibit A.

The Reimbursement Methodology Hierarchy will also be used to develop maximum allowable amounts and reimbursement policies for professional and home health services in the absence of provider contract provisions.

Reminder: Counting Minutes for Timed Therapy Codes in 15 Minute Units

This is a reminder that claims submitted for timed codes should be submitted in accordance with CMS coding standards, known as the "8-minute rule" for all lines of business. For a full explanation of this standard, please review CMS Claims Processing Manual.: Chapter 5, 20.2(C) "Counting Minutes for Timed Codes in 15 Minute Units", available at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c05.pdf.

Reimbursement Hierarchy for Professional and Home Health Services – Exhibit A

Anesthesia

- Primary Method
  - Anesthesia reimbursement guidelines
- Secondary Method
  - Basic values based on similar procedures

Surgery, Radiology, Laboratory (excluding Clinical lab), Diagnostic/Therapeutic Procedures, and Evaluation & Management Services

- **Primary Method**
  - Applicable reimbursement policies and procedures
  - Resource-Based Relative Value Scale (RBRVS) as defined by the Federal Register, Geographic Practice Cost Index (GPCIs) for Tennessee, and appropriate network conversion factor
- **Secondary Method**
  - Tennessee Medicare carrier (Palmetto) published flat rate or priced schedule with appropriate network multiplier once this has been established
    - Note: Network multiplier must be calculated based on appropriate network conversion factor and the Medicare conversion factor
  - Professional and technical component exceptions: If a primary and/or secondary pricing source is available for only two of the components, we'll add or subtract the fees to develop the omitted fee.
    - For example: If the primary and/or secondary source prices the Technical (TC) and 26, we'll add these together to develop the global rate. If the primary and/or secondary source prices the Global and 26 we'll subtract the 26 fee from the global fee to obtain the TC fee. If the primary and/or secondary source prices the global and TC we'll subtract the TC fee from the global fee to obtain the 26 fee
  - If the Centers for Medicare & Medicaid Services (CMS) or Palmetto has only one of the components, we'll default to Optum for the other two components. We can't accept site of service differential applied to alternate pricing sources
- **Tertiary Method**
  - Optum RBRVS, GPCIs for Tennessee, and appropriate network conversion factor
  - Based on fees for similar procedures in terms of time, skill, supplies, equipment, etc.
  - Percentage of charges applicable to date of service for each line of business:
    - 40% charge for Commercial lines of business
    - 25% charge for Medicare lines of business

Clinical Laboratory

- **Primary Method**
  - Applicable Reimbursement Policies and Procedures
  - Tennessee Medicare Clinical Lab Fee Schedule and appropriate network multiplier
- **Secondary Method**
  - Tennessee Medicare Clinical Lab Gapfill Final Determination Fee Schedule and appropriate network multiplier

- **Tertiary Method**
  - Tennessee Medicare carrier (Palmetto) and appropriate network multiplier
  - Optum RBRVS, GPCIs for Tennessee, and appropriate network conversion factor (note network conversion factor must be calculated based on appropriate network multiplier and the Medicare conversion factor)
  - Based on fees for similar procedures in terms of time, skill, supplies, equipment, etc.
  - Percentage of charges applicable to date of service for each line of business:
    - 40% charge for Commercial lines of business
    - 25% charge for Medicare lines of business

Radiopharmaceuticals and High Dose Contrast Material

- Primary Method
  - Reimbursement Policy for Radiopharmaceuticals and Contrast Materials
- Secondary Method
  - Acquisition cost per the manufacturer/supplier's invoice x 100%

Infusion Therapy, Immune Globulin, Immunosuppressive, Nebulizer, Chemotherapy and Other Injectable Drugs

- Primary Method
  - Reimbursement Policy for Infusion Therapy, Immune Globulin, Immunosuppressive, Nebulizer, Chemotherapy and Other Injectable Drugs

Vaccines and Toxoids

- Primary Method
  - Reimbursement Policy for Vaccines and Toxoids

Durable Medical Equipment, (Includes hearing aids), Medical Supplies, Orthotics and Prosthetics

- Primary Method
  - Applicable Reimbursement Policies and Procedures
  - Tennessee Medicare DME MAC Fee Schedule x appropriate network multiplier
- Secondary Method
  - Tennessee Medicare DME MAC carrier priced schedule x appropriate network multiplier
  - Retail price based on manufacturer, model, number of units x 100%
  - Acquisition cost per the unaltered, verified manufacturer/supplier's invoice x 120%

NOTE: Durable Medical Equipment Reimbursement Methodology applies to BCBST contracts only.

Dental-Commercial (Paid Under Member's Medical Benefits)

- 100% of the Preferred Base Dental Fee Schedule, unless the Provider's contract specifies a different rate be applied,
- Based on fees for similar procedures in terms of time, skill, supplies, equipment, etc.;
- Percentage of charges applicable to date of service for each line of business:
  - 40% for Commercial lines of business
  - 25% for Medicare lines of business

Hearing Products (e.g., hearing aids, accessories and services) – Commercial (excludes the Federal Employee Program (FEP) and Postal Service Health Benefits (PSHB))

Effective Aug. 1, 2018:

- Hearing related services and equipment should be billed using the most appropriate "V" HCPCS code and number of units as defined by HCPCS
- Hearing examinations, screenings, fitting/orientation/checking of hearing aid, ear impressions, non-disposable ear molds/inserts and conformity evaluations will be reimbursed based on the lesser of line level covered charges or the network maximum allowable fee schedule
- All hearing aid-related products and services should be billed on one claim, but break out each product or service as separate line items with the appropriate codes

Hearing aids billed with code(s) not having an established maximum allowable will require an unaltered, verifiable manufacturer's invoice and will be reimbursed based on the policy

Reimbursement Guidelines for Codes Classified as Durable Medical Equipment, Medical Supplies, Orthotics and Prosthetics without an Established Maximum Allowable, which is located in this section of the manual. Claims billed without an invoice may be rejected upfront or denied requesting this information.

- Hearing aid batteries, hearing aid accessories, assisted listening devices, disposable ear molds, dispensing fees, shipping/handling, and sales tax won't be separately reimbursed except when the member's benefit has specific group coverage
- Not all plans cover hearing aids and/or related hearing services for all members and some plans contain dollar limits for hearing aids. Please verify benefits before providing services
- To facilitate correct claim handling providers must include the right or left side (RT or LT) modifier with the appropriate HCPCS code for the unilateral hearing aid codes. The claim must have the unilateral hearing aid code and appropriate modifier for the left or right side submitted as the first line item on the claim. Claims for unilateral hearing aids filed without the appropriate right or left side modifiers will be denied. **No laterality modifier should be submitted for codes identifying bilateral procedures, or devices**

Note: For provider's contracted with the 2022 banded fee schedules, certain hearing aid HCPCS codes will reimburse from the applicable banded schedule. Otherwise, the hearing aid code will still be subject to manufacturer invoice review and pricing as indicated above. The effective date will be based on provider's signed contract.

Vision (e.g. frames, lens, contact lens) – Commercial

- Billed charges subject to member benefits

Home Health Agency

- Per Network Attachment and Billing Guidelines

Home Infusion Therapy

- Per Network Attachment and Billing Guidelines

Behavioral Health Services (Commercial and Medicare lines of business)

- Primary Method
  - Applicable Reimbursement Policies and Procedures
  - Based on provider-contracted Behavioral Health Fee Schedule
  - For new codes, RBRVS as defined by the Federal Register, GPCIs for Tennessee, and appropriate network conversion factor

4. Anesthesia Billing and Reimbursement Guidelines (Medicare lines of business will follow CMS guidelines)

Note*:* Anesthesia services provided by an anesthesiologist, nurse anesthetist, or anesthesiology assistant should be billed on a professional claim form.

Administration of Anesthesia

Administration of anesthesia must be billed using the most appropriate CPT® code 00100-01999 01995 or 01999.

The anesthesia administration code includes:

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

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

When multiple surgical procedures are performed during a single anesthetic administration, only the procedure with the highest basic value should be reported. Refer to the American Society of Anesthesiologist Relative Value Guide in effect for the date of service to determine the procedure with the

highest basic value. This applies to vaginal deliveries and cesarean sections followed immediately by a hysterectomy.

Billing more than one anesthesia administration code for a single anesthetic administration may result in a delay in reimbursement, rejection of charges or a returned claim.

a. First Modifier

Anesthesia services must be billed using the most appropriate anesthesia modifier. Acceptable anesthesia modifiers include:

Modifier	Description
AA	Anesthesia service performed personally by anesthesiologist
AD	Medical supervision by a physician; more than four concurrent procedures
QK	Medical direction of two, three, or four concurrent anesthesia procedures involving qualified individuals
QX	Nurse Anesthetist or Anesthesiology Assistant service with medical direction by a physician
QY	Anesthesiologist medically directs one nurse anesthetist
QZ	Nurse Anesthetist service without medical direction by a physician **(Refer to payment guidelines for this modifier found below in sub section of this reimbursement policy)**

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

b. Second Modifier

A physical status modifier may be billed in the second modifier field. Acceptable physical status modifiers include:

Modifier	Description
P1	A normal healthy patient
P2	A patient with mild systemic disease
P3	A patient with severe systemic disease
P4	A patient with severe systemic disease that's a constant threat to life
P5	A terminal patient who isn't expected to survive without the operation
P6	A declared brain-dead patient whose organs are being removed for donor purposes

c. Days or Units

Anesthesia time must be reported in minutes and can't be converted to units. Conversion to units will result in an incorrect payment.

d. Reimbursement Guidelines for Administration of Anesthesia

Maximum allowable amount for administration of anesthesia performed by an anesthesiologist, nurse anesthetist, or anesthesiology assistant are based on the provider's contract or the following formula:

Maximum Allowable = (Basic Value + Time Unit + Physical Status Unit Value) x Conversion Factor x Percentage

Reimbursement formula for Administration of Anesthesia Effective October 1, 2025:

Maximum Allowable =	(Basic Value + Time Unit) x Conversion Factor x Percentage

1. Basic values

Basic values are based on the American Society of Anesthesiologist (ASA) Relative Value Guide in effect for the date of service. In the event there's a delay in the publication of the ASA guide, we'll default to the CMS base unit values until the ASA guide becomes available.

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

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

2. Time

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

We'll convert anesthesia time in minutes to time units as indicated below:

- Fractional time units will be rounded up to the next whole unit (i.e., 1.1 units will be rounded to 2 units, 1.4 units will be round to 2 units, 1.5 units will be rounded to 2 units, 1.6 units will be round to 2 units, 1.9 units will be round to 2 units). Anesthesia time doesn't apply to daily hospital management services.

Effective July 21, 2021:

We'll convert anesthesia time in minutes to time units as indicated below:

- Fractional time units will be rounded up to the nearest tenth (i.e., 1.11 units will be rounded to 1.2 units, 1.41 units will be rounded to 1.5 units, 1.51 units will be rounded to 1.6 units, 1.61 units will be rounded to 1.7 units, 1.91 units will be rounded to 2 units). **Anesthesia time doesn't apply to daily hospital management services.**

3. Physical Status Unit Values

The American Society of Anesthesiologists (ASA) and CPT guidelines list six levels of patient physical status modifiers. Adding a physical status modifier to a time-based anesthesia code classifies the level of complexity.

Additional base units for physical status will be allowed:

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

(Refer to payment guidelines for these physical status modifiers eff. 10/1/25 found below in sub section of this reimbursement policy under **Medical Supervision of Anesthesia Services for AD Modifier**).

4. Time Units, Conversion Factors and Percentages

Conversion Factors and Percentages are:

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

Note: Effective January 1, 2026, Modifier QX will apply to Certified Anesthesiology Assistant (CAA) services, same as CRNA.

5. Medical Supervision of Anesthesia Services

Reimbursement for medical supervision of anesthesia services (Modifier AD), will be limited to three basic Values, one unit of time, physical status modifier units, when applicable, and 100% of the conversion factor for the anesthesiologist.

NOTES for QZ and Physical Status Modifiers Effective October 1, 2025:

1. Anesthesia Services provided by a Certified Nurse Anesthetist (CRNA) without medical direction by a physician should be filed with a QZ modifier appended to the claim. In these circumstances, the reimbursement will equal 85% of the appropriate fee schedule for all service lines billed on the claim.
2. Consistent with CMS payment policies, physical status modifiers will not be utilized for payment of anesthesia services. Specifically, BCBST will not provide additional reimbursement for anesthesia services based on the use of physical status modifiers P3 (ASA III), P4 (ASA IV), and P5 (ASA V).
3. Reimbursement for medical supervision of anesthesia services (Modifier AD), will be limited to three basic values, one unit of time, and 100% of the conversion factor for the anesthesiologist.

Maximum allowable amount for administration of anesthesia performed by an anesthesiologist, nurse anesthetist, anesthesiology assistant are based on the following formula unless otherwise stated in provider's contract:

Maximum Allowable =	(Basic Value + Time Unit) x Conversion Factor x Percentage

Qualifying Circumstances

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

Code	Description
99100	Anesthesia for patient of extreme age, under one year and over 70
99116	Anesthesia complicated by utilization of total body hypothermia
99135	Anesthesia complicated by utilization of controlled hypotension
99140	Anesthesia complicated by emergency condition

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

1. Modifiers

Don't bill qualifying circumstances with an anesthesia modifier (e.g., AA, AD, QK, QX, QY or QZ) or a physical status modifier (e.g., P1, P2, P3, P4, P5 or P6) because this may result in a delay in reimbursement, rejection of charges or a return of the claim.

2. **Days or Units**

   Qualifying circumstances should be billed with one service number.

   Don't bill anesthesia minutes in this field.

3. **Reimbursement Guidelines for Qualifying Circumstances for Anesthesia**

   Maximum allowable amounts for qualifying circumstances for anesthesia performed by an Anesthesiologist, nurse anesthetist, or anesthesiology assistant are based on the lesser of total covered charges or the following formula:

   Maximum Allowable = Unit Value x Conversion Factor

   The following are the unit values for qualifying circumstances for anesthesia:

Code	Description	Unit Value	Conversion Factor
99100	Anesthesia for patient of extreme age, under one year and over seventy	1	Refer to contract
99116	Anesthesia complicated by utilization of total body hypothermia	5	
99135	Anesthesia complicated by utilization of controlled hypotension	5	
99140	Anesthesia complicated by emergency condition	2	

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

Unusual Forms of Monitoring

Unusual forms of monitoring may be billed using the most appropriate CPT® or HCPCS code.

1. **Modifiers**

   Don't bill unusual forms of monitoring with modifier (AA, AD, QK, QX, QY, or QZ) or physical status modifier (e.g., P1, P2, P3, P4, P5 or P6) as this may result in a delay in reimbursement, rejection of charges or a return of the claim.

2. **Days or Units**

   Unusual forms of monitoring should be billed using the appropriate number(s) of service. Don't bill anesthesia minutes in this field.

3. **Reimbursement Guidelines for Unusual Forms of Monitoring of Anesthesia**

   Maximum allowable for unusual forms of monitoring such as intra-arterial, central venous, Swan-Ganz catheterization, and transesophageal echocardiography (TEE) provided in conjunction with anesthesia administration will be based on the lesser of total covered charges or the professional maximum allowable fee schedule.

   Postoperative Pain Management - Placement of Epidural

   If the operative procedure was performed or ends under general anesthesia and an epidural is placed for postoperative pain management purposes, placement of the epidural may be billed using the most appropriate CPT®:

   - Postoperative pain management-placement of epidural should be billed using the most appropriate CPT® code. Refer to the CPT® book in effect for the date of service for the most appropriate CPT® code.

4. **Modifiers**

   Don't bill postoperative pain management-placement of epidural with a modifier (e.g., AA, AD, QK, QX, QY, or QZ) or a physical status modifier (e.g., P1, P2, P3, P4, P5 or P6) as this may result in a delay in reimbursement, rejection of charges or the return of a claim.

5. **Days or Units**

   Postoperative pain management-placement of epidural should be billed using the appropriate number(s) of service.

Don't bill anesthesia minutes in this field.

6. **Reimbursement Guidelines for Postoperative Pain Management-Placement of Epidural**

   Maximum allowable amounts for placement of epidural for postoperative pain management services performed by an anesthesiologist, nurse anesthetist, or anesthesiology assistant are based on the lesser of total covered charges or the professional maximum allowable fee schedule.

   Postoperative Pain Management - Daily Hospital Management of Epidural (continuous) or Subarachnoid (continuous) Drug Administration

   Postoperative pain management daily hospital management should only be billed for postoperative days. Postoperative pain management daily hospital management shouldn't be billed on the same day as the operative procedure.

   Billing of postoperative pain management daily hospital management billed on the same day as the operative procedure may result in a delay in reimbursement, rejection of charges or the return of a claim.

   Postoperative pain management daily hospital management should be billed using the most appropriate CPT® code in effect for the date of service.

   Refer to the CPT® book in effect for the date of service for the most appropriate CPT® code.

7. **Modifiers**

   Don't bill postoperative pain management daily hospital management with a modifier (e.g., AA, AD, QK, QX, QY, or QZ) or a physical status modifier (e.g., P1, P2, P3, P4, P5 or P6) because this may result in delay in reimbursement, rejection of charges or the return of a claim.

8. **Days or Units**

   Postoperative pain management daily hospital management should be billed using one service number for each day of postoperative management.

   Don't bill anesthesia minutes in this field.

9. **Reimbursement Guidelines for Postoperative Pain Management-Daily Hospital Management of Epidural (continuous) or subarachnoid (continuous) Drug Administration**

   The maximum allowable amount for postoperative pain management daily hospital management of epidural (continuous) or subarachnoid (continuous) drug administration performed by an anesthesiologist or nurse anesthetist, or anesthesiology assistant is based on the lesser of total covered charges or the following formula:

   Maximum Allowable = Unit Value x Conversion Factor

   The following is the unit value for postoperative pain management daily hospital management of epidural (continuous) or subarachnoid (continuous) drug administration:

Code	Description	Unit Value	Conversion Factor
01996	Daily Management of epidural or subarachnoid drug administration	3	Refer to contract

   Reimbursement is limited to no more than three postoperative days of daily hospital management of epidural (continuous) or subarachnoid (continuous) drug administration.

5. Obstetric Anesthesia

Obstetric anesthesia for a planned vaginal delivery (01967) that ends in a cesarean section delivery (01968) must be billed on a single claim form using the date of delivery as the date of service.

Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code on a separate claim. Add-on codes submitted with no primary code or a different date of service result in rejection and non-payment of the add-on code.

In those cases, with obstetrical anesthesia for the planned vaginal delivery beginning on one day and the actual caesarean delivery on the following day, dates of service for both codes should have the same "from and through" date, (i.e., from beginning of anesthesia through to the completion). Obstetric anesthesia services involving more than one provider (e.g., two physicians or two nurse anesthetists) for the same episode must be submitted on a single claim, under one NPI, with the date of delivery as the date of service. Separate claims for multiple providers will result in denial for the add-on code.

6. Reimbursement Guidelines for Administration of Regional or General Anesthesia Provided by a Surgeon

Administration of regional or general anesthesia provided by a surgeon may be reported by appending modifier 47 (Anesthesia by Surgeon) to the appropriate procedure code in accordance with CPT® guidelines.

Reimbursement for administration of regional or general anesthesia provided by a surgeon is included in the reimbursement for the surgical or other procedure and isn't separately reimbursed.

Reimbursement for the surgical or other procedure is based on the lesser of total covered charges or the professional maximum allowable fee schedule.

Modifier 47 has no effect on the maximum allowable amount.

7. Reimbursement Policy for Moderate Conscious Sedation

Moderate (conscious) sedation provided by the same physician performing the diagnostic or therapeutic service that the sedation supports.

Moderate (conscious) sedation provided by a physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports.

For dates of service (DOS) prior to Dec. 31, 2016:

Moderate Conscious Sedation codes are identified in the CPT® codebook with a special symbol for Moderate Conscious Sedation.

For DOS beginning Jan. 1, 2017:

Reimbursement details for moderate (conscious) sedation and related services can be found at: bcbst.com/sedationcode

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

Note: See the policy for Quarterly Reimbursement Changes for schedule updates and exceptions impacting RVUs, GPCIs, and conversion factors.

This policy only applies when specifically referenced in the provider's agreement.

RBRVS is a reimbursement method that values services according to the relative costs required to provide them. The policy applies to most surgery, radiology, non-clinical lab, evaluation and management services, and diagnostic/therapeutic procedures.

The source for the physician work, practice expense (facility and non-facility), and malpractice RVUs, GPCI and conversion factor is the National Physician Relative Value Fee Schedule and/or program memorandums/transmittals published by Medicare. These documents can be located on the CMS website.

Unless stated otherwise, we reserve the right at our sole discretion not to implement one or more CMS changes to RBRVS, RVUs, GPCI, or other elements of the reimbursement method. We'll provide notice within 60 days of our decision not to implement such changes.

The RBRVS reimbursement method doesn't apply to anesthesia administration, clinical lab, immune globulins, vaccines, toxoids, injectable drugs, radiopharmaceuticals, medical supplies, durable medical equipment, orthotics, prosthetics, visions products (e.g. frames, lens, contact lens) or hearing products (e.g., hearing aids).

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

Relative Value Units (RVUs)

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

There are three types of RVUs including:

- **Physician Work RVUs** – Reflects the cost of the physician's time and skill related to each service provided.
- **Practice Expense RVUs** (facility and non-facility) – represents the physician's direct and indirect costs related to each service provided.

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

Indirect expenses include the cost of general office supplies, rent, utilities and other office overhead that can't be directly tied to a specific procedure. When a procedure is performed in a facility setting, the expenses related to non-physician labor, medical equipment, and medical supplies are incurred and billed by the facility. As a result, the physician's cost related to a procedure performed in a facility is less than the physician's cost related to a procedure performed in a non-facility.

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

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

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

Geographic Practice Cost Indices (GPCIs)

GPCIs are used to adjust the relative value units to reflect cost differences among geographic areas. There are three types of GPCIs:

- Physician work GPCI
- Practice expense GPCI
- Malpractice GPCI

We use the GPCIs assigned to Tennessee regardless of the geographic location in which the services are provided except for Medicare lines of business.

Conversion Factor

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

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

Network conversion factors are determined by the provider contract.

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

- **Non-facility Professional Maximum Allowable**

  ((Physician Work RVU x Physician Work GPCI) + (Non-Facility Practice Expense RVU x Practice Expense GPCI) + (Malpractice RVU x Malpractice GPCI)) x Conversion Factor

- **Facility Professional Maximum Allowable**

  ((Physician Work RVU x Physician Work GPCI) + (Facility Practice Expense RVU x Practice Expense GPCI) + (Malpractice RVU x Malpractice GPCI)) x Conversion Factor

Note: *The sum of the physician work, practice expense, and malpractice components of the RBRVS formula will be rounded to the nearest thousandth (i.e., to the 3rd decimal place, x.xxx) before the conversion factor is applied.*

There are other major components that may have an impact on the base maximum allowable amount under the RBRVS reimbursement method.

Information on these components is published by Medicare in the National Physician Fee Schedule Relative Value File and/or Program Memorandums/Transmittals These documents can be found online at www.cms.gov.

9. Status Indicators

a. Status B – Reimbursement Guidelines for Bundled Services Regardless of the Location of Service (This policy doesn't apply to Medicare lines of business)

Under the RBRVS method, Medicare considers reimbursement for certain codes bundled regardless of the service location. Medicare considers these codes as an integral part or incident to some other service even if billed alone. These codes are published by Medicare in the National Physician Fee Schedule Relative Value File and/or program memorandums/transmittals with a status code B. Unless specified otherwise in this policy, BCBST considers codes published by Medicare with a Status Code "B" as bundled regardless of the service location. The maximum allowable amount for these codes is $0.00 even when billed alone.

Updates resulting from changes by Medicare for codes with a status code B will be made in accordance with the Policy for Quarterly Reimbursement Changes.

Notes:

1. Reimbursement for CPT® code 99050 is considered bundled with the incidental service when the service is provided in all service locations with the exception of the physician's office (place of service 11).
2. Reimbursement for CPT® code 99078 is considered bundled with the incidental service except when the service is approved through an eligible initiative. NCCI edits may still occur for both codes.
3. Reimbursement for CPT® code 96040 is considered bundled with the incidental service except when the service is billed by a Genetic Counselor for a preventive diagnosis.
4. Reimbursement for CPT® code 96041 is considered bundled with the incidental service except when the service is billed by a Genetic Counselor.
5. Reimbursement for anesthesia CPT® codes 99100, 99116, 99135, and 99140 are considered bundled with the incidental service except when the service is performed by an anesthesiologist, CRNA, or CAA related to anesthesia administration.

b. Status M – Reimbursement Guidelines for Measurement Reporting Codes

The purpose of measurement codes is to aid performance measurement by easing the quality-of-care data collection. These codes generally describe either common components of evaluation and management services or test results that are part of a lab procedure. Each code is linked to a particular performance measure set.

We consider measurement reporting codes bundled to the incidental service. The maximum allowable amount for measurement reporting codes is $0.00 even when billed alone with the exception of when the service is approved through an eligible initiative.

Examples of codes classified as measurement reporting codes:

- CPT® Category II codes (i.e., xxxxF codes)
- Other CPT® or HCPCS codes assigned a status code M (measurement code, used for reporting purposes only) published on the Medicare Physician Fee Schedule Relative Value File
- These certain HCPCS codes Q5001-Q5010 for Hospice and Home Health services, as indicated by CMS.

c. Status P – Reimbursement Guidelines for Bundled Services when the Location of Service is the practitioner's office

Under the RBRVS method, Medicare considers reimbursement for certain codes bundled when the service location is the practitioner's office. Medicare considers these codes as an integral part of or

incident to some other service even if billed alone. These codes are published by Medicare in the National Physician Fee Schedule Relative Value File and/or Program Memorandums/Transmittals with a status code P. These documents can be found online at www.cms.gov.

Unless stated otherwise, we consider codes published by Medicare with a status code P as bundled when the service location is the practitioner's office. The maximum allowable amount for these codes is $0.00 even when billed alone.

Updates resulting from changes by Medicare for codes with a status code P will be made in accordance with the Policy for Quarterly Reimbursement Changes.

This policy applies to services billed on a professional claim form.

Exception:

When the service location is the practitioner's office (place of service 11), HCPCS code V2520 is eligible for reimbursement.

d. Status T – Injections

There are RVUS and payment amounts for these services, but they're only paid if there are no other services payable under the physician fee schedule billed on the same date by the same provider. If any other services payable under the physician fee schedule are billed on the same date by the same provider, these services are bundled into the physician services for which payment is made.

10. PC/TC Indicator – Global, Professional and Technical Components for Radiology, Lab and Other Diagnostic Procedures

Per the Reimbursement Policy for Professional and Technical Components for Radiology, Lab, and Other Diagnostic Procedures, reimbursement will be limited to procedures where a 26-professional component or TC-technical component modifier is appropriate per the Medicare Physician Fee Schedule Data Base, Federal Register or National Physician Fee Schedule Relative Value File and/or Program Memorandums/Transmittals in effect for the date of service. These documents can be found online at www.cms.gov.

Reimbursement will be based on the lesser of total covered charges or the maximum allowable fee schedule allowance for the procedure.

Note: For these lab CPT® codes: 81000, 85025, 87804, and 87880, please refer to your contract for reimbursement and effective date of change.

- If the code is eligible to be billed with modifier TC per the Reimbursement Policy for Technical and Professional Components for Radiology, Lab, and Other Diagnostic Procedures, only the technical component for a radiology, laboratory, or other diagnostic procedure, the provider should append modifier TC to the CPT® or HCPCS code.
- If the code is eligible to be billed with modifier 26 per the Reimbursement Policy for Technical and Professional Components for Radiology, Lab, and Other Diagnostic Procedures, only the professional component for a radiology, laboratory, or other diagnostic procedure, the provider should append modifier 26 to the CPT® or HCPCS code.
- If both the technical and professional components for radiology, lab, or other diagnostic procedures are performed, it's appropriate to bill the service as a global procedure (i.e. without a 26 or TC modifier appended to the CPT® or HCPCS code).

The following note on this payment policy is suspended for Commercial claims with dates of service on or after Jan. 1, 2018, through Dec. 31, 2018. Effective for claims with dates of service on or after Jan. 1, 2019, the following note on this payment policy will apply. Please contact your Provider Network Manager with questions.

Note: Regarding Technical Component for Professional Services

Performed in a Facility:

Commercial diagnosis related groups and outpatient case rates paid to a facility are all-inclusive of any technical component for professional services provided while a patient is in a facility setting. The facility must bill for the technical component of the services, even if these services are provided under

arrangements with or subcontracted out to another entity such as a lab, pathologist, or other provider. Payment isn't made under the physician fee schedule for technical components services furnished to patients in institutional settings. MedAdvantage claims should continue to be billed consistent with CMS guidelines.

11. Multiple Procedure Payment Policy Rule (MPPR) for Radiology

(Effective for claims with dates of service on and after October 1, 2025)

When designated multiple radiological procedures are performed in the same session, by the same provider or provider group (Tax ID), the reimbursement for the technical component (Modifier TC) of the procedure with the greatest allowable is reimbursed at 100% of the appropriate fee schedule. The reimbursement for the technical component (Modifier TC) of the second and each subsequent imaging procedure is then reimbursed at 50% of the appropriate fee schedule.

When designated multiple radiological procedures are performed in the same session, by the same provider or provider group (Tax ID), the reimbursement for the professional component (Modifier 26) of the procedure with the greatest allowable is reimbursed at 100% of the appropriate fee schedule. The reimbursement for the professional component of the second and each subsequent imaging procedure is then reimbursed at 95% of the appropriate fee schedule.

When designated multiple global radiological procedures are performed in the same session, by the same provider or provider group (Tax ID), as any technical or professional components of a designated procedure, the reimbursement of the global procedure with the greatest allowable will be 100% of the appropriate fee schedule. The reimbursement for the second and subsequent global imaging procedure will be 50% of the appropriate fee schedule.

This reduction will be applied to Magnetic Resonance Imaging (MRI), Computed Tomography (CT), and Ultrasound (US) Radiology services.

In situations where an applicable radiology CPT® code is submitted with more than one unit, the reduction will apply to the second and beyond unit. In situations where two or more radiology CPT® codes are submitted for the same date of service, but only one of the codes is in the applicable reduction code set, then the reduction will not apply.

A reduction will not apply in scenarios:

- where there is more than one separate patient encounter on a given date of service (modifier XE)
- where it is performed on a separate organ/structure (modifier XS)
- where it is performed by a different practitioner (modifier XP)
- where the use of a service is considered distinct because it does not overlap the usual components of the main service (modifier XU)
- where there is a RT/LT modifier appended to a designated imaging procedure

NOTE: When billing radiology codes, and more than one unit is filed for the same procedure/modifier, services should be billed on individual line items. By not complying with the below, claim may experience delay in reimbursement, rejection of charges or a returned claim. **Providers should utilize the appropriate modifiers to indicate repeat procedures, multiple distinct procedures performed on same date of service, etc., to clearly delineate the clinical situation to prevent unnecessary denials**.

This policy applies to services billed on both a professional claim form (CMS-1500) and facility claim form (CMS-1450) or the electronic equivalent. MedAdvantage will continue to follow CMS policy for radiology reduction.

12. BCBST Laboratory Testing Code Reimbursement Policy

This policy applies to reimbursement for BCBST Laboratory Testing Services as indicated below and billed on a professional or institutional claim form for all lines of business.

The list of Laboratory Testing Code Services will be reimbursed according to the provider's contracted reimbursement methodology based on BCBST's reimbursement policy code criteria edits as stated on the BCBST website:

This policy outlines that certain diagnostic laboratory code testing procedures will be reimbursed based on BCBST Laboratory Testing Code Reimbursement policy editing criteria. The allowable for each test is subject to the provider's contracted reimbursement methodology. Please refer to these policies located under the Code Edit section of the BCBST website at BCBST.com.

13. Global Days – Reimbursement Guidelines for Global Periods

The concept of the "Global Period" includes the routine preoperative history and physical including the hospital admission, operative procedure, and all care related to the surgical procedure. The CMS established global periods for certain surgical procedures. These assigned periods can be zero days, 10 days, or 90 days.

Global periods are determined based on the guidelines published by Medicare in the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals. These documents can be found online at www.cms.gov.

If Medicare hasn't assigned a global period for certain procedures, we reserve the right to assign a global period based on a similar service.

14. Preoperative, Intraoperative, and Postoperative – Reimbursement Guidelines for Preoperative Management Only, Surgical Care Only, and Postoperative Management Only Services (Modifiers 54, 55 56)

This policy applies to the following services billed on a professional claim form.

- Preoperative management only services billed with CPT® modifier 56
- Surgical care only services billed with CPT® modifier 54
- Postoperative management only services billed with CPT® modifier 55

Preoperative Management Only Services

When one physician performs the preoperative care and evaluation and another practitioner performs the surgical procedure, the preoperative component should be reported with CPT® modifier 56 appended to the appropriate procedure code.

Surgical Care Only Services

When one physician performs a surgical procedure and another practitioner provides preoperative and/or postoperative management, the surgical services should be reported with CPT® modifier 54 appended to the appropriate procedure code.

Postoperative Management Only Services

When one physician performs the postoperative management and another practitioner performs the surgical procedure, the postoperative component should be reported with CPT® modifier 55 appended to the appropriate procedure code.

Eligible preoperative management only, surgical care only, and postoperative management only services will be reimbursed based on the lesser of total covered charges or a percentage of the base maximum allowable for the procedure code as published by Medicare in the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals. These documents can be found online at www.cms.gov.

Updates resulting from changes to the percentages published by Medicare will be made in accordance with the Policy for Quarterly Reimbursement Changes.

15. Discontinued and Reduced Services/Procedures (Modifiers 52, 53, 73,74)

In surgical or procedural services represented with a CPT code, there are situations where the intended procedure is not fully completed, and these are identified on provider claims with a modifier 52 or 53, and on claims requiring anesthesia, with a modifier 73 or 74.

Specifically, modifier 52 should be attached to codes when the surgeon completed the procedure but did not fulfill all the requirements, and modifier 53 should be used for procedures that are terminated by the surgeon, typically because of the patient's condition. Modifier 52 indicates reduced services, while

modifier 53 indicates a discontinued procedure. If the surgeon discontinued the procedure without completing the treatment as planned, use modifier 53. If the service is complete, use modifier 52.

Modifier 73 should be appended to a procedure claim when the procedure is discontinued before planned anesthesia. Modifier 74 will apply when the procedure is discontinued after planned anesthesia. These modifiers apply only to procedures that require anesthesia. They are used to cancel an operation before or after anesthesia is provided. In scenarios where a laparoscopic or endoscopic procedure is converted to an open procedure or when a procedure is changed or converted to a more extensive procedure, discontinued services modifiers do not apply.

Effective for claims with dates of service on or after January 1, 2026, BCBST will reimburse discontinued or reduced services for providers as follows:

Reduced Services, identified with a modifier 52, at 50% of the appropriate fee schedule.

Discontinued Services, identified with a modifier 53, at 25% of the appropriate fee schedule.

Discontinued Services before planned anesthesia, identified with a modifier 73, at 25% of the appropriate fee schedule.

Discontinued Services after planned anesthesia, identified with a modifier 74, at 50% of the appropriate fee schedule.

This policy applies to services billed on both a professional claim form (CMS-1500) and facility claim form (CMS-1450) or the electronic equivalent.

16. Reimbursement Guidelines for Multiple Procedures Using Modifier 51 (Medicare lines of business will follow CMS guidelines)

This policy applies to multiple procedures billed for the same patient on the same date of service by the same provider on a professional claim form for all commercial business that have multiple surgery indicators of zero, one, two, three, and nine.

The maximum allowable for eligible multiple procedures with indicators of zero, one, two, three, and nine billed for the same patient on the same date of service by the same provider will be based on the multiple procedure indicator published by Medicare in the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals.

Codes published by the Medicare National Physician Relative Value Fee Schedule with a multiple procedure indicator three will be reimbursed based on the guidelines for multiple procedure indicator two.

Updates resulting from changes to the above multiple procedure indicators published by Medicare will be made in accordance with the Policy for Quarterly Reimbursement Changes.

The determination of the primary procedure when multiple procedures are billed for the same patient on the same date of service by the same provider will be based on the procedure with the highest allowed amount according to the appropriate base fee schedule. All base allowables will be evaluated for each line billed. The procedure with the highest dollar amount according to the fee schedule will be considered as the primary procedure.

17. Reimbursement Guidelines for Bilateral Procedures

This policy applies to bilateral procedures billed for the same patient on the same date of service by the same provider on a professional claim form for all commercial business.

The maximum allowable for eligible bilateral procedures billed for the same patient on the same date of service by the same provider will be based on the bilateral procedure indicator published by Medicare in the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals.

In accordance with HIPAA billing standards, bilateral procedures should be submitted as a single line item using the appropriate CPT® code accompanied by modifier 50 to indicate the service was performed on both sides of the body. For most CPT® codes, only one unit should be reported. However, certain procedures performed bilaterally may be submitted with modifier 50 and multiple units when appropriate. The use of modifier 50 and the number of billable units is determined by the bilaterial indicator assigned

to each code, which can be found in the Physician Fee Schedule Relative Value Unit Files. Only a limited set of codes qualify for submission with modifier 50 and more than one unit.

However, in certain situations, modifier 50 shouldn't be added to a procedure code. Some examples include, but aren't limited to:

- A bilateral procedure is performed on different areas of the right and left sides of the body (e.g., reduction of fracture, left and right arm)
- The procedure code description specifically includes the word "bilateral"
- The procedure code description specifically indicates the words "one or both"

Therefore, sometimes it's appropriate to bill a bilateral procedure with:

- A single line with no modifier and one unit
- A single line with modifier 50 and one unit and/or
- Two lines with modifier LT and one unit on one line and modifier RT and one unit on another line

18. Assistant-at-Surgery (Modifiers 80, 81, 82, AS)

(This policy doesn't apply to Medicare Advantage)

We adopted CMS as the primary source for medical appropriateness for assistant-at-surgery services for all lines of business.

CMS denotes whether a procedure is eligible for assistant-at-surgery services by assigning an indicator to each procedure code.

The following guidelines apply:

Assistant-at-Surgery Services Provided by a Physician

Assistant-at-surgery services provided by a physician should be reported by appending the Level I HCPCS – CPT® modifier 80 (Assistant Surgeon), 81 (Minimum Assistant Surgeon) or 82 (Assistant Surgeon when a qualified resident surgeon isn't available) to the procedure code.

The 80, 81 or 82 modifiers shouldn't be used to report assistant-at-surgery services provided by a physician assistant, nurse practitioner, or clinical nurse specialist.

We'll reimburse eligible assistant-at-surgery services provided by a physician based on the lesser of total covered charges or 16% of the maximum allowable fee schedule amount for all networks.

Assistant-at-Surgery Services Provided by a Physician Assistant, Nurse Practitioner or Clinical Nurse Specialist

Assistant-at-surgery services provided by a physician assistant, nurse practitioner, or clinical nurse specialist should be reported by appending the Level II HCPCS modifier AS (physician assistant, nurse practitioner, or clinical nurse specialist services for assistant-at-surgery). Assistant-at-surgery services provided by a nurse practitioner, or clinical nurse specialist is considered ancillary support. Reimbursement for assistant-at-surgery services provided by a nurse practitioner or clinical nurse specialist is included in the reimbursement to the licensed practitioner for services provided in the physician's office or in the reimbursement to the facility for services provided in an inpatient or outpatient setting. The maximum allowable for assistant-at-surgery services provided by a nurse practitioner or clinical nurse specialist will be $0.00. Participating and non-participating providers won't be permitted to bill the member for the difference between the charge and the maximum allowable for the AS modifier as the nurse practitioner or clinical nurse specialist should be compensated directly by the supervising physician or facility.

Eligible assistant-at-surgery services provided by a physician assistant credentialed as an assistant-at-surgery will be based on the lesser of total covered charges or 13.6% (i.e. 85% of 16%) of the maximum allowable fee schedule amount. The maximum allowable for assistant-at-surgery services provided by a physician assistant who isn't credentialed as an assistant-at-surgery will be $0.00.

Note: Physician assistants must bill assistant-at-surgery services using the unique provider number and/or NPI assigned for this purpose**. Assistant-at-surgery charges will only be reimbursed if filed with the appropriate taxonomy code.**

19. Reimbursement Guidelines for Procedures Performed by Two Surgeons (Modifier 62)

We adopted Medicare as the primary source for medical appropriateness for procedures performed by two surgeons for all lines of business. We follow Medicare's guidelines by assigning an indicator to each procedure code to denote whether the procedure is medically appropriate for co-surgery services.

Reimbursement for eligible procedures performed by two surgeons based on the lesser of total covered charges or 62.5% of the base maximum allowable fee schedule amount for the procedure for each surgeon (or a total of 125% of the base maximum allowable fee schedule amount for the procedure for both surgeons) when billed by the provider in accordance with standard coding and billing guidelines.

Each co-surgeon from a different specialty performs a distinct portion of the complete procedure and reports the exact same surgical procedure code with modifier 62. Each surgeon must dictate their own operative report. We use the payment policy indicators on the Medicare Physician Fee Schedule Database (MPFSDB) to determine if co-surgeon services are reasonable and necessary for a specific HCPCS/CPT® code.

20. Reimbursement Guidelines for Screening Test for Visual Acuity

According to CPT®, a screening test of visual acuity must employ graduated visual acuity stimuli that allow a quantitative estimate of visual acuity (e.g., Snellen chart). Other identifiable services unrelated to this screening test provided at the same time may be reported separately (e.g. preventive medicine services). When acuity is measured as part of a general ophthalmological service or of an evaluation and management service of the eye, it's a diagnostic examination and not a screening test.

The American Medical Association created code 99173 (Screening test of visual acuity, quantitative, bilateral) at the request of the American Academy of Ophthalmology in association with the American Academy of Pediatrics to enable pediatricians to bill for performing a visual screening test to ascertain whether future referral for visual care is needed. The code was also developed to electronically track visual screenings for pediatric patients to support proposed Utilization Review Accreditation Commission (URAC) and Healthcare Effectiveness Data and Information Set (HEDIS) efforts.

According to the American Academy of Pediatrics, a screening test of visual acuity is typically provided in conjunction with a preventive medicine service, which includes external inspection of eyes, tests for ocular muscle motility and eye muscle imbalance, and ophthalmoscopic examination.

Since a screening test of visual acuity wouldn't be provided as an independent/standalone service and the service involves minimal labor on part of the health care professional as does the external inspection of eyes, tests for ocular muscle motility and eye muscle imbalance, and ophthalmoscopic examination, reimbursement for code 99173 will be considered bundled with the incidental service such as the preventive medicine service. When billed with a primary service, the screening test for visual acuity code 99173 will be non-covered as not paid in addition to the primary service.

The maximum allowable for visual acuity will be $0.00 even when billed alone.

21. Reimbursement Guidelines for Visual Function Screening

According to CPT®, code 99172 may be used to report visual function screening which includes automated or semi-automated bilateral quantitative determination of visual acuity, ocular alignment, color vision by pseudoisochromatic plates, and field of vision. Code 99172 may also include all or some screening of the determination(s) for contrast sensitivity vision under glare. This service must employ graduated visual acuity stimuli that allow a quantitative determination of visual acuity (e.g., Snellen chart).

Code 99172 is intended for use by practitioners who provide occupational health services, usually involving the specialties of occupational medicine, internal medicine, family practice and emergency practitioners.

Code 99172 was created to facilitate reporting of federally mandated visual function screening services for certain workers in an occupational field where optimal vision is crucial and safety standards for vision exist (e.g. firefighter, heavy equipment controller, nuclear power plant operators). Since a visual function screening wouldn't be provided as an independent/standalone service and the service involves minimal labor on part of the health care professional as does the external inspection of eyes, tests for ocular

muscle motility and eye muscle imbalance, and ophthalmoscopic examination, reimbursement for code 99172 will be considered bundled with the incidental service.

22. Obstetrician-Gynecologist Services

Bill in accordance with CPT® and American College of Obstetricians and Gynecologist (ACOG) coding guidelines in effect for the date of service.

23. Reimbursement Guidelines for Independent Lab Services

Reimbursement for independent lab services billed on a professional claim form will be based on the lesser of total covered charges or at the contracted percentage of the published current Medicare fee schedule for Tennessee, and the provisions, as outlined below.

Services classified by Medicare as clinical lab services will be reimbursed based on the published current clinical lab, non-clinical lab, and pathology maximum allowable fee schedule. Updates for existing codes will be based on the "Quarterly Reimbursement Changes" standard.

Services reimbursed by Medicare based on the RBRVS method such as pathology and non- clinical lab, will be reimbursed based on RVUs and GPCIs for Tennessee as published in the Federal Register-Department of Health and Human Services, Health Care Financing Administration (Final Rules). Updates for existing codes will be based on the "Quarterly Reimbursement Changes" standard. Fees for independent lab services not published by Medicare will be reimbursed based on a reasonable allowable that we've determined. Our methods include, but aren't limited:

- Reimbursement Policies and Procedures
- OPTUM (or it's successors) RBRVS
- Fees for similar procedures in terms of time, skill, supplies, equipment, etc.

Updates to the Independent Lab Maximum Allowable Fee Schedule may result in increases or decreases in fees.

The Independent lab agrees to provide laboratory results to us electronically, in accordance with the HL7 data format standards we've provided to the Lab, which may be updated from time to time. We'll make updated standards available to the lab, either through providing a physical copy of updated standards on our website. We'll use reasonable efforts to provide the lab with no less than a 90 day notice to eliminating a previously acceptable standard.

24. Reimbursement Guidelines for STAT Services

STAT services reported to denote procedures processed as done immediately, as soon as possible, and/or processed with priority.

Reimbursement for STAT services will be considered bundled with the incidental service (e.g., specific lab, pathology codes) regardless of the service location.

The maximum allowable fee schedule amount for STAT services is $0.00 even when billed alone with the exception of when the service is approved through an eligible initiative.

25. Reimbursement Guidelines for Online Evaluation and Management (E&M) and New Technology Services

The American Medical Association (AMA) established CPT® codes to report an online E&M service, per encounter, provided by a physician or qualified non- physician healthcare professional using the internet or similar electronic communications network, in response to an established patient's request.

According to the AMA, an online medical evaluation is a type of E&M service provided by a physician or qualified healthcare professional, to a patient using internet resources in response to the patient's online inquiry. Reportable services involve the physician's personal timely response to the patient's inquiry and must involve permanent storage (electronic or hardcopy) of the encounter. This service shouldn't be reported for patient contacts (e.g., telephone calls) considered to be pre-service or post-service work for other E&M or non-E&M services. A reportable service would encompass the sum of communication (e.g., related telephone calls, prescription provision or lab orders) pertaining to the online patient encounter or problems.

The CMS has also established defined physician's services furnished using communication technology and several inter-professional internet consultation codes and clinical trial service codes that fall within these same guidelines.

The maximum allowable fee schedule amount for online E&M services will be $0.00 even when billed alone with the exception of when the service is approved through an eligible initiative (e.g., telehealth, telemedicine, etc.).

This policy applies to services billed on a professional claim form for all commercial business.

26. Guidelines for Evaluation and Management (E&M) New or Established Patient Determinations

For the purposes of distinguishing between new and established patients, professional services are face-to-face services rendered by a physician and reported by specific CPT® codes.

A new patient is one who hasn't received any professional services (i.e., E&M or other face-to-face services) from the physician, or another physician of the same specialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services (i.e., E&M or other face-to-face services) from the physician or another physician of the same specialty who belongs to the same group practice, within the past three years.

If an edit identifies a new patient E&M code is filed on a patient who has had a new patient E&M code filed by the physician or another physician of the same specialty who belongs to the same group within the past three years, the claim will be returned as a denial to the provider.

Audits will be performed to identify if a new patient E&M code is filed on a patient who has had a new patient E&M code filed by the physician or another physician of the same specialty who belongs to the same group within the past three years. For occurrences identified, we'll replace the new patient E&M code with an established patient E&M code as supported by CPT® to the most appropriate code.

CPT® codes and resources can be obtained from the American Medical Association.

Note: Medicare doesn't allow for reimbursement for consultation service CPT® codes 99242-99245 for office and other outpatient consultations and CPT® codes 99252-99255 for face-to-face medical consultations.

Effective for claims with dates of service on or after October 1, 2025, BCBST will not reimburse services filed with consultation CPT® codes 99242-99245 and 99252-99255, including when reported with telehealth modifiers.

For these services, claims will be denied and professional providers will be asked to bill using the Evaluation and Management (E&M) CPT® code which most appropriately describes the type of consultation service provided (e.g., office visit, hospital care, nursing facility care, or home service setting).

27. Same Day Evaluation & Management (E&M) and Preventive Medicine Exam Payment Policy

BCBST allows separate reimbursement for professional providers submitting claims for routine or problem focused E&M services with a preventive medicine service (CPT® codes 99381-99387 or 99391-99397) during the same patient encounter using a modifier 25 on the E&M service code line of the claim.

Effective for claims with dates of service on or after January 1, 2026, BCBST will reimburse separately for these services as follows:

- Modifier 25 should be appended to the E&M service code
- Appropriate diagnosis codes must be included on the claim for the respective services

If this criteria is met, then the E&M service will be reimbursed at 50% of the appropriate fee schedule. The Preventive Medicine service will be reimbursed at 100%.

This policy applies to services billed on a professional claim form – CMS-1500 or electronic equivalent.

28. Billing Guidelines and Documentation Requirements for CPT® Code 99211

The American Medical Association established the Evaluation and Management (E&M) CPT® code 99211 to report an office or other outpatient visit for the E&M of an established patient that may not require the presence of a physician. Usually, the presenting problems are minimal. Typically, five minutes are spent performing or supervising these services.

According to the American Medical Association, medical record documentation is required to record pertinent facts, findings, and observations about an individual's health history. The medical record facilitates the ability of the physician and other health care professionals to evaluate and plan the patient's immediate treatment and to monitor their health care over time.

There should be documentation in the medical record such as the patient/clinician face-to-face encounter exchanging significant and necessary information. There should also be some type of limited physical assessment or patient review. The encounter must be for a problem stated by the patient and not solely involve the performance of tests or services ordered at prior encounters where E&M services were provided. There should be documentation in the medical record of management of the patient's care via medical decision-making and the medical record should provide evidence that E&M services (consistent with the above) were provided.

Basic guidelines for billing CPT® code 99211:

- The patient must be an established patient
- The patient/clinician encounter must be face-to-face
- Some degree of an evaluation and management service must be provided
- Pertinent documentation in the medical record of the encounter is required and documented
- Patient must state a present problem

This policy applies to services billed on a professional claim form for all lines of business.

29. Genetic Counseling Services Billing Guidelines

All genetic counseling services should be billed on a professional claim form for any place of service (e.g. office, ER, outpatient or inpatient). When submitting ANSI-837 electronic claims, the Professional format must be used.

These guidelines apply to Genetic Counseling Specialty Contracted Providers only for services billed on a professional claim form using the following HCPCS/CPT® codes:

Type of Service	Description	HCPCS/CPT® Code	Procedure Code	Billing Unit
Genetic Counseling	Genetic counseling, under physician supervision, each 15 minutes	S0265	required	1 unit 15 min.
	Medical genetics and genetic counseling services, each 30 minutes of total time provided by the genetic counselor on the date of the encounter	96041	required	1 unit per 30 min.
	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient each 30 minutes	98961	required	1 unit per 30 min.
	Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient each 30 minutes; 2-4 patients	98962	required	1 unit per 30 min.

Type of Service	Description	HCPCS/CPT® Code	Procedure Code	Billing Unit
	Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by non-physician qualified health care professional	99366	required	1 unit per 30 min.

Genetic Counseling services not billed with the indicated HCPCS/CPT® codes will be rejected or denied.

To facilitate claims administration, a separate line item must be billed for each date of service and for each service previously indicated.

Allowable reimbursement will be per fee schedule indicated in the provider's contract. Non-contracted providers claims will be rejected or denied as non-contracted without member liability.

Out-of-Network provider's claims will be rejected or denied as non-contracted with member liability.

Reimbursement changes for Code updates published by AMA/Medicare will be made in accordance with our Quarterly Reimbursement Changes policy.

30. Lactation Services Billing Guidelines

Per Section 2713 of the Affordable Care Act (which is also 42 U.S.C. §300gg-13), we'll cover lactation training, with no cost-sharing requirement, patient preventive care and screening that's included in guidelines covered by HRSA. HRSA includes lactation training and support in its guidelines, which are found online at http://www.hrsa.gov/womensguidelines/.

Type of Service	Description	HCPCS/CPT® Code	Procedure Code	Billing Unit
Lactation Visits	Lactation classes, non-physician provider, per session	S9443	required	Per session
	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 15 minutes	99401	required	1 unit per 15 min.
	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 30 minutes	99402	required	1 unit per 30 min.
	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 45 minutes	99403	required	1 unit per 45 min.
	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure); approximately 60 minutes	99404	required	1 unit per 60 min.

Who Can Provide Lactation Services?

- Physicians, nurse practitioners, physician assistants or certified nurse midwives for whom lactation counseling, education or consultation is within their scope of practice
- International Board Certified Lactation Consultants/Registered Lactation Counselors (IBCLCs/RLCs)
- Certified Lactation Specialists (CLSs), Certified Breastfeeding Specialists (CBSs), Certified Lactation Counselors (CLCs) and Certified Lactation Educators (CLEs)
  - Services provided by a CLS, CBS, CLC, and CLE must be supervised and billed by a contracted, in-network provider
- CLSs, CBSs, CLCs, and CLEs can provide direct services under the supervision of:

- Physicians (MDs/Dos)
- Physician Assistants (PAs)
- Nurse Practitioners (NPs)
- Certified Nurse Midwives (CNMs)
- International Board Certified Lactation Consultants (IBCLCs) with medical licensure

NOTE: Billing for services occurs under the supervising provider General counseling and education can be provided by a CLS/CBS/CLC/CLE, with referrals to an IBCLC or medical provider, as appropriate, for situations requiring a higher level of care.

31. Chiropractor Billing and Reimbursement Guidelines (Doesn't apply to MedAdvantage, the Federal Employee Program (FEP), or Postal Service Health Benefits (PSHB)).

As of Oct. 1, 2016, the following chiropractor guidelines apply:

- Note: Applicable office E&M (excluding preventive medicine), manipulative, modality/therapeutic or radiology CPT® codes as indicated in table below must be billed in order to trigger payment. Reimbursement hierarchy order will be as follows:
  i. Manipulative
  ii. Modality/therapeutic
  iii. Evaluation & management
  iv. Radiology
- The billing policy stipulates services must be rendered within the chiropractic scope of practice.
- Please refer to provider agreement for reimbursement amounts.
- Lesser of guidelines don't apply.
- Current member benefit limits apply, (for example, 20 visits max per year).
- For proper adjudication and to help ensure no delay in processing, please file one visit per claim.
- For certain employer groups who cover acupuncture services, we'll reimburse $37.88 per service.
- All services rendered during a chiropractic episode of care must be submitted by the participating chiropractor on the same claim. Split billing of services for the same date of service or episode of care will be subject to review and potential recoupment.

The following CPT® codes apply:

70120	72050	72202	73501	73660	97028	97537	99213
70140	72052	72220	73502	76120	97032	97542	99214
70220	72070	73000	73521	76125	97036	97750	99215
70250	72072	73020	73551	76140	97037	97799	99241
70260	72074	73030	73552	76499	97039	98940	99242
71045	72080	73050	73560	77071	97110	98941	99243
71046	72081	73060	73562	77072	97112	98942	99244
71100	72082	73070	73564	97010	97113	98943	99245
71101	72100	73080	73565	97012	97116	99201 deleted 1/1/21	
71110	72110	73090	73590	97014	97124	99202	
71111	72114	73100	73600	97016	97139	99203	
71120	72120	73110	73610	97018	97140	99204	
71130	72170	73120	73620	97022	97150	99205	
72020	72190	73130	73630	97024	97530	99211	
72040	72200	73140	73650	97026	97535	99212	

Note: As of Oct. 1, 2018, chiropractors will be reimbursed for these certain acupuncture service codes in addition to the chiropractor service reimbursement previously mentioned:

- Billable codes are 97810, 97811, 97813 or 97814
- $60.00 reimbursement will be allowed only on the two primary codes (97810 or 97813) per date of service.
- Line level lesser of guidelines will apply.
- The acupuncture service reimbursement will be paid in addition to any eligible chiropractor services as indicated in the guidelines above.
- Member benefits still apply for those employer groups that have limits or may not allow reimbursement for acupuncture services.

32. Acupuncture Billing and Reimbursement Guidelines (Doesn't apply to MedAdvantage

Note: As of June 1, 2020, acupuncturists will be reimbursed for these certain acupuncture service codes:

- Billable codes are 97810, 97811, 97813, or 97814.
- $60.00 reimbursement will be allowed only on the two primary codes (97810 or 97813) per date of service.
- Line level lesser of guidelines will apply.
- Member benefits still apply for those employer groups that have limits or may not allow reimbursement for acupuncture services.

33. Injections and Immunizations

a. Reimbursement Guidelines for Vaccines and Toxoids

We'll reimburse providers for eligible vaccines and toxoids based on a percentage of Average Wholesale Price (AWP), or Wholesale Acquisition Cost (WAC), if there's no published AWP, using one of the following methods:

Method 1

The AWP/WAC based on the National Drug Code (NDC) for the specific product billed.

Method 2

1. For a single-source product, the AWP/WAC equals the AWP/WAC of the single product.
2. For a multi-source product, the AWP/WAC is equal to the lesser of the median AWP/WAC of all the generic forms of the product or the lowest brand name product AWP/WAC.

We reserve the right to select the method used to calculate AWP/WAC and the source for AWP/WAC for vaccines and toxoids.

We reserve the right to request the name of the product, NDC, specific dosage administered and number of units (based on packaging) to determine eligibility and reimbursement for a vaccine or toxoid for items billed with a miscellaneous, unlisted, or not otherwise classified CPT® or HCPCS code.

Reimbursement for the administration of vaccines and toxoids will be made when appropriately billed and submitted on the same claim form with the product administered.

b. Reimbursement and Billing Guidelines for Infusion Therapy, Immunosuppressive, Immune Globulin, Nebulizer, Chemotherapy and Other Injectable Drugs

Reimbursement Guidelines

The maximum allowable for eligible infusion therapy, immunosuppressive agents, immune globulins, nebulizer agents, chemotherapy and other injectable drugs for professional and home infusion therapy providers is based on a percentage of Average Sale Price (ASP) or Wholesale Acquisition Cost (WAC)/Average Wholesale Price (AWP) if there's no published ASP, using one of the below listed sources.

We'll update maximum allowables for infusion therapy, immunosuppressive agents, immune globulins, nebulizer agents, chemotherapy and other injectable drugs in accordance with the Policy for Quarterly Reimbursement Changes.

Source A

ASP as defined and published by the Centers for Medicare & Medicaid Services (CMS).

Source B

The WAC/AWP based on the NDC for the specific drug billed.

Maximum allowables for infusion therapy, immunosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs not published by Medicare Part B - Tennessee will be calculated based on a percentage of WAC/AWP according to one of the following methods:

Method 1

The WAC/AWP based on the National Drug Code (NDC) for the specific drug billed.

Method 2

For a single-source drug, the WAC/AWP equals the WAC/AWP of the single product.

For a multi-source drug, the WAC/AWP is equal to the lesser of the median WAC/AWP of all the generic forms of the drug or the lowest brand name product WAC/AWP.

We reserve the right to select the calculation method and published source for WAC/AWP for infusion therapy, immunosuppressive agents, immune globulins, nebulizer agents, chemotherapy and other injectable drugs without published ASP CMS.

To determine eligibility and reimbursement for an injectable drug, we reserve the right to request the name of the drug, NDC, specific dosage administered and number of units, based on the specific code description. For items billed with an unlisted, miscellaneous, not otherwise classified HCPCS code, specific dosage administered should be reported in the appropriate form and number of units.

Refer to the provider contract agreements for network percentages and specific sources for facilities, professional providers, and home infusion therapy providers.

Billing Guidelines

General

- When billing specific codes for drugs, the number of units billed should be based on the code description rather than the manufacturer's packaging.
- Medications billed with unlisted, miscellaneous, non-specific and Not Otherwise Classified (NOC) codes should be billed with a unit of one and require submission of drug name, NDC, and dosage administered in appropriate form as ordered by practitioner. Failure to submit this information may result in a delay in reimbursement.
- Place of service should indicate where the medication is administered or instilled into external/implanted pump as defined by CMS rather than where it's dispensed.
- Separate line items shouldn't be billed for the HCPCS when the same therapeutic agent is administered on the same date of service. If different packages of the same therapeutic agent, with different NDCs, must be utilized to obtain the order dosage. block 19 – Reserved For Local Use, section of the CMS-1500 or its equivalent should be utilized to report additional NDCs required.
- Saline and heparin, utilized for flushing and maintenance of infusion devices, are considered supplies included in professional services and home infusion therapy (HIT) per diems. These supplies aren't eligible for separate reimbursement.
- Basic pre-packaged intravenous (IV) fluids utilized for IV hydration administered in the practitioner's office and fluids (e.g., partial-fills, 50 /100 / 250 ml bottles/bags) utilized to mix or facilitate administration (elastomeric devices) of therapeutic agents in all places of service are considered supplies and aren't eligible for separate reimbursement.
- All supplies dispensed for home use by the practitioner's office should be billed with the most appropriate HCPCS supply codes (i.e., dressings, elastomeric devices, flushes) and the appropriate POS code to indicate the location of utilization.

Compounds

- Only off-the-shelf medications packaged as manufactured from a pharmaceutical company should be coded utilizing specific HCPCS Level II codes except of some inhalation mixtures having assigned specific codes.

- Refer to Compound Drugs in this manual section for guidelines on medications compounded from bulk powder or altered from the manufacturers' packaging.

Medication Wastage

Modifier JW should be reported for drug units that were *discarded*. Providers are responsible for using the most economical packing of medication to achieve the required dosage with the least amount of medication wastage necessary or per manufacturer's directions. Wastage shouldn't be billed for medications available in multi-dose vials (MDV) and isn't reimbursable.

Effective July 1, 2023, CMS requires the JZ modifier on all claims for single-dose containers where there are no discarded amounts. Billing guidelines with examples are provided in these sources:

Sources:

CR 9603-JW Modifier: Drug amount discarded/not administered to any patient

Internet Only Manual (IOM) 100-4-Claims Processing Manual; Chapter 17-Drugs and Biologicals; Sections 40-40.1

Discarded Drugs and Biologicals - JW Modifier and JZ Modifier Policy Frequently Asked Questions (cms.gov)

- To report claims with drug waste, submit two separate claim lines. One line should contain the HCPCS for the administered drug with no modifier, number of units and price calculated for the administered units only. A second line should report the HCPCS for the administered drug, with modifier JW to indicate amount wasted, number of units wasted, and the price calculated for the wasted units only. The total units for the two lines should not exceed the units contained in the most economical single dose vial.
- To report claims that have no waste, only one claim line should be submitted. This line should contain the HCPCS code for the drug administered, with modifier JZ to indicate there was no waste, the appropriate units of the drug administered and the price for the administered units.

c. Preventive Vaccines Administered by a Pharmacist

Claim Form

Preventive vaccines administered by a Licensed Pharmacist and covered under the member's medical plan must be billed on a professional claim form. Only those vaccines administered by the Pharmacist should be billed. Vaccines administered in the pharmacy quick-care clinic or by a subcontracted health care provider (i.e., flu clinics) shouldn't be billed under these provisions.

Block 24b - Place of Service

The POS should represent where the service is provided.

Block 24a - From and To Date(s) of Service

Enter the month, day and year for each vaccine and administration service provided.

Block 24d - Codes and Modifiers

Vaccines must be billed using the most appropriate CPT®/HCPCS code in effect for the date of service.

Block 24g – Days or Units

To report units for medications, the units must be billed in accordance with the CPT®/HCPCS definition in effect for the date of service and the practitioner's order.

General Billing Guidelines

We reserve the right to request the name of the vaccine drug, NDC, dosage per the practitioner's order and quantity.

Updates to the maximum allowable for existing codes will be made in accordance with the Reimbursement Policy for Immune Globulins, Vaccines and Toxoids.

- Due to frequent changes in AWP, we reserve the right to update the maximum allowable amount without prior notification.
- Updates to the maximum allowable may result in increases and decreases in fees.

d. Specialty Pharmacy Medications

Refer to Section XVII. Pharmacy in this manual for self-administered specialty pharmacy medications covered under the member's medical benefits plan and additional information for specialty pharmacy program.

Claim Form

Specialty pharmacy medications covered under the member's medical plan must be billed on a professional claim form. Self-administered specialty pharmacy medications must be billed through the member's pharmacy benefits manager.

Block 24b - Place of Service

The POS should represent where the service is provided.

Block 24a - From and To Date(s) of Service

Enter the month, day and year for each medication provided.

Block 24d - Codes and Modifiers

Medications must be billed using the most appropriate HCPCS code in effect for the date of service.

In the event there isn't a specific HCPCS code for the medication, the most appropriate unlisted code (e.g., J3490, J7599, J9999) in effect for the date of service may be used.

Unlisted, miscellaneous, non-specific and NOC codes should only be used when a more specific CPT® or HCPCS code isn't available or appropriate.

Medications billed with unlisted, miscellaneous, non-specific and NOC codes must be billed with the name of the drug, NDC, dosage per the practitioner's order and quantity.

Block 24g – Days or Units

To report units for medications, the units must be billed in accordance with the HCPCS definition in effect for the date of service and the practitioner's order.

Medications billed with unlisted, miscellaneous, non-specific and NOC codes should be billed with a unit of one and require submission of drug name, NDC, and dosage administered in appropriate form as ordered by practitioner.

General Billing Guidelines

We reserve the right to request the name of the drug, NDC, dosage per the practitioner's order and quantity.

Updates to the maximum allowables for existing codes will be made in accordance with the Reimbursement Policy for Infusion Therapy, Immunosuppressive, Nebulizer, Chemotherapy and Other Injectable Drugs.

Due to frequent changes in ASP/WAC/AWP, we reserve the right to update the maximum allowable amount without prior notification.

Updates to the maximum allowables may result in increases and decreases in fees.

Reimbursement for medications is limited to the amount prescribed and administered to the member.

Providers are responsible for using the most economical packaging of medication to achieve the required dosage for the member with the least amount of medication wastage.

Refer to Section XVII. Pharmacy in this manual for self-administered specialty pharmacy medications covered under the member's medical benefits plan.

e. Compound Drugs

Eligible compound drugs must be billed with the most appropriate HCPCS Level II code for compound drugs and contain at least one legend drug with a valid NDC and billed on a professional claim form.

Our maximum allowable is $0.00:

- Non-legend drugs
- Compounding and/or dispensing fees (may be considered for some lines of business – see related Compound Services Policy)
- Dilutants, solvents or other ingredients utilized to mix, combine, or alter legend drug components)

The maximum allowable for compound drugs is determined from individual claim review and may vary by claim based on supplemental information provided with the claim or related claims. Supplemental information includes, but isn't limited to:

- The name(s) of the drug component(s), NDC of legend drug component(s), and specific dosage of legend component(s) administered, instilled, inserted, or implanted.
- The maximum allowable for eligible compound drugs for professional providers is based on a percentage of Wholesale Acquisition Cost (WAC) or Average Wholesale Price (AWP) according to one of the following methods:

Method 1

The WAC/AWP based on the NDC for the specific drug billed.

Method 2

For a single-source drug, the WAC/AWP equals the WAC/AWP of the single product.

For a multi-source drug, the WAC/AWP is equal to the lesser of the median WAC/AWP of all the generic forms of the drug or the lowest brand name product WAC/AWP.

We reserve the right to select the calculation method and published source for WAC/AWP.

f. Compounding Services

Eligible compounding services must be billed with the most appropriate HCPCS Level II code for consideration of reimbursement to providers when eligible compound drugs are administered under the "incident to" provision and/or considered as eligible medical benefits. These services must be billed on a professional claim form for Commercial and Medicare Advantage lines of business.

A reasonable compounding allowance will be reimbursed, if applicable, for each date of service compound drugs are administered, instilled, inserted, or implanted. To be considered for reimbursement, a separate line item must be included for these compounding services. This service must be billed with the appropriate HCPCS code for pharmacy compounding and dispensing services.

Effective Dec. 1, 2019:

For intravitreal injections billed with appropriate code (J9035) and modifier, the units will be limited to two per date of service, (one unit per eye). The claim must show the eye(s) treated and filed with the appropriate modifier and the correct code for the medication injected. A separate line item shouldn't be submitted for compounding services. Compounding services for intravitreal injections are included in the allowance given for the compounded agent billed with appropriate code (J9035) and modifier.

g. Reimbursement and Billing Guidelines for Radiopharmaceuticals and Contrast Materials

This policy applies to all eligible drugs filed on a professional claim form for all lines of business.

The maximum allowable for eligible radiopharmaceuticals and contrast materials is based on the lesser of total covered charges or a percentage of Average Sale Price (ASP) or Wholesale Acquisition Cost (WAC)/Average Wholesale Price (AWP) if there's no published ASP, using one of the following sources:

Source A

ASP as defined and published by the CMS on the Medicare Part B Drugs Average Sale Price file.

Updates to maximum allowable amounts for radiopharmaceuticals and contrast materials published by CMS will be made in accordance with the Quarterly Reimbursement Changes policy.

Source B

The published WAC/AWP based on the NDC for the specific radiopharmaceutical or contrast material billed.

Maximum allowable amounts for radiopharmaceuticals and contrast materials not published by CMS will be calculated based on the lesser of total covered charges or a percentage of WAC/AWP according to one of the following methods:

Method 1

The WAC/AWP based on the NDC for the specific radiopharmaceutical or contrast material billed.

Method 2

For a single-source radiopharmaceutical or contrast material, the WAC/AWP equals the WAC/AWP of the single product.

For a multi-source radiopharmaceutical or contrast material, the WAC/AWP is equal to the lesser of the median WAC/AWP of all the generic forms of the radiopharmaceutical or contrast material or the lowest brand name product WAC/AWP.

We reserve the right to select the calculation method and published source of WAC/AWP for radiopharmaceuticals and contrast materials without an ASP published by CMS.

For codes where it isn't feasible to establish a maximum allowable for a radiopharmaceutical or contrast material (e.g., when the radiopharmaceutical or contrast material doesn't have an NDC, when the dosage depends on the weight of the patient), the maximum allowable will be based on a reasonable allowable that we've determined.

To determine a reasonable allowable, we reserve the right to request the manufacturer/supplier's invoice. When an invoice is requested, the name of the patient, specific radiopharmaceutical or contrast material, dosage and number of units must be provided. If multiple patients are listed on the invoice, the radiopharmaceutical or contrast material, dosage and number of units for the patient being billed should be clearly indicated.

Radiopharmaceuticals and contrast materials provided in a facility setting aren't billable or reimbursable on a professional claim form. Radiopharmaceuticals and contrast materials provided in a facility setting are considered facility services and must be billed by the facility:

- Reimbursement for medications is limited to the amount prescribed and administered to the member.
- If the radiopharmaceuticals and contrast materials are used in conjunction with a radiological procedure/service that's determined to be ineligible, the radiopharmaceutical and contrast material won't be reimbursed.
- Providers are responsible for using the most economical packaging of medication to achieve the required dosage for the member with the least amount of medication waste.

To be considered for reimbursement, radiopharmaceuticals and contrast materials must be billed on the same claim as the related radiological procedure/service.

Refer to Section XVII. Pharmacy in this manual for self-administered specialty pharmacy medications covered under the member's medical benefits plan.

h. Reimbursement Guidelines for Non-Injectable Medications When the Service Location is the Practitioner's Office

Reimbursement for prescription medications other than injectables, when the service location is the practitioner's office, won't be allowed. Exceptions to this policy include, but aren't limited to nebulized inhalation drugs and other prescription drugs addressed under Reimbursement Policy for Immune Globulins, Infusion Therapy, Immunosuppressive, Nebulizer, Chemotherapy and Other Injectable Drugs.

The maximum allowable fee schedule amount for non-injectable medications, when the service location is the practitioner's office, is $0.00 unless otherwise specified in the member's medical benefit plan. This policy applies to services billed on a professional claim form.

i. Reimbursement Guidelines for Self-Administered Prescription Medications Dispensed and Submitted by a Licensed Pharmacist

BCBST does not reimburse these medications separately whether administered in the facility, office or dispensed for home use. Charges billed to BCBST for self-administered medications will be denied indicating that the charges must be billed to the Pharmacy Benefit Manager.

Self-administered prescription drugs submitted by a licensed pharmacist on a professional or institutional claim form will be priced at $0.00 by BCBST as a medical benefit unless otherwise specified by the member's medical benefit plan.

j. Reimbursement Guidelines for Any Prescription Medications Dispensed by a provider Other Than a Licensed Pharmacist When the Service Location isn't the Practitioner's Office

Reimbursement for any prescription medication dispensed by a provider, other than a licensed pharmacist when the medication isn't administered in the practitioner's office isn't allowed. This ensures that only professionals who are properly trained will administer services at the contracted rates stipulated in the member's prescription drug benefit plan.

The maximum allowable fee schedule amount for prescription medications dispensed by a provider, other than a licensed pharmacist when the medication isn't administered in the practitioner's office, is $0.00.

This policy applies to prescription medications dispensed by a provider other than a licensed pharmacist for service locations other than 11 when the service location isn't 11 when billed and submitted on a professional claim form for all lines of business.

k. Reimbursement Guidelines for Medications Not Requiring a Prescription from a Licensed Pharmacist Regardless of the Service Location

Reimbursement for medications that don't require a prescription from a licensed physician, regardless of the service location, won't be covered.

The maximum allowable for medications that don't require a prescription from a licensed physician as will be $0.00.

This policy applies to medications that don't require a prescription from a licensed physician (e.g., over the counter drugs) regardless of the service location billed on a professional or institutional claim form for all lines of business.

l. Reimbursement Policy and Billing Guidelines for Professional Providers on the Tiered Drug Fee Schedule

BCBST shall reimburse professional providers contracted with the Tiered Drug Fee Schedule for eligible drug codes based on a percentage of the Average Sale Price (ASP), or in the absence of a published ASP, Wholesale Acquisition Cost (WAC). In the absence of both ASP and WAC, Average Wholesale Price (AWP) shall be used. The table below indicates the Base Drug Fee Schedule pricing for each of the above methodologies.

Professional Tiered Base Drug Fee Schedule

Pricing Methodology	Percentage
Average Sale Price (ASP)	100%
Wholesale Acquisition Cost (WAC)	94%
Average Wholesale Price (AWP)	84%

Tier 1 – Traditional

Tier 2 – Biosimilars

Tier 3 – Specialty Drugs

Tier 4 – Ultra High Cost

Not Otherwise Classified (NOC) and Unlisted/Miscellaneous/Non-Specific HCPCS Codes will be reviewed for manual pricing according to BCBST's policy for Unlisted, Miscellaneous, Non-specific, and Not Otherwise Classified Procedures/Services until a CMS fee has been established. These fees will be updated in accordance with BCBST's Policy "Quarterly Reimbursement Changes."

New codes will default to Tier 4 until the April 1 update at which time they will be placed in the appropriate Tier.

The maximum allowable for eligible drugs for professional providers is based on a percentage of Average Sale Price (ASP) or Wholesale Acquisition Cost (WAC)/Average Wholesale Price (AWP) if there's no published ASP, using one of the below listed sources.

Source A

ASP as defined and published by the Centers for Medicare & Medicaid Services (CMS).

Source B

The WAC/AWP based on the NDC for the specific drug billed.

Maximum allowables for drugs not published by Medicare Part B - Tennessee will be calculated based on a percentage of WAC/AWP according to one of the following methods:

Method 1

The WAC/AWP based on the National Drug Code (NDC) for the specific drug billed.

Method 2

For a single-source drug, the WAC/AWP equals the WAC/AWP of the single product.

For a multi-source drug, the WAC/AWP is equal to the lesser of the median WAC/AWP of all the generic forms of the drug or the lowest brand name product WAC/AWP.

We reserve the right to select the calculation method and published source for WAC/AWP for drugs without published ASP CMS.

To determine eligibility and reimbursement for a drug, we reserve the right to request the name of the drug, NDC, specific dosage administered and number of units, based on the specific code description. For items billed with an unlisted, miscellaneous, not otherwise classified HCPCS code, specific dosage administered should be reported in the appropriate form and number of units.

In the circumstance that an inappropriate payment has occurred, BCBST reserves the right to re-coup the reimbursement as necessary.

34. Home Infusion Therapy (HIT)

Home Infusion Therapy (HIT) is the continuous slow introduction of therapeutic agents such as analgesics, chemotherapy, prostaglandins, tocolytics, hydration solutions, antibiotics or, parenteral nutrition into the body on an intermittent basis. HIT is used to achieve practitioner-defined beneficial outcomes for the condition being treated in the member's residence.

- Therapeutic agents instilled into an implanted or ambulatory pump as defined by CMS in the practitioner's office aren't considered HIT.
- Medications delivered to the practitioner's office for infusion/instillation in the office setting aren't billable or reimbursable as HIT.
- Infusion therapy provided in a location other than a member's place of residence isn't billable or reimbursable as HIT.
- Field-based nursing services for drug infusions, peripherally inserted central catheters (PICCs), midline insertion or accessing implanted pumps are considered home health agency/private duty nursing services and aren't billable by the HIT provider.

Per diem is a payment for each day maintenance is performed or a therapeutic agent is infused or instilled into the body, in the member's private place of residence, as prescribed by the practitioner.

- A single per diem is reimbursable on the day therapeutic agent(s) are instilled into an implanted infusion device in the member's residence.

Maintenance is care of lumen infusion catheters or implanted access devices, including dressing changes and flushes necessary to maintain patency between ordered episodes of care with therapeutic agents. This includes monthly flushes of implanted access devices when no active HIT therapy is in progress, IV access flushes and dressing changes during the week(s) between chemotherapy episodes or "rounds" of antibiotic therapy while awaiting lab results and new orders.

- Maintenance per diem is only billable as a separate charge when the maintenance service is the only service provided on that date of service (DOS) and catheter care is administered.
- Maintenance services provided on the same DOS as HIT with therapeutic agents are included in the per diem for that infusion therapy and aren't separately billable.

Multiple infusion therapies are more than one class of service (i.e., pain management, chemotherapy, epoprostenol, tocolytic, hydration, total parenteral nutrition (TPN), anti-infective and miscellaneous) provided concurrently on the same date of service.

Adjunctive medications are additional therapeutic agents, administered parenterally, that are included in a synchronous practitioner ordered HIT regimen (e.g., intravenous pyelogram anti-emetic administered as needed for nausea related to chemotherapy or intravenous H2-receptor antagonist administered synchronously with TPN.)

Flushes for catheter maintenance aren't considered adjunctive therapeutic agents and aren't separately billable or reimbursable. These supplies (e.g., heparin, sterile saline, sterile water, ethanol lock solution, etc.) are included in the per diem reimbursement. (See Per Diems section below.)

Fluids utilized as diluents or vehicles for administration of other therapeutic agents aren't considered adjunctive therapeutic agents and aren't separately billable or reimbursable. These supplies are included in the per diem reimbursement. (See Per Diems section below.)

Intravenous push (IVP) is an injection/infusion of a therapeutic agent requiring the continuous presence of the health care professional during administration into a vein or an intravenous injection infusion of a therapeutic agent over 15 minutes or less.

- Therapeutic medication(s) administered by IVP, dispensed as adjunctive to HIT, may be billed with the appropriate HCPCS code for that ordered medication, but a separate per diem isn't billable or reimbursable.
- Length of infusion is determined based on administration recommendations from recognized sources (e.g. drug handbooks and drug package inserts).
- IVP medication(s) dispensed as the sole agent(s), not included in a concurrent practitioner ordered HIT regimen, for a specific DOS or span date aren't billable or reimbursable as part of HIT.

Other parenteral medications are therapeutic agents administered by intramuscular injection or subcutaneous injection.

- Other therapeutic parenteral medication(s), dispensed as adjunctive to HIT and not self-administered, may be billed with the appropriate HCPCS code, but a separate per diem isn't billable or reimbursable.
- Other parenteral medication(s) dispensed as the sole agent(s), not included in a concurrent practitioner-ordered HIT regimen, for a specific DOS or span date aren't billable or reimbursable as part of HIT.

Self-administered medications are oral, Topical, or self-administered injectable medications, including those indicated as Self-Administered Specialty Pharmacy Products. (Refer to the Specialty Pharmacy Program in Section XVII. of this manual.)

- These are considered a pharmacy benefit and aren't billable or reimbursable as HIT.

Claim Form

HIT must be billed on a professional claim form as follows:

Block 19 – Reserved for Local Use

Utilize this section for additional information. (See Additional Information section below).

- Additional NDC information when various packaged products must be used to obtain the most economical packaging and to achieve the practitioner-ordered dosage for the member.
- Practitioner's order for therapeutic agent(s) including dosage, route, frequency and duration of therapy.

Block 24a – From and To Date(s) of Service

Enter the month, day and year for each per diem and therapeutic agent:

- Therapeutic agents billed with a specifically assigned HCPCS code, with a description that includes a set amount per unit of the code, may be billed with "span dates" if additional information is submitted to indicate the practitioner order for the daily dosage amount. (See example in Additional Information section below.)
- Therapeutic agents billed with unlisted, miscellaneous, non-specific, or NOC codes must be billed on a separate line item for each DOS (no span dates) along with additional information including NDC, daily dosage, and drug name. Submitting NOC codes with span dates may result in errors and/or delayed reimbursement. (See example in Additional Information section below.)
- Per diem codes must be billed on a separate line item for each DOS (no span dates). Submitting per diem codes with span dates may result in errors and/or delays in reimbursement.
- All per diem and related therapeutic agent codes for the same DOS or span date must be billed on the same claim submission. Splitting these services into multiple claims may result in errors and/or delays in reimbursement. (See specific guidelines in Therapeutic agents, Per Diems and Modifiers for Multiple Therapies sections below.)

Block 24b – Place of Service

The place of service (POS) should indicate where the therapeutic agent is administered. /instilled rather than where it is dispensed. If the administration is rendered using an implanted or refillable infusion pump (as defined by CMS) the POS is where the refill was performed.

Block 24d – Codes, Modifiers and Additional Information (shaded area)

- Additional information should be submitted in the following format:
  NDC preceded by the N4 qualifier, dosage administered per day preceded by appropriate "basis of measurement qualifier" (i.e., GM, ME, ML, etc., as ordered by practitioner) and name of drug preceded by narrative description modifier, ZZ. (See examples in Additional Information section below.)
- All per diem and related therapeutic agent codes for the same DOS or span date must be billed on the same claim submission. Splitting these services into multiple claims may result in errors and/or delays in reimbursement. (See specific guidelines in Therapeutic agents, Per Diems and Modifiers for Multiple Therapies sections below.)
- More than one medication may be associated with a single per diem (e.g., adjunctive therapeutic agents administered as part of the primary therapy ordered by the physician). Therapeutic agents billed without an associated per diem are considered a pharmacy benefit and should be billed to the member's Pharmacy Benefits Manager (PBM).

Block 24g – Days or Units

Enter the number of units for each per diem and therapeutic agent using:

- Units for therapeutic agents, billed with specific HCPCS codes containing a defined unit amount. Must be reported in accordance with the code definition in effect for the DOS and the practitioner's orders.
- Units for therapeutic agents, billed with NOC codes or codes without a defined unit amount. Must be reported with a unit of one per line item/DOS. Reporting multiple units may result in errors and/or delayed reimbursement.
- Units for per diem codes must be reported with a unit of (1) per line item / DOS.

Additional Information

- Additional NDC information related to various packaged products assigned to the same CPT® or HCPCS code should be indicated in block 19 (Reserved for Local Use), its electronic equivalent, or submitted as an attachment.

Example for various packaged products assigned the same CPT® or HCPCS code:

Practitioner order of Octagam 500 mg/kg IV in divided doses over two days at 0.5 mg/kg/min q3wks.

19. RESERVED FOR LOCAL USE N468209084301 Octagam 500 mg/kg IV divided Wt. 150 lbs.

N468209084304 GM17 ZZOctagam														
12	01	XX	12	02	XX	12		J1568			A	XXXX	xx	68
12	01	XX	12	01	XX	12		S9379			A	XX	xx	1
12	02	XX	12	02	XX	12		S9379			A	XX	xx	1

The practitioner's order for therapeutic agent(s) including dosage, route, frequency and duration should be indicated in block 19, its electronic equivalent, or submitted as an attachment.

Example for specific HCPCS code billed with span dates:
Practitioner order of Rocephin 1 Gm IV q12h x 5 days is started at 8 p.m. on Dec. 1, 20XX.

19. RESERVED FOR LOCAL USE Rocephin 1 Gm IV q12h x5d

N4xxxxxxxxxx GM2 ZZRocephin														
12	01	XX	12	06	XX	12		J0696			A	XXX	xx	40
12	01	XX	12	01	XX	12		S9501			A	XX	xx	1
12	02	XX	12	02	XX	12		S9501			A	XX	xx	1
12	03	XX	12	03	XX	12		S9501			A	XX	xx	1
12	04	XX	12	04	XX	12		S9501			A	XX	xx	1
12	05	XX	12	05	XX	12		S9501			A	XX	xx	1
12	06	XX	12	06	XX	12		S9501			A	XX	xx	1

Example for NOC code:

Practitioner order of Abcxyz 400 mg IV q8h x 3 days is started at 4:00 p.m. on Dec. 1, 20XX.

19. RESERVED FOR LOCAL USE Abcxyz 400 mg IV q8h x3d														
N4xxxxxxxxxx ME400 ZZAbcxyz														
12	01	XX	12	01	XX	12		J3490			A	XXX	xx	1
N4xxxxxxxxxx GM1.2 ZZAbcxyz														
12	02	XX	12	02	XX	12		J3490			A	XXX	xx	1
N4xxxxxxxxxx GM1.2 ZZAbcxyz														
12	03	XX	12	03	XX	12		J3490			A	XXX	xx	1
N4xxxxxxxxxx ME800 ZZAbcxyz														
12	04	XX	12	04	XX	12		J3490			A	XXX	xx	1

Per diem (S9502) should be submitted as indicated in examples above for each of the DOS the therapeutic agent is administered.

Therapeutic agents

- Each therapeutic agent must be billed using the most specific CPT®/HCPCS code in effect for the DOS and the NDC. If these codes are billed with span dates, additional information indicating the practitioner-ordered daily dosage amount must be submitted. (See Additional Information section.)
- In the event there's not a specific CPT®/HCPCS code for a therapeutic agent ordered, the most appropriate unlisted code (e.g. J3490, J3590, J9999) in effect for the DOS may be used.
- Unlisted, miscellaneous, non-specific, and NOC codes should only be used when a more specific CPT®/HCPCS code isn't available or appropriate. Submitting an NOC code when a more specific code is appropriate may result in errors and/or delay in reimbursement.
- Therapeutic agents billed with an unlisted miscellaneous, non-specific, and NOC code must be accompanied by additional information as noted in the "Additional Information" section above. Failure to submit this information may result in reimbursement errors and/or delay of reimbursement.
- Reimbursement for therapeutic agents is limited to the amount prescribed and administered to the member.
- The HIT provider is responsible for using the most economical packaging of therapeutic agents to achieve the required dosage for the member with the least amount of waste.
- We reserve the right to request a copy of the original practitioner orders for HIT, if determined necessary for clarification.

Per Diems

Maintenance or home infusion therapy per diems must be billed using the most appropriate maintenance or "class of service" HCPCS code from one of the following tables:

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MAINTENANCE

Maintenance per diems may only be billed, as a “stand alone service,” on days when catheter care is administered and these maintenance services aren’t part of the per diem of another class of service code.

Maintenance per diems aren’t billable or reimbursable as secondary, tertiary or concurrent therapy.

Code	Type of Service	Description
S5498	Single Lumen	Home infusion therapy, catheter care/maintenance, simple (single lumen), includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem
S5501	Multiple Lumens	Home infusion therapy, catheter care/maintenance, complex (more than one lumen), includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S5502	Implanted Access Device	Home infusion therapy, catheter care/maintenance, implanted access device, includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (use this code for interim maintenance of vascular access not currently in use)

PAIN MANAGEMENT

Only one of these class of service codes may be billed per day.

Code	Type of Service	Description
S9326	Continuous Infusion	Home infusion therapy, continuous (24 hours or more) pain management infusion; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9327	Intermittent Infusion	Home infusion therapy, intermittent (less than 24 hours) pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9328	Implanted Pump Instillation	Home infusion therapy, implanted pump pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

CHEMOTHERAPY

Only one of these class of service codes may be billed per day.

Code	Type of Service	Description
S9330	Continuous Infusion	Home infusion therapy, continuous (24 hours or more) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary

Code	Type of Service	Description
		supplies and equipment (drugs and nursing visits coded separately), per diem
S9331	Intermittent Infusion	Home infusion therapy, intermittent (less than 24 hours) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

EPOPROSTENOL

Code	Type of Service	Description
S9347	Uninterrupted Infusion	Home infusion therapy, uninterrupted, long-term, controlled rate intravenous or subcutaneous infusion therapy (e.g., epoprostenol); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

TOCOLYTIC

Code	Type of Service	Description
S9349	Infusion Therapy	Home infusion therapy, tocolytic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

HYDRATION

IV fluids utilized as a diluent or vehicles for administration of other therapeutic agents aren't hydration services. Hydration per diems only apply when services are for the infusion of IV fluids in one-liter increments solely for the therapeutic treatment of dehydration or other volume-related conditions. Only one of these class of service codes may be billed per day.

Code	Type of Service	Description
S9374	One Liter	Home infusion therapy, hydration therapy; one liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9375	Two Liters	Home infusion therapy, hydration therapy; more than one liter but no more than two liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9376	Three Liters	Home infusion therapy, hydration therapy; more than two liters but no more than three liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

TOTAL PARENTERAL NUTRITION

Code	Type of Service	Description
S9379	TPN and / or lipids	Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

ANTI-INFECTIVE

Only one of these class of service codes may be billed per day.

Code	Type of Service	Description
S9500	Q 24 hours	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 24 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9501	Q 12 hours	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9502	Q eight hours	Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every eight hours, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9503	Q six hours	Home infusion therapy, antibiotic, antiviral, or antifungal; once every six hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem
S9504	Q four hours	Home infusion therapy, antibiotic, antiviral, or antifungal; once every four hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

MISCELLANEOUS

Code	Type of Service	Description
S9379	Infusion Therapy	Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem

- Per diem for classes of service not indicated in the above tables **must** be billed with the "miscellaneous" per diem code.
- The reimbursement allowed for the above-noted per diem codes includes **all** necessary supplies and equipment, including but not limited to:
  - IV start kits and sterile site dressing materials (e.g., angio-catheters, tape, antimicrobial ointments/pads, alcohol pads, betadine swabs, transparent film dressings, gauze dressings, etc.)

- IV fluids used as vehicles for administration of other therapeutic agents (e.g., keep-vein-open (KVO) solutions, partial-fills, etc.)
- Sterile saline or water used as a diluent for other therapeutic agents.
- Flush solutions (e.g., heparin, sterile saline, sterile water, ethanol lock solution, etc.)
- Tubing, filters, needles and syringes (e.g. pump cassettes with tubing, extension tubing, secondary sets, injection caps, in-line filters, etc.)
- Disposable drug delivery systems (e.g., elastomeric technology-based devices).
- Daily rental of ambulatory infusion pumps.
- Anaphylactic agents (e.g., EpiPen, etc.)

- Per diems for multiple drugs administered in a single class of service (e.g., three antibiotics) will be reimbursed as a single per diem based on the highest administration frequency.
- These items shouldn't be separately billed.

Modifiers for Multiple Therapies

- The primary class of service per diem must be billed using the most appropriate HCPCS code from the tables above without a modifier.
- The secondary class of service per diem must be billed using the appropriate HCPCS code from the tables above with the "SH" modifier in the first modifier field to indicate the second concurrently administered class of service on the same DOS.
- The tertiary or concurrent class of service per diems must be billed using the appropriate HCPCS code from the tables above with the "SJ" modifier in the first modifier field to indicate the third or more concurrently administered class of service on the same DOS.

General Billing Guidelines

- For members with primary Medicare coverage:
  - Supplies, drugs and equipment used in conjunction with HIT must be filed to the
  - appropriate Medicare carrier prior to filing for secondary payment.
  - Secondary claims for HIT services must be filed with the appropriate Medicare Part B and Part D electronic remittance advices indicating payment or denial of the services.
  - If Part D covers the drug, providers should submit a $0.00 charge for the drug. The $0.00 charge indicates that Part D covered the drug and no additional payment is expected.
  - If the DOS for therapeutic agents spans through a quarterly update, (e.g., July 1, etc.), the provider will need to split the lines on the claim to clearly document for different DOS segments to receive the appropriate reimbursement.
- **For BlueCard Program:**
  - HIT claims should be filed to the Plan in whose service area the member's home, or equivalent setting, is located as this is where services were rendered.

35. Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)

NOTE: Durable Medical Equipment Reimbursement Methodology applies to BCBST contracts only.

For dates of service on or after April 1, 2016, reimbursement for DME providers includes DME, medical supplies, orthotic and prosthetics. Specialty DME providers are locked at the 2015 CMS Medicare Region C DMEPOS fee schedule for Tennessee published as of Jan.1. There are no annual updates to the maximum allowable for existing codes since these schedules are locked at the 2015 CMS rates. Updates to these fee schedules for new codes are indicated below, as stated in provider's contract.

New codes added to the DMEPOS fee schedule after Jan. 1, 2016, will be locked:

- If CMS establishes a non-competitive bid payment amount for a new code, the highest CMS rate for Tennessee will be added and locked based on the contract percentage and the first published Medicare fee.
- If CMS establishes a Competitive Bid Program (CBP) single payment amount for a new code, the new code will be added with the rate locked at 100% of the first published Medicare fee.

Note: For dates of service on or after September 1, 2024, with actual effective date based on provider's contract, reimbursement of DME providers includes DME, medical supplies, orthotic and prosthetics. Specialty DME provider will be based on current year CMS Medicare Region C DMEPOS

fee schedule for Tennessee published as of Jan. 1. BCBST implements updates to the DMEPOS fee schedule on April 1 of each year. Services provided between January 1 and March 31 will be reimbursed based on the previous year's DMEPOS schedule.

a. Durable Medical Equipment (DME) and Medical Supplies

DME is any equipment that provides therapeutic benefits or enables the beneficiary to perform certain tasks that they're unable to undertake due to certain medical conditions and/or illnesses. DME is considered equipment, which can withstand repeated use and is primarily/customarily used to serve a medical purpose. It's generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home. There are items, although durable in nature, which may fall into other coverage categories such as braces and prosthetics.

CMS defines customized DME as DME items that have been uniquely constructed or substantially modified for a specific beneficiary according to the description and orders of the beneficiary's treating physician.

Source: https://www.cms.gov

Medical supplies are items for health use other than drugs, prosthetic or orthotic appliances, or durable medical equipment that have been ordered by a qualified practitioner in the treatment of a specific medical condition. They're consumable, non-reusable, disposable, for a specific rather than incidental purpose and generally have no salvageable value.

All supplies dispensed for home use by the practitioner's office should be billed with the most appropriate HCPCS supply codes (i.e., dressings, elastomeric devices, flushes, etc.) and the appropriate POS code to indicate the location of utilization.

Claim Form

DME and medical supplies must be billed on a professional claim form.

Block 24b – Place of Service (POS)

The POS should represent where the item is being used, not where it's dispensed. For DME provider types this could include POS codes: 04, 09, 12, 13, 14, 16, 27, 32, 33, 34, 54, 55, 56, and 99 as possible member residence.

Note: For all lines of business, DME providers must use "99" as the place of service code when submitting a claim for an item purchased by and delivered to a member at a retail store/place of business.

Block 24a – From and To Date(s) of Service

Enter the month, day and year for each procedure, service or supply.

The following items require the use of span dates (i.e. a span of time between the "from and to" dates of service). Failure to use span dates will result in incorrect payment for:

- Enteral feeding supply kits
- Continuous passive motion device
- Enteral formulae
- Food thickener
- External insulin pump supplies

Example: Code A4224 also includes all cannulas, needles, dressings and infusion supplies (excluding insulin reservoir A4225. (Supplies for external insulin infusion pump, syringe type cartridge, sterile each) related to continuous subcutaneous insulin infusion via external insulin infusion pump (E0784). Billing for more than one unit of service per week is incorrect use of the code and will be denied accordingly.

Source: http://www.cgsmedicare.com.

Suppliers who elect to bill for partial months should enter the date of service the rental period begins in the "From" field and the ending rental date of service in the "To" field of the CMS-1500/ ANSI-837P for each partial month of billing. In this case, the HCPCS code should be billed with the RR modifier in the first modifier field and the KR modifier in the second modifier field.

DO NOT SPAN DATES FOR ITEMS OTHER THAN THOSE LISTED.

All DME monthly rentals must not be billed with a DOS span and must bill only one unit per month.

Block 24d - Codes and Modifiers

DME must be billed using the most appropriate HCPCS code and applicable modifiers in effect for the date of service. Pricing modifiers published on the DME, Prosthetic, Orthotic and Supplies (DMEPOS) fee schedule are required for correct claim adjudication. In some cases, more than one pricing modifier is required. Claims billed with an inappropriate code and modifier combination will be returned to the provider for submission of a corrected claim and may result in delay in reimbursement.

- Unlisted, miscellaneous, non-specific, and NOC codes (e.g., E1399) should only be used when a more specific CPT® or HCPCS code isn't available or appropriate. Components of the primary equipment should be billed with the most specific CPT® or HCPCS code or the most specific unlisted, miscellaneous code.
- DME billed with an unlisted, miscellaneous, non-specific, and NOC codes must be billed with the name of the manufacturer, product name, product number and quantity provided.

Pricing modifiers are always appended first in the modifier fields. These will always impact the reimbursement. Information/descriptive modifiers are used in the subsequent modifier fields. These modifiers are informational or used for benefit management by Medicare but don't impact reimbursement amounts.

The following is a partial list of common pricing HCPCS modifiers reported with HCPCS durable medical equipment codes:

Modifier	Description
AU	Item furnished in conjunction with a urological, ostomy, or tracheostomy supply
AV	Item furnished in conjunction with a prosthetic device, prosthetic or orthotic
AW	Item furnished in conjunction with surgical dressing
KF	Item designated by FDA as class III device
KR	Rental item, billing for partial month
NU	New equipment
RR	Rental (use the 'RR' modifier when DME is to be rented)
UE	Used durable medical equipment
KL	DMEPOS item delivered by mail
KE	Bid under round one of DMEPOS competitive bidding program for use with noncompetitive bid base equipment

Labor for DME repairs to member-owned equipment should be billed using the most appropriate five-digit HCPCS code. A modifier won't be required with the labor codes.

Codes and modifiers must be billed with:

- DME Medicare Administrative Contractor (DME MAC) for Jurisdiction C guidelines which include, but aren't limited to:
  - DMEPOS Supplier Manual and Revisions
  - DME MAC Jurisdiction C Fee Schedule
  - Pricing, Data Analysis and Coding Contractor (PDAC*) Product Classification Lists
    - Pricing, Data Analysis and Coding Contractor (PDAC*) Coding Bulletins

*This document is located at https://www4.palmettogba.com/pdac_dmecs/.

Block 24g - Days or Units

For monthly rentals, one unit should be billed for each month the item is rented as the maximum allowable for the rental is for one month.

For partial-month rentals, one unit should be billed for each month the item is rented. We reserve the right to prorate the maximum allowable to reflect the partial-month rental.

For rentals with DME codes and supply kits requiring span dates, one unit should be billed for each day the item is rented or supplied because the maximum allowable is for one day. For enterals, food thickener and external insulin supplies requiring span dates, the units should be billed with the unit defined in the code description.

General Billing Guidelines

- The maximum allowable for DME constitutes full reimbursement for the item including all labor charges involved in the assembly and support services such as emergency services, delivery, set-up, education, and on-going assistance with the item. These services, including mileage, aren't separately billable.
- Supplier must honor all product warranties, expressed and implied, under applicable state law.
- Remote therapeutic monitoring treatment/assessment services furnished personally/directly by a non-physician qualified health care professional, are considered professional services and aren't billable by the DMEPOS/Supplier provider.

Maintenance and/or service charges for DME covered under a manufacturer or supplier's warranty aren't billable unless the charges are excluded from the warranty.

- Supplies and accessories billed for DME must follow guidelines DME MAC for Jurisdiction C and be on the same claim form as the rented DME.
- There must be a valid detailed order on file prior to submitting claims for supplies.
- Regular submission of claims for supplies that exceed the usual use may prompt a request for medical records to support the need for additional supplies.
  a. Additional supplies must be requested by a member or caregiver before being dispensed. Supplies shouldn't automatically be dispensed on a predetermined and regular basis.
  b. Claim submission for reimbursement consideration should be done on a monthly basis.
- The continued need for supplies and the amount on hand must be verified prior to dispensing additional supplies.

If codes without a published Medicare fee, we reserve the right to request the name of the manufacturer, product name, product number and quantity provided.

- Leased DME should be billed in accordance with guidelines for rented DME. Reimbursement for leased DME will be based on the reimbursement provisions for rented DME.

Ventricular Assist Device (VAD) Supply or Accessory

Effective Dec. 1, 2017, supplemental information is no longer required when filing medical CMS-1500/ANSI-837P claims with HCPCS Codes Q0508 and Q0509 (Miscellaneous supply or accessory for use with an implanted ventricular assist device) unless specifically requested as indicated below.

The most appropriate codes to use for these dressing supplies are HCPCS codes Q0508 or Q0509. The prepackaged supplies typically contain various items including but not limited to gloves, gauze, tape, anchoring device, bouffant cap, local antiseptic (betadine/dyna dex/chloraprep), and facemask. If there's a specific code for an associated supply or accessory, that specific code should be billed for the item. When billing for a miscellaneous supply or accessory for use with a VAD, (Q0508 or Q0509), the following documentation should be on file and available upon request:

- Physician's order for supply/accessory listing frequency and duration of its use
- Invoice for supply/accessory provided
- List of supply/accessory provided whether individually or in a kit
- Office/progress notes for the member documenting the presence of a left ventricular assist device (LVAD)

Q0508 or Q0509 will be reimbursed as 1 unit per month and should include all supplies necessary to treat members' VAD dressing changes.

Aerosol Therapy

- Equipment used in conjunction with aerosol therapy must be billed by a DME provider.
- Supplies used in conjunction with aerosol therapy must be billed by a DME provider or medical supplier.
- Inhalation medication used in conjunction with aerosol therapy must be billed through the member 's pharmacy program.

Enteral Therapy

Equipment used with enteral therapy must be billed by a DME provider.

Supply kits, pumps and formulae used with enteral therapy must be billed by a DME provider or medical supplier. These items must be billed with the most appropriate HCPCS code and modifier, if applicable. DME used for enteral feedings should be billed as follows:

Supply Kits – The appropriate "B" HCPCS code should be billed with span dates using one unit for each day a kit is used. These are disposable supply items and no modifier is required to indicate a purchase. A span date indicates the date(s) services were provided (i.e., 01012015 to 01152015). Because of the use of span dates, a separate line item isn't required for each day.

The codes for enteral feeding supplies include all supplies, other than the feeding tube itself, required for the administration of enteral nutrients to the beneficiary for one day. These supply kit codes describe a daily supply fee rather than a specifically defined "kit". Some items are changed daily; others may be used for multiple days. Items included in these codes aren't limited to pre-packaged "kits" bundled by manufacturers or distributors. These supplies include, but aren't limited to, feeding bag/container, flushing solution bag/container, administration set tubing, extension tubing, feeding/flushing syringes, gastrostomy tube holder, dressings (any type) used for gastrostomy tube site, tape (to secure tube or dressings), Y connector, adapter, gastric pressure relief valve, declogging device, etc. These items must not be separately billed using the miscellaneous code (B9998) or using specific codes for dressings or tape. The use of individual items may differ from beneficiary to beneficiary and from day to day. Only one unit of service may be billed for any one day. More than one unit of service per day will be rejected as incorrect coding.

Source: http://www.cgsmedicare.com/

Pump (if used) – Pumps are considered as monthly rentals. The "from" and "to" dates on the claim should indicate the month, day and year for the rental (i.e., 01012015 to 01012015). One unit should be used for each month the pump is rented.

Formulae – Span dates should be used to indicate the period formulae were provided. Formulae are billed with one unit for 100 calories. If formulae hasn't been assigned a specific HCPCS code by a Pricing, Data Analysis and Coding Contractor (PDAC), bill the formulae using B9998 with one unit for each 100 calories. We require the complete brand name and NDC for formulae billed with this miscellaneous code to determine appropriate reimbursement.

Note: If different formulas which share the **same HCPCS code** are provided, only **a single line item of the code** should be billed. The units should indicate the total calories (i.e., 1 unit = 100 calories) of all formulas supplied with this same code during the same span date. The NDC and/or product name of one formula may be reported in the "Additional Information" section (See **Additional Information** section above). Block 19 – Reserved For Local Use, section of the CMS-1500 or its electronic equivalent, may be utilized if reporting of additional NDC/formula product information is required. Billing multiple lines of the same formula code for the same span date may result in delay of reimbursement.

Food Thickener - Span dates should be used to indicate the period thickener was provided. Food thickener is billed with one unit for each ounce of product. All brands of commercially manufactured food thickener, used as an additive, should be billed with the specific HCPCS code assigned by the PDAC. Bill pre-thickened foods, juices and other liquids using B9998 with one unit for each bottle, box or container. We require the

complete brand name, volume of container supplied, manufacturer's name, and product number for pre-thickened foods billed with this miscellaneous code to determine appropriate reimbursement.

Note: Claims for orally administered nutrition must include the appropriate HCPCS code and BO modifier or they will be considered an enteral tube feeding.

DME Repairs, Adjustments, and Replacements

- If the item is rented, the repair, adjustment or replacement of the equipment and its components are included in the maximum allowable for the equipment rental and aren't separately billable.
- Reimbursement for reasonable and necessary parts and labor to member-owned equipment that isn't covered under any manufacturer or supplier warranty may be allowed. Parts should be billed using the most appropriate HCPCS code with the appropriate new or used purchase modifier in the modifier 1 field. Labor should be billed using the most appropriate HCPCS code. A modifier won't be required with the labor codes.
- Repairs to member-owned DME are billable when necessary to make the item functional. If the expense for repairs exceeds the estimated expense of purchasing another entire item, no payments can be made for the excess amount.
- Billable parts and labor must be billed on the same claim form.
- Mileage isn't separately reimbursed or billable.
- Temporary replacement for member-owned equipment while being repaired requires a description and procedure code of the member-owned equipment being repaired. Bill K0462.
- 30 days is allowed for rental or loaner equipment when member-owned equipment is being repaired.

Guidelines for Wheelchairs

- All accessories related to the purchase of a wheelchair base must be billed on the same claim form as the wheelchair base itself.
- If multiple accessories are provided using the miscellaneous code K0108, each should be billed on a separate claim line.
- Code E1028 is appropriate for swing-away, removable or retractable hardware (e.g., joystick, head rest or laterals). E1028 is inappropriate for screws, bolts or any fixed hardware (e.g., hardware for seat, back or tray).
- A separate claim line is required for each item billed with code E1028. Submission of multiple units of E1028 on a single claim line may result in delayed claim adjudication.
- Bilateral accessories should be submitted with the right and left modifiers in the secondary modifier fields.

For information on items appropriately billed with code E1028, refer to the DME Product Classification List located at https://www4.palmettogba.com/pdac_dmecs/.

b. Reimbursement Guidelines for DME Purchases and Rentals

This policy applies to durable medical equipment purchases and rentals billed on a professional claim form for all Commercial lines of business (Blue Networks L, P and S).

The maximum allowable for DME classified as capped rental, inexpensive/routinely purchased, TENS and enteral nutrition infusion pumps (i.e., purchases and rentals) will be the lesser of total covered charges or the contracted network percentage of the DME MAC for Jurisdiction C DMEPOS Fee Schedule for Tennessee.

DME will be considered purchased after the equipment has been rented for a period of 10 months.

The published Medicare fees for DME classified as capped rentals are based on a 13-month rental period where the Medicare allowable for the first three months is 100% and the Medicare allowable for the remaining 10 months is at 75%. Because we consider DME purchased after the equipment has been rented for 10 months, the published Medicare fees for capped rentals (except power-driven wheelchairs) will be adjusted:

Published Medicare Fee for Capped Rental x 3 months x 100%

\+ Published Medicare Fee for Capped Rental x 10 months x 75%

= Medicare Purchase Fee

Purchase Allowable = Medicare Purchase Fee x Contracted Network %

Rental Allowable = Purchase Allowable/10 months

Capped Rental for Power-Driven Wheelchairs:

Because we consider DME purchased after the equipment has been rented for 10 months, the published Medicare fees for DME classified as capped rentals for power driven wheelchairs will be adjusted:

Published Medicare Fee for Capped Rental x 3 months x 150%

+ Published Medicare Fee for Capped Rental x 10 months x 60%

= Medicare Purchase Fee

Purchase Allowable = Medicare Purchase Fee x Contracted Network %

Rental Allowable = Purchase Allowable/10 months

If the member changes to different but similar equipment (e.g. from a non-heated humidifier to a heated humidifier) when the equipment is medically necessary (i.e. the member's medical needs have substantially changed and the new equipment is necessary), a new 10-month rental period begins with the new equipment. Otherwise, we'll reimburse the least expensive piece of equipment (continuing to count against the current 10-month period). If the 10-month rental period has already expired, no additional rental payments can be made.

Reimbursement for supplies used in conjunction with DME rentals will be determined by the DME MAC for Jurisdiction C guidelines.

Rental rates include reimbursement for repair, adjustment, maintenance and replacement of equipment and its components related to normal wear and tear, defects, obsolescence or aging.

The maximum allowable for DME constitutes full reimbursement for the item including all labor charges involved in the assembly and support services such as emergency services, delivery, set-up, education, and on-going assistance with the item.

All maximum allowable amount for rentals are monthly rates unless otherwise noted on the Maximum Allowable Detail Report.

We reserve the right to pro-rate the maximum allowable for partial month rentals.

Providers are contractually obligated to provide services at the agreed upon rates, regardless of patient acuity or nursing skill level. DME providers must follow the CMS DME Quality Standards, which include:

- Assistive Technology certification for custom wheelchair suppliers
- Certified Respiratory Therapists on staff when respiratory equipment is supplied
- Accreditation verified by the Credentialing Department

c. Oxygen Contents, and Supplies

This policy for Oxygen systems, supplies, and contents billed on a professional claim form applies for all Commercial lines of business.

We reserve the right to pay for the rental of oxygen systems including oxygen contents, oxygen supplies and accessories for as long as the patient's needs it.

Reimbursement for the rental of oxygen, contents, supplies and accessories will be based on the lesser of total covered charges or our contracted percentage of the Medicare Region C DMEPOS Fee Schedule for Tennessee as stipulated in the Provider Agreement.

Reimbursement for rental of oxygen systems, contents, supplies and accessories for all networks including BlueCare and Corporate Medicare will be limited to services eligible for separate reimbursement according to the DME MAC for Jurisdiction C DMEPOS in effect for dates of service prior to Jan. 1, 2006.

The maximum allowable for DME constitutes full reimbursement for the item including all labor charges involved in the assembly and support services such as emergency services, delivery, set-up education, and on-going assistance with the item.

All maximum allowable amounts for reimbursement rentals are monthly rates unless specified otherwise.

To be considered for reimbursement, oxygen systems, contents, supplies and accessories for eligible services must be billed with standard coding and billing guidelines.

Rental rates include reimbursement for repair, adjustment, maintenance and replacement of equipment and its components for normal wear and tear, defects, obsolescence or aging.

d. Reimbursement Guidelines for Home Pulse Oximetry

Spot Home Pulse Oximetry

A spot home pulse oximetry check is a single measurement of oxygen saturation that may provide complementary information for the clinician. It's no different than any other routine vital sign (e.g., blood pressure) obtained as part of a general patient assessment. Reimbursement for home pulse oximetry is included in the reimbursement for the rental of oxygen equipment or home health service when used as a spot oxygen saturation check. For this purpose, home pulse oximetry shouldn't be billed separately from the rental of oxygen equipment or the home health visit.

Continuous Home Pulse Oximetry

Reimbursement for medically appropriate continuous home pulse oximetry will be limited to the rental of the pulse oximetry equipment. Medically appropriate home pulse oximetry equipment will be considered purchased when the rental payments have reached the network cap limitation.

This policy applies to home pulse oximetry services billed with HCPCS code E0445 on a professional claim form for all lines of business.

e. Prosthetics and Orthotics – Applies to Commercial lines of business

Qualified Providers

Providers who are billing prosthetic and orthotic equipment must meet credentialing requirements outlined in Section XIV. Credentialing, in this manual.

Prosthetic devices (other than dental) are devices that replace all or part of an Internal or external body organ or replace all or part of the function of a permanently inoperative or malfunctioning internal or external body organ. Source: https://www.cms.gov.

Orthotics are rigid or semi-rigid devices, often called braces, which are applied to the outside of the body as a means used either to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. A prefabricated or custom-fitted orthosis is one, which is manufactured in quantity without a specific beneficiary in mind. A prefabricated orthosis may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific beneficiary (i.e., custom fitted). An orthosis that is assembled from prefabricated components is considered prefabricated. Any orthosis that doesn't meet the definition of a custom-fabricated orthosis is considered prefabricated.

Custom fitted orthotics are:

- Devices that are prefabricated.
- They may or may not be supplied as a kit that requires some assembly. Assembly of the item and/or installation of add-on components and/or the use of some basic materials in preparation of the item doesn't change classification from off-the-shelf to custom fitted.
- Classification as custom fitted requires substantial modification for fitting at the time of delivery to provide an individualized fit (i.e., the item must be trimmed, bent, molded with or without heat, or otherwise modified resulting in alterations beyond minimal self-adjustment).
- The fitting at delivery requires the expertise of a certified orthotist or an individual who has equivalent specialized orthosis training to fit the item to the individual beneficiary.

Off-the-shelf (OTS) orthotics are:

- Items that are prefabricated.
- They may or may not be supplied as a kit that requires some assembly. Assembly of the item, installation of add-on components and/or the use of some basic materials in preparation of the item doesn't change its classification from OTS to custom fitted.
- OTS items require minimal self-adjustment for fitting at the time of delivery for appropriate use and don't require expertise in trimming, bending, molding, assembling, or customizing to fit an individual.
- This fitting doesn't require expertise of a certified orthotist or an individual who has equivalent specialized orthosis training to fit the item to the individual beneficiary. It's inherent in the definition of "prefabricated" that a particular item is complete. Custom-fabricated additions are only appropriate for custom-fabricated base orthotics and will be denied as not reasonable and necessary if billed with prefabricated base orthotics.

Source: https://www.cms.gov

Claim Form

Prosthetics and orthotics must be billed on a professional claim form.

Block 24b - Place of Service

The place of service (POS) should represent where the item is being used, not where it's dispensed.

Note: Effective Sept., 1, 2018, DME providers will need to use "99" as the new place of service code when submitting a claim for an item purchased by and delivered to a member at a retail store/place of business.

Block 24a - From and To Date(s) of Service

Enter the month, day and year for each procedure, service or supply.

Block 24d - Codes and Modifiers

Prosthetics and orthotics must be billed using the most appropriate HCPCS code and applicable modifiers in effect for the date of service.

Claims billed with inappropriate codes and modifier combinations will be returned to the provider for submission of the corrected claim and results in a delay in reimbursement.

- Unlisted, miscellaneous, non-specific and NOC codes (e.g., L0999, L1499, L2999, L3649, L3999, L5999, L7499, L8039, L8499, L8699, L9900) should only be used when a more specific CPT® or HCPCS code isn't available or appropriate.
- Failure to submit the most specific CPT® or HCPCS code or the omission of modifiers will result in a denial and the return of claim to provider for the most appropriate coding.
- Prosthetics or orthotics billed with an unlisted, miscellaneous, non-specific and NOC codes must be billed with the name of the manufacturer, product name, product number, and quantity provided.
- We reserve the right to request the name of the manufacturer, product name, product number, and quantity provided for codes without a published Medicare fee.

Current DME MAC Jurisdiction C guidelines indicate claims for bilateral orthotics coded with a single code and provided on the same dates of service should be submitted on separate claim lines using the LT modifier on one line, the RT modifiers on the other line and one unit of service per line.

Codes and modifiers must be billed in accordance with the following:

- DME MAC for Jurisdiction C guidelines which includes, but aren't limited to:
  - DMEPOS Supplier Manual and Revisions
  - DME MAC for Jurisdiction C Fee Schedule
  - Pricing, Data Analysis and Coding Contractor (PDAC*) Product Classification Lists
  - Pricing, Data Analysis and Coding Contractor (PDAC*) Coding Bulletins

*This document is located at https://www4.palmettogba.com/pdac_dmecs/.

Prosthetics

- Repairs, Adjustments, and Replacements

- An adjustment is any modification to the prosthesis due to change in the patient's condition or to improve the function of the prosthesis.
- A repair is a restoration of the prosthesis to correct problems to due to wear or damage.
- A replacement is the removal and substitution of a component of a prosthesis that has a HCPCS definition.

➢ These items are included in the reimbursement for a prosthesis aren't separately billable:
- Evaluation of the residual limb and gait
- Fitting of the prosthesis
- Cost of base component parts and labor contained in HCPCS base codes
- Repairs due to normal wear or tear within 90 days of delivery
- Adjustments of the prosthesis or the prosthetic component made when fitting the prosthesis or component and for 90 days from the date of delivery when the adjustments aren't made necessary by changes in the residual limb or the patient's functional abilities

➢ Routine periodic servicing, such as testing, cleaning, and checking the prosthesis isn't separately billable.

➢ Repairs to prostheses are billable when it's necessary to make the prosthesis functional. If the expense for repairs exceeds the estimated expense of purchasing another entire prosthesis, no payment can be made for the excess amount. Maintenance, which could be made necessary by the manufacturer's recommendations or the construction of the prosthesis and must be performed by the prosthetist, is billable as a repair.

Reimbursement for reasonable and necessary parts and labor, which aren't covered under any manufacturer or supplier warranty, may be allowed. Parts and labor should be billed using the most appropriate HCPCS code (e.g., L7500, L7520).

Billable parts and labor must be billed on the same claim form.

Orthotics

➢ Evaluation of the patient, measurement and/or casting, and fitting of the orthosis are included in the allowance for the orthosis and aren't separately billable. There is no separate payment for these services.

➢ Repairs to an orthotic due to wear or accidental damage are billable when they're necessary to make the orthosis functional. The reason for the repair must be documented in the supplier's record. If the expense for the repairs exceeds the estimated expense of providing another entire orthosis, no payment will be made for the excess amount.

➢ Replacement of a complete orthotic or component of an orthotic due to loss, significant change in the member's condition, irreparable wear, or irreparable accidental damage is billable if the device is still medically necessary. The reason for the replacement must be documented in the supplier's record.

➢ The allowance for the labor involved in replacing an orthotic component that's coded with a specific L code is included in the allowance for that component and isn't separately billable.

➢ The allowance for the labor involved in replacing an orthotic component that's coded with the miscellaneous code L4210 is separately billable in addition to the allowance for that component.

Billable orthotic components and labor must be billed on the same claim form.

f. Reimbursement and Billing Guidelines for Hearing Services/Equipment (excludes the Federal Employee Program (FEP) and Postal Service Health Benefits (PSHB))

Reimbursement and billing guidelines for hearing-related services and equipment:

➢ Hearing related services and equipment should be billed using the most appropriate V code and number of units as defined by HCPCS.

➢ Hearing exams, screenings, fittings/orientations/hearing aid checks, ear impressions, non-disposable ear molds/inserts and conformity evaluations will be reimbursed based on the lesser of line level covered charges or the network maximum allowable fee schedule.

➢ All hearing aid-related products and services should be billed on one claim. Providers should break out each product or service as separate line items with the appropriate codes.

➢ Hearing aids billed with code(s) not having established maximum allowable will require **an unaltered, verifiable manufacturer's invoice** and will be reimbursed based on the

Reimbursement Guidelines for Codes Classified as DME, Medical Supplies, Orthotics and Prosthetics without an Established Maximum Allowable policy, which is located further down in this section. Claims billed without an invoice may be rejected.

- Hearing aid batteries, accessories, assisted listening devices, disposable ear molds, dispensing fees, shipping/handling and sales tax won't be reimbursed separately except when the member's benefit has specific group coverage.
- Not all plans cover hearing aids and/or related hearing services for all members and some plans contain dollar limits for hearing aids. Please verify benefits before providing services.
- To facilitate correct claim handling providers must include the right side or left side (RT or LT) modifier with the appropriate HCPCS code for the unilateral hearing aid codes. Claims for unilateral hearing aids filed without the appropriate modifiers will be denied. **No lateral modifier should be submitted for codes identifying bilateral procedures or devices.**
- These guidelines apply to services billed on a professional claim form for all commercial business excluding the Medicare, Federal Employee Program (FEP), and Postal Service Health Benefits (PSHB) lines of business, unless otherwise noted in the contract.

Note: For provider's contracted with the 2021 or after banded fee schedules, certain hearing aid HCPCS codes will reimburse from the applicable banded schedule. Otherwise, the hearing aid code will still be subject to manufacturer invoice review and pricing as indicated above. The effective date will be based on the provider's signed contract.

g. Reimbursement Guidelines for Codes Classified as DME, Medical Supplies, Orthotics and Prosthetics Without an Established Maximum Allowable

Codes classified as DME **(includes hearing aids)**, medical supplies, orthotics, and prosthetics without an established maximum allowable requires submission of the manufacturer name, product name, product number, and quantity.

The maximum allowable for these services will be based on the lesser of billed charges or the following percentages of the manufacturer's visibly published and date of service appropriate list price. Shipping & handling, and state sales tax are excluded from reimbursement.

100% Medical Supplies
100% Durable Medical Equipment
100% Orthotics
100% Prosthetics

We reserve the exclusive right to determine the manufacturer's visibly published and date of service appropriate list price. We've used sources to determine the manufacturer's published list price that include, but aren't limited to:

Information visibly published by the manufacturer (e.g., product catalogs, product price listings and manufacturer order forms).

In the event we're unable to verify the list price using one of the aforementioned sources, we reserve the right to request an **unaltered manufacturer/supplier's invoice** indicating the product acquisition cost after all discounts and rebates. The maximum allowable for these items will be the lesser of total covered charges or 120% of the acquisition cost after all discounts and rebates per the manufacturer/supplier's invoice.

This policy applies to:

- Durable medical equipment **(includes hearing aids)**, medical supplies, orthotics and prosthetics billed on the professional claim form
- Medical supplies on the Home Health Non-routine Supply List billed by a home health agency on the Institutional claim form

Reimbursement for codes classified as durable medical equipment **(includes hearing aids)**, medical supplies, orthotics and prosthetics without an established maximum allowable is subject to the Medicare Administrative Contractor for Jurisdiction C (DME MAC) guidelines, as well as our reimbursement and billing guidelines.

h. Acknowledgement of Financial Responsibility for the Cost of Equipment Upgrades and Supplies Waiver Form

We developed the Acknowledgement of Financial Responsibility for the Cost of Equipment Upgrades and Supplies waiver form for provider use when a member wishes to receive equipment or supplies that may not be covered by their benefit plan.

This form should be used when a member requests an upgraded supply or equipment and shouldn't be used for medical procedures or services. (Please refer to Section V. Member Policy of this manual for information regarding the Acknowledgement of Financial Responsibility for the Cost of Services waiver form.)

Provider Waiver Form Billing Guidelines

- Verify member benefits prior to providing service.
- Use this form when a member requests an upgraded supply or equipment.
- Use one line for each upgraded item/service.
- Each service line on the waiver form must have a corresponding line on the claim form.
- All upgraded services should be submitted with procedure code S1001 and the cost of the upgrade or deluxe item.
- Accessories included in the base procedure code reimbursement shouldn't be submitted with this form.
- The waiver form is only valid for one date of service.
- Submit the original copy of the waiver form with the claim, give a copy to the member, and keep a copy for your records.
- Other versions of waiver forms aren't acceptable.

A sample copy of the Acknowledgement of Financial Responsibility for the Cost of Equipment Upgrades and Supplies waiver form follows:

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of Tennessee

Acknowledgement of Financial Responsibility For the Cost of Equipment Upgrades and Supplies

Provider:

Please use this form for your patients who wish to receive health care services from you that may not be covered by their BlueCross BlueShield of Tennessee benefit plan. Acknowledgement of responsibility must include item/service provided and estimated cost.

Member:

Be sure to check the box by the option you choose below and sign the form. By signing this form, you agree to be financially responsible for the payment of item/service provided below if not covered under your BlueCross plan. If you have questions about this notice or if the item/service is covered by your BlueCross plan, call the number on the back of your BlueCross ID card.

Provider_____ Provider Number _____

Patient Name_____ BlueCross ID Number _____

Date of Service	Service Description (S1001) Please list each item with cost.	Estimated Cost

Reason(s) Service May Not Be Covered:

_____

_____

_____

Choose one of the following options:
☐ **OPTION 1.** I've agreed to the item/service listed above and request the claim filed to BlueCross for an official decision on payment. If my BlueCross plan doesn't cover item/service, I understand I'm responsible for the cost of the item/service. If my BlueCross plan covers the item/service, I'll receive a refund for any payments for the cost of the item/service, less co-pays or deductibles.
☐ **OPTION 2.** I don't want the item/service listed above. I understand I'm not responsible for payment.

Signature:_____ Date Signed: _____

BlueCross BlueShield of Tennessee, Independent Licensee of the Blue Cross Blue Shield Association

19PED607833 (8/19)

36. Telehealth Originating Site Fees and Billing Guidelines

We reimburse for services rendered via telehealth in accordance with the Tennessee Telehealth mandate (TCA 56-7-1003). By filing claims for encounters rendered via telehealth, providers are attesting that said claims are rendered according to these rules and guidelines. This reimbursement may not apply to certain self-funded groups if telehealth is listed as a coverage exclusion in their contract. We follow all CMS guidelines regarding billing and reimbursement.

During the pandemic, we greatly expanded our telehealth coverage so providers could continue to provide quality care to our members. As mentioned in previous BlueAlert articles, we're also reviewing codes to make sure we don't cover services that need to take place in a provider's office.

As of June 1, 2022, we've started denying telehealth claims that truly can't be performed via telehealth (e.g., blood draws, surgeries, etc.).

We'll share more information about other telehealth guidelines in future issues of the BlueAlert newsletter. As well, please continue to visit our telehealth section at **bcbstupdates.com** for the latest information.

Telehealth service modifiers for informational purposes include **GT, 93**, **95, G0, or GQ**, **CS**, **FQ**, or **FR**, but these claims must be billed with the correct place of service **(POS) 10**: Telehealth provided in patient's home or **POS 02**: Telehealth provided other than in patient's home to ensure appropriate reimbursement.

Effective Sept. 30, 2019:

Any service code not on the current CMS Telehealth qualifying code list that also includes the two eligible AMA codes (CPT® codes 90863 and 96040) billed by the originating or distant site provider with POS code 02 will be denied as a non-contracted service.

The GT and 95 modifiers are no longer required.

Q3014 billing will be audited and dollars recouped for billing outside the policy and/or billing guidelines when no corresponding distant site claim encounter with POS 02 is on file for the same date of service.

Effective Aug. 1, 2018:

The GT modifier is no longer required per CMS guidelines. We'll accept this modifier for informational purposes only. However, all telehealth-related services should be filed with code 02 for both the originating and distant site providers. Not following this billing requirement may affect reimbursement.

Effective for dates of service 1/1/15 and after, Commercial and BlueAdvantage Originating Site Providers may bill and receive a flat fee payment for Q3014 when the Originating Site Provider isn't affiliated with the Distant Site Practitioner. For the Originating Site, code Q3014 is allowed for each qualifying unit of service received via Telehealth for all appropriate Provider type claims. If CMS designates a replacement code for Q3014 or updates the fee for Q3014 or its replacement code, BlueCross will utilize the new code reimbursement to replace the current flat fee. While it is acceptable to render services via Telehealth from satellite to satellite as a convenience for multi-site Providers (as indicated by a GT or 95 modifier), under these circumstances, it is not appropriate to bill code Q3014.

Q3014 billing will be audited and dollars recouped for billing outside the policy and/or billing guidelines when no corresponding distant site claim encounter is on file for the same date of service that isn't filed with POS 02.

Medicare guidance can be found at the following websites:

- www.cms.gov/Medicare/Medicare-General-Information/Telehealth
- http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/TelehealthSrvcsfctsht.pdf

Final HIPAA Privacy Rules, including a section on "How might HIPAA affect Telemedicine providers" can be found at http://www.hrsa.gov/telehealth.

Note: On March 27, 2017, per State Legislative Law: SB 0195/HB 0338: Coverage for Telehealth Services Provided in Schools, the following applies to the Telehealth mandate provision for contracted providers in addition to standard CMS requirements as an originating site provider. The new law amends

the definition of “qualified site” to include a public elementary or secondary school staffed by a health care services provider (licensed in TN) where previously it only referenced a “school clinic.”

37. Air Ambulance Services

Effective Jan. 1, 2018, this policy applies to rotary wing service HCPCS codes A0431 and A0436 filed on a professional CMS-1500/ANSI-837P claim form. Any other service codes filed for air ambulance transports won’t receive reimbursement. **Note:** International services, where applicable, will be handled based on Federal Employee Program (FEP)/Postal Service Health Benefits (PSHB) guidelines for FEP/PSHB Members.

Fixed Wing Services	
HCPCS Code	**Code Description**
A0225	Fixed wing air transport, neonatal
A0430	Fixed wing air ambulance
A0435	Fixed wing air mileage – per statute mile

Rotary Wing Services	
HCPCS Code	**Code Description**
A0431	Rotary wing air ambulance
A0436	Air mileage – Rotary wing

Emergency transports occur from the scene of accidents, as indicated by appropriate origin and destination modifiers filed on the claim. All other transports *may be* reviewed retrospectively for appropriateness as an emergency transport.

- Base rate reimbursement should include all associated supplies and services other than separate reimbursement for mileage charges.
- Any service codes billed other than those listed above specifically for fixed and rotary wing services won’t be reimbursed.
- Claims filed for ambulance services should be billed with the appropriate origin and destination modifiers as outlined by national standards.
- Prior authorization is required for all **non-emergent** transports.
- Rotary Transports are capped at 250 miles.
- Providers must billed with an appropriate tax code, mileage and pick-up/drop-off zip code for proper adjudication.
- Mileage can be billed with partial units (decimals).

Note - For air ambulance services submitted on the CMS1500 claim form, the pick-up location zip code should be submitted in block 23. Multiple zip codes shouldn’t be submitted in this block. If the points of pick-up are in different zip codes a separate claim form should be submitted for each trip. The correct zip code is five numeric digits; if a nine-digit zip code is submitted the last four digits are ignored. If the pick-up location zip code is missing, invalid, or submitted in an incorrect format, the claim will be returned unprocessed.

38. Allergy Immunotherapy – CPT® Code 95165

We updated our Commercial health plan reimbursement policy for allergy immunotherapy, effective April 1, 2019. This long-term treatment decreases allergen sensitivity, relieves symptoms and is a clinical approach that consists of allergy immunotherapy subcutaneous injections.

Currently, the Commercial benefit defines a dose of allergen immunology as 1cc of extract and limits reimbursement not to exceed 30 doses per day.

Effective April 1, 2019, our Commercial health plan reimbursement policy for allergy immunotherapy covers an annual (12-month rolling) limit of up to 160 doses. Any amount over this limit will be denied.

Billing Requirements

The units must be filed in increments not to exceed 160 units. Line-item units will be totaled in sequential order. If a line/unit exceeds 160, all units thereafter will be denied. See claim examples indicated below:

Incorrect Billing Example:

CPT®	Date of Service	Units (Doses)	Charge	Allowed	
95165	12-1-19	80	$100.00	$100.00	
95165	1-1-20	40	$ 50.00	$ 50.00	
95165	2-1-20	50	$ 60.00	$ 0.00	(This entire line non-covered because the lines weren't split to equal the total 160-dose annual rolling limit)
95165	3-1-20	20	$ 25.00	$ 0.00	(This entire line non-covered because the lines weren't split to equal the total 160-dose annual rolling limit)

Correct Billing Example:

CPT®	Date of Service	Units (Doses)	Charge	Allowed	
95165	12-1-19	80	$100.00	$100.00	
95165	1-1-20	40	$ 50.00	$ 50.00	
95165	2-1-20	40	$ 50.00	$ 50.00	
95165	3-1-20	10	$ 10.00	$ 0.00	(This entire line non-covered because the lines weren't split to equal the total 160-dose annual rolling limit)

Claims are subject to a post-payment audit and medical necessity review. Additionally, providers must follow practice guidelines according to the following:

- Joint task force on practice parameters of the American Academy of Allergy, Asthma, and Immunology
- Joint Council of Allergy, Asthma, and Immunology

39. Advanced Practice Health Care Practitioner (APHCP) Policy

Effective with dates of service on or after August 15, 2025, BCBST will pay for services furnished by APHCPs based on CMS payment policy.

- This policy applies to APHCPs as defined by BCBST and includes the following credentialed provider specialties (including any sub-specialties to these specialties):
  - Physician Assistant
  - Nurse Practitioner (excluding Psychiatric/Mental Health sub-specialty)
  - Clinical Nurse Specialist
  - Nutritionist
  - Dietitian
  - Certified Nurse Midwife
- This policy applies to services furnished by all APHCPs, regardless of whether they contract with BCBST to participate in a BCBST provider network (i.e., regardless of whether the professional is an "in-network" or "out-of-network" provider).

Payment Guidelines

- In accordance with its general policy, BCBST pays APHCP professional services only when the service is covered under the member's benefit plan and claims for such services follow the guidelines and requirements set forth by BCBST.
- APHCPs must submit claims using their individual NPI number when rendering services to members. See "Staff Supervision Requirements for Delegated Services, Provider Categories/Billing and Supervision Requirements, Licensed Providers Requiring Supervision by Retrospective Review" for more information.
- BCBST pays APHCP professional services at 85% of the physician's rate under the allowed amount pursuant to the applicable professional fee schedule.
- For BCBST's guidelines for assistant-at-surgery services, please refer to the Assistant-at-Surgery Policy of this subsection.
- For BCBST's guidelines for "incident to" services, please refer to the Incident to Services and Supplies Policy of this subsection.

40. Incident To Services & Supplies

Effective with dates of service on or after August 15, 2025, BCBST will pay for "incident to" services furnished by Supervising Health Care Practitioners and APHCPs based on CMS payment policy.

"Incident to" services and supplies are those provided as an integral, although incidental, part of the Supervising Health Care Practitioner's personal professional services during diagnosis and treatment.

- This policy applies to Supervising Health Care Practitioners and APHCPs.
- This policy applies to services furnished by all Supervising Health Care Practitioners and APHCPs, regardless of whether they contract with BCBST to participate in a BCBST provider network (i.e., regardless of whether the professional is an "in-network" or "out-of-network" provider).

For purposes of this policy, "Supervising Health Care Practitioners" are physicians and nonphysician practitioners who are authorized to have services provided by APHCPs. Supervising Health Care Practitioners include medical clinicians described as autonomous providers in the Staff Supervision Requirements for Delegated Services policy, such as MDs, DOs, DCs, and DPMs.

For purposes of this policy, only APHCPs have the option of providing services incidental to the professional services of a Supervising Health Care Practitioner.

Payment Guidelines

- In accordance with its general policy, BCBST pays for incident to services and supplies only when the service is covered under the member's benefit plan and claims for such services follow the guidelines and requirements set forth by BCBST.
- APHCPs must submit claims using the Supervising Health Care Practitioner's NPI number when rendering incident to services to members and append the SA modifier to such services.
- BCBST pays incident to services and supplies only when the services comply with applicable state and federal law and meet all requirements set forth by CMS for incident to services and supplies.

41. Use of Imaging Studies for Uncomplicated Low Back Pain

One measure we collect for the National Committee for Quality Assurance (NCQA) evaluates the appropriate use of imaging studies for uncomplicated low back pain (LBP). This measure evaluates the percentage of members ages 18 to 75 diagnosed with LBP who:

- Haven't received a prior diagnosis of LBP in the past six months
- Haven't had diagnostic imaging studies within the first 28 days of the diagnosis (including plain film radiographs, MRI and CT scans)

When treating a patient with low back pain (LBP), it's important to document and code for any exclusions that would warrant use of imaging studies. Patients with a diagnosis of uncomplicated LBP should wait 28 days or more after receiving a primary diagnosis before they undergo a diagnostic imaging study (plain film radiographs, MRI, or CT scan).

Diagnostic Imaging services may be appended with the use of modifier KX to indicate that NCQA HEDIS® exclusionary criteria were met. Any required prior authorization for the imaging study must still be obtained.

These exclusionary criteria include:

- **At any time** before the advanced diagnostic imaging study
  - Diagnosis or history of cancer; or
  - HIV infection; or
  - Major organ transplant on immunosuppression therapy; or
  - Evidence of osteoporosis therapy; or
  - Prior lumbar spine surgery; or
  - Spondylopathy diagnosis.
- **Within 12 months** before the advanced diagnostic imaging study
  - IV drug abuse: or
  - Neurologic impairment; or
  - Spinal infection; or
  - Prolonged corticosteroid use for 90 days consecutively; or
  - Hospice services; or
  - Palliative care services.
- **Within six months but more than 28 days** before the advanced diagnostic imaging study
  - Uncomplicated low back pain
- **Within three months** before the advanced diagnostic imaging study
  - Recent trauma; or
  - Fragility or osteoporosis fracture of the spine.

If any one of the above exclusions has been met, then use of the KX modifier on the claim is appropriate, assuming any required prior authorization for the imaging study was obtained. If none of the above is applicable to the member, then use of the KX modifier is not appropriate due to potential improper use of diagnostic imaging studies for a diagnosis of uncomplicated low back pain. By using the KX modifier, Providers are attesting that the imaging study meets medical necessity requirements.

This policy applies to services billed on both a professional claim form (CMS-1500) and facility claim form (CMS-1450) or the electronic equivalent.

D. Institutional Claim Billing and Reimbursement Guidelines – Section 1

1. Revenue Codes (CMS-1450)

We'll use the Uniform Billing Editor published by OPTUM, Appendix, "Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments", as a guide to determine appropriate billing services rendered. Otherwise, billing will be based on the Institutional contract.

2. Split and Interim Billing

All services rendered must be reported on the claim. For example, an ER revenue code with the related CPT® code can't be omitted, if the patient received care or was admitted through the ER. Such omissions are recoverable and if deemed to be intentional, the network contract is subject to cancellation. To correct a claim with a coding error the entire claim must be refiled.

We don't accept split billing unless requested to reflect covered charges allocated for approved and denied dates of service. Split bills that haven't been requested are subject to denial or recovery. All services for the same patient, same date of service, same place of service, and same provider must be billed on a single claim submission.

Interim bills are claims filed for a portion of a large inpatient hospital stay. All interim billing submitted by a facility is required in no less than 30-day increments, with the exception of final billing. Any interim bill, with the exception of final billing, that contains fewer than 30 days is subject to denial or recovery.

Interim bills are identified by the last digit of the type of bill code found in field locator #4 on the institutional claim form. When billing electronically, the ANSI-837I (Institutional) format must be used:

First claim	Type of bill (last digit) =2	11**2** or 12**2**
Continuing claim	Type of bill (last digit) =3	11**3** or 12**3**
Last claim	Type of bill (last digit) =4	11**4** or 12**4**

Note: This format only applies to **inpatient claims. Ou**tpatient claims shouldn't be filed as interim bills.

3. Electronic Billing Instruction

For those facilities wishing to submit claims electronically, additional information may be obtained from e-Business Service. A copy of the Electronic Billing Format Specifications is available for download. You may make additional electronic billing inquiries to:

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

Or call, fax or e-mail:

Phone: 423-535-5775
Fax: 423-535-7523
e-mail: eBusiness_Service@bcbst.com

4. Explanation Codes

Explanation codes are the processing codes found on the Provider Remittance Advice.

5. Adjusted Claims

To adjust a claim you've previously filed, a complete corrected claim must be resubmitted.

6. Late Charges

We don't accept late charges. To receive consideration for late charges, a corrected claim should be resubmitted.

7. Member Liability

Revenue codes considered member liability may be billed to the member as follows:

Member Liability Revenue Codes	
Revenue Code	**Service**
0624	FDA Investigational Devices (requires member consent)
0990	General - patient convenience items
0991	Cafeteria/guest tray
0992	Private linen service
0993	Telephone
0994	TV/Radio
0995	Non-patient room rentals
0996	Late discharge
0997	Admission kits
0998	Cosmetic services
0999	Other patient convenience items

8. Lesser-Of Calculation

Effective for dates of service on nor after Jan. 1, 2018, Lesser-Of is dependent on the facility's individual contract. Non-contracted (including any services and/or codes that aren't specifically documented), codes on a fee schedule with a $0.00 rate and no "BR" indicator and non-covered services are excluded from the claim level lesser-of calculation.

Note: In accordance with Medicare anti-fraud statutes at 42 USC 1320 et seq, when Medicare is primary, providers can't accept secondary payments above the Medicare allowed amounts. This rule overrides any Lesser-Of contractual agreements allowing amounts greater than the charges.

For Ambulatory Surgery Centers (ASCs), when secondary to Medicare, we'll accept services billed on CMS-1500 claim form and apply Line Level Lesser Of reimbursement.

For a Rural Health Clinic (RHC) or a Federally Qualified Health Center (FQHC), when secondary to Medicare, we'll accept services billed on a CMS-1450 claim form and apply Line Level Lesser Of reimbursement.

Provider must promptly notify us when they're certified as an FQHC or RHC, or of any change in their certification. Providers will send their certifications or changes in certification to their Provider Network Manager. If you're unsure who your Provider Network Manager is, go to provider.bcbst.com/contact-us/my-contact.

Methods for calculating Lesser-Of:

a. Claim Level Lesser-Of Calculation:

Acute Care facilities holding contracts with claim level lesser-of language will have claims with dates of services on or after the contract effective date processed according to the following methods. Claim level lesser-of calculation compares the lesser of total covered charges for covered services against the contracted rates outlined in schedules 1 and 2 of the institution contract. If the total covered charges filed on the claim are less than the amounts outlined in the contract, we'll allow the lesser of the total covered charges as submitted by the facility. Claims adjudicated using claim level lesser-of calculation are dependent upon the date of service and the contract in effect at the time of service.

Items excluded from claim level lesser-of calculation

When calculating the lesser of total covered charges for inpatient or outpatient services, there are three categories of services that are excluded. Examples of these exclusions are:

- Services reimbursed based on a percentage of total covered charges, or discount off of charges.
- Services that are considered incidental, or part of the primary service
- Services that are identified as non-covered under the institution contract, or the member's health care plan

b. Line Item Lesser-Of Calculation:

- In the line item lesser-of calculation, the lesser-of calculation for an inpatient claim is based on a per day method. The covered ancillary charges shown on each claim are totaled and divided by the number of total days shown on the claim to calculate an average covered ancillary charge per day. This average covered ancillary charge per day is then added to the actual room charge per day for each service category (defined by each facility's contract) to arrive at a total charge per day for that service category. The total covered charge per day applicable to each service category is multiplied by total days associated with same and a comparison of total covered charges by service category is made to that of negotiated payment per contract for that same category. The lower of these two amounts is the amount that will be paid on the claim for that service category.
- This same method is used for the outpatient lesser of calculation when applicable. Some outpatient services stand alone and don't receive allocations while others roll to a case or per procedure pricing method. If an outpatient claim has two or more of these cases or per procedure items then the appropriate ancillary lines will be allocated to each, based on a percentage of number of cases/procedures to total. Total covered charges for the case/procedure will then be compared to the negotiated rate for each and the lower of the two amounts is paid.

The following examples show two inpatient per diem contract scenarios, one isn't impacted by lesser-of while the other is:

***Two days @ $900**

Not Impacted by Lesser-Of						
Days	**Type of Service**	**Charges**	**Allocation**	**Re-allocated**	**Per Diem**	**Reimb.**
Two	Medical	$700	$1,533	$2,233	*$1800	$1800
One	ICU	500	767	1,267	1,200	1,200
	Ancillary Charges	2,300				
	Total	$3,500	$2,300	$3,500	$3,000	$3,000

****Three days @ $900**

Impacted by Lesser-Of						
Days	**Type of Service**	**Charges**	**Allocation**	**Re-allocated**	**Per Diem**	**Reimb.**
Three	Medical	$1,050	$1,875	$2,925	**$2,700	$2,700
One	ICU	500	625	1,125	1,200	1,125
	Ancillary Charges	2,500				
	Total	$4,050	$2,500	$4,050	$3,900	$3,825

Note for per diem contracts: Only the per diem amount will be allowed for inpatient services. No reimbursement will be given for any other revenue code, unless specifically contracted.

9. Non-Standard Billing Requirement

We make every effort to structure our Commercial provider network contracts and specific billing guidelines to meet the reporting requirements imposed by federal and state agencies. However, due to contract terms in our Commercial networks and other business requirements, it can become necessary to require a facility bill in a way that doesn't conform to these reporting requirements.

Additionally, we provide services to a diverse member population whose benefits may or may not be provided by federal and state agencies. The billing guidelines required for these services may not always be conducive to the requirements of federal and state agencies.

In circumstances where our billing requirements aren't consistent with federal and state agency reporting, providers are still required to remain in compliance with all reporting requirements mandated by those agencies. The provider's medical records, census documents and financial reporting should never change because of our billing requirements. We recognize this may cause a discrepancy between the provider's reporting records and the actual billing documents. However, the billing is a contractual requirement only for claims payment and should never impact regulated reporting requirements.

The most common example of a non-standard billing requirement is billing for observation services when we've only authorized outpatient observation services and the admitting physician has written an inpatient admission order. In this case, to receive payment for observation services, the provider is required to bill as follows:

- Change the type of bill from inpatient to outpatient (13x)
- Convert the room and board revenue code to observation (76x)

In this example the provider should make no changes to their medical records, continue to report the days as inpatient on their census reports and reflect charges under the room & board revenue codes on their financial system. This will keep the provider in compliance with Medicare reporting but will allow payment under contractual terms of their provider contract.

10. Acute Care Facilities – Inpatient

a. Diagnosis Related Groups (DRG) Business Rules

The following guidelines apply to all hospitals having DRG contracts with all of our lines of business.

Grouper

We'll make DRG assignment via CMS-based grouper as defined by the provider's contract purchased from a third party software vendor.

DRG Code Update

DRGs, which are deleted by CMS after the establishment of the schedule, will be removed. For new DRGs added by CMS after the establishment of the schedule, we'll use the initial CMS Relative Weight and ALOS published in the Federal Register.

We'll change its CMS-based MS-DRG (v25 and after) grouper to the current version being used by CMS no later than Jan. 1 of each year unless the CMS effective date for the new DRG grouper is delayed past Oct. 1 of the preceding year. In this event we'll change its CMS-based MS-DRG grouper no later than 90 days after the final CMS effective date.

DRG Payment Application

The DRG assignment will be based on the principal diagnosis, up to 24 other secondary diagnoses, additional associated present on admission codes, as well as age, sex and discharge status of the patient. If CMS changes the DRG assignment criteria, we'll remain on current grouper assignment until a time and in a manner mutually agreed upon by the parties to ensure revenue neutrality to both parties. Until the parties mutually agree, the contracted DRGs will be utilized. In the event the parties can't reach an agreement, the dispute will be resolved by the Provider Dispute Resolution Procedure as described in this manual. The base rate and relative weights in effect at the admission date are used to calculate the payment level.

- **Regular DRG Payment** The formula to calculate the Regular DRG Allowed follows:

Regular DRG Allowed = DRG Relative Weight X Institution Base Rate

Total Payment = Regular DRG Allowed – Deductible and Coinsurance

- **Outlier Payments**

The formula for calculating the Total Allowed Amount for an inpatient stay qualifying as an Outlier Stay is as follows:

Total Allowed Amount = Regular DRG Payment + ((Regular DRG Payment/ ALOS x 70%) x (Approved LOS – Outlier Day Threshold))

Claim Assumptions			Allowed Calculation	
Admit Date	July 1, 2022		**Normal DRG:**	
Discharge Date	July 18, 2022		Base Rate	$3,992
Authorization Date	July 8, 2022		Relative Weight	1.1120
DRG	014		Normal DRG Allowed	$4,439
DRG (ALOS)	4			
Relative Weight	1.1120		**Outlier:**	
Outlier Threshold	12		Total Outlier Days	5*
Base Rate	$3,992		Outlier Per Diem	$777
Outlier Per Diem	$777		Outlier Allowed	$3,885*

Claim Assumptions			Allowed Calculation	
Length of Stay	17		Total Claim Allowed	$8,324*

*Outlier days and Stop Loss will be reviewed for Medical Necessity.

Exclusions from DRG Reimbursement

The following conditions and/or treatments are specifically excluded under the DRG network attachment. Facilities intending to provide these services for our members must execute a separate network attachment covering the provision of these services.

- Mental Disease and Disorders (MDC 19*)
- Alcohol and Drug Use (MDC 20*)
- Transplants (Excluding Kidney)

*For these services, if a member is admitted under a covered medical diagnosis, we'll allow reimbursement based on the provider's contracted type of reimbursement method (e.g., CMS-DRG, MS-DRG, Per Diem).

Effective Jan. 1, 2022:

*For these services, if a member is admitted under a covered medical diagnosis, we'll allow reimbursement based on the provider's contracted type of reimbursement method (e.g., CMS-DRG, MS-DRG, Per Diem). We'll allow reimbursement to include an outlier/stoploss based on the provider's contract. *Outlier days and Stop Loss will be reviewed for medical necessity.

This policy only applies to our members. For out of state patients we don't own the authorization, those cases would still have to be reviewed through the reconsideration/appeal process.

Ungroupable DRG(s)

Claims that are linked to an ungroupable DRG won't be reimbursed and will require the institution to file a corrected claim for payment.

b. Relative Weight Revisions

Relative weights are updated according to one of two schedules for revisions. To determine which schedule you're on, refer to your contract.

c. Annual Base Rate Adjustments

Base rates are updated annually on Jan. 1 in accordance with the contract.

d. Private Room Differential

The DRG payment is a total payment to include all room and board services provided during the inpatient stay. Private room differentials are considered part of the DRG and shouldn't be balance billed to any member.

e. Birth Parent and Newborn

A combined claim is required for both the birth parent and newborn. A separate DRG payment won't be made for a normal newborn because payment for this claim is combined with the birth parent's DRG payment.

f. Implants and Prosthetics

Implants and prosthetics aren't reimbursed separately. Reimbursement for these items is included in the base rate and relative weights that determine DRG payment.

g. Kidney Transplants

Kidney transplants are reimbursed under the DRG agreement.

Every participating hospital is contracted for both the DRG and the organ acquisition cost. The schedule of payments in the contract contains the relative weight, base rate, and outlier per-diem for the appropriate kidney transplant DRG. Organ acquisition cost has been included in the relative weight and is reimbursed through the DRG payment. Organ acquisition cost as defined below is the responsibility of the transplant hospital.

- **Administrative and payment policies for kidney transplants are:**
  - Requires prior authorization and must be within the utilization management guidelines.
  - The claim should be filed in accordance with the Tennessee Uniform Billing Guidelines.
  - Organ acquisition costs, which are billed by other providers and paid by us will be accumulated and deducted from the DRG payment to the transplant hospital through our retrospective audit process.
  - Practitioner costs associated with organ acquisition costs aren't included in the definition of organ acquisition costs and should be billed separately on a professional claim form.
  - The lesser of total covered charges or DRG-allowed adjusted for deductible and coinsurance represents payment for the transplant including the organ acquisition cost.
  - Hospitals not contracted under a DRG reimbursement method need to contact us to negotiate a single patient agreement prior to providing services to a member.
  - Refer to "Tips for Completing CMS-1500, CMS-1450 and Electronic Claims Filing" section of this manual for donor/recipient special billing instructions.
- **Organ acquisition costs Include:**

  Living d***onor:***

  - Kidney recipient registration fees
  - Lab test (including tissue typing of recipient and donor)
  - Hospital services that are directly related to the excision of the kidney

  Cadaver Kidneys:

  - Operating room services
  - Intensive care cost
  - Preservation supplies (perfusion materials and equipment)
  - Preservation technician's services
  - Transportation cost
  - Tissue typing of the cadaver organ

h. Pre-Admission Services

Pre-admission diagnostic services performed on an outpatient basis that are related to the member's facility admission by the admitting hospital, or by an entity wholly owned or operated by the facility (or by another entity under arrangements with the facility) within three days of an inpatient admission will be covered under the inlier portion of the DRG payment. No separate payment will be made for pre-admission diagnostic services within the three-day period.

Other pre-admission non-diagnostic services related to the member's facility admission performed by the admitting facility or by an entity wholly owned or operated by the facility (or by another entity under arrangements with the facility) during the three days immediately preceding the date of admission will be covered under the inlier portion of the DRG payment for approved admissions. No separate payment will be made for these services. All testing performed on the day of discharge or within one day following the discharge will also be covered under the inlier portion of the DRG payment. No separate payments will be made for outpatient testing within the one-day period.

i. Transfer Payments

We allow a transfer per diem multiplied by the number of days, not to exceed the amount allowed under the DRG to the transferring hospital. These claims are identified by the discharge status codes listed in the Provider Agreement. **Please Note**: If the Provider Agreement does not contain any discharge status codes, the claims are identified by the following codes filed on the claim as follows: 02, 05, 66, 70 or 82-95. The receiving hospital is reimbursed according to its acute care contract.

j. Readmissions (Doesn't apply to Medicare Advantage)

A readmission is defined as a preventable, unplanned admission occurring within 14 days after a hospital discharge. The readmission would occur in the same facility for a condition related to, or complication of the original hospital stay or admission resulting from a modifiable cause.

Congestive heart failure, chronic obstructive pulmonary disease and Class I surgeries are eligible for 14-day readmission review. A Class I surgery is considered a clean wound, which shows no signs of infection or inflammation. It often involves the eye(s), skin or vascular system. Claims for patients at

either a DRG or per diem facility that are re-admitted under these circumstances aren't eligible for multiple payments and only a single payment will be made. These guidelines are subject to the provider's contract.

If more than one payment has been made, we reserve the right to re-coup the overpayment.

Examples of readmissions that MAY NOT be authorized:

- Respiratory admissions, (COPD)
- Complications from Class I surgical procedures
- Congestive heart failure (CHF)

Examples of readmissions that MAY be authorized are:

- NICU admissions
- Planned admissions
- Cancer diagnoses for chemotherapy
- Complications of pregnancy
- Admissions for coronary artery bypass surgery following an admission for chest pain
- Children 18 years and under admitted to any facility
- Admissions for complications due to rejection of transplant/implant surgery

Note: The member can't be held liable for payment of services received when not authorized.

k. Reimbursement Guidelines for Inpatient Services Based on Admission

We updated our reimbursement policy for inpatient facilities participating in all lines of business.

These facilities were transitioned to a reimbursement method based on the *earliest agreement date*.

For these providers, reimbursement for inpatient services will be based on the contracted rates in effect at the time of admission. The contracted rates in effect on the admit date will be used to calculate a payment for the entire stay. In some instances, a patient's admission date may span multiple provider agreements. In this situation, charges for all approved days will still be reimbursed based on the rates that were in effect on the date of admission and will remain in effect until the patient is discharged.

The following grid lists provider types that may be affected by this method. Please refer to your specific contract in effect on the date of the patient's admission to determine applicable reimbursement rates:

Provider's affected by Earliest Agreement Date
Acute care hospital
Freestanding inpatient rehabilitation hospital
Skilled nursing facility
Hospice facility

l. Policy for Present on Admission (POA) Indicators

This policy applies to claims billed on an Institutional claim form for all lines of business.

For all inpatient admissions to general acute care hospitals, we require the Present on Admission code on primary and secondary diagnoses (Form Locator 67) for all discharges, by using National Coding Standard guidelines. This may impact reimbursement.

POA indicators are needed when Acute Inpatient Prospective Payment System (IPPS) hospital providers bill for selected Hospital Acquired Conditions (HACs), including some conditions on the National Quality Forum's (NQF) list of serious reportable events (commonly referred to as "never events"), these certain conditions have been selected according to the criteria in section 5001(c) of the Deficit Reduction Act (DRA) of 2005 and are reportable by CMS POA Indicator Options.

Note: For all inpatient admissions to general acute care hospitals, based on National Coding Standard guidelines, the following POA Indicator Option "1"reporting guidelines apply:

Present on Admission (POA) Indicator Options:

Y=	Diagnosis was present at time of inpatient admission.
N =	Diagnosis wasn't present at time of inpatient admission.
U =	Documentation insufficient to determine if the condition was present at the time of inpatient admission.
W =	Clinically undetermined. provider unable to clinically determine whether the condition was present at the time of inpatient admission.
1 =	Unreported/not used. Exempt from POA reporting on paper claims. A blank space is only valid when submitting this data via the ANSI 837 5010 version.

When filing electronic ANSI 837 inpatient facility claims, providers should no longer enter Indicator Option "1" in the POA field when exempt POA reporting. The POA field should be left blank for EDI format 5010 claims.

When filing paper CMS-1450 inpatient facility claims, providers should enter a "1" in the POA field when exempt from POA reporting.

When any other POA indicator options apply, they should be reported in the POA field on **both** electronic and paper claims.

Claims will reject if:

- POA "1" is submitted on an electronic "ANSI 837 inpatient claim
- POA is left blank on a paper CMS-1450 (UB04) inpatient claim
- POA is required, but not submitted.

The guidelines for reporting POA Indicators can be found on the CMS website at www.cms.gov/HospitalAcqCond/.

m. Reimbursement Policy for Selected Hospital Acquired Conditions (HACS) Not Present on Admission (POA)

This policy applies to claims billed on an Institutional claim form for all lines of business.

We'll use POA indicators to determine DRG assignment for selected HACs (a.k.a. avoidable hospital conditions) not present on admission as outlined by CMS National Reimbursement Policy.

POA adjustment reimbursement for Commercial lines of business will be based on individual provider contracts. In addition to the provider contracts, any reimbursement adjustments for HACS that are recognized as Serious Reportable Adverse Events will be made as defined by CMS guidelines.

We accept POA indicator codes on inpatient hospital claims.

Note: Medicare Advantage lines of business follow CMS guidelines for both reimbursement and reporting.

n. Billing and Reimbursement Guidelines for Durable Medical Equipment, Medical Supplies, Orthotics and Prosthetics (O&P) (DMEPOS) Dispensed by a Facility (Inpatient or Outpatient)

When a facility partners with a DME supplier for the provision of equipment, supplies, or O&P used with surgical or other procedures, the facility is responsible for submitting all charges associated with the service. Separate claims submitted by the DME supplier for any unbundled charges related to the facility service won't be reimbursed. The member can't be held liable in these cases, as reimbursement for DME is part of the all-inclusive global payment for inpatient and/or outpatient surgeries to contracted facilities.

Should a facility choose to partner with a DME supplier for the provision of equipment associated with the facility services, the facility will be responsible for submitting all charges to us and is responsible for payment of the DME supplier.

Unbundling of charges is a violation of contract, National Coding Conventions, and legal requirements. Under certain situations, inappropriate bundling could be considered abusive or even fraudulent.

These guidelines are in accordance with the Institution Agreement. Please contact your Provider Network Manager for any questions concerning your provider contract.

11. Acute Care Outpatient Services

a. Outpatient Surgery

Outpatient Surgery is reimbursed based on an all-inclusive rate. This all-inclusive rate will fully compensate the facility for all related facility services and supplies provided in association with a particular surgical procedure. Pre-admission testing (PAT), which is provided by the facility or any facility wholly owned or operated by the facility at which the surgery is performed up to three days prior to the surgery is included in the all-inclusive rate and must be filed on the same claim as the outpatient surgery. Services not related to PAT should be filed on a separate claim for appropriate reimbursement and will be subject to audit.

The maximum allowable for eligible multiple procedures billed on the same date of service by the same provider is subject to the provider's contract. The primary procedure will be determined by the code with the greatest base maximum allowable.

All procedures performed in an outpatient surgery setting and not shown in the applicable schedule of the provider's contract will be reviewed and assigned to an outpatient surgery grouping if appropriate for payment. The outpatient surgery is considered an all-inclusive service. Re-bundling charges will occur when appropriate.

Grouped surgical procedures are rendered in the radiology department due to stationary radiology equipment or imaging guidance, the breast center due to use of imaging guidance or the cardiac cath lab in conjunction with cardiac procedures. We'll accept and reimburse based off of the outpatient surgical grouping guidelines for the appropriate HCPCS code when filed with RC(s) 0360, 0490 or 0499. RC(s) 0360, 0490 or 0499 shouldn't be filed if the procedure isn't rendered in the operating room suite, radiology department, breast center, or cardiac cath lab. We reserve the right to audit.

Note: For donor lymphocyte infusion (DLI) in Commercial acute care facilities, any eligible outpatient surgical HCPCS/CPT® codes appropriately filed with revenue codes 0362, 0810, 0815 or 0819 that aren't included in an all-inclusive transplant rate will be reimbursed according to the outpatient surgical facility (OSF) guidelines, unless otherwise contracted. All surgical reimbursement policies will apply.

b. Bilateral Procedures

The aggregate maximum allowable for eligible bilateral procedures will be 150% of the base maximum allowable. When a bilateral procedure is performed in conjunction with other surgeries, the reimbursement for the bilateral procedure will be 75% of the fee schedule, when determined that the bilateral procedure isn't the primary procedure.

In accordance with HIPAA billing standards, bilateral procedures should be submitted as a single line item using the appropriate CPT® code accompanied by modifier 50 to indicate the service was performed on both sides of the body. For most CPT codes, only one unit should be reported. However, certain procedures performed bilaterally may be submitted with modifier 50 and multiple units when appropriate. Only a limited set of codes qualifies for submission with modifier 50 and more than one unit.

Only surgical procedures filed on an Institutional claim form as indicated above will receive bilateral reimbursement.

However, in certain situations, modifier 50 shouldn't be added to a procedure code. Some examples, include, but aren't limited to:

- A bilateral procedure performed on different areas of the right and left sides of the body (e.g., reduction of fracture, left and right arm)
- When the procedure code description specifically includes the word "bilateral"
- When the procedure code description specifically indicates the words "one or both"

Sometimes it's appropriate to bill a bilateral procedure with:

- A single line with no modifier and one unit
- A single line with modifier 50 and one unit; and/or

- Two lines with modifier LT and one unit on one line and modifier RT and one unit on another line.

c. Endoscopic Gastrointestinal Procedures

Revenue code 0750 indicates endoscopic gastrointestinal procedures performed in the GI lab and not in an operating room. The endoscopic gastrointestinal procedure is considered an all-inclusive service when filed with a contracted surgical grouper CPT® code. Re-bundling of charges will occur when appropriate.

d. Minor Surgery

Minor surgery (revenue code 0361) codes are outpatient surgery codes that should be performed in a physician office setting. These codes have been assigned to Group 0. The agreed maximum allowable amount is $0.00. We won't make any payment for the supplies or room charges when these procedures are performed in the facility.

If a minor surgery is performed in conjunction with an all-inclusive service, the minor surgery will bundle to the all-inclusive service. If an all-inclusive service isn't billed on a claim then the line item will disallow.

e. Outpatient/Ambulatory Surgery – Group Zero Encounters and Non-Grouped Procedures Reimbursement Policy

This policy applies to all Commercial networks for acute care facilities and free-standing ambulatory surgery facilities for outpatient/ambulatory surgery. Group zero encounters and non-grouped procedures performed outside the surgical coding range when rendered in the operating room suite (as detailed in this policy content) for services billed on a CMS-1450/ANSI-837I claim form.

Group Zero Encounters

Commercial Networks

The fee schedules governing the group zero (minor surgery) procedures will retain the current configuration of $0.00 unless the provider contract states otherwise for:

- Commercial acute care and free-standing ambulatory surgical facilities (see schedule - Exhibit A).

We'll reimburse acute care facilities and ambulatory surgical facilities for outpatient surgeries as a group zero encounter and non-grouped procedures performed outside of the surgical coding range (10000 - 69999) when rendered in the operating room suite that aren't reimbursed from any other contracted fee schedule. This flat rate reimbursement will be applied on a reconsideration basis for situations that necessitate a facility setting according to the criteria used by clinical staff during their review process for the primary procedure.

The services addressed under this policy won't be considered for payment when they're a secondary or subsequent procedure, filed in conjunction with a flat and/or case rate service, and/or attached to a fee schedule listed in the provider's contract or Provider Administration Manual.

For procedures without an ASF/OSF grouping that clinical staff determines to be medically necessary, we'll reimburse these CPT®/HCPCS codes based on the flat fee indicated below for the Commercial networks. We'll reimburse a flat fee of $274.00 for Commercial networks.

If a provider is contracted for group zero procedures and a CPT®/HCPCS code is on one of the appropriate group zero procedures schedules, the procedure will be reimbursed at the rate in the provider's contract or fee indicated on the schedule, where applicable.

If a provider is contracted for group zero procedures and the CPT®/HCPCS code isn't on one of the appropriate group zero procedure schedules, but determined to be medically necessary, the primary procedure will be reimbursed at the flat fee indicated above for all Commercial networks.

f. Observation Services Billing & Reimbursement Guidelines

Observation services include the use of a bed and periodic monitoring by a hospital's nursing staff, which are reasonable and necessary to evaluate a patient's condition.

We'll consider reimbursement for the following outpatient observation services:

- For members, who, after six hours of recovery for outpatient services, aren't medically stable for discharge, provided an authorization is obtained.

We'll base the observation time on when the member arrives in a designated observation bed and when they leave observation, after the six hour recovery time, if applicable.

We won't consider reimbursement for the following outpatient observation services:

- Observation services the day before an elective inpatient surgery
- Inpatient stays billed as observation services. Members with an inpatient stay must have an authorization within one business day from the date of admission
- Charges for observation services in addition to payment for inpatient services
- Charges for observation services following an outpatient surgical procedure unless authorization is given. On those authorized, observation services may not be billed until six hours after surgery. Recovery times up to six hours are included in the outpatient surgery all-inclusive rates

Observation services billed for convenience such as holding a member overnight in the hospital if their regular post-surgery recovery period ends late at night

- Observation services require prior authorization. We don't reimburse labor and delivery services billed under revenue code 0721 "Labor Room/Delivery – Labor" or 0722 "Labor Room / Delivery – Delivery." These services should be billed under revenue code 0762 "Treatment or Observation Room – Observation Room" *.

Note: Fetal stress and fetal non-stress tests should be billed as observation under revenue code 0762 with the number of hours as units. However, fetal stress tests don't require prior authorization.

Observation services billed with revenue code 0762 don't require a HCPCS/CPT® code in Form Locator 44 on an institutional claim form unless the provider is billing for fetal stress and non-stress tests. Adding an evaluation and management code with the observation code may result in delayed or denied payment of the service. We'll allow up to 23 hours for the observation services if medically necessary and medically appropriate. Hours billed over 23 hours won't be allowed.

Revenue Code	Type of Service	HCPCS/ CPT® Code	Allowed
0762	Observation Room	N/A	Allowed at an hourly rate per contract, not to exceed 23 hours.

How to calculate observation services

Less than 23 hour stay	
Observation Service Charges Billed by Facility	$ 1,500.00
Observation Services Maximum Allowed Charge	$ 900.00
Hourly Rate (Indicated by Provider Contract)	$ 39.13
Total Hours Billed by Facility (1-hour increments)	3
Total Allowed Amount for Revenue Code 762	$ 117.39
Over 23 hour stay	
Observation Service Charges Billed by Facility	$ 1,500.00
Hourly Rate	$ 39.13
Total Hours Billed by Facility (1-hour increments)	30
Total Hours Allowed by BCBST (1-hour increments)	23
Total Allowed Amount for Revenue Code 762	$ 900.00

Note: For providers contracted with base fee schedule version 7 or later, observation is a case rated service and won't be paid at an hourly rate. Please refer to the provider's contract for specific reimbursement details.

g. Acute Care ER Services

ER services for an emergency condition don't require prior authorization. If the member is admitted to the hospital as inpatient from the ER, in-network providers are responsible for contacting us within two business days of the inpatient admission. **Note**: Medicare Advantage timeframe is 24 hours or the next business day. These claims will be reimbursed on an all-inclusive negotiated case rate or total covered charges, subject to the lesser of provision found in the facility's contract. Only the contracted HCPCS codes will be reimbursed when filed with revenue code 0450, 0451, and/or 0459. Any other HCPCS code filed with revenue code 0450, 0451 and/or 0459 will be reimbursed at zero.

12. Acute Care All-Inclusive Rates

a. Cardiac Catheterization and Ablation Services

Cardiac catheterization and ablation services are all-inclusive and reimbursement will fully compensate the facility for all covered services provided in connection with these services and the exceptions based on the provider's contract. Claims billed with multiple contracted codes for RCs 0480 and 0481 may be reviewed for re-bundling.

b. Angioplasty Services

Angioplasty services, including stents, are all-inclusive and reimbursement will fully compensate the facility for all covered services provided in connection with these services (except outpatient surgery), approved observation services and the exceptions based on the provider's contract. Claims billed with multiple contracted codes for RCs 0480 and 0481 may be reviewed for re-bundling.

Note: Due to significant HCPCS/CPT® code set changes where single codes were deleted and replaced with multiple codes, we'll only allow reimbursement for one cardiac ablation case rate per day, one cardiac catheterization case rate per day, and one angioplasty case rate per day. RCs 0480 and 0481 are interchangeable between these services.

c. Lithotripsy Services

Lithotripsy will reimburse the contracted rate when billed with RC 0790. Lithotripsy services are all-inclusive services. Other surgical RCs billed for this service will default to Institutional Surgery Grouper Fee Schedule. This applies to Acute Care and Ambulatory Surgery Center facilities as applicable based on provider's contract.

13. Acute Care Fee Schedules

We'll update the facility fee schedule for quarterly additions and deletions to HCPCS/CPT® codes effective Jan. 1, April 1, July 1 and Oct. 1 of each year in accordance with the American Medical Association (AMA). For new HCPCS/CPT® codes, the allowable reimbursed beginning with the effective date of the code from Jan.1 until March 31 will be considered an interim allowable based on the reimbursement pricing method below. Revisions for the existing HCPCS/CPT® codes allowable reimbursement will be updated effective April 1 of each year in accordance with the provider's contract.

a. Lab Services

Lab services will be allowed according to the contract unless performed with an all-inclusive service. When filed with an all-inclusive service, the lab services will be bundled with the all-inclusive service. The fee schedule will be allowed when filed separately. These fee schedules are priced at the current Medicare reimbursement rate and updated on April 1 of each year.

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
0300	Lab	Requires a valid HCPCS/CPT® code.	Reimbursement is based upon the contract. Refer to lab fee schedule.
0301	Chemistry		
0302	Immunology		
0304	Non-routine dialysis		

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
0305	Hematology		
0306	Bacteriology and microbiology		
0307	Urology		
0309	Other lab		
0310	General		
0311	Cytology		
0312	Histology		
0314	Biopsy		
0319	Other		

Technical Component for Professional Services Performed in a Facility:

Commercial DRG and outpatient case rates paid to a facility are all-inclusive of any technical component for professional services provided while a patient is in a facility setting. The facility must bill for the technical component of the services, even if these services are provided under arrangements with or subcontracted out to another entity such as a lab, pathologist or other provider. Payment isn't made under the physician fee schedule for technical component services furnished to patients in institutional settings. Medicare Advantage claims should continue to be billed consistent with CMS guidelines.

b. Reference Lab Services

For acute care contracts without reimbursement for reference labs, these services must be separately contracted. TOB 014x won't pay for services under the acute care contract.

c. Radiology Services

When filed with all-inclusive services, the radiology procedure will be bundled with the all-inclusive service. The fee schedule will be allowed when filed separately. These fee schedules are priced at the current Medicare reimbursement rate and updated on April 1 of each year.

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
0320	Radiology diagnostic	Requires a valid HCPCS/CPT® code.	Reimbursement is based on the contract. Refer to radiology fee schedule.
0321	Angiocardiography		
0322	Arthrography		
0323	Arteriography		
0324	Chest X-ray		
0329	Other radiology services		
0330	Radiology therapeutic		
0333	Radiation therapy		
0340	General radiology		
0341	Diagnostic procedures		
0342	Therapeutic procedures		
0349	Other radiology services		
0400	Other Imaging services		

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
0401	Diagnostic mammography		
0402	Ultrasound		
0403	Screening mammography		
0404	Positron emission tomography (PET)		
0409	Other imaging services		

MRI/MRA/CT Scan

MRI/MRA/CT scan reimbursement is allowed in addition to other all-inclusive rate(s). The reimbursement includes pharmacy, anesthesia, and/or supplies used in conjunction with these radiology services.

Note: For providers contracted with the base fee schedule version 7 or later, MRI/MRA/CT scans are no longer reimbursed in addition to other all-inclusive rate services.

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
0350	General scans	Requires a valid HCPCS/CPT® code.	Reimbursement is based on the contract. Refer to MRI/MRA/CT scan fee schedule.
0351	Head scan		
0352	Body scan		
0359	Other CT scan		
0610	Magnetic resonance technology (MRT) General MRI technology		
0611	MRI – brain (including brainstem)		
0612	MRI – spinal cord (including spine)		
0614	MRI – other		
0615	Magnetic resonance angiography – (MRA) head and neck		
0616	MRA – lower extremities		
0618	MRA – other		
0619	MRT – other		

Note: Supplies incidental to radiology (RC 0621) and supplies incidental to other diagnostic services (RC 0622) should be filed accordingly with the appropriate HCPCS/CPT® code but won't be reimbursed in addition to the MRI/MRA/CT scan because this is an all-inclusive service as indicated above.

d. Facility Fee Schedule Reimbursement Methodology Policy

This policy applies to claims filed on an Institutional claim form/transaction. It defines the reimbursement method used for all new codes and existing HCPCS/CPT® codes for all lines of business on the Facility Fee Schedule. The purpose is to establish a consistent method to add and update HCPCS/CPT® codes on the Facility Fee Schedule for all contracts.

We'll update the Facility Fee Schedule for quarterly additions and deletions to HCPCS/CPT® codes that are effective Jan. 1, April 1, July 1, and Oct. of each year in accordance with the American Medical Association (AMA). For new HCPCS/CPT® codes, the allowable amount reimbursed beginning with the effective date of the code from Jan 1 until March 31 will be considered an interim allowable based on the reimbursement pricing method below. Revisions for the existing HCPCS/CPT® codes allowable reimbursement will be updated effective April 1 of each year in accordance with the provider's contract.

To establish the codes added to the Facility Fee Schedule, we'll use the Appendix, "Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments," of the OPTUM Uniform Billing (UB) Editor. These codes will be updated annually on July 1 from the First Quarter OPTUM UB Editor Updates.

The reimbursement method within this policy doesn't apply to "C" codes such as drugs, biologicals, radiopharmaceuticals, and devices that have alternate reimbursement methods.

The established facility allowable amount will be based on the published maximum allowable non-facility rate. We won't establish an allowable amount for an unlisted code. Some exceptions may apply.

To determine the allowable, we'll use the following reimbursement pricing method hierarchy (excluding labs - see lab pricing grid):

Order	Description
1	Current year Medicare RBRVS fee schedule TC component (calculated using the CMS formula) x contract multiplier %.
2	Current year Medicare RBRVS fee schedule global* (calculated using the CMS formula) x contract multiplier %.
3	Current year Palmetto GBA (or its successor) complete RBRVS TC component x contract multiplier %.
4	Current year Palmetto GBA (or its successor) complete RBRVS *Global x contract multiplier %.
5	Current year OPTUM (or its successor) complete RBRVS TC component (calculated using the CMS formula) x contract multiplier %.
6	Current year OPTUM (or its successor) complete RBRVS *Global (calculated using the CMS formula) x contract multiplier %.
7	Current year National Medicare APC Payment Rate x contract multiplier %.
8	Allowable amounts that weren't priced by any source mentioned above remain at zero dollars with "BR – By report" to be reviewed and priced using a similar HCPCS/CPT® code.
9	Last resort pricing for eligible services with no other means of pricing: - 25% of charge for Medicare lines of business - 40% of charge for Commercial lines of business

To determine the allowable amount, we'll utilize the following reimbursement pricing method hierarchy for lab:

Order	Description
1	Current year Palmetto GBA (or its successor) clinical Laboratory fee schedule x contract multiplier %.

Order	Description
2	Current year Medicare physician fee schedule TC component (calculated using the CMS formula) x contract multiplier %.
3	Current year Medicare physician fee schedule *global (calculated using the CMS formula) x contract multiplier %.
4	Current year Palmetto GBA (or its successor) physician fee schedule TC component x contract multiplier %.
5	Current year Palmetto GBA (or its successor) physician fee schedule *global x contract multiplier %.
6	Current year OPTUM (or its successor) complete RBRVS TC component (calculated using the CMS formula) x contract multiplier %.
7	Current year OPTUM (or its successor) complete RBRVS *global (calculated using the CMS formula) x contract multiplier %.
8	Current year National Medicare APC Payment Rate x contract multiplier %
9	Allowable amounts that weren't priced by any source mentioned above remain at zero dollars with "BR – By report" to be reviewed and priced by using a similar HCPCS/CPT® code.
10	Last resort pricing for eligible services with no other means of pricing: - 25% of charge for Medicare lines of business - 40% of charge for Commercial lines of business

* Global represents the five-digit code on fee schedule with no modifiers.

e. Reimbursement Policy and Billing Guidelines for the BCBST Facility Drug Schedule

Note: RCs 0891 and 0892 effective Aug. 1, 2023

This policy establishes the codes added to the BCBST Facility Drug Fee Schedule. We'll use the Appendix, "Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments," of the OPTUM UB Editor.

We'll identify the HCPCS codes that are appropriate to be billed under RC(s) 0250, General Drugs; 0251, Generic Drugs; 0252, Non-generic Drugs; 0254, Drugs Incident to Other Diagnostic Services; 0255, Drugs Incident to Radiology; 0257, Non-prescription; 0258, IV Solutions; 0259, Other Pharmacy; 0343, Radiopharmaceuticals Diagnostic; 0344, Radiopharmaceuticals Therapeutic; and 0636, Drugs Requiring Detail Coding, and 0891, Pharmacy – Special Processed Drugs Approved Cell Therapy, and 0892, Pharmacy – Special Processed Drugs Approved Gene Therapy, as indicated in the OPTUM UB Editor or its successor and add these codes to the fee schedule.

Drug codes submitted for consideration, but not listed in the Facility Drug Fee Schedule aren't eligible for reimbursement and will be denied as non-contracted. Any of the above indicated RC(s) filed without a HCPCS/CPT® code will also be denied as non-contracted. Drug codes submitted that are on this schedule with a $0.00 fee and no indicator in the note to review for manual pricing will be denied (exceeds the scheduled rate). If an inappropriate payment has occurred, we reserve the right to re-coup the reimbursement as necessary.

We'll reimburse acute care hospitals contracted for a Facility Drug Fee Schedule for eligible outpatient drug codes based on a percentage of the Average Sale Price (ASP), or in the absence of a published ASP, Wholesale Acquisition Cost (WAC) or Average Wholesale Price (AWP). The table below indicates the Base Facility Drug Fee Schedule pricing for each of the above methods.

BCBST Base Facility Drug Fee Schedule

Pricing Method	Percentage of Base Allowed
ASP	108 %
WAC	100 %
AWP	84 %

Eligible outpatient drugs will be reimbursed in addition to other outpatient services filed on the CMS-1450 (UB-04 or successor) claim form, including but not limited to outpatient surgery, ER, observation and cardiac care.

If a valid outpatient drug C code is considered to be a covered procedure and there isn't an acceptable CPT® code that could be used, we'll reimburse the C code by using ASP multiplied by an indicated contract percentage. The source for this reimbursement is derived from the Medicare Hospital Outpatient Prospective Payment System (OPPS) method.

Any new eligible outpatient drug codes that apply to this schedule and do not have a fee will be added to the schedule with $0.00 allowable and "BR" indicator. These codes as well as Not Otherwise Classified (NOC) and Unlisted/Miscellaneous/Non-Specific HCPCS codes will be reviewed for manual pricing according to our policy for Unlisted, Miscellaneous, Non-specific, and Not Otherwise Classified Procedures/Services until a CMS fee is established. In situations where fees may not be established for an eligible drug, invoice pricing may be used. These fees will be updated in accordance with the Policy "Quarterly Reimbursement Changes." Failure to submit the following information for these codes will result in delay of reimbursement.

Not Otherwise Classified (NOC) and Unlisted/Miscellaneous/Non-Specific HCPCS Codes:

- Must be billed with a unit of one
- Requires submission of drug name; National Drug Code (NDC) in field 43, "Revenue Description/ IDE/ Medicaid Drug Rebate" on the CMS-1450 claim form; and dosage administered

Note: Percentages and base allowable amounts described in the BCBST Base Facility Drug Fee Schedule aren't eligible for an annual contract increase pursuant to the outpatient language excluding services reimbursed at a percentage of Medicare or percentage of covered charges. Also, any items identified as over the counter (OTC) or drugs not requiring a prescription, self-administered and oral medications and medications not reimbursed by Medicare have been excluded from this Facility Drug Fee Schedule.

The appropriate HCPCS/CPT® code should be billed in conjunction with the corresponding RC according to the following chart:

Revenue Code	Description	CPT®/HCPCS Code
0250	General Drugs	Required
0251	Generic Drugs	Required
0252	Non-generic Drugs	Required
0254	Drugs Incident to Other Diagnostic Services	Required
0255	Drugs Incident to Radiology	Required
0257	Non-prescription	Required
0258	Intravenous (IV) Solutions	Required
0259	Other Pharmacy	Required
0343	Radiopharmaceuticals Diagnostic	Required, if applicable

Revenue Code	Description	CPT®/HCPCS Code
0344	Radiopharmaceuticals Therapeutic	Required, if applicable
0636	Drugs Requiring Detail Coding	Required, if applicable
0637	Self-Administrable Drugs	Required, if applicable Not eligible for reimbursement unless stated in provider's contract

Providers filing electronic claims should refer to the electronic billing Instructions of this manual.

f. C Codes – Outpatient Prospective Payment System

If a valid C code is considered a covered procedure and there's no acceptable CPT® code that could be used, we'll reimburse the C code based on the Facility Commercial Base Fee Schedule Reimbursement Update Policy *. Revisions to existing codes will be made effective Jan. 1 of each year. The effective date of new and deleted codes will coincide with CMS. The replacement code(s) will be added according to the CMS reimbursement method - technical component if applicable - related to that code.

The reimbursement method described in this policy doesn't apply to C codes such as drugs, biologicals, radiopharmaceuticals and devices that have alternate reimbursement methods.

We only recognize C Codes only on CMS-1450/ANSI-837I claims.

***Note:** Valid drug C codes considered a covered procedure when there isn't an acceptable CPT® code that could be used, will be reimbursed based on the Facility Drug Fee Schedule Policy contracted by the provider.

g. Ambulance Services

Ambulance services shall be paid in accordance with the Institutional Ambulance Fee Schedule. The ambulance codes are based on those established by CMS codes. These codes are reimbursed based on provider's contract and updated April 1 of each year.

h. Implants and Pacemaker and Orthotic/Prosthetic Devices

Facilities that bill BCBST in excess of the contracted amount are subject to recovery. Likewise, hospitals that cannot support a charge for an Implant or Pacemaker with a manufacturer's invoice, or other documentation, meeting BCBST satisfaction verifying the cost, (that excludes shipping & handling and state sales tax) and a medical record indicating that it was provided to a BCBST member are subject to recovery.

Orthotic and Prosthetic (O & P) devices must be billed with an appropriate HCPCS code under RC 0274. The reimbursement for all these services is based on the provider's contract. When not specifically contracted, the allowable will be zero.

BCBST requires providers to file the most appropriate HCPCS codes in accordance with the National Uniform Billing Guidelines on an Institutional claim form for Implant RCs 0275, and 0278.

14. Other Acute Care Outpatient Services

a. Clinic Visits

We don't make payment for the clinic revenue codes UNLESS otherwise stated in contract. However, we'll allow other eligible services based on the contracted rate or total covered charges, whichever is less when filed in conjunction with clinic visits.

b. Venipuncture

Venipuncture services will be allowed according to the contract unless performed with an all-inclusive service.

Revenue Code	Type of Service	HCPCS/CPT® code	Allowed
0300	Venipuncture	Requires a valid HCPCS/CPT® Code	Reimbursement is based on the contract.

c. Cardiac and Pulmonary Rehabilitation

Prior authorization requirements for cardiac and pulmonary rehabilitation services will be driven by the member's health plan.

To ensure appropriate payment is made for cardiac and pulmonary rehabilitation services, providers are encouraged to verify available benefits and prior authorization requirements under the member's health plan by calling the Provider Service line at 1-800-924-7141 or via e-health Services® located on Availity. For health plans requiring prior authorization, penalties will continue to apply for non-compliance.

d. Wound Care

We may reimburse wound care services if they've been contracted. Wound care services won't be reimbursed if they haven't been contracted.

Wound care services must be performed by a certified wound care nurse or other qualified health care professional. The services must be considered medically necessary as determined by our clinical decision process.

At least one of the HCPCS codes listed in the contract must be billed in Form Locator 44 on the CMS-1450 claim form. HCPCS codes not listed shouldn't be billed. All wound care services should be billed with revenue code 0519, Other Clinic, in Form Locator 42. Only wound care services should be billed under revenue code 0519. Any non-wound care services billed with revenue code 0519 are subject to recovery.

e. Sleep Study

Sleep studies must be performed in a certified service location, as required by applicable state and federal regulations, and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and/or American Osteopathic Association (AOA) and/or the American Academy of Sleep Medicine. The evaluating physician and staff are required to have specialized training that meets the standards set by the American Academy of Sleep Medicine. To help ensure the most appropriate member benefit is applied, providers are reminded to submit claims with the most appropriate revenue code, procedure code and HCPCS code in effect on the date of service. The appropriate revenue code can be determined using the Uniform Billing Editor by OPTUM Appendix, "Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments", and/or the revenue codes indicated on the fee schedule in the provider's contract.

f. Other Diagnostic Services

The other diagnostic services will be allowed according to the contract unless performed with an all-inclusive service.

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
0920	Other Diagnostic Services	Requires a valid HCPCS/CPT® code.	Reimbursement is based upon the contract.
0921	Peripheral Vascular Lab		Also see all other outpatient services, if contracted
0922	Electromyogram		
0923	Pap Smear	Requires a valid HCPCS/CPT® code.	Reimbursement is based upon the contract.
0924	Allergy Test		
0925	Pregnancy Test		

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
0929	Other Diagnostic Services		

g. Other Therapeutic Services

Other therapeutic services will be allowed according to the contract unless performed with an all-inclusive service.

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
0940	Other Therapeutic Services	Requires a valid HCPCS/CPT® code.	Reimbursement is based upon the contract.
0941	Recreational Therapy	Requires a valid HCPCS/CPT® code.	Reimbursement is based upon the contract
0944	Drug Rehabilitation		
0945	Alcohol Rehabilitation		
0946	Complex medical equipment - routine		
0947	Complex medical equipment - ancillary		
0948	Pulmonary Rehabilitation		
0949	Other therapeutic services		

h. Acute Care Dialysis

We'll allow an all-inclusive composite rate for qualified acute care dialysis services as negotiated in the provider's contract. Except where specifically noted in the contract, the composite rate includes all services such as, drugs, supplies associated with dialysis, dialysis training, or a combination of dialysis and training. The composite rate may only be billed when an actual dialysis treatment has been performed within the acute care facility.

This standard applies to all Commercial networks for acute care facility agreements and reimbursement is based on negotiated rates established in the provider's contract. This standard doesn't apply to inpatient services. In situations where Acute Care services haven't been contracted, reimbursement will be set at zero.

To be considered for reimbursement, qualified dialysis services must be billed with revenue code (RC) 0829* and one of the following diagnosis codes for acute renal failure: 584.5, 584.6, 584.7, 584.8 or 584.9. These diagnosis codes were established and will be updated per CMS as outlined in the ICD Code Manual.

For ICD-10 conversion, the diagnosis codes for acute renal failure are: N17.0, N17.1, N17.2, N17.8, or N17.9.

*RC 0829 will be reimbursed in addition to primary outpatient services (e.g. observation, ER, outpatient surgery, case rates, etc.). If an overpayment has been made, we reserve the right to re-coup the reimbursement as necessary.

i. Birthing Center Payment Reimbursement Policy

This policy applies to charges billed on an Institutional claim form for all lines of business to establish a consistent reimbursement method for payment when a member gives birth at the birthing center and the member transfers to an acute care facility.

If a member delivers their baby at the birthing center and is transferred to an acute care facility for follow-up care related to the delivery or for other medical conditions, we'll allow the delivery rate, not the transfer rate.

The birthing center will receive the transfer rate when the member is in labor but is transferred to an acute care facility for delivery.

15. All Other Outpatient Services

All other outpatient services are defined as services that can't be appropriately categorized for reimbursement in other sections within the outpatient services in schedule 2 of the applicable schedule in the facility's contract and are approved for reimbursement.

The following RCs will be considered according to the All-Other Outpatient Services section of the contract unless performed with an all-inclusive service. **If any of the following RCs are on any other fee schedules, these guidelines don't apply.**

Note: This isn't an all-inclusive list of "All Other Outpatient Service" RCs:

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
0250	Pharmacy	HCPCS/CPT® Code doesn't affect reimbursement. Facility is required to file a valid HCPCS/CPT® Code when appropriate.	Reimbursement is based on the contract.
0251	Generic Drugs		
0252	Non-Generic Drugs		
0257	Non-Prescription		
0258	Intravenous (IV) Solutions		
0263	IV Therapy/Drug Supply Delivery		
0272	Sterile Supply		
0280	Oncology		
0289	Other oncology		
0331	Radiology/Therapeutic and/or chemotherapy administration		
0332	Radiology/Therapeutic/ chemotherapy - oral		
0335	Radiology/therapeutic chemotherapy - IV		
0370	Anesthesia		
0379	Other Anesthesia		
0380	Blood		
0381	Blood - packed red cells		
0382	Blood - whole blood		
0383	Blood – plasma		

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
0384	Blood – platelets		
0385	Blood - leucocytes		
0386	Blood - other components		
0387	Blood - other derivatives (Cryoprecipitates)		
0389	Blood - other blood		
0390	Blood storage & processing		
0391	Blood storage & processing - blood administration		
0399	Blood storage & processing - other blood storage & processing		
0410	Respiratory services		
0412	Respiratory services - inhalation services		
0413	Respiratory services - Hyperbaric oxygen therapy	HCPCS/CPT® Code doesn't affect reimbursement. Facility is required to file a valid HCPCS/CPT® Code when appropriate.	Reimbursement is based on the contract.
0419	Respiratory services - other respiratory services		
0420	Physical therapy		
0421	Physical therapy - visit charge		
0422	Physical therapy - hourly charge		
0423	Physical therapy - group rate		
0424	Physical therapy - evaluation or re-evaluation		
0429	Physical therapy - other physical therapy		
0479	Audiology - other Audiology		
0482	Cardiology - stress test		

Revenue Code	Type of Service	HCPCS/CPT® Code	Allowed
0483	Cardiac Echocardiology		
0489	Cardiology – other cardiology	HCPCS/CPT® Code doesn't affect reimbursement. Facility is required to file a valid HCPCS/CPT® Code when appropriate.	Reimbursement is based on the contract. RC 0637 not eligible for reimbursement unless stated in provider's contract.
0636	Drugs Requiring Detailed Coding		
0637	Drugs Requiring Specific Identification – Self-Administrable Drugs		
0730	EKG/ECG (Electrocardiogram)		
0731	EKG/ECG (Electrocardiogram) – Holter Monitor		
0732	EKG/ECG (Electrocardiogram) - Telemetry		
0739	EKG/ECG (Electrocardiogram) – Other EKG/ECG		
0740	EEG (Electroencephalogram)		
0749	EEG (Electroencephalogram) – Other EEG		
0770	Preventive Care Services		
0771	Vaccine Administration		
0779	Other Preventive Care Services		
0921	Peripheral Vascular lab	HCPCS/CPT® Code doesn't affect reimbursement^. Facility is required to file a valid HCPCS/CPT® Code when appropriate.	Reimbursement is based on the contract.
0922	Electromyogram		

16. Other Acute Care Exclusions

a. Outpatient Revenue Code Treatment

We have three categories of revenue codes that aren't paid under the outpatient agreement. Outlined below is a brief description of those codes:

- Incidental to Acute Service: Services that are considered part of the contracted rate and not paid in addition to the rate. For example, ancillary services, inpatient or outpatient (e.g., revenue code 0220 or 0235, for special charges and incremental nursing services) wouldn't be paid in addition to a case rate or fee schedule.

- Invalid/Excluded Revenue Codes: Revenue codes associated with services not covered under the acute care contract, and those, which are invalid via the revenue code description.
- Revenue Codes that Require a More Detailed Revenue Code: In some cases we require the detail revenue code in lieu of the general revenue code.

b. Non-Contracted Services

We've contracted specific outpatient services for each facility network and line of business. In situations where services shown on these contracts haven't been contracted, a rate must be negotiated prior to billing those services or reimbursement will be set at zero. In addition, services not included in the contract that would require a separate contract for payment of those services are listed in the table below:

For specific information about the services listed below, or to discuss contracting those services not currently contracted, please call your Provider Network Manager.

Non-Contracted Services

Retail pharmacy	Hospice	Durable medical equipment
Independent or outreach lab	Skilled nursing facilities	Sub-acute care
Clinic-based services	Physician services	Wound care
Home health	Dialysis	Sleep study
Home infusion therapy	Reference lab	

17. Other Institutional Facility Types

a. Ambulatory Surgery Centers

Outpatient surgery is reimbursed based on an all-inclusive rate. This all-inclusive rate will fully compensate an institution for all related facility services and supplies provided in association with a particular surgical procedure. Pre-admission testing, which is provided by the facility or any facility wholly owned or operated by the facility at which the surgery is performed up to three days prior to the surgery, is included in the all-inclusive rate and must be filed on the same claim as the outpatient surgery.

Services paid at an all-inclusive rate are assigned to an outpatient surgery group for payment. Current outpatient surgery group assignments are contained in the provider's contract. For services payable under this section without an assigned outpatient surgery group, assignment may be made in a method consistent with that used in previous outpatient surgery group assignments.

When multiple outpatient procedures are performed on the same day, the rate for the second and subsequent procedures must be 50% of the all-inclusive rate assigned to the outpatient surgery group for the procedure, subject to the lesser of total covered charges. When a procedure is repeated on the same day, no additional amount will be paid for the second procedure.

For more detailed billing and reimbursement guidelines regarding bilateral and multiple surgery procedures, refer to outpatient surgery under the Acute Care Outpatient Services section of this manual.

b. Inpatient Rehabilitation

- Inpatient rehabilitation claims must be billed following the CMS-1450 format.
- Inpatient services must be billed with a Type of Bill 11X in Form Locator 4.

Revenue Code	Description
0118	Private Room and Board
0128	Semi-Private Room and Board (2 Beds)
0138	Semi-Private Room and Board (3 or 4 Beds)
0148	Private Deluxe Room and Board

Revenue Code	Description
0158	Ward Room and Board

When incidental revenue codes are filed, they'll be included with the room and board charges and the appropriate per diem rate will be applied.

The appropriate admitting, principal, and subsequent diagnosis codes must be filed in accordance with the current International Classification of Diseases Clinical Modification (ICD CM) according to the patient's date(s) of service. Form Locator 67 is reserved for the principal diagnosis code, whereas the subsequent diagnosis codes would be indicated in Form Locators 67 – A through Q. Form Locator 69 must be used for the admitting diagnosis code.

Prior authorization is required for all inpatient admissions. When obtaining prior authorization for a patient on a ventilator, the provider must specify authorization is for a patient on a ventilator to receive the ventilator per diem.

c. Outpatient Rehabilitation – Not Applicable to Acute Care

Units billed should be appropriate for each code as described in the CPT® and/or HCPCS Level II codes for the current year.

Outpatient rehabilitation services should be billed with an appropriate Type of Bill in Form Locator 4 according to the Type of Facility as indicated below:

Type of Bill	Type of Facility
13X	Freestanding inpatient rehabilitation facilities providing outpatient therapy services
23X	Skilled nursing facilities providing outpatient therapy services
74X or 75X	Freestanding outpatient rehabilitation facilities

Note: If the provider's contract provides for per diem reimbursement, we won't reimburse more than one service type per day for outpatient services.

The appropriate RC should be billed according to the following:

Revenue Code	Description
0270	General Supplies
0413	Hyperbaric Oxygen Therapy
042X	Physical Therapy
043X	Occupational Therapy
044X	Speech Therapy
047X	Audiology
051X	Clinic Visit
055X	Skilled Nursing Visit
0623	Surgical Dressings

- Only those CPT® and HCPCS codes that are appropriate to bill under the revenue codes listed in the previous table will be paid. Codes that aren't appropriate to the revenue codes billed will be subject to recovery by audit.
- Revenue Code 0413, Hyperbaric Oxygen Therapy, can only be billed when medically necessary. Units billed under revenue code 0413 should be appropriate for each code as described in the *Current Procedural Terminology* (CPT®) and/or the *HCPCS Level II Codes* for the year of the codes.

- Evaluation and management (E&M) codes aren't reimbursed in addition to rehabilitation therapies.
- The following guidelines apply when billing G0128:
  - G0128 can't be billed with any other codes other than supplies and 99211.
  - G0128 can be billed when a registered nurse provides direct (face to face with the patient) skilled nursing services in a comprehensive outpatient rehabilitation facility, each 10 minutes beyond the first five minutes. The first five minutes can be billed with CPT® code 99211.
  - G0128 and 99211 can be billed only in conjunction with wound care services and must be provided by a certified wound care nurse. Practitioners can't bill for these codes. All other E&M codes for practitioners aren't reimbursed unless wound care services are contracted.
  - G0128 can't be billed when debridement services are performed.
- Visit/Unit/Service – Bill in increments of one (1) each time visit/unit/service is performed.
- Modalities are limited to:
  - A limit of three charged modalities to one specific body area per treatment session should be used as a billing practice.
  - Any billing beyond three modalities per body part per treatment session will be subject to review of documentation by our auditors for appropriate billing practice.
  - When billing multiple modalities, redundancies of the same CPT® code will also be subject to audit for appropriate billing practice.

d. Skilled Nursing Facility

Skilled nursing facility (SNF) claims must be billed on an Institutional claim form. Inpatient services billed on an institutional claim form must be billed with a Type of Bill 21X or 22X in form locator 4. The related levels of care outlined in the Skilled Nursing Fee Schedule must be billed according to the table below. Reimbursement for SNF services will be based on the lesser of total covered charges or the listed per diem.

Revenue Code	Description
0191	Level I - Skilled Care
0192	Level II - Comprehensive Care
0193	Level III - Complex Care

- Outpatient services must be billed with a Type of Bill of 23x in Form Locator 4.
- The revenue codes for eligible ancillaries will be combined with the appropriate per diem code. The revenue codes for non-covered services will be denied as member liability.
- A participating DME provider must submit charges/claims for customized wheelchairs.
- All other DME/supplies must be submitted by the skilled nursing facility.
- The per diems are all inclusive (excluding customized wheelchairs).

e. Home Health and Private Duty Nursing

To comply with NUBC guidelines, providers should use Type of Bill 032X for claims filed for home health services. All home health and private duty nursing services should be billed on the Institutional claim form. When submitting electronic claims, the Institutional format must be used.

Home health and private duty nursing services should be billed using the following RCs and billing units unless otherwise stated in contract:

Type of Service	Description	Revenue Code	Procedure Code	Billing Unit
Home Health Agency Visits	Home Health Agency Physical Therapy	0421	Not required	1 unit per visit
	Home Health Agency Occupational Therapy	0431	Not required	1 unit per visit
	Home Health Agency Speech Therapy	0441	Not required	1 unit per visit

Type of Service	Description	Revenue Code	Procedure Code	Billing Unit
	Home Health Agency Skilled Nursing (RN or LPN)	0551	Not required	1 unit per visit
	Home Health Agency Medical Social Services	0561	Not required	1 unit per visit
	Home Health Agency Home Health Aide	0571	Not required	1 unit per visit
Private Duty Nursing	Private Duty Nursing (RN or LPN)	0552	Not required	1 unit per hour
	Private Duty Nursing (Home Health Aide)	0572	Not required	1 unit per hour

One unit per hour should be billed for private duty nursing services. Fractional hours should be rounded to the nearest whole hour (e.g., 1 hour 15 minutes should be rounded to 1 unit, 1 hour 29 minutes should be rounded to 1 unit, 1 hour 30 minutes should be rounded to 2 units, 1 hour 31 minutes should be rounded to 2 units, 1 hour 45 minutes should be rounded to 2 units).

Home health visits and private duty nursing services not billed with the indicated RCs will be rejected or denied. A procedure code for these services aren't required and may impede reimbursement.

To facilitate claims administration, a separate line item must be billed for each date of service and for each service previously indicated.

Supplies on the Home Health Agency Non-Routine Supply List should be billed using the indicated RCs and HCPCS codes. Units should be billed based on the HCPCS code definition in effect for the date of service. HCPCS code definitions can be found in the HCPCS Manual.

Supplies not billed with the indicated RCs and HCPCS codes will be rejected or denied.

Reimbursement for supplies not indicated on the Home Health Agency Non-Routine Supply List used in conjunction with the above services are included in the maximum allowable for the home health or private duty nursing service and won't be reimbursed separately.

Billing of supplies including those provided by third party vendors such as medical supply companies that are used in conjunction with a home health visit or private duty nursing service are the responsibility of the home health agency.

Supplies not used in conjunction with a home health visit or private duty nursing services aren't billable by the home health agency or private duty nursing provider.

The only supplies that may be billed in addition to the above services are indicated on the Home Health Agency Non-Routine Supply List shown below:

The following codes should be used when billing home health agency non-routine supplies with revenue code 027x:

A4212	A4333	A4360	A4378	A4394	A4413	A4429	A4623	A5073	A6531	A7522	T4530
A4248	A4334	A4361	A4379	A4395	A4414	A4430	A4625	A5081	A6532	A7523	T4531
A4310	A4338	A4362	A4380	A4396	A4415	A4431	A4626	A5082	A7045	A7524	T4532
A4311	A4340	A4363	A4381	A4398	A4416	A4432	A5051	A5083	A7047	A7526	T4533
A4312	A4344	A4364	A4382	A4399	A4417	A4433	A5052	A5093	A7501	A7527	T4534
A4313	A4346	A4366	A4383	A4400	A4418	A4434	A5053	A5102	A7502	A9272	T4535
A4314	A4349	A4367	A4384	A4404	A4419	A4435	A5054	A5105	A7503	T4521	T4537
A4315	A4351	A4368	A4385	A4405	A4420	A4436	A5055	A5112	A7504	T4522	T4540

A4316	A4352	A4369	A4387	A4406	A4422	A4437	A5056	A5113	A7505	T4523	T4541
A4320	A4353	A4371	A4388	A4407	A4423	A4455	A5057	A5114	A7506	T4524	T4542
A4321	A4354	A4372	A4389	A4408	A4424	A4456	A5061	A5120	A7507	T4525	T4543
A4326	A4355	A4373	A4390	A4409	A4425	A4459	A5062	A5121	A7508	T4526	T4534
A4328	A4356	A4375	A4391	A4410	A4426	A4461	A5063	A5122	A7509	T4527	
A4330	A4357	A4376	A4392	A4411	A4427	A4463	A5071	A5126	A7520	T4528	
A4331	A4358	A4377	A4393	A4412	A4428	A4481	A5072	A5131	A7521	T4529	

The following codes should be used when billing home health agency non-routine supplies with revenue code 0623:

A6010	A6205	A6221	A6237	A6252	A6407	A6451
A6011	A6206	A6222	A6238	A6253	A6410	A6452
A6021	A6207	A6223	A6239	A6254	A6412	A6453
A6022	A6208	A6224	A6240	A6255	A6441	A6454
A6023	A6209	A6228	A6241	A6256	A6442	A6455
A6024	A6210	A6229	A6242	A6258	A6443	A6456
A6154	A6211	A6230	A6243	A6259	A6444	A6457
A6196	A6212	A6231	A6244	A6261	A6445	A6545
A6197	A6213	A6232	A6245	A6262	A6446	A7040
A6198	A6214	A6233	A6246	A6266	A6447	A7041
A6199	A6215	A6234	A6247	A6402	A6448	A7048
A6203	A6219	A6235	A6248	A6403	A6449	A6257
A6204	A6220	A6236	A6251	A6404	A6450	

f. Home Obstetrical Management

All home obstetrical management services should be billed on the institutional claim form using Type of Bill 32X. When submitting electronic claims, the institutional format must be used.

Home obstetrical management services must be billed using the following RCs, procedure codes, and billing units:

Description	Revenue Code	Procedure Code	Billing Unit
Home management of preterm labor	0559	S9208	1 unit per day
Home management of gestational hypertension	0559	S9211	1 unit per day
Home management of preeclampsia	0559	S9213	1 unit per day
Home management of gestational diabetes	0559	S9214	1 unit per day

Home obstetrical management services not billed with the indicated RCs and procedure codes will be rejected or denied. To facilitate claims administration, a separate line item must be billed for each date of service for the above services.

The maximum allowable for home obstetrical management services per diems constitutes full reimbursement for all administrative services, professional pharmacy services, care coordination, and all necessary supplies or equipment.

The per diem doesn't include home health agency skilled nursing (RN or LPN) visits. Home health agency skilled nursing (RN or LPN) visits should be billed in accordance with the home health billing guidelines.

g. Dialysis Freestanding Facility

The following dialysis billing and reimbursement guidelines were effective on Dec. 1, 2013 for all participating dialysis providers based on the contract date.

- **Treatment Rate** – The base composite rate is adjusted by the treatment multiplier to arrive at the treatment rate we'll allow for end stage renal disease (ESRD) related services. The adjusted treatment rate is an all-inclusive charge for services, teaching, supplies, lab and drugs. We allow the lesser of total covered charges or the treatment rates negotiated in the contract.

  The treatment rate should only be billed to us when an actual dialysis treatment has been performed. Reimbursement for these services is an all-inclusive rate.

  We won't reimburse for services billed in addition to the treatment rat as indicated in following chart. Any "other" services billed without a treatment RC as "stand alone" will deny as "not paid in addition to primary service." The relevant CPT® or HCPCS code is required in FL 44 in conjunction with appropriate RC in FL 42 for proper reimbursement. Claims submitted without required coding will be returned to the provider or denied per billing guidelines as a "non-contracted service." Codes not specifically listed in the contract aren't allowed and may not be billed to a BCBST member.

  Form locators related to the composite rate should be completed on the institutional claim form as described in the following table. Use the Institutional format when submitting electronic claims.

Service Description	Revenue Code FL 42	CPT® Code/Required FL 44	Unit/ Frequency FL 46	Treatment Rate FL 47
Hemodialysis, in-center - Composite or Other Rate	0821	90999	Per Visit	Treatment Rate
Hemodialysis, home - Composite or Other Rate	0821	90989	Per Visit	Treatment Rate
Hemodialysis, training in-center, Composite or Other Rate	0821	90993	Per Visit	Treatment Rate
IPD, in-center - Composite or Other Rate	0831	90999	Per Visit	Treatment Rate
CAPD, treatment per day - Composite or Other Rate	0841	90945	Per Visit	Treatment Rate
CAPD, training - Composite or Other Rate	0841	90993	Per Visit	Treatment Rate
CCPD, treatment per day - Composite or Other Rate	0851	90945	Per Visit	Treatment Rate
CCPD, training - Composite or Other Rate	0851	90993	Per Visit	Treatment Rate
Ultrafiltration, in center	0881	90999	Per Visit	Treatment Rate

Condition Code Descriptions	Condition Code	Informational Only/ Doesn't affect reimbursement FL(s) 18 - 28
Home – Self-Administered Anemia Management Drug	70	Required
Full care in unit	71	Required
Self-care in unit	72	Required
Selfcare training	73	Required
Home	74	Required
Home – 100% reimbursement	75	Required
Back-up in facility Dialysis	76	Required

- **No Shows** – If a facility sets up in preparation for a dialysis treatment, but the treatment is never started (the patient never arrives), no payment is made.
- **Non-Reimbursable Revenue Codes (RCs)** – Unless specifically indicated in the contract, we won't reimburse for services billed in addition to the composite rate. To administer the contract, we don't utilize the general RCs. Detail RCs and CPT® or HCPCS codes are required.

h. Hospice (These guidelines don't apply to Medicare Advantage)

Hospice services must be billed in accordance with our billing guidelines:

- Hospice claims must be billed on an Institutional claim form.
- To facilitate claims administration, a separate line item must be billed for each date of service.
- Hospice Providers may bill with either Type of Bill (TOB) 081X or 082X in Form Locator 4 as long as the inpatient and outpatient services are on separate claims.
- Type of Bill should determine Place of Service (POS). Only when a patient dies in a hospice facility will the inpatient per diem be reimbursed. If a patient dies at home, the POS should be home, not the hospice facility.
- The statement from/thru dates must also correspond with the total days billed on the inpatient care.
- Hospice discharge date is eligible for payment and won't be considered as an exclusion.
- Discharge status should reflect where the patient dies.
- Hospice claims should be billed with the hospice provider number and/or NPI referenced in the network attachment.
- Reimbursable allowable rate per unit will be rounded up to the second decimal amount (e.g., $8.7110 would reimburse as $8.72).

In all cases reimbursement for hospice services is based on:

- Per diems allowed on a per day basis only;
- The lesser of total covered charges or maximum allowable hospice fee schedule;

Standard reimbursement for Hospice services is based on the Medicare allowed published by the Centers of Medicare and Medicaid (CMS) Hospice rates and is updated annually on Jan. 1st . BCBST will utilize the highest regional rate out of the five regions for the State of Tennessee. The reimbursement rate differs by the type of hospice service rendered and is based on the pricing methodology, which can be located under Medicare information downloads at this CMS web site: http://www.cms.gov/center/hospice.asp

Note: In all cases reimbursement for hospice services is based on per diems allowed per day, not per visit. Charges submitted for non-covered services aren't eligible for meeting the per diem amount.

The related levels of care outlined in the hospice fee schedule should be billed according to the following table:

Revenue Code	Description/Service
0651	Routine Home Care (RHC) – less than 8 hours of care (1 day = 1 unit)
0652	Continuous Home Care Full Rate - 24 hours of care based on an hourly rate. A separate line item must be billed for each date of service using the appropriate number of units in the unit field.(Billed in 15-minute increments)
0653	Invalid
0654	Invalid
0655	Inpatient Respite Care – Family member or other caregiver requiring a short relief period (limited to 5 consecutive days)
0656	General Inpatient Care – Inpatient stays, which meet general inpatient care criteria.

Note: For continuous home care (CHC), one unit will equal 15 minutes. CHC won't be reimbursed when it's less than eight hours of service (32 units) and will be capped at 24 hours (96 units) per calendar day. CHC hours are defined as being between eight and 24 cumulative hours within a 24-hour period, as defined by Medicare.

Providers are contractually obligated to provide service at the agreed upon rates regardless of patient acuity.

Allowed amounts are all-inclusive except for practitioner services not related to hospice care. This includes but isn't limited to hospice practitioner services, drugs, DME, medical supplies, etc. practitioner services are excluded from the Hospice allowed amounts when not related to hospice care and should be billed to us on a professional claim form.

When a member receives care for hospice services and is admitted as inpatient for hospice related care, the assigned hospice provider must bill us for the services and will receive the contracted rates for covered services. We shouldn't receive any claims from the admitting facility. It's the responsibility of the hospice provider to reimburse the admitting facility. We reserve the right to audit. (See Section XXIII. Provider Audit Guidelines in this manual.)

Prior authorization is required for inpatient services for commercial fully insured products. Benefits should be verified prior to providing services for other commercial business.

Effective Jan. 1, 2016, we implemented the CMS rule that changes payment method for RHC (RC 0651). These changes are:

- **Day 1- 60:** Allow a higher rate based on the admission date.
- **Day 61 and thereafter:** Allow a lower rate based on the admission date.
- **Service Intensity Add-on (SIA Payment):** SIA payment is equal to RC 0652 hourly rate for services billed by either RC 0561-Social Worker Services or RC 0551-Registered Nurse visits for a maximum of combined four hours per day with a minimum of one unit to a maximum of 16 units billed. These services are only eligible when billed in conjunction with RHC services. To receive the SIA add-on payment, claims must include the appropriate discharge status code and only applies when these services are performed within the last seven days of life.

Note: We utilize the Medicare hospice rates for continuous home care, inpatient respite care and general inpatient care that reflect compliance with the quality reporting requirements.

E. Institutional Claim Billing and Reimbursement Guidelines – Section 2

The following guidelines/policies apply to ambulatory surgical facilities that have contracted for the institutional surgical groupers 0-10 and UL (unlisted) and acute care facilities contracted for the institutional surgical groupers 0-10 and UL with the Facility Base Fee Schedule version 6 or later. The guidelines/policies indicated below will apply. Otherwise, refer to applicable category in D. Institutional - Section 1.

1. Outpatient Surgery

We've established all-inclusive institutional surgery groupers between 0 through 10 and UL. Providers must refer to their contract for applicable services. A published list of surgery CPT®/HCPCs codes and revenue codes is provided when contracted. All services must be billed based on where services are rendered.

We may revise the information in the outpatient (OP) surgery grouper listing based on newly published and/or deleted codes and updated outpatient surgery information developed by CMS, which may be modified to include procedures that aren't maintained by CMS but are considered for reimbursement. Recalibration is based on the CMS OPPS weights effective annually on January 1. As the weights change, codes may be moved up or down in the grouper listing based on pre-established weight ranges for each grouping. The Outpatient Groupers will be subject to updates and recalibration to occur on April 1; provided, however, codes hitting the UL category may be reviewed and assigned throughout the year to the appropriate surgery grouper as evaluated by BCBST.

Note: Unless otherwise stated in provider's contract, facilities that have contracted for the BCBST Base Fee Schedule Version 6:

When multiple surgical procedures are performed on the same day, the payment for the first procedure will be 100% of the Per Case payment, the payment for the second procedure will be 50% of the Per Case payment and the payment for the third procedure will be 50% of the Per Case payment. No additional payments will be made for procedures beyond the third procedure. When a procedure is repeated on the same day there will be no additional payment for the second procedure.

Note: Please refer to provider's contract for OP Surgery reimbursement for facilities that are attached to the BCBST Base Fee Schedule Version 7 or later.

2. Minor Surgery

As of Jan. 1, 2018, regardless of date of service, CPT®/HCPCS codes eligible for reimbursement and billed with minor surgery revenue code 0361 will automatically default to the Group 0 payment rate indicated in the provider's contract.

Note: For providers who have contracted for the Base Fee Schedule Version 7 or later:

CPT®/HCPCS codes eligible for reimbursement and billed with minor surgery revenue code 0361 will reimburse from whatever grouper rate the CPT®/HCPCS code is assigned based on the institutional surgical groupers 0-10 and UL indicated in the provider's contract.

3. Acute Care Fee Schedules

There are no revisions for the existing CPT®/HCPCS codes allowable reimbursement for the acute care fee schedules indicated below as they'll remain static to Jan. 1, 2014, CMS rates until contract renewal. **Refer to D. Institutional - Section I for any new or deleted code updates.** A published list of HCPCs Codes and revenue codes is provided when contracted.

BCBST Facility Fee Schedule Version 6 or later

Laboratory
MRI/MRA/CT scan
Radiology

Note: For providers who have contracted for the base fee schedule version 7 or later:

There are no revisions for the existing CPT®/HCPCS codes allowable reimbursement for the acute care fee schedules indicated below as they'll remain static to Jan 1, 2019, CMS rates until contract renewal. **Refer to D. Institutional – Section I for any new or deleted code updates**. A published list of HCPCS Codes and revenue codes is provided when contracted.

Laboratory
MRI/MRA/CT scan
Radiology

4. Acute Care ER Services

ER services for an emergency condition don't require prior authorization. However, if the member is admitted to the hospital as inpatient from the ER, In-network providers are responsible for contacting us within two business days of the inpatient admission.

Note: Medicare Advantage timeframe is 24 hours or next business day. These claims will be reimbursed as an all-inclusive negotiated case rate or total covered charges, subject to the lesser of provision found in the facility's contract. Only the contracted HCPCS codes will be reimbursed when filed with revenue code 0450, 0451, 0452, and/or 0459. Any other HCPCS code filed with revenue code 0450, 0451, 0452, and/or 0459 will be reimbursed at zero.

5. Intravenous (IV) Therapy Services

When contracted, the reimbursement for IV Therapy services is considered all-inclusive except for the base fee schedule (version 6) and the Separately Reimbursed Facility Drug Fee Schedule. All other services billed with IV Therapy are considered as ancillaries paid under the "per visit" rate and won't be separately reimbursed. IV therapy services will only be paid when not billed with a case rated service.

6. Reimbursement Policy and Billing Guidelines for the Separately Reimbursed Facility Drug Fee Schedule

To establish the codes that are added to the Separately Reimbursed Facility Drug Fee Schedule, we'll utilize the Appendix, "Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments," of the OPTUM Uniform Billing (UB) Editor or its successor.

BCBST will identify the eligible outpatient drug HCPCS/CPT® codes that are appropriate to be billed under RC(s) 0343, Radiopharmaceuticals Diagnostic; 0344, Radiopharmaceuticals Therapeutic; and 0636, Drugs Requiring Detail Coding, as indicated in the OPTUM Uniform Billing (UB) Editor or its successor and add these codes to the fee schedule.

Drug codes submitted for consideration, but not listed in the Separately Reimbursed Facility Drug Schedule are not eligible for separate reimbursement. Any of the above indicated RC(s) filed without a HCPCS/CPT® code will be denied as procedure code required for RC.

In the circumstance that an inappropriate payment has occurred, we reserve the right to re-coup the reimbursement as necessary.

BCBST shall reimburse acute care hospitals contracted for the Separately Reimbursed Facility Drug Fee Schedules for eligible outpatient drug codes based on a percentage of the Average Sale Price (ASP), or in the absence of a published ASP, Wholesale Acquisition Cost (WAC) or Average Wholesale Price (AWP). The table below indicates the Base Facility Drug Fee Schedule pricing for each of the above methodologies.

SR Base Facility Drug Fee Schedule

Pricing Methodology	SR 1 Percentage of Base Allowed	SR 2 Percentage of Base Allowed
Average Sale Price (ASP)	108%	106%
Wholesale Acquisition Cost (WAC)	100%	100%
Average Wholesale Price (AWP)	84%	84%

If facility is contracted with one of these schedules, eligible outpatient drugs on the schedule will be reimbursed in addition to all other services filed on the CMS-1450 (UB-04 or successor) claim form.

In the event a valid outpatient drug C code is considered to be a covered procedure and there is not an acceptable HCPCS/CPT® code that could be used, we'll reimburse the C code by using ASP multiplied by an indicated contract percentage, where applicable. The source for this reimbursement is derived from the Medicare Hospital Outpatient Prospective Payment System (OPPS) methodology.

Any new eligible outpatient drug codes that apply to these schedules and do not have a fee will be added to the schedule with a $0.00 allowable and "BR" or UL" indicator. These codes as well as Not Otherwise Classified (NOC) and Unlisted/Miscellaneous/Non-Specific HCPCS Codes will be reviewed for manual pricing according to BCBST's policy for Unlisted, Miscellaneous, Non-specific, and Not Otherwise Classified Procedures/Services until a CMS fee has been established. These fees will be updated in accordance with BCBST's Policy "Quarterly Reimbursement Changes." Failure to submit the following information for these codes will result in delay of reimbursement.

Not Otherwise Classified (NOC) and Unlisted/Miscellaneous/Non-Specific HCPCS Codes:

- Must be billed with a unit of one; and
- Requires submission of drug name; National Drug Code (NDC) in field 43, "Revenue Description/ IDE/ Medicaid Drug Rebate", on the CMS-1450 Claim form; and dosage administered.

NOTE: Percentages and base allowable as set forth in the SR Facility Drug Fee Schedules are not eligible for an annual contract increase pursuant to the Outpatient language excluding services reimbursed at a percentage of Medicare or percent of covered charges.

Exclusions for SR 1 & 2 Fee Schedules:

Any items identified as over the counter or drugs not requiring a prescription, self-administered and oral medications, and medications not reimbursed separately by Medicare based on status indicator. Updates to these schedules will occur annually on April 1 for existing codes that have changed and now may or may not meet the above descriptive or revenue code criteria.

7. Reimbursement Policy and Billing Guidelines for the Advanced Therapeutic Fee Schedule

To establish the codes that are added to the Advanced Therapeutic Fee Schedule, we'll utilize the Appendix, "Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments," of the OPTUM Uniform Billing (UB) Editor or its successor.

BCBST will identify the eligible outpatient HCPCS/CPT® codes that are appropriate to be billed under RC(s): 0636, Drugs Requiring Detail Coding, 0891, Special Processed Drugs – FDA Approved Cell Therapy, and 0892, Special Processed Drugs – FDA Approved Gene Therapy as indicated in the OPTUM Uniform Billing (UB) Editor or its successor and add these codes to the fee schedule.

Drug codes submitted for consideration, but not listed in the Advanced Therapeutic Fee Schedule are not eligible for separate reimbursement. Any of the above indicated RC(s) filed without a HCPCS/CPT® code will be denied as procedure code not contracted.

In the circumstance that an inappropriate payment has occurred, BCBST reserves the right to re-coup the reimbursement as necessary.

BCBST shall reimburse acute care hospitals contracted for the Advanced Therapeutic Fee Schedule for eligible outpatient therapeutic codes based on a percentage of the Average Sale Price (ASP), or in the absence of a published ASP, Wholesale Acquisition Cost (WAC). The table below indicates the Base Drug Fee Schedule pricing for each of the above methodologies.

Base Drug Fee Schedule

Pricing Methodology	Percentage of Base Allowed
Average Sale Price (ASP)	106%
Wholesale Acquisition Cost (WAC)	102%

Any new eligible outpatient drug codes that apply to this schedule and do not have a fee will be added to the schedule with a $0.00 allowable and “BR” or UL” indicator. These codes as well as Not Otherwise Classified (NOC) and Unlisted/Miscellaneous/Non-Specific HCPCS Codes will be reviewed for manual pricing according to BCBST’s policy for Unlisted, Miscellaneous, Non-specific, and Not Otherwise Classified Procedures/Services until a CMS fee has been established. These fees will be updated in accordance with BCBST’s Policy “Quarterly Reimbursement Changes." Failure to submit the following information for these codes will result in delay of reimbursement.

8. Reimbursement Policy and Billing Guidelines for the Tiered Facility Drug Fee Schedule

To establish the codes that are added to the Tiered Facility Drug Fee Schedule, we’ll utilize the Appendix, "Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments," of the OPTUM Uniform Billing (UB) Editor or its successor.

BCBST will identify the eligible outpatient HCPCS/CPT® codes that are appropriate to be billed under RC(s) 0343, Radiopharmaceuticals Diagnostic; 0344, Radiopharmaceuticals Therapeutic; and 0636, Drugs Requiring Detail Coding; 0891, Special Processed Drugs – FDA Approved Cell Therapy; and 0892, Special Processed Drugs – FDA Approved Gene Therapy as indicated in the OPTUM Uniform Billing (UB) Editor or its successor and add these codes to the fee schedule.

Drug codes submitted for consideration, but not listed in the Tiered Facility Drug Fee Schedule are not eligible for separate reimbursement. Any of the above indicated RC(s) filed without a HCPCS/CPT® code will be denied as procedure code not contracted.

In the circumstance that an inappropriate payment has occurred, BCBST reserves the right to re-coup the reimbursement as necessary.

BCBST shall reimburse acute care hospitals contracted for the Tiered Facility Drug Fee Schedule for eligible outpatient therapeutic codes based on a percentage of the Average Sale Price (ASP), or in the absence of a published ASP, Wholesale Acquisition Cost (WAC). The table below indicates the Base Drug Fee Schedule pricing for each of the above methodologies.

Tiered Facility Base Drug Fee Schedule

Pricing Methodology	Percentage
Average Sale Price (ASP)	100%
Wholesale Acquisition Cost (WAC)	94%
Average Wholesale Price (AWP)	84%

Tier 1 – Traditional
Tier 2 – Biosimilars
Tier 3 – Specialty Drugs
Tier 4 – Ultra High Cost

If facility is contracted with this schedule, eligible outpatient drugs on the schedule will be reimbursed in addition to all other services files on the CMS-1450 (UB-04 or successor) claim form.

In the event a valid outpatient drug C code is considered to be a covered procedure and there is not an acceptable HCPCS/CPT® code that could be used, we’ll reimburse the C code by using ASP multiplied by an indicated contract percentage, where applicable. The source for this reimbursement is derived from the Medicare Hospital Outpatient Prospective Payment System (OPPS) methodology.

Any new eligible outpatient drug codes that apply to this schedule and do not have a fee will be added to the schedule with a $0.00 allowable and “BR” or UL” indicator. These codes as well as Not Otherwise Classified (NOC) and Unlisted/Miscellaneous/Non-Specific HCPCS Codes will be reviewed for manual pricing according to BCBST’s policy for Unlisted, Miscellaneous, Non-specific, and Not Otherwise Classified Procedures/Services until a CMS fee has been established. These fees will be updated in

accordance with BCBST's Policy "Quarterly Reimbursement Changes." Failure to submit the following information for these codes will result in delay of reimbursement.

Not Otherwise Classified (NOC) and Unlisted/Miscellaneous/Non-Specific HCPCS Codes:

- Must be billed with a unit of one; and
- Requires submission of drug name; National Drug Code (NDC) in field 43, "Revenue Description/IDE/Medicaid Drug Rebate", on the CMS-1450 Claim form, and dosage administered.

NOTES: Percentages and base allowables as set forth in this Fee Schedule are not eligible for an annual contract increase pursuant to the Outpatient language excluding services reimbursed at a percentage of Medicare or percent of covered charges.

Any items identified as over the counter or drugs not requiring a prescription, self-administered and oral medications, and medications not reimbursed separately by Medicare based on status indicator have been excluded from this Facility Fee Schedule.

Updates to this schedule will occur annually on April 1 for existing codes that have changed and now may or may not meet the above descriptive or revenue code criteria. New codes will default to Tier 4 until the April 1 update at which time they will be placed in the appropriate Tier.

9. Reimbursement Policy and Billing Guidelines for the Ultra High Cost Fee Schedule

To establish the codes that are added to the inpatient Ultra High Cost Fee Schedule, BlueCross BlueShield (BCBST) will utilize the Appendix, "Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments," of the OPTUM Uniform Billing (UB) Editor or its successor.

BCBST will identify the eligible HCPCS/CPT® codes that are appropriate to be billed under RC(s): 0636, Drugs Requiring Detail Coding, 0891, Special Processed Drugs - FDA Approved Cell Therapy, and 0892, Special Processed Drugs - FDA Approved Gene Therapy as indicated in the OPTUM Uniform Billing (UB) Editor or its successor and add these codes to the fee schedule.

BCBST will pay for inpatient drugs listed in the Ultra High Cost Fee Schedule, in accordance with the Reimbursement and Billing Guidelines for the Ultra High Cost Fee Schedule contained in this policy in addition to the Ultra High Cost Therapy Admission filed on the CMS-1450 (UB-04 or successor) claim form.

Drugs shown on the Ultra High Cost Fee Schedule and associated with Not Otherwise Classified ("NOC") or Unlisted/Miscellaneous/Non-Specific HCPCS Codes or with no established fee shown will be manually priced in accordance with BCBST's policy for Unlisted, Miscellaneous, Non-Specific and Not Otherwise Classified Procedures/Services, but may not be eligible for payment. Such drugs must be billed with a unit of one (1) and require submission of: (i) drug name; (ii) National Drug Code ("NDC") in field 43 "Revenue Description/ IDE/ Medicaid Drug Rebate" on the CMS-1450 claim form; and (iii) dosage administered. Failure to submit this information will result in delayed reimbursement.

Drug codes submitted for consideration, but not shown on the Ultra High Cost Fee Schedule are included in the Inpatient reimbursement and are not eligible for additional payment.

The Ultra High Cost Fee Schedule will be updated in accordance with BCBST's Policy "Quarterly Reimbursement Changes."

Notwithstanding the DRG Payment Rate set forth in the Inpatient Payment Category Table for a covered Inpatient Stay, when Provider submits a claim for payment of a drug listed on the Ultra High Cost Fee Schedule, the Provider will be paid the Per Diem listed in the Inpatient Payment Category Table for the Ultra High Cost Therapy Admission and the applicable Payment Rate for the drug set forth on the Ultra High Cost Fee Schedule instead of the applicable DRG Payment Rate.

Ultra-High Cost Base Fee Schedule

Pricing Methodology	Percentage
Average Sale Price (ASP)	100%

Pricing Methodology	Percentage
Wholesale Acquisition Cost (WAC)	94%
Average Wholesale Price (AWP)	84%

10. Observation Services

For providers contracted with the Base Fee Schedule Version 7 or later, observation is a case rated service and won't be paid at an hourly rate. Please refer to the provider's contract for specific reimbursement details.

11. MRI/MRA/CT Scan

For providers contracted with the Base Fee Schedule Version 7 or later, these radiology services will no longer be reimbursed in addition to other all-inclusive rate services.

12. All Other Outpatient Services:

We've established a new All Other class for services that aren't categorized for reimbursement within other sections of the Acute Care Outpatient Schedule 2 facility contract.

The following RCs will be considered according to the new All Other Outpatient Services section of the contract unless performed with an all-inclusive service.

Note: If any of the following RCs are on any other fee schedules, these guidelines don't apply.

Revenue Code	Type of Service
0240	All -Inclusive Ancillary-General
0241	All -Inclusive Ancillary-Basic
0242	All -Inclusive Ancillary-Comprehensive
0243	All -Inclusive Ancillary-Specialty
0249	All -Inclusive Ancillary-Other
0623	Surgical dressings

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VII. UTILIZATION MANAGEMENT PROGRAM

A. Program Overview

Our Utilization Management (UM) Program is committed to providing quality and cost effective healthcare services to its members. The UM program is designed to manage, evaluate and improve the quality, appropriateness and accessibility of healthcare services while achieving member and provider satisfaction.

The UM Program monitors compliance with the National Committee for Quality Assurance (NCQA) standards to maintain accreditation. Our UM decision-making is based only on appropriateness of care and service and existence of coverage. The organization doesn't reward practitioners or other individuals for issuing denials of coverage or care and financial incentives for UM decision-makers don't encourage decisions that result in underutilization.

The program is directed, guided and monitored by our medical director who actively seeks input from network-participating practitioners and other regulatory agencies. The medical director is ultimately responsible for facilitating medical management in the following UM areas:

- Prior Authorization Review
- Provider Appeals
- Medical Quality Management
- Specialty Services
- Concurrent Review
- Medical Policy
- Retrospective Review
- Delegate Oversight
- Disease Management
- Technology Assessment
- Transition of Care/Discharge Planning

Evaluation of the UM Program

- The UM Program is formally evaluated on an annual basis and revised as needed. Designated staff evaluate the consistency with which healthcare professionals involved in the UM process apply criteria in decision making through physician and non- physician inter-rater reliability (IRR). The program is reviewed to add or modify activities necessitating the quality improvement of effective and efficient service to BlueCross BlueShield of Tennessee members.
- Marketing, Customer Services and UM departments provide member satisfaction data which are reviewed to add or modify activities necessitating the quality improvement of effective and efficient service to our members.
- UM nurses coordinate referrals to the clinical risk management department and the medical director. Trend reports are utilized to determine areas of need for corrective action, as well as areas that show improvement.

Note: The term "provider" may include "practitioner", "facility", or "other licensed professional".

B. Medical Review

Medical reviews are prospective, concurrent, or retrospective of selected interventions and are performed where evidence suggests safe, effective alternatives exist or because of mandates from oversight agencies. Prior authorization review results in efficient use of covered healthcare services and helps to ensure members receive the appropriate level of care in the appropriate setting.

Note: We administer both insured and self-funded arrangements. Because of differences in relationships, some prior authorization requirements may differ. Benefits are always subject to verification of eligibility and coverage at the time services are rendered.

If the provider chooses to render services that haven't received prior authorization, or that don't meet medical necessity criteria according to our clinical decision process, the member isn't financially liable for the charges. "Not Medically Necessary" and "Clinical Requirements Not Met" are used interchangeably throughout Utilization Management documentation.

However, if the provider obtains a BlueCross Acknowledgement of Financial Responsibility for the Cost of Services Form for the specific procedure, and any related services prior to the services being rendered, the member may be held liable. This form can't be utilized to waive the provider's prior authorization

requirements. Members obtaining services out of network or outside the State of Tennessee from a non-BlueCard PPO provider, the member may be responsible for all or a substantial share of the charges.

A complete list of services that require prior authorization can be found in the provider section of www.bcbst.com at the following link:

www.bcbst.com/docs/providers/Commercial-Prior-Auth-Requirements.pdf

Find Upcoming Prior Authorization Changes

You can easily find the latest changes to prior authorizations under *Upcoming Prior Authorization Changes* in the *News & Updates* section of our *Documents & Forms* page. You can access prior authorization changes 60 days before the effective date.

We use the following clinical decision process to promote consistent utilization management across all product lines,

- Member's benefit plan
- Medical policy
- Utilization management guidelines
- MCG care guidelines
- Centers for Medicare & Medicaid Services (CMS) and Local Coverage Determinations (LCD)

MCG care guidelines are nationally recognized guidelines that are updated annually by a panel of consultants including, but not limited to practitioners and registered nurses. An MCG care guideline can be reviewed under MCG Cite Guideline Transparency in the Manuals, Policies and Guidelines section of www.bcbst.com.

CMS LCD's are utilized for determining appropriate codes and medical necessity when criteria is not available through the Member's Benefit Plan, Medical Policy, Utilization Management Guidelines, and MCG Care Guidelines. These guidelines can be viewed online at https://www.cms.gov/medicare-coverage-database/search.aspx.

Utilization Management Guidelines

We use MCG Care Guidelines to assist in our clinical decision-making processes. There are times when we must modify or supplement certain MCG criteria to meet practice patterns in Tennessee (i.e., a guideline doesn't exist, the length of stay needs to be modified, or the decision criteria needs to be modified). MCG criteria that we've modified are published on our website. This allows providers the opportunity to review and be aware of any changes or variances made to MCG criteria. Providers may appeal our Utilization Management Guidelines (UMGs) by following the Utilization Management Guideline Appeals Process in the Manuals, Policies and Guidelines section our company website.

Prior Authorization Reviews

Prior authorization reviews can be initiated by the member, designated member advocate, practitioner, or facility. However, it's ultimately the facility and practitioner's responsibility to contact us to request an authorization and to provide the clinical and demographic information that's required to complete the authorization. Scheduled admissions/services must be authorized at least 24 hours prior to admission. Emergent inpatient admissions/services must be authorized within two business days following an admission. **Note**: Medicare Advantage timeframe is 24 hours or next business day.

When a request for an authorization of a procedure, an admission/service or a concurrent review of the days is denied, the penalty for not meeting authorization guidelines will apply to both the facility and the practitioner rendering care for the day(s) or service(s) that have been denied. Our non-payment is applicable to both facility and practitioner rendering care. The member is held harmless if the member is eligible at the time services are rendered and the covered services are received from a network provider.

Nurse reviewers receive requests for prior authorization, including necessary medical information. The nurse reviews the medical information, applying benefits, medical policies, our Utilization Management Guidelines and/or MCG criteria, and LCDs to render decisions. Nurses have the authority to approve all situations that meet those guidelines, e.g., approve admissions, assign lengths of stay, and number of services.

For urgent care, the decision must be completed as soon as possible based on the clinical situation, but no later than 72 hours of the receipt of the request for a UM determination. For non-urgent care, the decision must be made within 15 calendar days or seven (7) days for non-urgent care requests submitted electronically for Fully Insured and Marketplace members.

The practitioner and/or facility is notified via telephone and/or electronically of the determination. If the organization provides verbal notification of a denial decision as specified for an urgent concurrent or urgent preservice request, it has an additional 3 calendar days following verbal notification to provide electronic or written notification. In the event of an adverse determination, written confirmation to the practitioner, facility and member follows. Timeframes begin with receipt of the UM requests and include the issuance of the initial notification and/or confirmation of the decision.

Nurse reviewers refer potential denials or questionable cases to a medical director for review. Additional information may be submitted via the regular authorization process when an adverse determination is issued. This information may be submitted from the provider or provider representative. If one of our medical directors denies a request for prior authorization, the provider or member may appeal the decision. (See Provider Appeals Process at the end of this section.)

Concurrent/extended stay reviews are performed for inpatient admissions (per diem) and concurrent/extended service reviews are performed for ancillary services. Approval of the admission or an initial length of stay is assigned upon admission to a facility and an initial length of service is assigned upon onset of ancillary service. However, to receive payment beyond the initial length of stay or length of service, additional medical information, which meets criteria and/or demonstrates medical necessity, must be submitted by the facility/practitioner contacting the Utilization Management Department either by telephone, fax or electronically with the additional information to support the request.

Our contracted providers can submit authorization requests via telephone, facsimile or e-Health Services® in Availity. Fax transmissions will be received Monday through Thursday, 24 hours a day, and Friday until 4 p.m., ET. The fax will be turned off from 4 p.m. Friday until 6 a.m. Monday, and will be turned off on holidays until the next business day at 6 a.m. Otherwise, the requests should be received via phone, fax or e-Health Services® within two business days. Approval and denial notifications can be viewed in Availity on Auth Inquiry. Providers will not receive an approval notice via fax or mail. **Note**: Medicare Advantage timeframe is 24 hours or next business day.

To access e-Health Services®, enter your ID number and password in the Availity secure login box or for first-time users, go to Availity.com and click "**Register**" in the upper right corner of the home page, select "**Providers**", click "**Register**" and follow the instructions in the Availity registration wizard. If you have an urgent case in need of an urgent response, please call the Utilization Management Department at **1-800-924-7141**. A voicemail line will be available after business hours and on weekends/holidays for providers to contact us about concurrent or urgent information. These calls will be returned by the next business day. Providers faxing their requests should use the authorization request form: https://provider.bcbst.com/tools-resources/documents-forms. When submitting electronically, attaching the completed request form for the service will help ensure complete and accurate clinical submission.

The form must be completed in its entirety for fax request; any authorization requests received that aren't on this form will be returned.

Prior authorization requests can receive online approval. Simply select the option to apply MCG criteria and answer a few clinical questions. If the authorization meets specific criteria, you'll receive online approval and a reference number. Your request will be recorded in our computer system in real time as it's received. This service is available 24 hours a day, 7 days a week for all registered providers.

Diagnostic-Related Group (DRG) Inpatient Stays

- Contact the UM Department on the date specified with current clinical information.
- Clinical information is needed to implement and to discuss discharge planning efforts. The date of the update will be determined at the time of call from provider.

- DRG admissions will be assigned a length of stay. Date of update will be determined at the time of call from the provider.
- All claims submitted for DRG reimbursement with outlier and stop loss days/charges will be reviewed for medical necessity.

Per Diem Admissions Needing Extensions

- Contact the UM Department with the required clinical information on the originally scheduled day of discharge when a member's condition indicates a need for additional days. Extension requests can also be arranged via phone, fax, or eHealth Services ® via Availity.

Discharge Dates

- Discharge information should be sent daily to help ensure appropriate member follow-up and coordination of care. Discharge dates may be entered online, e-mailed to dcdates@bcbst.com, faxed to **(423) 591-950**1, or toll-free to **1-855-339-9781** for all lines of business. If faxing or e-mailing, providers may submit one list with all member names as long as the appropriate line of business is indicated. Provider cover sheets should include the facility name and NPI number to help ensure appropriate and efficient processing.

Transfers for a Prior Authorization

- BCBST will honor any elective approvals from a prior carrier for the initial ninety (90) days of an enrollee's coverage without a medical necessity review, if documentation is supplied to indicate what services have been approved. Documentation may include, but is not limited to: an approval letter, screen print from website, etc. After 90 days, a new medical necessity review will be required using BCBST criteria and guidelines.

C. Medical Review Requirements

Types of reviews required are subject to change. You can easily find the latest changes to prior authorizations under *Upcoming Prior Authorization Changes* in the *News & Updates* section of our *Documents & Forms* page. You can access prior authorization changes 60 days before the effective date.

All information is subject to verification by review of the medical record and other sources. (See medical record submission guidelines later under "Provider Appeal Process".)

When prior authorization* is required, providers must obtain authorization prior to scheduled services or within two business days of emergent services. **Note**: Medicare Advantage timeframe is 24 hours or next business day.

Failure to comply within specified authorization timeframes will result in a denial or reduced benefits due to non-compliance, and our participating providers won't be allowed to bill members for covered services rendered, except for any applicable copayment/deductible and coinsurance amounts. Prior authorization requests may be requested via e-Health Services ® in Availity, called in to **1-800-924-7141** or faxed to **1-866-558-0789** using the appropriate fax form located at https://provider.bcbst.com/tools-resources/manuals-policies-guidelines. When submitting electronically, attaching the completed request form for the service will help ensure complete and accurate clinical submission.

Requests for tests, procedures or services requiring prior authorization must contain adequate information for review. Requests for authorization where clinical information is requested, but not received by the end of the next calendar day, will be reviewed based upon clinical information currently available. Covered services that have not been authorized may not be billed to the member.

**We administer both insured and self-funded arrangements. Because of differences in relationships, some prior authorization requirements as well as benefit coverages may differ. Benefits are always subject to verification of eligibility and coverage at the time services are rendered.*

The following describes specific medical review guidelines:

1. Inpatient Admission

a. Acute Care Facility

All inpatient stays require prior authorization. Authorization will be issued when care and treatment are determined to be medically necessary and appropriate in an inpatient setting.

Basic information needed for processing a prior authorization request:

- Member's identification number and name
- Patient's name and date of birth
- Practitioner's name, provider number and/or National Provider Identifier (NPI), address, telephone number and caller's name
- Hospital/facility's name, provider number and/or NPI, address, telephone number and caller's name

Clinical information required for prior authorization:

- Procedure/operation to be performed, if applicable
- Diagnosis with supporting signs/symptoms
- Vital signs and abnormal lab results
- Elimination status
- Ambulatory status
- Hydration status
- Co-morbidities that impact patient's condition
- Complications
- Prognosis or expected length of stay
- Current medications
- Test results

b. Skilled Nursing Facility (SNF)

All inpatient stays require prior authorization. Authorization will be issued when care and treatment are determined to be medically necessary and medically appropriate in an inpatient setting. Skilled services are services requiring the skills of qualified technical or professional health personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists and/or audiologists. Skilled services must be provided directly by or under the general supervision of technical or professional healthcare personnel.

Basic information needed for processing a prior authorization request:

- Member's identification number and name
- Patient's name and date of birth
- Practitioner's name, provider number and/or NPI, address, telephone number and caller's name
- Hospital/facility's name, provider number and/or NPI, address, telephone number and caller's name
- Initial review, concurrent review or reconsideration request with admission date, admitting diagnosis, symptoms and treatment
- Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care that would influence the medical necessity determination

If a covered benefit, SNF admission may be approved for members with all the following:

- A condition requiring skilled nursing services or skilled rehabilitation services on an inpatient basis, at least daily
- A practitioner's order for skilled services
- Ability and willingness to participate in ordered therapy
- Medical necessity for the treatment of illness or injury (this includes the treatment being consistent with the nature and severity of the illness or injury and consistent with accepted standards of medical practice)
- Expectation for significant reportable improvement within a predictable amount of time

Evaluation and Plan of Care

- Evaluation of the member must be submitted including the following:
  - Primary diagnosis
  - Ordering practitioner and date of last visit
  - Circulation and sensation
  - Gait analysis

- Date of diagnosis onset
- Baseline status
- Current functional abilities
- Functional potential
- Strength
- Range of motion
- Cooperation and comprehension
- Developmental delays (pediatric patients)
- Other therapies or treatments
- Patient's goals
- Medical compliance
- Support system

- Plan of care must be submitted including the following:
  - Short- and long-term goals
  - Discharge goals
  - Measurable objectives
  - Functional objectives
  - Home program
  - Proposed admission date
  - Frequency of treatment
  - Specific modalities, therapy, exercise
  - Safety and preventive education
  - Community resources

Therapy Services

Therapy services appropriate for SNF include occupational therapy, physical therapy and speech therapy not possible on an outpatient basis. Specific therapy services that may be appropriate for SNF include, but aren't limited to:

- Complex wound care requiring hydrotherapy
- Preventing complications and the start or revision of the member's maintenance therapy plan
- Gait evaluation and training to restore function in a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality

Nursing Services

Nursing services appropriate for skilled nursing facilities include skilled nursing services not possible on an outpatient basis. Specific nursing services that may be appropriate for SNF include, but aren't limited to:

- Intramuscular injections or intravenous injections or infusions
- Burns
- Open lesions
- Widespread skin disorder treatments
- Initiation and training for care of newly placed patients
  - Tracheostomy
  - Pain management
  - In-dwelling catheter with sterile irrigation and replacement
  - Colostomy
  - Gastrostomy tube and feedings
- Complex wound care involving medication application and sterile technique
- Ulcer treatment with any stage 3 or 4 pressure ulcer or 2 or more ulcers

Nursing and Therapy Services Not Requiring SNF Placement

SNF placement isn't necessary for the services listed below. This list is **not** all-inclusive.

- Administration of routine oral, intradermal or transdermal medications, eye drops, and ointments
- Custodial services, e.g., non-infected postoperative or chronic conditions
- Activities or programs primarily social or diversional in nature
- General supervision of exercises in paralyzed extremities, not related to a specific loss of function
- Routine care of colostomy or ileostomy
- Routine services to maintain functioning of in-dwelling catheters
- Routine care of incontinent patients
- Routine care in connection with braces and similar devices
- Prophylactic and palliative skin care (i.e., bathing, application of creams, or treatment of minor skin problems)

- Duplicative services - physical therapy services that are duplicative of occupational therapy services being provided or vice versa
- Invasive procedures (i.e., iontophoresis involving needle)
- General supervision of aquatic exercise or water-based ambulation
- Heat modalities (hot packs, diathermy or ultrasound) for pulmonary conditions or wound treatment, or as a palliative or comfort measure only (whirlpool and hydrocollator)
- Hot and cold packs applied in the absence of associated modalities
- Diagnostic procedures performed by a physical therapist (i.e., nerve conduction studies)
- Electrical stimulation for strokes when there is no potential for restoration of functional improvement. Nerve supply to the muscle must be intact.

Extension of Services

Extension of services requires the following documentation:

- Clinical progress in meeting goals
- Updated goals
- Compliance and participation with any ordered therapy
- Discharge plans and target date

c. Rehabilitation Facility

All inpatient stays require prior authorization. Authorization will be issued when care and treatment are determined to be medically necessary and medically appropriate in an inpatient setting. Inpatient rehabilitation provides multidisciplinary, structured, intensive therapy for members meeting criteria. Rehabilitation goals are to prevent further disability, to maintain existing ability, and to restore maximum levels of functioning within the limits of the member's impairment.

Potential inpatient rehabilitation admissions include members who recently experienced a stroke, head trauma, multiple trauma or a spinal cord injury.

Basic information needed for processing a prior authorization request:

- Member's identification number and name
- Patient's name and date of birth
- Practitioner's name, provider number and/or NPI, address, telephone number and caller's name
- Hospital/facility's name, provider number and/or NPI, address, telephone number, caller's name
- Initial review, concurrent review or reconsideration request with admission date, admitting diagnosis, symptoms, treatment, frequency of therapies, member's ability to participate in treatment
- If the member is ventilator dependent or not
- Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care that would influence the medical necessity determination

If a covered service, inpatient rehabilitation admission may be approved for members with:

- Rehabilitative potential, to include assessment and/or current functional status from illness or injury and premorbid condition
- Ability and willingness to actively participate in a minimum of three hours of daily therapy, five days per week, or therapy at least 15 hours per week (seven consecutive days)
- A condition requiring 24-hour rehabilitation nursing and 24-hour availability of a practitioner with special training in the field of rehabilitation
- A requirement for at least two therapies and a multidisciplinary team approach
- Medical necessity for the treatment of illness or injury (this includes the treatment being consistent with the nature and severity of the illness or injury, and consistent with accepted standards of medical practice)
- Acute medical condition stabilized
- Reasonable and reportable goals in a written plan of care submitted with the request for admission
- Documented family commitment to the rehabilitation program (where family involvement will eventually be required).

In addition, a request for an additional inpatient rehabilitation admission for a member previously admitted to inpatient rehabilitation for essentially the same condition needs to be carefully assessed. The date and length of previous rehabilitation, along with the improvement attained, need to be carefully considered. Alternatives in these cases may be outpatient rehabilitation, home therapy or therapies, or SNF placement.

Evaluation and Plan of Care

- Evaluation of the member must be submitted as appropriate:
  - Ordering practitioner and date of last visit
  - Primary diagnosis
  - Date of diagnosis onset
  - Baseline status
  - Current functional abilities
  - Functional potential
  - Strength
  - Range of motion
  - Gait analysis
  - Circulation and sensation
  - Cooperation and comprehension
  - Developmental delays (pediatric patients)
  - Other therapies or treatments
  - Patient's goals
  - Medical compliance
  - Support system
- Plan of care must be submitted as appropriate:
  - Short- and long-term goals
  - Discharge goals
  - Measurable objectives
  - Functional objectives
  - Home program
  - Proposed admission date
  - Frequency of treatment
  - Specific modalities, therapy, exercise
  - Safety and preventive education
  - Community resources

Extension of Services

Extension of services requires the following documentation:

- Clinical progress in meeting goals
- Updated goals
- Compliance and participation with therapy
- Demonstrating measurable practical improvement in function with evaluation of current level of functioning
- Discharge plans and target date
- Team conference reports (at least every two weeks or with any significant change in the member's condition)

Note: A sample copy of the Skilled Nursing Facility/Inpatient Rehabilitation form is available at provider.bcbst.com.

2. Emergency Admission

In-network providers are responsible for contacting us within two business days of the inpatient admission. **Note**: Medicare Advantage timeframe is 24 hours or next business day.

Although emergency procedures don't require prior authorization, benefits are subject to verification for medical necessity and medical appropriateness and eligibility of coverage.

If an emergency hospital admission occurs after normal office hours, you may submit the information online for registered users, or contact the Utilization Management Department within two business days. **Note**: Medicare Advantage timeframe is 24 hours or next business day.

If the member is still admitted at that time, an admission review will be initiated. If the member has been admitted and discharged, a retrospective review will be completed.

3. Observation Stays

The goal of observation stays is to either complete treatment, e.g., hydration, or rule out need for inpatient stays; (e.g., chest pain isn't caused by an acute myocardial infarction). Members in this status may advance to admission status if the clinical situation warrants. Admissions need to be reported to the

Utilization Management Department before a scheduled admission or, within the next business day for conversion to inpatient admission to determine medical necessity and medical appropriateness.

23-Hour Observation Room Services Policy

The medical record must support the need for observation and a specific practitioner's order for observation must be documented. The record must also show the time and date of arrival and discharge from the facility. Observation stays don't require prior authorization.

4. Non-Compliance

Services requiring prior authorization rendered without obtaining approval are considered "non-compliant." Emergency admissions require authorization within two business days after services have started or within one business day after conversion from observation to inpatient status. **Note**: Medicare Advantage timeframe is 24 hours or next business day. Concurrent reviews should be requested prior to approval expiration or within one business day of the last day approved.

When prior authorization is required for elective procedures, providers must obtain authorization prior to scheduled services. Non-compliance applies to initial review as well as concurrent review for ongoing services beyond dates previously approved.

Failure to comply within specified authorization timeframes will result in a denial or reduced benefits due to non-compliance. Our contracted providers can't bill members for covered services denied due to non-compliance by the provider.

If a member doesn't inform the provider about their coverage with us, and the provider discovers that the member does have coverage, the provider should send a copy of the medical record relevant to the admission or services, along with the face sheet, including the reason the authorization wasn't obtained. The medical records will be reviewed only when a valid reason for not obtaining a prior authorization is provided with the request. providers should follow the provider appeal process within 60 days of the initial denial.

An appeal will only be overturned if medical necessity is determined and there's clear evidence that the facility wasn't aware that the member had coverage at the time services were rendered.

5. Maternity, Labor and Delivery, Newborn

Normal deliveries don't require notification or authorization. Complication of pregnancy continues to require authorization.

Newborns require notification/prior authorization if:

- Continued hospitalization is required after the mother has been discharged
- They're admitted to any level other than a well-baby nursery
- They're transferred to another facility due to their fragile condition

6. Home Health Services/Skilled Nursing Visits

Home health services may require prior authorization. Home health services are hands-on, skilled care/services, by or under the supervision of a registered nurse that are needed to maintain the member's health or to facilitate treatment of the member's illness or injury. For the services to be covered, the member must have a medical condition that makes them unable to perform personal care and meet medical necessity and medical appropriateness criteria. Documentation must support the member's limitations, homebound status, and the availability of a caregiver/family and degree of caregiver/families' participation/ability in the member's care.

Home Health Services normally covered include, but aren't limited to:

- Part-time intermittent Skilled Nursing Services
- Medical Social Service
- Home Infusion Therapy
- Dietary guidance
- Rehabilitative Therapies such as physical therapy, occupational therapy, etc.

Home Health Services not normally covered include, but aren't limited to:

- Non-treatment services
- Routine transportation
- Homemaker or housekeeping services
- Behavioral counseling
- Supportive environmental equipment
- Maintenance or custodial care
- Social casework
- Meal delivery
- Personal hygiene
- Convenience items
- Home health aides
- Private duty nursing

For an approval of Skilled Nursing/Home Health Visit services to be issued, the following criteria must be met:

- The member requires the skills of a nurse on an intermittent basis
- The member has a condition that requires active skilled care
- The services must be reasonable and necessary to the care of the condition
- The member must be determined by us to be homebound during the episode of care

Documentation for prior authorization:

- Practitioner's verbal or signed medical orders and plan of care for dates of service
- Number of services requesting
- Nurse's visit and progress notes
- Therapist's visit and progress notes, if applicable
- Availability of a caregiver
- Homebound status

Home health visits should be for skilled nursing services. Visits for assessment and teaching should be for services beyond those one would expect to be taught in the practitioner's office and the request must include the frequency and duration of services, and must specify what services will be provided. An insulin-dependent diabetic may have up to three skilled nursing visits to teach diabetic care. However, these visits should be lengthy, comprehensive and show evidence that clinical problem solving is actively used.

7. Transitional Care/Discharge Planning

We acknowledge a vested interest in assuring patient care is provided in the most appropriate setting and will continue to assist providers with discharge planning for its patients who are our members. Discharge planning should begin upon admission. Our transition of care/discharge planning nurses will assist providers and members upon admission, during the prior authorization process, or prior to admission if a scheduled admission.

Authorization for the following services should be completed and providers notified of the determination prior to the anticipated discharge and service date:

- Hospital admissions, select procedures
- Skilled nursing facility/restorative care unit admissions
- Inpatient rehabilitation admission
- Home health services (skilled nursing visits and home infusion therapy)
- Certain durable medical equipment
- Speech therapy, occupational therapy, physical therapy

8. Cosmetic Surgery

Cosmetic surgery isn't a covered service. However, breast reconstructive and symmetry surgery following a mastectomy is a covered service.

Reconstructive breast surgery, in all stages, on the diseased breast as a result of a mastectomy (not including a lumpectomy) is considered medically necessary.

9. Out-of-Network Services

Benefits may be limited, reduced or not be available in accordance with the terms of the member's healthcare benefits plan even if required prior authorization is obtained.

Emergency out-of-network services (based on admitting and discharge diagnosis filed on claim) are covered but must be reported to us within two business days. **Note**: Medicare Advantage time frame is 24

hours or the next business day. We may need to assist the provider in returning the member to the network when it is medically safe.

10. Transplant Services

Please see Section X. Case Management for transplant specifics.

11. Hospice Services

Hospice services are for terminally ill members where life expectancy is six months or less. Inpatient services may require prior authorization.

Hospice services normally covered include, but aren't limited to:

- Part-time intermittent nursing care
- Bereavement counseling
- Home health aide services
- Medical social services
- Medications for control or palliation of the illness
- Physical or respiratory therapy for symptom control

Hospice services not normally covered include, but** aren't **limited to:

- Homemaker or housekeeping services
- Meals
- Supportive environmental equipment
- Private duty nursing
- Routine transportation
- Funeral or financial counseling
- Practitioner visits
- Inpatient and outpatient care
- Ambulance
- Chemotherapy
- Radiation therapy
- Enteral and parenteral feeding
- Home hemodialysis
- Psychiatric care
- Convenience or comfort items not related to the illness

12. Ambulatory Surgeries (Appropriateness Review), Diagnostic and Other Procedures

Some outpatient surgical/diagnostic procedures may require prior authorization. These procedures may be performed in outpatient surgical facilities, hospital outpatient departments, outpatient diagnostic centers, and in practitioners' offices. Providers may call our Provider Service Line at the phone number listed on the member's ID card to determine prior authorization requirements. Some procedures don't require prior authorization if performed on an outpatient basis; however, if performed on an inpatient basis, a prior authorization is required for the hospitalization. Non-emergency elective procedures should be submitted up to 30 days, but not less than 24 hours prior to the scheduled procedure. Failure to obtain prior authorization will result in denial of payment for covered services.

Prior authorization requirements are listed on www.bcbst.com

https://www.bcbst.com/docs/providers/Commercial-Prior-Auth-Requirements.pdf

Covered services that haven't been authorized may not be billed to the member if rendered by a provider in our network. Denials for failure to request an authorization must be appealed within 60 days of notification of denial. This doesn't preclude provider responsibility for claims timely filing requirements. The practitioner may appeal a medical necessity denial to us within 180 days of notification of denial.

Note: Select outpatient procedures are subject to focused retrospective review.

Providers should call the Provider Service line, **1-800-924-7141**, or visit e-Health Services® in Availity to determine prior authorization requirements.

13. Specialty Pharmacy Medications

Certain high-risk/high-cost specialty pharmacy medications administered in any setting other than inpatient hospital requires prior authorization for all lines of business. This authorization requirement

applies to all provider types including home infusion therapy providers, specialty pharmacies, hospitals providing outpatient infusions, and injections.

- A complete listing of provider-administered specialty pharmacy drugs can be found at
  - https://www.bcbst.com/docs/pharmacy/provider-administered-specialty-pharmacy-list.pdf.

  and
  - https://www.bcbst.com/docs/providers/MA-DSNP-Specialty-Pharmacy-List.pdf
- For members with Advanced Specialty Benefit Management, providers will need to follow this process.
  - Practitioners may contact one of our Specialty Pharmacy Network providers. A complete listing of our Specialty Pharmacy providers are located online at https://www.bcbst.com/docs/pharmacy/specialty-pharmacy-network.pdf.
  - The specialty pharmacy will obtain the necessary information and request prior authorization.
  - Pharmacy will ship the drug to either the provider's office (for provider-administered drugs) or directly to the member (for self-administered drugs).
  - Specialty pharmacy will bill us for the drug(s) and collect any necessary copays or coinsurance from the member.

If the provider is supplying a provider-administered drug that requires prior authorization, please use the following process:

- Call our Pharmacy Management department at **1-800-924-7141** and choose the "**Specialty Pharmacy**" authorization option

  or
- Submit the request via Availity, BCBST's secure portal on bcbst.com. We may request additional information if required to complete the review process.

In addition to the member information, the following is required when requesting prior authorization for provider-administered specialty drugs:

- Provider NPI number (more than one of your subsidiaries may share the same number)
- Tax ID number (more than one of your subsidiaries may share the same number)
- Appropriate taxonomy code in Block 33b (taxonomy code should be specific for specialty pharmacy, HIT, etc.)
- HCPCS code (J, Q or S code)
- Drug name
- Strength of drug
- National drug code (NDC)
- Number of units being billed
- Frequency of dosing
- Dosage
- Days' supply if billing an "ambulatory" drug on a medical claim (for example, when accepting Assignment of Benefits for members who have to pay 100% up front)
- Clinical Information to support the request (reference our Medical Policy Manual)

Some Commercial members may not have coverage for certain high-cost therapies depending on their group benefit. The list of potentially excluded products can be found at the following link:

https://www.bcbst.com/docs/pharmacy/advanced-therapeutics-drug-classes.pdf

The above list applies primarily to CAR-T and Advanced Therapy Medicinal Products (ATMP), although other drug types may be added in the future. Members can check whether they have coverage by referring to their Evidence of Coverage (EOC) or by calling member service. Providers can check whether their patients have coverage when they request prior authorization.

Advanced Therapeutics are defined as high-cost drugs that are based on cell therapy, gene therapy, or tissue engineering.

- CAR-T (Chimeric Antigen Receptor T-Cell Therapy) – Advanced cancer treatment to genetically reprogram a patient's T-cells.

- ATMP (Advanced Therapy Medicinal Products) – Medicines that primarily rely on editing genes, tissues, or cells.
- Gene Therapy – treatment that adds a new gene or replaces or repairs mutated (changed) genes inside the body's cells to help prevent or treat certain disease, such as cancer.

Note: New drugs may be periodically added to the specialty pharmacy list and those products requiring authorization are subject to change. Changes will be communicated via the BlueAlert newsletter or updates to this Manual.

If you're not satisfied with our decision, you can file a provider appeal by sending a written request, along with the supporting documentation, a copy of the denial notice and any pertinent medical information to:

BlueCross BlueShield of Tennessee
Attn: Pharmacy Management
1 Cameron Hill Circle
Chattanooga, TN 37402

Phone:

Commercial/Exchange: 1-800-924-7141
BlueAdvantage: 1-800-332-5762
BlueCare Plus: 1-800-899-1407
BlueCare: 1-800-468-9736
CoverKids: 1-888-325-8386
FEP: 1-800-572-1003
PSHB: 1-866-780-7742

Fax: 1-888-343-4232

Self-administered specialty pharmacy drugs are found in the Preferred Formulary guidebook and are marked with a "PA" indicator to reflect which drugs require prior authorization. For self-administered drugs requiring prior authorization, **not** supplied by a Specialty Pharmacy Network provider, call 1**-800-924-7141** or submit a prior authorization request via CoverMyMeds or SureScripts (**covermymeds.com** or the links in Availity.)

For additional information on Specialty Pharmacy Medications, see Section XVII. Pharmacy, in this Manual.

14. Home Infusion Therapy

Home Infusion Therapy (HIT) is the administration of medications, nutrients or other solutions intravenously, subcutaneously, epidurally, intramuscularly or via implanted reservoir while in the member's private residence. A request for HIT originates with a prescription from a qualified practitioner to achieve defined therapeutic results. HIT must be provided by a licensed pharmacy. Home nursing for patient education, medication administration, training, and monitoring are handled directly by a qualified home health agency.

A complete listing of Provider-Administered Specialty Pharmacy drugs can be found at https://www.bcbst.com/docs/pharmacy/provider-administered-specialty-pharmacy-list.pdf for Commercial and https://www.bcbst.com/docs/providers/MA-DSNP-Specialty-Pharmacy-List.pdf for Medicare. Those requiring prior authorization under the member's medical benefits plan are identified by "PA".

Authorization listings are subject to change. Changes will be communicated in the BlueAlert newsletter or updated to this Manual. Case Management may assist the practitioner in arranging HIT for extraordinary cases and when medical necessity and medical appropriateness warrant close attention.

When an authorization is needed, specific information is required. Authorizations are valid for the dates approved; any break in service requires a new authorization. HIT providers requesting approval of HIT services should submit the following information to Utilization Management:

- Member name, address, date of birth, sex, ID number
- Practitioner name, address, phone number
- HIT agency name, address, phone number, HIT-related provider number and/or National Provider Number (NPI) and a contact person

- Type of request: initial prior authorization, extension of services or change of services
- Type of therapy (e.g., palliative, long-term therapy, short-term antibiotic therapy) should include dosage, frequency, date and length of service, including NDC number, HCPCS code and grams of protein for TPN
- Primary and HIT diagnosis
- Clinical documentation (e.g., lab values, cultures, X-rays) to support reason and need for HIT services
- A practitioner's verbal or signed medical order

The administration of intramuscular (IM) drugs (Rocephin, Phenergan, Procrit, etc.) isn't considered HIT and therefore, shouldn't receive HIT benefits. If nursing is required to administer the drug and/or conduct teaching for the member, these services may require prior authorization under Home Health guidelines. If the HIT provider is dispensing the drug, they are required to follow our requirements for prior authorization. All self-administered drugs must be authorized and billed through the member's appropriate PBM. (See Section XVII. Pharmacy in this Manual.)

Authorization decisions will be phoned, faxed, sent electronically, or mailed to the HIT provider, the prescribing practitioner and member. Adverse decisions are rendered if medical necessity and medical appropriateness aren't shown.

If you're not satisfied with our decision, you can file a provider appeal by sending a written request, along with the supporting documentation, a copy of the denial notice and any pertinent medical information to:

BlueCross BlueShield of Tennessee
Attn: Medical Appeals Department
1 Cameron Hill Circle
Chattanooga, TN 37402

Phone:

Commercial/Exchange: 1-800-924-7141
BlueAdvantage: 1-800-924-7141
BlueCare Plus: 1-800-899-1407
BlueCare: 1-800-468-9736
CoverKids: 1-888-325-8386
FEP: 1-800-572-1003
PSHB: 1-866-780-7742

Fax: 1-423-591-9514

Extension of Services

When prior authorization is required and services are needed beyond the number of days authorized, the HIT supplier must have the additional services authorized.

Changes/Termination in Services

When prior authorization is required, the HIT provider must notify BlueCross BlueShield of Tennessee of any changes in therapies/medication, dosages, and/or an order for discontinuation by the ordering practitioner, during the time frame authorized.

15. Rehabilitation Therapy Outpatient Services

Therapies/Rehabilitative services must be medically necessary and medically appropriate therapeutic and rehabilitative services intended to restore or improve bodily function lost as a result of illness or injury.

Prior authorization requirements for cardiac rehabilitation services are driven by the member's healthcare benefit plan. We administer both insured and self-funded arrangements and because of differences in relationships, some prior authorization requirements may differ.

To ensure appropriate payment is made for cardiac and pulmonary rehabilitation services, providers are encouraged to verify the member's healthcare benefit plan's prior authorization requirements by calling the Provider Service line at, **1-800-924-7141** or via e-Health Services ® at bcbst.com. For healthcare benefit plans requiring prior authorization, penalties will continue to apply for non-compliance.

Therapy services normally covered include:

- Outpatient, home health or office therapeutic and rehabilitative services, which are expected to result in significant and measurable improvement in the member's condition resulting from an acute disease or injury. The services must be performed by, or under the direct supervision of a licensed therapist.
- Services must be performed in a practitioner's office, outpatient facility or home health setting;
- Physical therapy
- Speech therapy (limited to coverage for disorders of articulation and swallowing, following an acute illness)
- Occupational therapy
- Manipulative therapy
- Cardiac and pulmonary rehabilitative services

Therapy services **normally not covered** include, but aren't limited to:

- Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care;
- Enhancement therapy which is designed to improve the member's physical status beyond their pre-injury or pre-illness state;
- Complementary and alternative therapeutic services, which include, but aren't limited to:
  - Massage therapy
  - Acupuncture
  - Craniosacral therapy
  - Neuromuscular reeducation
  - Vision Exercise therapy
  - Cognitive therapy
- Modalities that don't require the attendance of a licensed therapist:
  - Activities primarily social or recreational in nature
  - Simple exercise programs
  - Hot and cold packs applied in the absence of associated therapy modalities
  - Repetitive exercises or tasks which can be performed by the member without a therapist and in a home setting
  - Routine dressing changes
  - Custodial services that can ordinarily be taught to a caregiver or the member themselves
  - Behavioral therapy
  - Play therapy
  - Communication therapy
  - Therapy for self-correcting language dysfunctions
  - Duplicate therapy (therapies should provide different treatments and not duplicate the same treatment).

a. Speech therapy services (provided in a non-acute setting)

For speech therapy services to be considered for benefits, the services must be medically necessary and medically appropriate to the treatment of the member's illness or injury. Unskilled services aren't eligible for coverage.

- **The following information must be included when authorization request is submitted:**
  - Date of last visit
  - Primary diagnosis
  - Date of diagnosis onset
  - Baseline status/current abilities
  - Functional potential
  - Prior level of functioning
  - Diagnostic and assessment services used to ascertain the type, causal factors, and severity of speech and language disorders
  - Support system
  - Developmental delays

- Other therapies or treatments
- Patient's goals
- Therapy compliance
- Prior speech therapy received and outcome

➢ **Treatment plan**

- Long and short-term goals
- Discharge goals
- Measurable objectives
- Functional objectives
- Home program, if applicable
- Duration of therapy
- Frequency of therapy
- Date therapy is to begin
- Specific therapy techniques

Note: We utilize MCG criteria when reviewing requests for speech therapy services provided in a non-acute setting.

b. Occupational therapy services (provided in a non-acute setting)

For occupational therapy services to be considered for benefits, the services must be medically necessary and medically appropriate to the treatment of the member's illness or injury. Unskilled services aren't eligible for coverage.

➢ ***The following information must be included when an authorization request is submitted:***

- Date of last visit
- Primary diagnosis
- Date of diagnosis onset
- Baseline status/current abilities
- Functional potential
- Prior level of functioning
- Diagnostic and assessment services used to ascertain the type, causal factors, and severity of dysfunction or disorders
- Support system
- Developmental delays
- Other therapies or treatments
- Patient's goals
- Medical compliance
- Prior occupational therapy received and outcome

➢ **Treatment plan**

- Long- and short-term goals
- Discharge goals
- Measurable objectives
- Functional objectives
- Home program
- Duration of therapy
- Frequency of therapy
- Dates of service
- Specific modalities and therapy

Note: We use MCG criteria when reviewing requests for occupational therapy services provided in a non-acute setting.

c. Physical therapy services (provided in a non-acute setting)

For physical therapy services to be considered for benefits, the services must be medically necessary and medically appropriate to the treatment of the member's illness or injury. A prior authorization may be required for physical therapy based on the member's benefit coverage. Unskilled services are not eligible for coverage.

- **The following information must be included when an authorization request is submitted:**
  - Date of last visit
  - Primary diagnosis
  - Baseline status
  - Functional potential
  - Current functional abilities
  - Strength
  - Range of motion
  - Circulation and sensation
  - Cooperation and comprehension
  - Support system
  - Developmental delays/pediatrics
  - Other therapies, treatments, chiropractic
  - Patient's goals
  - Medical compliance
  - Homebound status
- **Treatment plan**
  - Short- and Long-term goals
  - Discharge goals
  - Measurable objectives
  - Functional objectives
  - Home exercise program
  - Time frame (frequency and duration)
  - Date therapy is to begin
  - Frequency of treatment
  - Specific modalities, therapy, exercise
  - Safety and preventive education
  - Community resources

Note: We use MCG criteria when reviewing requests for physical therapy services provided in a non-acute setting.

16. Medical Supplies (Outpatient Rehabilitation Services)

The following coverage criteria apply to medical supplies billed to us:

- Records must clearly support that supplies were used during the member's treatment.
- Must be prescribed by the member's practitioner.
- Must be medically necessary and medically appropriate for treating illness or injury.
- Generally recognized as therapeutically effective and primarily medical in nature.
- Must be at the level and quality required (not "luxury" in nature).
- Can't be for environmental control, personal hygiene, comfort, or convenience.
- Can't be reusable.
- Supplies required for use with rental items are included in the rental fee.

17. Durable Medical Equipment

Certain Durable Medical Equipment (DME) purchases, rentals, or repairs require prior authorization for most lines of business. DME may be subject to retrospective review for medical necessity.

DME may be covered if it is determined to be medically necessary and medically appropriate for the member's condition. The following guidelines and documentation requirements apply to DME whether equipment is purchased or rented:

- The member's diagnosis should substantiate the need and use of the equipment in the medical record.
- Documentation of the member's capability to be trained in the appropriate use of the equipment.
- Rental equipment is generally considered equipment that requires frequent and substantial servicing and maintenance and/or estimated period of use is finite.
- Certain rented DME is purchased after the equipment has been rented for a total of 10 months.

- Documentation for customized equipment should specify the need for the custom equipment versus standard equipment.
- Reimbursement may be determined for a more cost-effective alternative if medical necessity and appropriateness for the equipment isn't demonstrated in the documentation submitted for review.

Information that needs to be submitted with the claim and/or prior authorization request (when applicable):

- Practitioner's order (if not submitted with the claim, it may be requested at any time and payment recouped if unavailable)
- Member's diagnosis and expected prognosis
- Estimated duration of use
- Limitations and capability of the member to use the equipment
- Itemization of the equipment components, if applicable
- Appropriate HCPCS codes for equipment being requested
- The member's weight and/or dimensions (needed to determine coverage of manual or power wheelchairs), if available

The following guidelines apply to reimbursement for repair of DME equipment:

- Equipment less than one year old requires documentation related to the warranty coverage. Repairs covered by the warranty won't be reimbursed
- Documentation supporting need for services and/or items being billed; initial purchase date of equipment should be included, if available
- Prior authorization may be required for DME repairs for some of our lines of business

We'll only provide benefits for medically necessary and medically appropriate equipment. Requests for extraordinary items require justification.

We won't provide benefits for Investigational DME.

Complex Rehabilitation Technology (CRT) Durable Medical Equipment (DME)

For Complex Rehabilitation Technology, all codes/line items to be billed must be provided to pre-review for billable codes and provide coverage determinations for services. For DME to be reviewed as CRT you must complete the CRT DME Authorization Form with the required information. Forms are located on BCBST.com in the provider section. https://provider.bcbst.com/tools-resources/documents-forms

Prior authorization isn't required for repairs of such technology or equipment unless:

- The repairs are coved under a manufacturer's warranty
- The cost of the repairs exceeds the cost to replace the CRT or manual wheelchair; OR
- The CRT or manual wheelchair in need of repair is subject to replacement because the age of the CRT or manual wheelchair exceeds, or is within one year of the expiration of, the recommended lifespan of the CRT or manual wheelchair.

18. Advanced Imaging/High-Tech Imaging

Prior authorization is required for select advanced imaging radiology procedures performed in an outpatient setting*. Prior authorization isn't required for imaging procedures performed during an inpatient admission or ER visit.

Procedures requiring prior authorization include, but aren't limited to:

- Computed tomography (CT)
- Computed tomography angiography (CTA)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Positron emission tomography (PET)
- Magnetic resonance spectroscopy (MRS)
- Nuclear cardiology

Applies to fully insured members. This program is an optional add-on for Administrative Services Only (ASO) members.

19. Musculoskeletal (MSK) Management

The Musculoskeletal Management Program applies to fully insured members. This program is an optional add-on for ASO members. Prior authorization is required for select MSK and procedures performed in an outpatient or pre-scheduled inpatient setting. Prior authorization isn't required by the MSK vendor for MSK performed during an unplanned admission or ER visit.

Procedures requiring prior authorization include, but are not limited to:

- Pain management
- Spinal surgeries
- Joint surgeries (hip, knee and/or shoulder)

20. Neonatal Intensive care (NICU)/Special Care Nursery (SCN) through First-Year Care Management

Prior authorization is required for newborns admitted to the NICU or SCN. Prior authorization reviews for these cases are processed by the NICU team and are reviewed for medical necessity throughout the hospitalization. The date of the next clinical review will be determined with each review. The NICU team will review:

- Birth inpatient admission to NICU or SCN
- All subsequent inpatient and outpatient admissions through member's first birthday

NICU requests can be submitted via phone at **1-800-924-7141** or fax to **1-866-230-3424**, or make your request to e-Health Services® via Availity**.**

21. Performance Evaluations of Delegate Vendors and Providers

The Delegate Oversight Program provides an organized and systematic approach to help ensure oversight of delegated administrative functions, which include utilization management, quality improvement, credentialing, independent record review, case management, claims, customer service, complaints, grievance and/or appeals, transportation, EPSDT, and medical records review.

We'll complete, at minimum, an annual assessment of reports and annual performance evaluations of vendors to whom activities have been delegated. The purpose of a performance evaluation is to ensure compliance with standards of all the applicable state and federal laws and regulations, as well as those of all applicable accrediting and regulatory review agencies, including but not limited to NCQA, the Tennessee Department of Commerce and Insurance (TDCI), and our policies and procedures.

The performance evaluation includes, but isn't limited to:

- Desktop and /or onsite evaluation of the vendor's compliance with all applicable standards
- Documentation and file review to determine the compatibility of the organization's goals and objectives with BlueCross BlueShield of Tennessee goals and objectives
- Criteria, methods, and process for determining medical necessity and medical appropriateness of care
- Written evaluation of the vendor's capabilities to perform delegated functions, staffing capabilities, and performance record

The delegate vendor will support us in meeting our requirements of annual and periodic performance evaluations by providing access to all records, policies, procedures, reports, and other documents as necessary to demonstrate compliance with the delegate program.

22. Second Surgical Opinion

We'll pay for any second surgical opinion requested by a member. This includes not only major surgery, but also other procedures (e.g., pacemakers, ambulatory surgery procedures, etc.).

The following guidelines apply to second surgical opinions:

- A surgeon (one who isn't in the same group or practice as the practitioner who rendered the first opinion) must render the second opinion.
- The practitioner rendering the second surgical opinion must be in network and proper referrals must be in place, if applicable.

23. Non-Emergent Air Ambulance Transportation

- Prior authorization is required for non-emergent air ambulance transportation.
- Prior authorization isn't required for emergency air ambulance transportation (e.g., from the scene of an accident when ground transport isn't appropriate or would pose a threat to the member).

Requests can be submitted via phone at **1-800-924-7141** or make your request to e-Health Services® via Availity.

24. Molecular and Genomic Testing

Prior authorization is required for select molecular and genomic testing. Prior authorization isn't required for genetic testing performed during an inpatient admission or ER visit.

Applies to fully insured members. This program is an optional add-on for ASO members.

25. Radiation Oncology

Prior authorization is required for select oncology/radiation therapy procedures. A separate prior authorization isn't required for oncology/radiation therapy procedures performed during an inpatient admission or ER visit.

This program doesn't apply to fully insured members. It's optional for certain ASO members.

26. Lab Sleep Studies

Prior authorization is required for sleep studies performed in the lab setting for adults 18 years or older. *Prior authorization isn't required for sleep studies performed in the home setting.

To request prior authorization for lab based sleep studies call **1-800-924-7141** https://provider.bcbst.com/tools-resources/documents-formsor make your request to e-Health Services ® via Availity. When submitting electronically, attaching the completed request form for the service will help ensure complete and accurate clinical submission.

*Applies to fully insured members. This program is an optional add-on for ASO members.

D. Emergency Services

ER services for an emergency condition don't require prior authorization. We communicate to our members to go to the nearest ER if they're suffering from an emergency condition.

An emergency is defined as a sudden and unexpected medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect to result in: serious impairment of bodily functions; serious dysfunction of any bodily organ or part; or placing the prudent layperson's health in serious jeopardy. These services may be provided by facility-based providers. It's understood that in those instances where a physician makes emergency care determinations, the physician will use the skill and judgment of a reasonable physician in making such determinations.

Note: Prior authorization isn't required for ER visits.

E. Investigational Services

Investigational services are services that do not meet our definition of medical necessity. New and established technologies are researched and evaluated by our Medical Policy Research & Development Department and are assessed using sources that rely on evidence based studies.

The definition of "investigational" is based on our technology evaluation criteria. Any technology that fails to meet all of the following criteria is considered to be investigational.

1. The technology must have final approval from the appropriate governmental regulatory bodies:
   a. This criterion applies to drugs, biological products, devices and any other product or procedure that must have final approval to market from the U.S. Food and Drug Administration or any other federal governmental body -with authority to regulate the use of the technology.

   b. Any approval that's granted as an interim step in the U.S. Food and Drug Administration's or any other federal governmental body's regulatory process isn't sufficient.
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes:
   a. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.
   b. The evidence should demonstrate that the technology could measure or alter the physiological changes related to a disease, injury, illness, or condition. In addition, there should be evidence or a convincing argument based on established medical facts that such measurement or alteration affects health outcomes.
3. The technology must improve the net health outcome:
   a. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.
4. The improvement must be attainable outside the investigational setting:
   a. In reviewing the criteria above, the Medical Policy Panel will consider physician specialty society recommendations, the view of prudent medical practitioners practicing in relevant clinical areas and any other relevant factors.

The medical director, in accordance with applicable the Employee Retirement Income Security Act (ERISA) standards, will have discretionary authority to determine if a service or supply is an investigational service. If the medical director doesn't authorize the provision of a service or supply, it won't be a covered service.

In making such determinations, the medical director will rely on any or all of the following, at their discretion:

1. Your medical records, or
2. The protocol(s) under which the proposed service or supply will to be delivered, or
3. Any consent document that you've executed or will be asked to execute, in order to receive the proposed service or supply, or
4. The published authoritative medical or scientific literature regarding the proposed service or supply in connection with the treatment of injuries or illnesses such as those experienced by you, or
5. Regulations or other official publications issued by the FDA and HHS, or
6. The opinions of any entities that contract with the plan to assess and coordinate the treatment of members requiring non-experimental or Investigational services, or
7. The findings of the BlueCross BlueShield Association Technology Evaluation Center or other similar qualified evaluation entities.

These criteria are used in making such determinations as whether a service is considered investigational or medically necessary. Providers have access to these policies via the Medical Policy Manual in the Manuals, Policies and Guidelines section of bcbst.com and are informed of new and revised medical policies via monthly provider e-mail notification messages. Newly approved medical policies may be viewed on our Upcoming Medical Policies web page bcbst.com.

If a network provider renders services that are investigational or don't meet medically necessary and appropriate criteria, the provider must obtain a written statement from the member, prior to the service(s) being rendered, acknowledging that the member understands they'll be responsible for the cost of the specific service(s). It's essential the signed statement be kept on file. It may be necessary to provide a copy of the written statement if the member questions the member liability amount reflected on their explanation of benefits (EOB). Once we contact the provider, they'll be asked to provide a copy of the signed written statement within two business days. If the provider isn't able to supply the written statement, the claim will be adjusted to reflect provider liability and the member won't be responsible for those charges.

To help assist in this process, we developed the Acknowledgement of Financial Responsibility for the Cost of Services form for provider use. A sample copy of this form is in Section V. Member Policy, in this Manual. Providers are encouraged to use this form. However, it doesn't waive prior authorization requirements.

F. Clinical Trials

A clinical trial is a prospective biomedical or behavioral research study performed with human subjects that's designed to answer specific questions about biomedical or behavioral interventions (vaccines, drugs, treatments, devices, or new ways of using known drugs, treatments or devices) to improve the diagnosis of disease and the quality of life of the patient. Clinical trials are used to determine whether new biomedical or behavioral interventions are safe, efficacious and effective. Such studies aren't authorized by us.

Generally, only routine patient care associated with a clinical trial (but not the clinical trial itself) will be covered under the member's health care benefit plan in accordance with our utilization policies. If there are specific differences between what's listed in this Manual and what's reflected in the member's health care benefit plan, the terms and conditions of the member's benefit plan control.

Member health care benefits may be verified by calling Provider Services at **1-800-924-7141**, the Member Service number listed on the member's ID card or accessing e-Health Services ® via Availity.

G. Medically Necessary and Medically Appropriate Policy

We cover medically necessary and medically appropriate healthcare services not otherwise excluded under our healthcare benefits plans.

Medically Necessary or Medical Necessity

Medically necessary refers to procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice; and
- Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, physician or other healthcare provider, and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.

Medically Appropriate

Medically appropriate refers to services determined by us to be of value in the care of a specific member. To be medically appropriate, a service must:

1. Be medically necessary.
2. Be consistent with generally accepted standards of medical practice for the member's medical condition.
3. Be provided in the most appropriate site and at the most appropriate level of service for the member's medical condition.
4. Not be provided solely to improve a member's condition beyond normal variation in individual development, appearance and aging.
5. Not be for the sole convenience of the provider, member or member's family.

We may request medical records when the complexity of a case requires a review of the medical records in order to determine if a service is medically necessary and medically appropriate.

Note: *According to contract, we won't reimburse for photocopying expenses.*

We encourage open practitioner/patient communication regarding appropriate treatment alternatives.

H. Prospective and Retrospective Review

These reviews are conducted based on MCG criteria (if applicable), our adopted utilization management guidelines, medical policy, Physician's CPT®, CMS Common Procedure Coding System and the member's healthcare benefits plan.

The following listed services aren't all-inclusive and may be subject to prospective or retrospective review:

- Possible cosmetic services
- Potential investigational services
- Skilled nursing facility confinements
- Chiropractic services
- Outpatient therapies
- Durable medical equipment (when prior authorization isn't required)
- Prosthetics, orthotics, and supplies
- Practitioner office services
- Dental, accident related and temporomandibular joint dysfunction
- Pain management
- Unbundled codes and/or code combinations
- Non-participating provider or no prior authorization obtained

Types of reviews may change based on policy or guideline changes, identification of the need for focused reviews, etc.

I. Provider Appeal Process

It's our policy to make available to treating practitioners a peer-to-peer review to discuss, by telephone, determinations based on medical appropriateness. These reviews can be requested:

1. Anytime during the hospital stay
2. Within 24 hours of notification of decision if already discharged
3. For elective services, prior to services being rendered or filing an appeal

Providers can reach a dedicated voicemail system by calling the Provider Service line at **1-800-924-7141**, Monday through Thursday, 8 a.m. to 6 p.m. ET and Friday, 9 a.m. to 6 p.m. ET. All messages left before 3 p.m. ET will be returned the same day. Messages left after 3 p.m. ET will be returned the next business day. The voicemail system requires two specific dates and times to schedule the physician-to-physician review as well as other member demographics indicated by the voicemail prompts. If the provider is still not satisfied following a peer-to-peer discussion, the provider should proceed to the next level of appeal (i.e., Provider Dispute Resolution).

Utilization Management Appeals

Providers must file an appeal to obtain specialty match review for medical necessity.

Reconsideration Prior to Service

Additional information may be submitted via the regular authorization process when an adverse determination is issued. This information may also be submitted from the provider or provider representative.

Provider office staff should only initiate a physician-to- physician discussion with one of our medical directors when the attending or ordering physician requests, and is aware of the discussion.

Expedited Appeal

The request for an expedited appeal must be initiated by phone and should include a request for expedited appeal along with any pertinent information not originally submitted.

1. An expedited appeal may or may not require a peer-to-peer conversation.
2. An expedited appeal can be requested when the provider believes that the adverse determination:

a. Could seriously jeopardize the life or health of the member and the ability of the member to regain maximum function, and/or
b. In the opinion of the practitioner with knowledge of the member's medical condition would subject the member to severe pain that can't be adequately managed without the care or treatment that's the subject of the case.

An expedited appeal will be completed and notification issued to the member and provider no later than 72 hours after the initial request of the appeal. However, the clinical circumstances will help determine the speed of the response.

Expedited appeals may be requested by calling the appropriate prior authorization number. You should verbally request the review to be labeled as an expedited appeal for us to ensure the review is completed within the timeframe. (Refer to Section II. Quick Reference Telephone Guide in this Manual.)

Non-Compliance Denial Appeal

There's no reconsideration of a non-compliance denial. If a party is dissatisfied with a non-compliance denial, they may appeal the denial. Appeals of non-compliance denials must be submitted within 60 days of the initial denial. The request should include a copy of any pertinent clinical information, face sheet, if applicable, and a statement from the practitioner/facility indicating the reason(s) for the appeal and a copy of the denial letter. If the party is still dissatisfied with the decision, they can proceed to arbitration pursuant to Section II C. of the PDRP.

Standard Appeal

The standard appeal process can be used if reconsideration resulted in an adverse determination result or the provider can file an appeal without completing a reconsideration. Requests for standard appeal for medical necessity denials must be received in writing by the Utilization Management department within 180 days of the date of the initial denial notification. This doesn't preclude timely filing requirements.

Exhausting the above noted process satisfies Section II. A. and B. of the Provider Dispute Resolution Procedure (PDRP) outlined in Section XIII in this Manual. If the party is still dissatisfied, they can appeal the adverse decision pursuant to Section II. C. of the PDRP.

Medical record submission guidelines

Occasionally, medical records are received without a clear indication of who requested the information, what's being requested or complete member identification. Medical records may be submitted via hardcopy, fax or CD-ROM.

When submitting medical records for appeal:

1. Submit any request or notification letter from us as the **first** page of your medical record or the UM appeals form located at http://www.bcbst.com/providers/forms/Utilization-Management-Appeal-Form.pdf. **Failure to do so may result in a delayed response to your request or your request being returned until appropriate documentation is supplied**.
2. If submitting multiple records for a single patient or multiple records for multiple members, ensure the individual records are secured with a clip or other indicator if mailed in the same envelope.
3. Medical records may be submitted through certified mail and must be legible with all appropriate information pertinent to the presenting case.
4. Include all member information in a clear, legible format. We must be able to identify the member and the relationship to our health plans.
5. Claims must be attached behind the medical record. If attached to the front, it will be mistaken for a claim needing adjudication rather than a medical record needing review.

Fax appeal to: ***(preferred method)***

(423) 591-9451

Mail appeal to:

BlueCross BlueShield of Tennessee
Commercial Appeals/Retrospective Claims Review
1 Cameron Hill Circle, Suite 0017
Chattanooga, TN 37402-0017

Pharmacy Pricing Appeal

Pharmacy pricing appeals should be submitted directly to our pharmacy benefit manager using directions in the following link:

https://www.caremark.com/portal/asset/MAC_Portal_Access_Appeals_Process.pdf

Medical claim pricing appeals for specialty pharmacies contracted in BCBST's specialty network should be submitted to BCBST using the Standard Appeal process referenced above.

J. Medical Policy Manual

The Medical Policy Manual contains medical policies approved by BlueCross BlueShield of Tennessee. Medical policies address specific new or evolving medical technologies or pharmaceutical agents.

Medical policies are based on evidence-based research using published studies, and/or professional association guidelines, and/or prevailing Tennessee practice, and/or prior authorization vendor management recommendations. Determinations with respect to technologies are made using criteria developed by the BlueCross BlueShield Association's Technology Evaluation Center. The criteria includes:

1. The technology must have final approval from the appropriate governmental regulatory bodies.
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
3. The technology must improve the net health outcome.
4. The technology must be as beneficial as any established alternatives.
5. The improvement must be attainable outside the investigational settings.

The medical policies specifically state whether a technology is considered medically necessary, Not medically necessary, investigational, or cosmetic. Definitions of these terms are found within the Medical Policy Manual Glossary. Providers may view the Medical Policy Manual in its entirety at https://provider.bcbst.com/tools-resources/manuals-policies-guidelines.

Many policies also contain a medical appropriateness section, or a Criteria for Initial Approval section. These sections contain the criteria used in determining whether a particular technology is appropriate in a particular case (i.e., for a specific individual).

Administrative Services Policies

Administrative services policies contain corporate positions and/or criteria that reflect our business decisions. These documents are often associated with a member's benefit plan (i.e., Evidence of Coverage) and they may be used in the adjudication of claims and requests for medical, dental, vision and/or pharmacy related services. Providers may view the Administrative Services Policies at https://provider.bcbst.com/tools-resources/manuals-policies-guidelines.

Medical Policy Appeals

Our network providers may appeal a draft or active medical policy. A medical policy appeal is a formal notice from a network provider stating dissatisfaction with any medical policy determination. The dissatisfaction could be questioning the investigational status of a medical policy or the medical appropriateness criteria contained in a medical policy. Published, peer-reviewed studies supporting the appealing providers position must be submitted with each medical policy appeal.

The medical policy appeal process of an active medical policy:

- Provider submits a written request for appeal of a medical policy, along with full-text copies of supporting documentation to the Provider Appeals Department.
- Provider Appeals Coordinator sends the request to the division representative for the Medical Policy Research & Development Department.
- Medical Policy Research & Development Department reviews the appeal and supporting documentation.
- The appeal decision is returned to the Provider Appeals Department with a detailed response for the provider.
- A written response is sent via registered mail to the network provider.

Network providers may submit a written medical policy appeal along with supporting documentation to:

Provider Appeals Coordinator
Provider Network Management
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle, Ste 0039
Chattanooga, TN 37402, 0039

K. Transparency

We provide access to MCG's Cite Guideline Transparency (CGT) tool located on **bcbst.com** and within Availity. MCG developed CGT to allow their clients to enhance transparency by providing our members and providers the ability to view MCG's clinical content. CGT also contains the Utilization Management Guidelines and selected medical policies. The CGT isn't a prior authorization tool, but will allow providers to preview the content before requesting or providing a service to help ensure they have the necessary information available to meet our clinical decision process. CGT provides disclaimer information to inform the end-user if the guideline has been modified (altered) from MCG's original content. It also provides MCG's Evidence Summaries, Inconclusive and Non-Supportive information, Clinical Indication Criteria, Alternative Care Planning and Care Alternatives. The CGT tool doesn't provide goal length of stay (GLOS) information.

If you have questions about CGT, contact eBusiness Technical Support at **(423) 535-5717**, **option 2,** or by e-mail at eBusiness_Service@bcbst.com.

L. Directing Members to Participating Providers in Members' Network

When a member needs additional care outside your practice, you can assist them by directing them to participating providers in the member's network. Members seeking care outside their network will have significant reductions in benefits or no benefits. An illustration of the increased member liability for out-of-network utilization:

Example:

Physician charges = $300.00
Member's maximum allowed = $180.00

Utilizing an in-network provider

Provider network physician discount = $120.00
Health Plan payment = $150.00 (or 80% of $180 maximum allowed)
Member payment = $30.00

Utilizing an out-of-network provider

Provider network physician discount = $0
Health plan payment = $108.00 (or 60% of $180 maximum allowed)
Member payment = $192.00

By helping your patients utilize in-network providers, you can help ensure they receive the highest level of benefits. An online directory of participating providers by network-type is available at bcbst.com. Both members and providers may access the provider directories by selecting "Find Care" located on our home page.

M. Utilization Management Resources

The following tools are utilized in the clinical decision process:

Member's Contract

The member's contract is the first tool in the clinical decision process. If the service is provided within the contract, it may require evaluation of medical appropriateness.

Medical Policy

Our medical policies and/or administrative services policies are the second tool in the clinical decision process. The Medical Policy Manual will provide evidence or state mandate-based policy statements and medical appropriateness criteria used to determine medical necessity. administrative services Policies provide business-based criteria or guidelines used in adjudicating claims and requests.

Clinical Guidelines

The utilization management criteria is the third tool in the clinical decision process. Clinical guidelines include MCG, and our Utilization Management Guidelines. If the contract addresses the service, but the medical policy doesn't, the clinical guidelines should be applied to the request for services

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VIII. CARE MANAGEMENT

Our Care Management programs accept referrals from our provider network. Specific program information can be found below.

Programs:

- Chronic Care Management
- Women's Health, including Healthy and High-Risk OB and Perimenopausal Care
- Children's Health including NICU Management, First Year of Life, and Children's Wellness
- Transplant Case Management
- Complex Case Management
- Management for Newly Diagnosed Conditions – Cancer, Type I Diabetes, Life Altering Injury
- Behavioral Health
- Care Coordination Services
- Site of Care Services
- Care Support

Referrals to our Care Management Programs should include:

- Requesting practitioner's name and telephone number
- Member name, member ID number and telephone number
- Diagnosis and current treatment plan/clinical information
- Current treatment setting (e.g., patient has COPD with frequent hospital admissions)
- Level of urgency of care management need

After we receive the request for Care Management, a Care Team member will make an initial call to the member within two business days. If an urgent request is needed, please specify in the phone or email message.

Telephone: 1-800-818-8581, option 2
FEP Telephone: 1-866-907-5556
Email: THM_Referrals_GM@BCBST.com

A. Care Management Team and Process

The **Care Management Team** is a multidisciplinary group that includes Registered Nurses, Behavioral Health Clinicians, Social Workers, Registered Dieticians/Certified Diabetes Educators, Certified Lactation Counselors, and Health Navigators. Medical Directors are available to provide consultation and oversight as needed.

Care Managers maintain ongoing communication with members throughout the course of treatment. Their role is to:

1. Coordinate clinical needs and health plan coverage requirements
2. Support families in accessing community resources
3. Ensure continuity of care across providers

Once enrolled, the Care Manager works in partnership with the member, their practitioner, and other providers to design and implement an individualized plan of care. Progress and evolving health needs are regularly evaluated, with updates shared with both the member and their care team.

When the member achieves clinical stability or the plan of care has met its objectives, Care Management services may be discontinued or transitioned to a less intensive program.

B. Transplant Care Management

The Transplant Care Management team consists of Registered Nurses specifically trained in the areas of solid organ and stem cell transplantation, Medical Directors, and benefit specialists who have claims and transplant benefit management experience.

It's critically important, to both the practitioner and member, that the Transplant process be initiated as soon as you think the member may need a transplant:

- If prior authorization from Transplant Utilization Management isn't obtained, the transplant and related services may not be covered, or reimbursement may be reduced substantially.
- Most members' health care benefits plans encourage them to receive transplant services at a Blue Distinction Center for Transplants (BDCT).
- Transplants performed outside of the **BDCT or Transplant Networks** may not be covered or reimbursement may be greatly limited (depending on the member's health care benefits plan).

Not all in-network practitioners and hospitals (e.g., Blue Networks P, S, and E) are in the BDCT, or **Transplant Network**. Seeking care outside of these networks can reduce benefits and require substantial payment by the member. Please contact the Transplant Care Management team to see which hospitals are in the BDCT or **Transplant Network** before referring members for transplant evaluation.

The Blue Distinction Centers (BDCT) for Transplant Network

BlueCross BlueShield of Tennessee and the Blue Cross Blue Shield Association administer and contract with the transplant centers that make up The Blue Distinction Centers for Transplant.

This national network of transplant centers offers comprehensive transplant services through a coordinated, streamlined program of transplant management. Participating centers are major clinical programs and leading research institutions located throughout the country. The BDCT currently contracts for heart, single or bilateral lung, combination heart-bilateral lung, liver, (including living donor), pancreas, kidney, simultaneous pancreas-kidney, and bone marrow/stem cell (autologous/allogeneic).

For further information about becoming a BDCT facility or questions specifically regarding the BlueCross BlueShield Association or BDCT program, call **1-800-263-7893**.

Participating facilities receive a BDCT Procedure Manual from the BlueCross BlueShield Association. This manual contains detailed instructions, forms and contact lists for Participating and Referring BlueCross BlueShield Plans. We're a Referring and a Participating Plan in the BDCT Network. The guidelines outlined in the BDCT Procedure Manual must be followed, in addition to those outlined in this manual, for maximum allowable reimbursement of transplants and transplant-related services.

Transplant Network

These facilities (e.g., Participating Blue Networks P, S, and E BlueCard®/BlueCard® PPO) may receive a reduced level of reimbursement for some members. If member benefits are available, reimbursement may be subject to the Transplant Maximum Allowable Charge (TMAC) for the global transplant period. The member is liable for any amounts more than the TMAC up to the contracted fee schedule amount. (Eligibility for TMAC is determined by the ASO. TMAC doesn't apply to fully-insured groups.)

Out-of-Network

If a facility isn't contracted with BDCT, the member's health plan (e.g., Blue Networks P, S, L, and BlueCard®/BlueCard® PPO); or otherwise contracted with the local BlueCross BlueShield Plan, the facility is Out-of-Transplant Network. Members may have benefits at these facilities, but reimbursement and benefits are reduced as compared with **Transplant Network** benefits and reimbursement.

BlueCard®

The BlueCard program links participating healthcare practitioners and the independent BlueCross BlueShield plans across the country and around the world. Not all members have BlueCard coverage. Not all BlueCard facilities participate in our **Transplant Network**. Transplants for members that occur at BlueCard® facilities, not in our **Transplant Network**, will be reimbursed in accordance with the member's health plan. To determine eligibility and benefits of a BlueCard® member call **1-800-676-BLUE (2583)**. Provide the operator with the member's ID, including the alpha-prefix. You'll be transferred to the member's Home Plan. If you have questions about BlueCard®, go to bluecard.com or Section XVI. in this manual.

Referrals, Care Management, and Prior Authorization

Referrals

All transplants require prior authorization. The prior authorization process will trigger a referral and outreach to the member and provider from our Transplant team which includes benefit specialists, and registered nurses. These resources will work to ensure that members are receiving care from our BDCT or **Transplant Network** facilities or there will be significant reduction in benefits, including no benefits for some members.

Care Management

100% of Transplant eligible members are monitored through our Transplant Care Management program. The Transplant Care Manager will work with the member and practitioner to identify high-risk members who will need additional assistance and care management services. Contact Transplant Care Management at **1-888-207-2421, ext. 4042** prior to all member referrals for any transplant-related medical care, including evaluation to help ensure the services are covered and the member receives the highest level of benefits available

Denials

Transplant care determined by the Transplant Utilization Management Program as not meeting clinical criteria will be reviewed by a medical director. The member and the practitioner will be given the determination in writing.

Appeals

Refer to Section VIII. UM Program and Section XIII. Provider Dispute Resolution, in this manual.

Prior Authorization

The transplant facility must provide BCBST with the member name, identification number(s), type of transplant, and proposed dates of service (inpatient/outpatient). The facility is required to submit clinical information to obtain prior authorization for the transplant once the member has been evaluated. The facility must notify us within one business day of a transplant services admission (inpatient/outpatient).

BDCT facilities must also notify the referring Blue Cross Blue Shield Plan (if appropriate per BDCT practitioner Procedure Manual), the BlueCross BlueShield Association and submit the appropriate forms provided in the BDCT Practitioner Procedure Manual.

Length of Stay

The facility must notify us to obtain initial authorization as well as provide clinical updates throughout the transplant procedure and recovery. The Transplant Care Manager will authorize the initial admission for transplant and will outline the schedule for clinical updates required for extending the stay.

Transplant Global Period

Transplant benefits and reimbursement are calculated as a global period. Participating facilities, contracted to provide transplant services, may be eligible for additional reimbursement beyond the global rate, (outlier charges). To be eligible for outlier reimbursement the facility must contact us for authorization of the outlier days. Prior authorized outlier days will be reimbursed in accordance with the contracted per diem rate if the member is inpatient exceeding of the following predetermined length-of-stay days:

- Stem cell: 50 days, plus pre-transplant treatment days
- Kidney: 20 days
- Lung: 38 days
- Liver: 39 days
- Heart: 38 days
- Combination heart-bilateral lung: 43 days
- Simultaneous pancreas-kidney: 34 days

Claims

Claims should be submitted to us according to the facility's contract and participation in the **BDCT Network** or other Networks as described previously in this section.

BDCT Facilities

The participating BDCT facility must submit the global transplant claim to the member's Home Plan as outlined in the BDCT Hospital Procedures Manual when:

- Facility is contracted with BDCT for the transplant type
- Member's BlueCross BlueShield Home Plan is a Referring Plan in BDCT
- Transplant has been authorized

Mail bundled claims and attachments, in one envelope, to the member's Home Plan Transplant Coordinator and/or Global Claims Contact, designated in the Billing Section of the BCBS Referring Plan Authorization Form submitted by the referring plan.

Mail member claims to:

BlueCross and BlueShield of Tennessee
1 Cameron Hill Circle CH 2.3
Chattanooga, TN 37402

Email bundled claims and attachments to:

Transplant_Claims@BCBST.com

Note: This would apply to BCBS TN Members who were referred by BCBS TN to access the BDCT Agreement. BDCT global packets for Out-of-Area Members referred through the BDCT program to a TN facility would be sent to the respective BCBS Referring Plan.

Note: See BDCT Hospital Procedures Manual for a complete listing of BDCT Referring BlueCross BlueShield Plans and all referenced forms. Participating BDCT Facilities may obtain additional copies of the BDCT Hospital Procedures Manual from BCBS TN or BDCT.

Out-of-Transplant Network Facilities (In Tennessee)

Our participating facilities, not participating in BDCT for the transplant type must submit transplant claims to us as outlined in the participating practitioner's Institutional Agreement between us and the facility.

Mail member claims to:

BlueCross BlueShield of Tennessee
1 Cameron Hill Circle CH 2.3
Chattanooga, TN 37402

If the member's Home Plan isn't a referring plan in BDCT, and the member isn't a member, contact the member's Home Plan for billing and claims instructions.

Note: Transplants performed outside of the **Transplant Network** may not be covered or reimbursement may be greatly limited (depending on the member's health plan). If the member has access to Out-of-Transplant Network Benefits, reimbursement and benefits are reduced as compared with **Transplant Network** benefits and reimbursement.

Coordination of Benefits

When we'll be paying secondary to other commercial insurance or other insurance will be paying secondary to us, Transplant Care Management should be notified.

If secondary to Medicare, Transplant Care Management won't review for medical appropriateness. Payment will be handled according to Medicare guidelines. This excludes the Federal Employee Program (FEP) and Postal Service Health Benefits (PSHB).

If secondary to another commercial carrier, Transplant Care Management will review for medical appropriateness. Approved transplants will be paid according to the member's health plan. If the other (primary) commercial insurance denies benefits, Transplant Care Management will coordinate benefits and handle as if we're primary. For Federal Employee Program (FEP) and Postal Service Health Benefits

(PSHB), the prior approval requirement for solid organ and blood or marrow stem cell transplants applies even when the Service Benefit Plan is secondary to other coverage.

Travel, Meals and Lodging

If the member has travel benefits (as defined in the member's health plan), these benefits are paid to the member, not the practitioner. Travel benefits may vary. Examples of travel expenses include:

- Travel expenses for evaluation of a member prior to a covered procedure
- Transportation to and from the site of a covered procedure
- Meals and lodging expenses for the member and one caregiver

Transitional Care

Should the facility or member contract change after the transplant has been medically approved, but before the transplant has occurred, Transplant Care Management will notify the member and practitioner of the change and how benefits and reimbursement will be affected.

Donor Organ Procurement

The cost of Donor Organ Procurement is included in the total cost of the member's organ transplant. It's included in the global TMAC calculation, when applicable, or any contracted global or care rates. Donor services are covered only to the extent not covered by the health coverage of the donor.

- Covered services for the donor are limited to those services and supplies directly related to the transplant service itself:
  - Testing for the donor's compatibility
  - Removal of the organ from the donor's body
  - Preservation of the organ
  - Transportation of the organ to the site of transplant
- Services not covered for the donor include:
  - Complications of donor organ procurement.
  - Payment to an organ donor or the donor's family as compensation for an organ, or payment required to obtain written consent to donate an organ
  - Donor services including screening and assessment procedures not prior authorized by the member's health plan

C. Evaluation of Care Management Programs

The Care Management programs are evaluated annually based on quality guidelines and member feedback. The programs are revised to add or modify activities to provide the highest quality and most effective and efficient service to our members.

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IX. PREVENTIVE CARE

Preventive care benefits vary according to the member's health care benefits plan. Providers can verify member eligibility and benefits via Availity. If a provider isn't registered, they can go to http://www.Availity.com and click on "New to Availity? Get Started" in the upper right corner of the home page, select Providers, click "Create User Account" and follow the instructions in the Availity registration wizard.

If providers are unable to obtain the benefits or eligibility information that's needed, they can click the contact payer option in Availity and utilize FastPath. FastPath will provide a special 800 number to reach the FastPath team for further assistance.

If providers need assistance with a claims status that Availity couldn't provide, they'll be given a reference claim number for their inquiry. The provider may then call the Provider Service line at, 1-800-924-7141, provide the claim number given by Availity, and receive assistance.

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X. QUALITY IMPROVEMENT PROGRAM (QIP)

A. Introduction

BlueCross BlueShield of Tennessee, Inc. (BlueCross) is committed to improving the quality and safety of care and service to its members. We demonstrate this commitment through the implementation of a comprehensive Quality Improvement Program (QIP), which provides the structure that supports quality improvement activities.

The purpose of the QIP is to assess and improve the quality and safety of clinical care and service received by our members. This is achieved by planning and implementing quality improvement activities that are integrated and coordinated across departmental lines. This purpose is accomplished by creating an infrastructure and a set of business processes that support the achievement of high quality outcomes in care and service as an integral part of the way we do business. Our practitioners and providers will allow their performance data to be used for quality improvement activities.

The QIP includes a written program description, work plan, program evaluation and a committee structure that supports the program. The QIP reflects goals that support our mission and objectives, and it's integrated throughout the organization with each department sharing the responsibility for improving care or service to members. Additionally, the QIP is compliant with all relevant federal and state regulations and complies with accrediting agency standards. Continuous Quality Improvement (CQI) processes are incorporated into our health care delivery system.

B. Scope

The scope of the population served by the QIP includes all members. Participation in QIP activities include, but aren't limited to:

- Primary care practitioners and specialty providers
- Institutional settings (hospital, skilled nursing facilities, home health agencies, pharmacies, long-term care facilities and rehabilitation facilities)
- Non-institutional settings (free-standing surgical centers, urgent care centers, ER and physical therapy)
- Internal operations

C. Authority and Structure

Authority and Responsibility

Our Board of Directors (BOD) has the ultimate responsibility and accountability for the quality and safety of care and services rendered, and for the QIP. The BOD has formally delegated the oversight of the QIP and associated quality improvement activities to the Enterprise Quality Oversight Committee. This committee meets at least biannually and is responsible for, but not limited to, the review and approval of the QIP. A complete committee structure is in place to support the QIP's clinical and service quality activities and oversee the development and implementation of the QIP. Additionally, designated regional physicians are also involved in Quality Improvement (QI) activities. Network practitioners are actively involved in the QIP through their participation in appropriate committees, development of clinical policies, adoption of clinical practice guidelines, peer review, review of Utilization Management (UM) criteria modifications and medical policy review.

Confidentiality

Any employee or participating practitioner engaging in Continuous Quality Improvement (CQI) activities must uphold the established principles of member and practitioner confidentiality. Employees, contractors and practitioners will sign an affidavit of confidentiality. CQI data and reports are only accessible to those individuals participating in the QIP and those agencies responsible for ascertaining the existence of an ongoing and effective program. Summary results may be released through marketing requests for information. Any request for information from attorneys or consumers must be submitted in writing to the Legal Department indicating the purpose of the request.

Conflict of Interest

No person may participate in the review and evaluation of any case or issue in which they've been personally or professionally involved or where a conflict of interest may exist, which potentially compromises objective evaluation. A practitioner serving on any committee or subcommittee, acting as a Physician advisor, or serving as peer reviewer will disqualify themselves from evaluating or reviewing a case in which they, or their immediate associates have been personally or professionally involved, or if a direct personal or economic interest exists.

Quality Improvement Activities

A defined methodology ensures a systematic approach to the collection of objective, statistically valid data, to evaluate and improve quality of care and the services offered to members and practitioners. The collected data also provides an opportunity to assess structure, processes and outcomes for improvement opportunities.

We focus on clinical and service objectives and issues relevant for a significant portion of our members. Reviewing the results of population assessments identifies important aspects of clinical care that significantly impact members and providers. Some of these activities may include, but aren't limited to:

- Fostering a supportive environment to help practitioners and providers improve the safety of practices.
- Evaluating and acting on opportunities to improve the quality of clinical and non-clinical aspects of care and service, including the availability, accessibility, coordination and continuity of care.
- Developing and promoting health, disease and risk management activities that identify and evaluate medical and behavioral health risks and implementation of actions to control or eliminate those risks.

Program Evaluation and Workplan

The overall effectiveness of the QIP is evaluated at least annually and documented in a written QIP Evaluation. The evaluation addresses:

- Progress and status of annual goals
- Completed and ongoing Quality Improvement activities
- Trending of clinical, service and other performance measurements
- Analysis of results for demonstrated improvements in quality
- Opportunities for improvement
- Overall effectiveness of the QIP
- Goals and recommendation for the workplan for the following year

Based on the annual program evaluation, the QIP is revised and a Quality Improvement plan is developed. The purpose of the annual plan is to focus on the QIP goals, objectives and planned projects/activities for the following year. The annual plan also identifies responsible party(ies)/person(s), timeframes for achievement of activities, and committee reporting. The plan is utilized as an action plan to document the status of activities and achievement of goals throughout the year.

Clinical Risk Management (CRM)

The Clinical Risk Management Department (CRMD) and Committee, which are parts of the BCBST Quality Improvement Program (QIP), were created to address clinical risk events identified as deviations in quality of care for our members as well as regulatory compliance, credentialing, and member-provider relations issues. The CRMD is responsible for the collection, evaluation, investigation and resolution of quality of care related high-risk concerns. The CRM program is designed to promote quality of care and service with its primary focus on member safety and improving quality of care for all BCBST members. The Medical Director of Medical Risk Management is the manager/medical leader of this program, and works closely with the Quality Management and Credentialing Departments to ensure member safety and improvement in the quality of care for BCBST members.

Credentialing

Member safety is an integral part of the QIP. The Credentialing Program, also part of the BCBST QIP, assists by ensuring that the BCBST membership is served by the most qualified practitioners/providers. The activities listed below are examples of how the Credentialing Program assists with member safety:

1. Conducting initial and recredentialing process
2. On-going monitoring including monthly disciplinary reports
3. Utilizing and reporting to the National Practitioner Database
4. Conducting site audits and medical record review processes
5. Performing peer review functions
6. Monitoring acute care facilities participation in Leapfrog
7. Conducting final peer review of practitioners' performance on CRM Medical Corrective Action Plans

Information about the QIP will be made available upon request. For more information about the Quality Improvement Program, please call **(423)-535-6705**.

Clinical Practice Guidelines

We adopt and disseminate clinical practice guidelines relevant to our membership for the provision of preventive and non-preventive health, acute and chronic medical and behavioral health services. These guidelines are intended to assist practitioners in making appropriate health care decisions for specific clinical circumstances.

Our policies and procedures advise that nationally recognized guidelines be utilized when available. All clinical practice guidelines are reviewed at least annually, with more frequent review being initiated if new national standards are published prior to the review date.

Adopted Clinical Practice Guidelines (CPGs) can be viewed on our website at https://provider.bcbst.com/tools-resources/manuals-policies-guidelines.

D. Medical Management Corrective Action Plan

This procedure statement outlines how we may initiate corrective actions if a participating provider fails to comply with applicable medical management requirements set forth in section I, below. This statement also outlines how we'll process denials of initial applications. Our medical management programs include provider credentialing, utilization review, quality management and member grievance resolution activities overseen by professional review committees. Our Board of Directors designated the Enterprise Quality Oversight Committee and its subcommittees as the professional review committees responsible for performing peer review activities in accordance with the Federal Health Care Quality Improvement Act (the "HCQIA"), TCA section 63-1-150 and other applicable laws governing the organization and operation of professional peer review or medical review committees.

Our staff has been authorized to provide necessary support services to the Enterprise Quality Oversight Committee. Members of the board, committee members, staff members and anyone providing information to the committee are intended to be protected against liability to the fullest extent permitted by the Peer Review Laws. The terms of this procedure statement have been incorporated by reference into the plan's provider participation applications and agreements. As partial consideration for being permitted to apply to become a participating provider and, if applicable, selected to participate in the plan, participating provider agree not to seek to hold the plan or such individuals liable for acts taken in good faith in accordance with this procedure statement.

This procedure only applies to matters that involve committee actions. Matters that don't involve committee actions include the non-acceptance of a participation application because the provider fails to satisfy the plan's pre-credentialing application standards (e.g., failure to provide evidence of licensure or insurance), the termination of a provider's participation other than by reason of that provider's failure to comply with applicable participation requirements (e.g., the participation agreement is terminated without cause); and disputes related to claims payment or authorization decisions. Such matters must be resolved in accordance with the plan's Provider Dispute Resolution Procedure statement.

Records or information concerning the activities of the committees must be treated and maintained as privileged and confidential peer review records to the fullest extent permitted by the Peer Review Laws. Reports to the committees, the Board of Directors or regulatory agencies concerning actions taken pursuant to this procedure statement won't alter the status of such records or information as privileged and confidential information.

II. PARTICIPATION REQUIREMENTS

The plan's Chief Medical Officer or their designee will monitor participating provider's performance to ensure they comply with the plan's participation requirements. The following is intended to provide a non-exclusive summary of those participation requirements:

A. Participating providers must cooperate, in good faith, to facilitate the plan's medical management activities. Such cooperation includes returning telephone calls, responding to written inquiries or requests from the plan, providing information and documents requested by the plan and cooperating with plan staff members as they perform their medical management activities.
B. Participating providers must render or order medically necessary and appropriate services for member patients.
C. Participating providers must obtain prior authorization of services in accordance with applicable plan medical management program policies and procedures.
D. Participating providers must comply with accepted professional standards of care, conduct and competence.
E. Participating providers must continue to satisfy the plan's credentialing requirements as set forth in the plan's credential process, including, without limitation:

1. The provider's licenses or certifications must be in good standing.
2. The provider's liability insurance coverage must remain in full force and effect.
3. There have been no unreported material changes in the provider's status such that the credentialing information submitted to the plan is no longer accurate.

III. CORRECTIVE ACTIONS

A. INVESTIGATION

The plan's staff will investigate and report any apparent non-compliance with the participation requirements to the Chief Medical Officer or their designee, after making a reasonable effort to obtain material facts concerning that matter. Providers must submit requested information and fully cooperate with those staff members as a condition of their continued participation in the plan. Staff members or the Chief Medical Officer may, at their discretion:

1. Consult with the provider
2. Review material documents, including members medical records
3. Contact other providers or persons who have knowledge concerning the matter being investigated

B. BASIS OF ACTIONS

The Chief Medical Officer or a committee may initiate a corrective action if a participating provider doesn't comply with applicable participation requirements, and

1. There's a reasonable belief that the action will promote the objectives of the plan's medical management program.
2. There's been a reasonable effort to obtain the facts concerning the provider's alleged non-compliance.
3. The proposed action is reasonably warranted by the facts known after the investigation has been completed.

C. ACTIONS BY THE CHIEF MEDICAL OFFICER

After determining that a participating provider hasn't complied with the plan's participation requirements, the Chief Medical Officer may initiate corrective actions including, without limitation:

i. Counseling the provider concerning specific actions that should be taken to address identified problems. A summary of the counseling session and the plan of corrective action will be included in the provider's credentialing file.
ii. Submitting information regarding the provider's conduct to the appropriate committee for further consideration and action.
iii. Imposing corrective actions, following the issuance of a "notice of corrective action" including without limitation:

a. Imposing practice restrictions, such as, focused review, mandatory prior authorizations for specified treatments or services, mandatory consultation, preceptorship, continuing medical education, closure of the provider's practice to new members, and/or imposition of a practice improvement plan.
b. Terminating the provider's participation.
c. Imposing financial penalties such as an increased withhold, a one-time financial penalty (e.g., the cost of services incurred because of the provider's non-compliance) or the denial of fees for inappropriate or unauthorized services.

iv. Imposing a summary suspension. The Chief Medical Officer must notify the provider, by certified mail, of the summary suspension of the provider's participation, if such action is necessary to protect members health and welfare or to protect the plan's reputation or operations.

1. If the Chief Medical Officer or a committee requires additional time to investigate allegations concerning a provider's conduct, competence, practices or reputation, the summary suspension shall remain in effect pending the completion of that investigation. Such investigation must be completed within 14 days after the imposition of the summary suspension.
   a. If, after such investigation, it's determined that the provider's conduct, competence, practices or reputation may result in an imminent danger to members health or welfare, or impair the plan's reputation or operations, the suspension will continue in effect unless the provider's participation is reinstated following a hearing conducted in accordance with section III, below.
   b. The Chief Medical Officer will make appropriate arrangements to have other providers render services to members who are under the care of the suspended provider. The suspended provider must cooperate in referring members to such other provider's in accordance with this Corrective Action Plan and the terms of their participation agreement.
   c. If a provider is a member of a medical group or an Independent Physician Association (IPA), the Medical Director of that group or IPA shall be notified, in writing, of the imposition of corrective actions pursuant to this section.

D. ACTIONS BY THE COMMITTEE

1. Committee Meetings

   If the Chief Medical Officer refers the matter to a committee, that committee must consider information submitted to it concerning a provider's non-compliance with the plan's participation requirements during its next regularly scheduled meeting or at a special meeting called by the Chief Medical Officer to consider the matter.

   Members of the committee may participate in such meetings in person or by telephone conference call and may take actions by consent. Any meeting of a committee concerning a provider's alleged non-compliance will be conducted in confidence and any information concerning the meetings will be maintained as privileged and confidential information to the fullest extent permitted by applicable Peer Review Laws.

2. Committee Investigations

   A committee may direct the Chief Medical Officer or their designee to further investigate and submit additional information concerning a provider's alleged non-compliance. The committee may also request that the provider submit specified information or attend a meeting to respond to questions concerning such alleged non-compliance. The provider otherwise has no right to participate in committee proceedings.

3. Corrective Actions

The committee may request the Chief Medical Officer to take any of the corrective actions described in section II.C, above. In addition, the committee may take any of the corrective actions described in section II. C. above except for II.C.4. (imposing a summary suspension). The Credentialing Committee may deny or revoke a provider's credentials.

E. NOTICE OF CORRECTIVE ACTION

The Chief Medical Officer or the Chairperson of the Committee will immediately notify the provider, by certified or overnight mail, of the imposition of a corrective action. If the provider is a member of an IPA or medical group, a copy of that notice will also be sent to the Medical Director of that IPA or medical group. The corrective action shall become effective as of the date of the letter, unless the Chief Medical Officer or committee elects to defer the effective date of the action.

The notice letter must include:

1. A description of the corrective action
2. A general description of the basis of that action
3. A statement explaining how to request an appeal to the imposition of that action (to the extent that action is subject to appeal), specifying that such an appeal must be requested within 30 days after the date of that notice letter
4. If applicable, a statement that the action may be reported to the State licensing board or other entities as mandated by law if the provider doesn't request an appeal or if that action is affirmed following exhaustion of the appeal process

IV. APPEAL PROCEDURES

A. APPEAL OF NON-REPORTABLE ACTION BY A PARTICIPATING PROVIDER

1. Written Appeal
   a. The provider may appeal by submitting a written statement of their position within 30 days of the date of the notice of imposition of the corrective action. The written appeal will be reviewed by the committee or Chief Medical Officer imposing the corrective action. A written response will be sent to the provider within 60 days of our receipt of the written appeal.
   b. The provider must comply with the terms and conditions of the corrective action while the appeal is pending, unless specifically directed otherwise by the committee or Chief Medical Officer.
2. Informal Subcommittee Meeting
   a. The committee, in its sole discretion, may offer an informal subcommittee meeting to the provider. The subcommittee will consist of individuals from the committee and its purpose is to have an informal and open discussion with the provider. The provider has the option of accepting this offer for an informal subcommittee meeting, or may proceed to the next level of appeal as defined in this section. The provider doesn’t waive any appeal rights by participating in the subcommittee meeting and may proceed with any appeals should the committee uphold its decision after the subcommittee meeting.
   b. If an informal subcommittee is granted, the provider may not be represented by an attorney and the meeting can’t be tape recorded or recorded by a court reporter.
   c. After the conclusion of the meeting, the subcommittee will make a recommendation to the appropriate committee or the Chief Medical Officer concerning continued imposition of the corrective action. The subcommittee's recommendation will be considered at the next regularly scheduled committee meeting unless the Chief Medical Officer calls a special meeting to consider that report. The committee may accept, modify or reverse the subcommittee's recommendation, at its discretion. The provider won’t have the right to appeal or to otherwise participate in the committee's deliberations concerning the subcommittee's recommendation. The committee will notify

the provider of its decision within 10 business days after the date of the meeting.

3. Binding Arbitration

a. After the final decision by BlueCross, all parties agree to take any dispute to binding arbitration. The provider must make a written request that the adverse action be submitted to binding arbitration pursuant to the Commercial Arbitration Rules of the American Arbitration Association (current ed.). Either party may make a written request for binding arbitration within 30 days after the date of the plan's response. The venue for the arbitration must be in Chattanooga, Tennessee unless otherwise agreed. The arbitration must be conducted by a panel of three qualified arbitrators, unless the parties otherwise agree. The arbitrators may sanction a party, including ruling in favor of the other party, if appropriate, if a party fails to comply with applicable procedures or deadlines established by those Arbitration Rules.

b. The claimant must pay the applicable filing fee established by the American Arbitration Association, but the filing fee may be reallocated or reassessed as part of an arbitration award either, in whole or in part, at the discretion of the arbitrator/arbitration panel if the claimant prevails upon the merits. If the claimant withdraws its demand for arbitration, it forfeits its filing fee and it may not be assessed against BlueCross.

c. Each party is responsible for half of the arbitration agency's administrative fee, the arbitrators' fees and other expenses directly related to conducting the arbitration. Each party is otherwise solely responsible for any other expenses incurred in preparing for or participating in the arbitration process, including the party's attorney's fees.

d. The arbitrators: are required to issue a written decision explaining the basis of their decision and the manner of calculating any award; must limit the review to whether or not the plan's action was arbitrary and capricious; may not award punitive or exemplary damages; may not vary or disregard the terms of the provider's participation agreement, the certificate of coverage and other agreements, if applicable; and is bound by controlling law; when issuing a decision concerning the issue. Emergency relief such as injunctive relief may be awarded by an arbitrator/arbitration panel. A party must make application for any such relief pursuant to the Optional Rules for Emergency Measures of Protection of the American Arbitration Association (most recent edition). The arbitrators' award, order or judgment will be final and binding upon the parties. The decision may be entered and enforced in any state or federal court of competent jurisdiction. The arbitration award may only be modified, corrected or vacated for the reasons set forth in the United States Arbitration Act (9 USC § 1).

e. This arbitration provision supersedes any prior arbitration clause or provision contained in any other document. This arbitration clause may be modified or amended by BlueCross and the provider will receive notice of any modifications through updates to the Provider Manual.

B. APPEAL OF NON-REPORTABLE ACTION BY AN APPLICANT

1. Written Appeal

a. The provider may appeal by submitting a written statement of their position within 30 days of the date of the notice of the denial of application. The written appeal will be reviewed by the committee or Chief Medical Officer. A written response will be sent to the provider within 60 days of our receipt of the written appeal.

2. Binding Arbitration

a. If the provider still isn't satisfied with the committee's decision, they may make a written request that the matter be submitted to binding arbitration in accordance with the procedure set forth in section III.A.3 above.

C. APPEAL OF A POTENTIALLY REPORTABLE ACTION BY PARTICIPATING PROVIDERS OR APPLICANTS

1. Informal Subcommittee Meeting

a. The committee, in its sole discretion, may offer an informal subcommittee meeting to the provider. The subcommittee will consist of individuals from the committee and its purpose is to have an informal and open discussion with the provider. The provider has the option of accepting this offer for an informal subcommittee meeting, or may proceed to the next level of appeal as defined in this Section. The provider doesn't waive any appeal rights by participating in the subcommittee meeting and may proceed with any appeals should the committee uphold its decision after the subcommittee meeting.

b. If there's an informal subcommittee meeting, the provider may not be represented by an attorney and the meeting can't be tape recorded or recorded by a court reporter.

c. After the conclusion of the meeting, the subcommittee will make a recommendation to the appropriate committee or the Chief Medical Officer concerning continued imposition of the corrective action. The subcommittee's recommendation will be considered at the next regularly scheduled committee meeting unless the Chief Medical Officer calls a special meeting to consider the report. The committee may accept, modify or reverse the subcommittee's recommendation, at its discretion. The provider doesn't have the right to appeal or to otherwise participate in the committee's deliberations concerning the subcommittee's recommendation. The committee will notify the provider of its decision within 10 business days after the date of the meeting.

2. Hearing

a. Appointment of the Hearing Officer

The provider may request a hearing regardless of whether there was an informal subcommittee meeting. In that event, the Chief Medical Officer will appoint a qualified designee to serve as the Hearing Officer within 30 business days after receiving the request. The Hearing Officer:

1. Can't receive a financial benefit from the outcome of the hearing and can't act as a prosecutor or advocate for the plan.
2. May not be in direct economic competition with the provider requesting the hearing.
3. Must be acting as member of the committee while performing their duties.

b. Notice of Hearing

The Hearing Officer will contact the provider to establish a mutually acceptable date, time, and place for the hearing; which shall be conducted no less than 30 days after that date. The formal hearing must be conducted within 120 days of appointment of the Hearing Officer unless both parties agree to extend this time limit. If the parties are unable to agree, the Hearing Officer will schedule the hearing. The Hearing Officer will then issue a written notice of hearing to the provider summarizing: the scheduled time, date and place where the hearing will be conducted; the applicable hearing procedure; a detailed description of the basis of the corrective action, including any acts or omissions which the provider is alleged to have committed (the "Allegations"); and a statement concerning whether that action may be reportable to the State licensing agency or other entities as mandated by law in accordance with applicable Peer Review Laws.

c. Hearing Procedure

The hearing will be an informal proceeding. Formal rules of evidence or legal procedure won't be applicable during the hearing. The Hearing Officer may

reschedule or continue the hearing at their discretion or upon reasonable request of the parties. The provider may forfeit the right to a hearing. However, if the provider fails to appear at the hearing without good cause, the right to schedule another hearing is also forfeited. In addition to any procedure adopted by the Hearing Officer:

1. The provider has the right to be represented by an attorney or other representative. If the provider elects to be represented, such representation is at their own expense.
2. The hearing will be recorded by a court reporter.
3. The provider and the plan must provide the other party with a list of witnesses expected to testify on its behalf during the hearing and any documentary evidence that it expects to present during the hearing, as soon as possible following issuance of the notice of hearing. Either party may amend that list at any time, but not less than 10 business days before the date of the hearing.
4. Each party has the right to inspect and copy any documentary information that the other party intends to present during the hearing, at the inspecting party's expense, upon reasonable advance notice, at the location where such records are maintained.
5. During the hearing, each party has the right to:
   i. Call witnesses
   ii. Cross-examine opposing witnesses
   iii. Submit a written statement at the close of the hearings
6. Following the hearing, each party may obtain copies of the record of the hearing, upon payment of the charges for that record. Each party will also receive a copy of the Hearing Officer's report and recommendation.

d. Hearing Officer’s Report

The Hearing Officer will issue a written report and recommendation within 30 days after the conclusion of the hearing. That written report will set forth the Hearing Officer's recommendation concerning the imposition of the corrective action, if any, and the basis for that recommendation.

e. Action by the Committee

The Hearing Officer's report will be submitted to the appropriate committee for consideration during its next regularly scheduled meeting, unless the Chief Medical Officer calls a special meeting to consider that report. The committee may accept, modify or reverse the Hearing Officer's recommendation at its discretion. The provider won’t have the right to appeal or participate in the committee's deliberations concerning the Hearing Officer's report. The committee will notify the provider of its decision within 10 business days after the date of that meeting. The committee’s decision is the final internal action by BlueCross. In the event the decision is an adverse decision as defined by applicable federal and/or state laws, we’ll report to the appropriate agencies or Boards as required by the applicable federal or state laws.

f. Appeal of Decision

Any action based upon or related to the committee's decision must be submitted to binding arbitration in accordance with paragraph III.A.3 above.

V. REPORTING CORRECTIVE ACTIONS

A. REPORTING TO REGULATORY AGENCIES

Certain actions must be reported in accordance with both state and federal law, including the National Practitioner Data Bank (NPDB). The Chief Medical Officer will consult with the plan’s

General Counsel prior to initiating any corrective action, if there is a question concerning a reportable action.

1. The following actions must generally be reported:
    a. All professional review actions adversely affecting a participation in the plan for longer than 30 days based upon the provider's professional conduct or competence.
    b. A summary suspension that's in effect for longer than 14 days.
2. Reports required by federal or state law, including the NPDB, must include:
    a. The provider's name
    b. A description of the facts and circumstances that form the basis for that action
    c. Any other relevant information requested by the licensing board
3. The following actions are generally not reportable:
    a. Actions that don't adversely affect the provider's participation for longer than 30 days
    b. Actions based on the provider's failure to comply with participation requirements that aren't directly related to the provider's professional conduct or competence

B. INTERNAL REPORTING REQUIREMENTS

All corrective actions whether reportable to a licensing board or not, must be reported to:

1. The involved provider.
2. The plan's General Counsel.
3. The plan's Provider Networks and Contracting Department.
4. The Medical Director of each participating Medical Group or IPA if the provider is a member of that entity.

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XI. PROVIDER DISPUTE RESOLUTION PROCEDURE

PURPOSE: To address and resolve matters causing participating providers or BlueCross BlueShield of Tennessee or its affiliated companies to be dissatisfied with any aspect of their relationship with the other party. Providers are encouraged to contact a representative of BlueCross' Provider Network Management Division if they have any questions about this procedure statement or concerns related to their network participation.

Note: Non-contracted, non-participating, and out-of-state providers may also use this Provider Dispute Resolution Procedure in accordance with BlueCross policy.

I. INTRODUCTION.

A. This procedure describes the exclusive method of resolving any disputes related to a provider's participation in our network(s). It's incorporated by reference to the participation agreement between the parties and survives the termination of that agreement.

B. This procedure only applies to resolving disputes subject to BlueCross' or the provider's control, such as claims, administrative or certification issues. It's not applicable to issues involving third parties that aren't within a party's control (e.g., determinations made by a customer purchasing administrative services only ["ASO Customers"] from us).

C. This procedure isn't applicable to actions that may be reportable pursuant to the Federal Health Care Quality Improvement Act. Matters involving peer review evaluation of an applicant's professional qualifications, conduct or competence must be resolved pursuant to our Medical Management Corrective Action Plan (Section X. D in this Manual).

D. The initiation of a dispute doesn't require a party to delay or forgo taking any action that's otherwise permitted by the participation agreement.

E. This procedure statement establishes specific time periods for parties to respond to inquiries and requests for reconsideration. If it's not reasonably possible to provide a final response within those time periods, the responding party may, in good faith, advise the other party that it needs additional time to respond to that matter. In such cases, the responding party must advise the other party of the status of that matter at least once every 30 days until it submits a final response to the other party.

F. A party must commence an action to resolve a dispute pursuant to this Dispute Resolution Procedure within 18 months of the date of the event causing the dispute that occurred (e.g., the date of the letter informing the provider of a determination) Or, with respect to a provider request for reimbursement of unpaid or underpaid claims, within 18 months of the date the provider received payment or, in the event of an unpaid claim, the date the provider received notice that the claim was denied. This provision doesn't extend the period during which a participating provider must submit a claim to BlueCross pursuant to applicable provisions of the provider's agreement(s) with us, although the provider may commence a dispute related to the denial of a claim that wasn't filed in a timely manner within 18 months after receiving notice of the denial of that claim. If we discover a matter creating a dispute with a participating provider during an audit, which is in progress at the end of the 18 month period referenced in this paragraph, it must have 120 days from the conclusion of that audit to initiate a dispute concerning that matter. The failure to initiate a dispute within that period specified in this subsection will bar any type of action related to the event causing that dispute, unless the parties agree to extend the time period for initiating an action to resolve that dispute pursuant to this procedure statement.

G. ALL DISPUTES WILL BE SUBJECT TO BINDING ARBITRATION IF THEY CAN'T BE RESOLVED TO THE PARTIES' SATISFACTION PURSUANT TO SECTIONS II (A-B) OF THIS PROCEDURE STATEMENT.

II. DESCRIPTION OF THE DISPUTE RESOLUTION PROCEDURE.

A. INQUIRY/RECONSIDERATION

Providers should contact a representative of the **BlueCross** division or department **that's** directly involved in any matter that may cause a **dispute** between the parties. (**e.g.,** the Claims Service Department if there is a question concerning a **claims-related** issue). If **provider**s **don't** know whom to contact, they **can** contact a representative of the Provider

Network Management Division for **help** directing their inquiries to the appropriate **representative**. **BlueCross** may initiate an inquiry by contacting the **provider** or the person that the **provider** designates to respond to such inquiries (**e.g.,** an office manager). If a party **can't** respond immediately to the other party's inquiry, it **must** make a good faith effort to investigate and respond to that inquiry within **30** days.

B. APPEAL.

If not satisfied, a party may submit a written appeal within **60** days after receiving the other party's response to its inquiry/reconsideration. That request **must** state the basis of the **dispute**, why the response to its inquiry/reconsideration **isn't** satisfactory, and the proposed method of resolving the **dispute**. The receiving party will make a good faith effort to respond, in writing, within **90** days after receiving that appeal.

C. BINDING ARBITRATION.

If the parties **don't** resolve their **dispute**, the next and final step is binding arbitration. If a party **isn't** satisfied with an adverse decision, then it **must** make a written demand that the **dispute** be submitted to binding arbitration pursuant to the Commercial Arbitration Rules of the American Arbitration Association (current ed.). Either party may make a written demand for binding arbitration within **60** days after it receives a response to its appeal. The venue for the arbitration **will** be Chattanooga, **Tennessee** unless otherwise agreed. The arbitration **will** be conducted by a panel of **three** qualified arbitrators, unless the parties otherwise agree. The arbitrators may sanction a party, including ruling in favor of the other party, if appropriate, if a party fails to comply with applicable procedures or deadlines established by those Arbitration Rules.

Each party **is** responsible for **half** of the arbitration agency's administrative fee, the arbitrators' fees and other expenses directly related to conducting that arbitration. Each party **must** otherwise be solely responsible for any **expenses** incurred in preparing for or participating in the arbitration process, including that party's **attorney** fees.

The claimant shall pay the applicable filing fee established by the American Arbitration Association, but the filing fee may be reallocated or reassessed as part of an arbitration award either, in whole or in part, at the discretion of the arbitrator/arbitration panel if the claimant prevails upon the merits. If the claimant withdraws its demand for arbitration, then the claimant forfeits its filing fee and it may not be assessed against BCBST.

The arbitrators: **must** consider each claimant's demand individually and **shouldn't** certify or consider multiple claimants' demands as part of a class action; **are** required to issue a reasoned written decision explaining the basis of their decision and the manner of calculating any award; **must** limit review to whether or not the **plan's** action was arbitrary or capricious; may not award punitive, extra-contractual, treble or exemplary damages; may not vary or disregard the terms of the **provider's participation agreement**, the certificate of coverage and other agreements, if applicable; **are** bound by controlling law; when issuing a decision concerning the **dispute**. Emergency relief such as injunctive relief may be awarded by an arbitrator/arbitration panel. A party **must apply** for any such relief pursuant to the Optional Rules for Emergency Measures of Protection of the American Arbitration Association (most recent edition). The arbitrators' award, order or judgment **will** be final and binding upon the parties. That decision may be entered and enforced in any state or federal court of competent jurisdiction. **The** arbitration award may only be modified, corrected vacated for the reasons set forth in the United States Arbitration Act (9 USC § 1).

This arbitration provision supersedes any prior arbitration clause or provision contained in any other document. This arbitration clause may be modified or amended by **BlueCross** and the **provider** will receive notice of any modifications through updates to the Provider **Administration** Manual.

D. EFFECTIVE DATE.

This procedure statement was adopted by **BlueCross** on June 1, 1997.

Last date of revision, April 1, 2018

Notices for arbitration should be sent to:
BlueCross BlueShield of Tennessee. Inc.
Attention: General Counsel
1 Cameron Hill Circle
Chattanooga, TN 37402

Note: The Provider Dispute Form has been replaced with fillable forms on our website:

Provider Reconsideration Form
https://www.bcbst.com/providers/forms/ProviderReconsiderationForm23PED2036002.pdf

Provider Appeal Form

https://www.bcbst.com/providers/forms/ProviderAppealForm23PED2035401.pdf

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XII. CREDENTIALING

A. Introduction

The BlueCross BlueShield of Tennessee/BlueCare Tennessee Credentialing Program was established Aug. 1, 1995. The Credentialing Program is designed around goals that reflect the BlueCross/BlueCare mission, as well as regulatory and accrediting requirements.

To ensure consistent standards for network participation and compliance with regulatory requirements, we have established a network participation process that includes our Credentialing program.

- **Individual practitioners** seeking network participation must complete an application through the **Council for Affordable Quality Healthcare (CAQH)**. CAQH Solutions provides a centralized platform that streamlines the submission of provider information.
- In addition, all providers are required to submit a **Provider Enrollment Form** via **Availity**.
- **Organizational Providers** are required to submit a completed organization application provided by BlueCross BlueShield of Tennessee.

Using the submitted CAQH or facility application, we conduct a **preliminary evaluation** to determine eligibility for network participation. All applicants must:

- Complete the application in full
- Submit all required documentation
- Successfully complete the credentialing process

Credentialing must be finalized before network participation can begin. For more information on the network participation process, please see the Provider Networks section of this Manual.

Verifying credentials of practitioners and organizational providers is an essential component of an integrated health care system. The credentialing process includes a continuous evaluation of the quality of care provided by individual practitioners and organizational providers seeking participation in our networks. Major components of the credentialing program include:

- Credentialing Committee
- Policies and procedures
- Initial credentialing process
- Recredentialing process
- Delegated credentialing activities

The Credentialing Committee (the Committee) is a peer review committee and is subject to the rights and privileges set forth in TCA Section 63-1-150.

The Committee may, in its discretion, make case-by-case decisions regarding the credentialing or continued credentialing of practitioners or organizations that meet exception criteria. While some may be approved under these criteria, others may be denied or have their credentials terminated, based on the Committee's evaluation. Each case is individually assessed to determine whether credentialing aligns with the best interests of BlueCross BlueShield of Tennessee and its members. The Committee may also choose to deny credentialing to practitioners or organizations within a specific exception category if it determines that doing so is necessary to protect the health and welfare of our members.

Practitioners and organizational providers have the right to:

- **Review** information submitted with their credentialing or recredentialing application, excluding peer-review protected materials.
- **Request** corrections to any erroneous information within **30 calendar days** of receipt of the completed application. Requests should be submitted via the contact methods listed below.
- **Inquire about the status** of their credentialing or recredentialing application at any time.

For questions or concerns regarding the credentialing process or specific applications, please contact:

BlueCross BlueShield of Tennessee – Credentialing Department
Toll-Free Phone: 1-800-924-7141
Fax: 1-423-535-8357

Alternate Fax: 1-423-535-6711
Email: Credentials@bcbst.com

Note: For information regarding denial or appeal rights, please refer to the **Medical Management Corrective Action Plan** in **Section X.(D)** of the **Quality Improvement Program** section of this Manual.

B. Credentialing Application

Credentialing applications are used to consistently collect key information from all practitioners and organizational providers seeking to join our networks.

Our credentialing standards apply to all **licensed independent practitioners** and **organizational providers** who maintain a direct contractual relationship with us.

The **Credentialing Program** evaluates whether these individual practitioners and organizational providers licensed by the state and contracted with us and are qualified to deliver services and meet the minimum standards set by:

- The **National Committee for Quality Assurance (NCQA)**
- The **Centers for Medicare & Medicaid Services (CMS)**
- The **TennCare Contractor Risk Agreement**

Verifying all required credentials is a critical part of this process to ensure quality and compliance.

Once practitioners and organizational providers have completed the credentialing process, they'll receive written notification within 10 days from our Credentialing Department.

Note: ***This notification doesn't guarantee acceptance in our networks; practitioners and organizational providers are not considered participating in our networks until they receive an acceptance letter from our Contracting*** **Department.**

C. Credentialing Policies

Please note that credentialing policies are subject to change. Final decisions regarding credentialing status are made by the **Credentialing Committee**.

For questions regarding credentialing or if assistance is needed, providers may contact their **Provider Representative** by visiting our Contact Us page at https://provider.bcbst.com/contact-us/my-contact.

Alternatively, Customer Service may be reached directly at 1-800-924-7141.

1. Credentialing Process for Practitioner: (Medical and Behavioral Health)

BlueCross obtains practitioner data for the credentialing process from **CAQH**. Practitioners are required to complete their CAQH profile fully and accurately, and must attest to the information within **120 calendar days** prior to submitting their application for participation in a BlueCross network.

Additionally, practitioners must submit an **online enrollment form through Availity** to request, add, or update a specialty. For more details, refer to the section title **Provider Networks**.

As part of the credentialing process, BlueCross will verify all required information based on the data attested to in the CAQH application. Any exceptions to the standard or additional criteria will be reviewed and determined by the **Committee**.

Base practitioner credentialing criteria (section references are to the CAQH application):

- **Section 1, Personal information and Professional IDs**
  - **Personal Email Contact**. Ensure the personal email contact is correct (we use this contact only if there is no response using the Section 3 contact)
  - **Drug Enforcement Administration (DEA**). BlueCross requires a current, valid, and unrestricted DEA with all schedules

- **License**. BlueCross requires a current, valid, full, and unrestricted license to practice as a healthcare professional in the state(s) where services will be rendered.

➢ **Section 2, Education and Training**
- **Education and training**. BlueCross will use the provided education and training to determine specialty eligibility.

➢ **Section 3, Professional/Medical Specialty Information**
- **Board Certification**, if applicable. BlueCross will use the provided board certification information to determine specialty eligibility.
- **Certificatio**n. Certifications for nurse practitioners and physician assistants should be listed in this section. BlueCross requires submission of a copy of the ANCC or AANP certificate.
- **Primary Credentialing Contact**. BlueCross will use this contact for all credentialing correspondence, regardless of what is submitted on the enrollment form.

➢ **Section 4, Practice Location Information**
- **Current practice location**. BlueCross will use this information to determine where the practitioner is currently practicing.
- **Call Coverage**. BlueCross requires 24-hour, seven-day-a-week call coverage or arrangements with a BlueCross credentialed or contracted practitioner or hospitalist group. Please note this is indicated on the CAQH application as "Covering Colleagues"

➢ **Section 5, Hospital Affiliations**
- **Hospital Privileges**. BlueCross requires unrestricted hospital privileges.
- **Admitting arrangements**. The Credentialing Committee will determine if an admitting arrangement will be allowed. If allowed, the admitting arrangement must be with a BCBST credentialing practitioner or hospitalist group.

➢ **Section 6, Professional Liability Insurance Carrier**
- **Certificate of Insurance**. BlueCross requires malpractice coverage in amounts of not less than $1,000,000 per occurrence and $3,000,000 aggregate (exceptions made for state employees).

➢ **Section 7, Work History and References**
- **Work History**. BlueCross requires work history for the last five years with documented gaps in employment over six months.

➢ **Section 8, Disclosure Questions**
- **Disclosure questions**. BlueCross requires an answer to all 26 disclosure questions. A detailed explanation of any question(s) answered "Yes" on the application will be required.

Some practitioner specialties may require specific licenses, certifications, or education. Others might be exempt from certain base requirements. These differences are listed below. If a specialty isn't listed, the general base requirements above apply.

Acupuncturist

- **Licensed as an Acupuncturist.**
- Certified by the National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM)
- DEA certificate isn't required.
- Call coverage isn't required.
- Hospital privileges aren't required.

Audiologist:

- **Licensed as an Audiologist**
- DEA certificate isn't required.
- Call coverage isn't required.
- Hospital privileges aren't required.

Behavior Analyst (CBA)

- **Licensed in the state of Tennessee as a Behavior Analyst**
- Provider must be a board-certified Behavior Analyst-Doctoral (BCBA D) by Behavior Analyst Certification Board (BACB).

- DEA certificate isn't required
- Call coverage isn't required
- Hospital privileges aren't required.

Certified Anesthesiologist Assistant (CAA or AA)

- **Licensed as an Anesthesiologist Assistant in Tennessee**
- DEA Certificate isn't required.
- Hospital privileges aren't required

Certified Registered Nurse Anesthetist (CRNA):

- **Licensed as a Registered Nurse and an Advance Practice Nurse with qualifications listed as Nurse Anesthetist**
- DEA Certificate isn't required
- Hospital privileges aren't required

Chiropractor*:*

- **Licensed as a Chiropractor**
- Hospital privileges aren't required.
- Call coverage can be answering machine, cell phone, answering service or another provider in a like specialty
- DEA certificate isn't required.

Chiropractor for performing Acupuncture:

- If the State license has acupuncture listed at the bottom, the practitioner has met the state's educational requirements to perform acupuncture.

Dentist – Dental Anesthesiology:

- **Licensed as a Dentist (DDS or DMD)**
- Completion of residency in Dental Anesthesia or Board certification from the American Dental Board of Anesthesiology (ADBA)

Dentist – Endodontics; Periodontist; Prosthodontics:

- **Licensed as a Dentist**
- Hospital privileges aren't required

Dentist - General:

- **Licensed as a Dentist**
- Hospital privileges aren't required
- Call coverage isn't required
- DEA certificate isn't required

Dentist – Oral & Maxillofacial Surgeon (DDS, or DMD)

- **Licensed as a Dentist (DDS or DMD)**
- Completion of residency in Oral and Maxillofacial Surgery or ABOMS board certification

Dentist- Orthodontics:

- **Licensed as a Dentist – must list specialty of Orthodontics and Dentofacial Orthopedics**
- Hospital privileges aren't required
- Call coverage isn't required
- DEA certificate isn't required

Dentist – Pediatric:

- **Licensed as a Dentist**
- Completion of Pediatric Dentist residency or license must list specialty of Pediatric Dentist
- Hospital privileges aren't required
- Call coverage isn't required
- DEA certificate isn't required.

Dermatology:

- **Licensed as a MD or DO with specialty of Dermatology**

- Hospital privileges are required for Micrographic Surgery (MOHS). If practitioner doesn't have their own privileges, an admitting arrangement or hospital group is acceptable.

Dietitian/Nutritionist:

- **Licensed as a Dietitian/Nutritionist.**
- Accreditation from the Commission on Dietetic Registration (CDR)
- Call coverage isn't required
- DEA certificate isn't required
- Hospital privileges aren't required

Genetic Counselors

- **State licensed or certified at the highest level of independent practice in the state where practice is to occur.**
- Hospital privileges aren't required
- Call coverage can be answering machine, cell phone, answering service or another provider in a like specialty
- DEA certificate isn't required

Hospice & Palliative Care Practitioner

- **Licensed as a MD or DO**
- Hospital privileges aren't required
- Call coverage isn't required

Lactation *Specialist*

- **Licensed as a BCBST recognized specialty**
- Certification with IBCLC: Global Certification for Lactation Consultant required.
- Hospital privileges aren't required.
- Call coverage isn't required.
- DEA certificate isn't required

Licensed Clinical Social Worker (LCSW):

- **Licensed** as **a Clinical Social Worker**
- DEA certificate isn't required
- Call coverage can be answering machine, cell phone, answering service or another provider in a like specialty
- Hospital privileges aren't required

Marriage and Family Therapist:

- **Licensed as a licensed Marriage and Family Therapist**
- DEA certificate isn't required
- Call coverage can be answering machine, cell phone, answering service or another provider in a like specialty
- Hospital privileges aren't required

Nurse Practitioners or Nurse Mid-Wife:

- **Registered Nurse (RN) License**
- **Advanced Practice Nurse (APN) certificate in Tennessee and applicable prescriptive authority for contiguous states**
- Hospital admitting arrangement is required. The admitting physician must be credentialed and/or contracted with BCBST. A hospitalist group may also be listed as admitting.
- DEA certificate isn't required.

Nurse Practitioner – Master's Clinical Nurse Specialist/Psychiatric Nurse

- **RN License – May be from any state if it says multi-state**
- **Advanced Practice Nurse (APN) certificate in TN (Must have an active NP license in each state that they practice)**
- Certification by American Nurse Credentialing Center as Nurse Practitioner – Psychiatric / Mental Health is required.

- Hospital admitting arrangement is required. The admitting physician must be credentialed and/or contracted with BCBST. A hospitalist group may also be listed as admitting.
- DEA certificate isn't required

Occupational Therapist

- **Licensed as an Occupational Therapist**
- DEA certificate isn't required
- Call coverage isn't required
- Hospital privileges aren't required

Optometrist*:*

- **State license must contain Therapeutic Certification**
- Hospital privileges aren't required.
- DEA certificate isn't required.
- Call coverage isn't required.

Pathologist*:*

- **Licensed as a MD or DO with the specialty listed as Pathologist**
- Hospital privileges aren't required.
- DEA certificate isn't required.
- Call coverage isn't required.

Pharmacist – (Clinical, Immunizing, or Disease Management)*:*

- **Licensed as a Pharmacist**
- Hospital privileges aren't required.
- Call coverage isn't required.
- DEA certificate isn't required

Physical Therapist

- **Licensed as a Physical Therapist**
- Hospital privileges aren't required.
- Call coverage isn't required.
- DEA certificate isn't required

Physician Assistant:

- **Licensed as a Physician Assistant**
- Admitting physician is required. The admitting physician must be credentialed and/or contracted with BCBST. A hospitalist group may also be listed as admitting.
- DEA certificate isn't required

Physician Assistant - Surgical Assist

- **Licensed as a Physician Assistant**
- National Commission on Certification of Physician Assistants (NCCPA) certification is required
- DEA certificate isn't required
- Admitting physician is required. The admitting physician must be credentialed and/or contracted with BCBST. A hospitalist group may also be listed as admitting.

Podiatrist

- **Licensed as a Podiatrist**
- Hospital privileges aren't required

Podiatrist – Foot and Ankle Surgery

- **Licensed as a Podiatrist**
- Hospital privileges are required – Admitting arrangement with a BCBST credentialed and/or contracted provider or hospitalist group is acceptable.

Professional Counselors

Includes Addiction Counselors, Alcohol and Drug Counselors, Mental Health Counselors, Senior Psychological Examiner (SPE), and Employee Assistance Professional Counselor (EAP)

- **State licensed or certified at the highest level of independent practice in the state where practice is to occur.**
- Hospital privileges aren't required.
- Call coverage can be answering machine, cell phone, answering service or another provider in a like specialty
- DEA certificate isn't required

Psychologists – Clinical or Clinical Child & Adolescent Psychologists (includes Psychologist and Psychoanalyst)

- **Licensed as a Psychologist**
- DEA certificate isn't required
- Call coverage can be answering machine, cell phone, answering service or another provider in a like specialty.
- Hospital privileges aren't required

Psychologists –Tele-Health Provider with a PSYPACT license

- **Provider must have a PSYPACT license**
- **Provider must be licensed as a Psychologist in the APIT Home State listed on the PSYPACT license**
- Doctoral degree (PhD, EdD, PsyD) in clinical psychology or counseling psychology from an accredited college or university
- DEA certificate isn't required
- Call coverage can be answering machine, cell phone, answering service or another provider in a like specialty
- Hospital privileges aren't required

Radiologist - Diagnostic

- **Licensed as a MD or DO with the specialty listed as Radiologist**
- DEA certificate isn't required
- Call coverage isn't required
- Hospital privileges aren't required.

Radiology - Interventional

- **Licensed as a MD or DO with the specialty listed as a Radiologist**
- Hospital privileges are required – Practitioner **must** have his/her own privileges.

Sleep Medicine

- **Licensed as a MD or DO**
- Education and/or board certification in Sleep Medicine required

Speech Language Pathologist or Speech Therapist

- **Licensed as a Speech Language Pathologist**
- DEA certificate isn't required
- Call coverage isn't required
- Hospital privileges aren't required

Surgery, General

- **Must be licensed as a MD or DO**
- Education and/or board certification in Surgery Hospital privileges are required
- Hospital privileges are required. Practitioner must have his/her own admitting privileges

2. Credentialing Process for Medical and Behavioral Health Organizational Providers

Obtaining valid/current copies of the following information as submitted with the credentialing application is essential to ensuring decisions are based on the most accurate, current information available. The following types of medical and behavioral health organizational providers require verification of specific requirements to be considered by the Credentialing Committee. The following pages list these requirements:

Organizational providers must be recredentialed every 36 months to meet federal and state regulatory guidelines.

The following information is the minimum criteria required and/or that must be verified for organizational providers:

- **Licensed in the State of Tennessee**. Providers receive a new license each year and it's considered proof of compliance; therefore, no site visit is required.
- Professional liability coverage of $1,000,000 per case/ $3,000,000 aggregate.
- Malpractice claims history for the past five years. NPDB reports or self-reported.
- Accreditation by: AAAASF (QUAD A), AAAHC/URAC, AAPM, AASM, ABCOP, ACHC, AOA, CABC, CARF, CHAP, CIHQ, COA, CORF, CUC, DNV-GL, HFAP, HQAA, National Association of Boards of Pharmacy, NBAOS, SAMHSA, UCAOA / CAUCQ, or The Joint Commission (TJC). If not accredited, State or Federal review in lieu of a site visit in the last 3 years.
- Clinical Laboratory Improvement Amendments (CLIA) certificate, if applicable
- DEA certificate, if applicable
- History of federal and/or state sanctions
- An attestation to the correctness and completion of the application.

Acute Care Facility Hospital

- **Licensed as an Acute Care Facility in Tennessee**
- Other States: Licensed in accordance with that state's licensing laws
- DEA certificate, if applicable
- CLIA certificate, if applicable
- TJC, CHAP, CIHQ, AAAHC, Det Norske Veritas accreditation required
- If not accredited, State or Federal review in lieu of a site review in the last 3 years

Ambulatory Infusion Center (AIC)

- **Licensed as an Acute Care Facility in Tennessee**
- Other States: Licensed in accordance with that state's licensing laws
- DEA certificate, if applicable
- CLIA certificate, if applicable
- TJC, CHAP, AAAHC, CIHQ or Det Norske Veritas accreditation required
- If not accredited, State or Federal review in lieu of a site visit in the last 3 years

Ambulatory Surgical Facility

- **Licensed as an Ambulatory Surgery Facility in Tennessee**
- Other States: Licensed in accordance with that state's licensing laws
- CLIA Certificate, if applicable
- TJC, CHAP, AAAHC, AAAASF (QUAD A), or CIHQ certification

Applied Behavior Analysis (ABA)

Note: Services will be provided at an Outpatient Mental Health Clinic level of intensity.

- **Licensed as a Mental Health Outpatient Facility**
- Must receive oversight from a licensed behavioral health or Behavior Analyst Certification Board (BACB) - certified professional.

Birthing Centers

- **Licensed as a Birthing Center in Tennessee**
- Other States: Licensed in accordance with that state's licensing laws
- CLIA Certificate, if applicable
- TJC, CHAP, AAAHC, or CIHQ certification required

Community Mental Health Center

- **Licensed as a Mental Health Outpatient Facility**

Crisis Stabilization Unit

- **Licensed as a Crisis Stabilization Unit**

- Program must be part of a TJC accredited hospital or health care organization that provides psychiatric services or accredited by, CARF, CIHQ, or COA or accredits the program itself as an observation/holding bed program that provides psychiatric services
- Accreditation isn't required

Dialysis Facility

- **Licensed as End Stage Renal Disease (ESRD) Facility**
- Other States: Licensed in accordance with that state's licensing laws
- CLIA Certificate

Durable Medical Equipment (DME) Providers

- **Licensed as a DME Provider in Tennessee**
- Other States: Licensed according to that state's licensing laws
- DEA certificate, if applicable
- Pharmacy License, if applicable
- TJC, CHAP, AAAHC, BOC, The Compliance Team, ABC, NBAOC, CARF, CIHQ, HQAA or ACHC required

Health Department

- **License isn't required**
- State Tort Insurance
- CLIA Certificate

Home Infusion Therapy Providers

- **TN: Licensed as a Pharmacy License**
- Other States: Licensed according to that state's licensing laws
- DEA certificate, if applicable
- Accreditation isn't required

Home Health Agency

- **Licensed as a Home Health Provider in Tennessee**
- Other States: Licensed according to that state's licensing laws
- CLIA certificate, if applicable
- Accreditation isn't required

Hospice Provider

- **Licensed as a Hospice Provider in Tennessee**
- Other States: Licensed according to that state's licensing laws
- CLIA certificate, if applicable
- Accreditation isn't required

Independent Lab

- **Licensed as a Laboratory in Tennessee – Labs located in Physician Office, Hospital, etc., are exempt from licensure requirements**
- Other States: Licensed according to that state's licensing laws
- Must have referral from a BCBST participating/network practitioner
- Accreditation isn't required
- CLIA certificate required

Inpatient Rehabilitation Facility

- **Licensed as an Inpatient Rehabilitation Facility in Tennessee**
- Other States: Licensed according to that state's licensing laws
- CLIA certificate, if applicable
- DEA certificate, if applicable
- TJC, CARF, or CIHQ accreditation required (no exceptions)

Intensive Outpatient (Psychiatric)

- **Licensed as a Mental Health Outpatient Facility**
- DEA certificate isn't required

- Must provide services at least three hours per day, at least two days a week.

Intensive Outpatient (Substance Abuse Disorder)

- **Licensed as an Alcohol and Drug Non-Residential Treatment Center**
- DEA certificate isn't required
- Must provide services at least three hours per day, at least two days a week.

Non-Licensed DME Providers (Non-motorized equipment only e.g., walker canes, crutches)

- **License isn't required**
- DEA certificate isn't required
- Accreditation isn't required

On-Site Clinics

- **State Business License**
- Accreditation by Urgent Care Association of America (UCAOA) / Commission on Ambulatory and Urgent Care Quality (CAUCQ), Joint Commission, AAAHC, or a certificate from Certified Urgent Care (CUC) Program required

Orthotic/Prosthetic Supplier

- **License isn't required**
- Board of Certification/Accreditation (BOC) is required

Opioid Treatment Program

- **Licensed as an Opioid Treatment Program (OTP) in Tennessee**
- Other States: Licensed according to that state's licensing laws
- DEA certificate is required
- CLIA certification, if applicable
- Certification by a SAMHSA required
- Must be accredited by, TJC, CARF, or COA

Outpatient Diagnostic Facility

- **Not licensed**
- CLIA certification, if applicable

Outpatient Mental Health Facility

- **Licensed as a Mental Health Outpatient Facility**
- Accreditation isn't required
- DEA certificate isn't required

Outpatient Substance Abuse Disorder Clinic

- **Licensed as an Alcohol and Drug Non-Residential Treatment Center**
- Accreditation isn't required
- DEA certificate isn't required

Outpatient Rehabilitation Facility

- **Not Licensed**
- Accreditation isn't required
- CLIA isn't required unless they have an onsite laboratory

Pain Management Center

- **Licensed as an Ambulatory Surgical Facility in Tennessee**
- Other States: Licensed according to that state's licensing laws
- DEA certificate isn't required
- Must have CARF accreditation or American Academy of Pain Management accreditation

Partial Hospitalization (Psychiatric)

- **Licensed as a Mental Health Partial Hospitalization Facility**
- Accreditation isn't required
- DEA certificate isn't required

Partial Hospitalization Substance Use Disorder

- **Licensed as an Alcohol and Drug Non-Residential Rehabilitation Treatment Facility license, Mental Health Partial Hospital Facility, and Alcohol and Drug Outpatient Detox license**
- Accreditation isn't required
- DEA certificate isn't required

Professional Support Services Licensure

- **TN: Licensed as a Professional Support Service**
- Member of DDA (Department of Disability and Aging)

Psychiatric Hospital

- **TN: Licensed as a Mental Health Hospital Facility**
- Other States: licensed in accordance with that state's licensing laws
- DEA certificate, if applicable
- CLIA certificate, if applicable
- TJC, CHAP, CIHQ, AAAHC, or Det Norske Veritas accreditation required
- If not accredited, State or Federal review in lieu of a site visit in the last 3 years

Psychiatric/Residential

- Licensed as a Mental Health Residential Treatment Center
- Accreditation isn't required
- DEA certificate isn't required

Psychosocial Rehabilitation Center

- **Licensed as a Mental Health Psychosocial Rehabilitation Center**
- Accreditation isn't required
- DEA certificate isn't required

Rural Health Clinics

- **Not licensed**
- State Tort insurance
- CLIA certification required
- Accreditation isn't required

Skilled Nursing Facility (No Swing Beds)

- **TN: Licensed as a Nursing Home**
- Other States: Licensed in accordance with that state's licensing laws
- CLIA isn't required
- DEA certificate isn't required
- Accreditation isn't required

Sleep Labs

- **Not licensed**
- Accreditation by American Academy of Sleep Medicine (AASM) or TJC or CIHQ required

Substance Abuse Disorder Residential

- **Licensed as an Alcohol and Drug Residential Treatment Center**
- DEA certificate isn't required
- Accreditation isn't required

Supportive Housing

- **Licensed as either a Supportive Living Facility or a Supportive Residential Facility**
- Assisted Care Living Facility (ACLF) Residential Facility, Mental Health Supportive Living Facility, or DDA license are acceptable
- Accreditation isn't required
- DEA certificate isn't required

Urgent Care Centers

- **State Business License**

- Accreditation or certification by Urgent Care Association of America (UCAOA), Joint Commission, AAAHC, or a certificate from Certified Urgent Care (CUC) Program required

3. Recredentialing Process

All medical or behavioral health practitioners will be recredentialed every 36 months.

In addition to the information that will be verified by primary or secondary sources, we'll include and consider collected information for the participating practitioner's performance within the health plan, including information collected through the health plan's quality management program.

Recredentialing will begin approximately three to six months prior to the expiration of the credentialing cycle. Providers are sent a letter stating their file will be placed in a recredentialing status and we'll retrieve their application from CAQH to begin the recredentialing process. To help ensure the recredentialing process is handled expediently with no interruptions in network participation we encourage the Practitioner to visit the CAQH ProView™ website, https://proview.caqh.org, to update their information.

Failure to comply with the request may result in immediate disenrollment from the Provider network. Credentialing information that's subject to change must be re-verified from primary sources during the recredentialing process. The provider must attest to any limits on their ability to perform essential functions of the position and attest to absence of current illegal drug use.

4. Approved Specialties

We recognize and maintain the current list of specialties of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), American Academy of Pediatrics (AAP), the American Board of Podiatric Surgery (ABPS), and the American Dental Association (ADA) Boards or others as deemed necessary by peer review to support business needs.

Providers must designate a specialty on the credentialing application. To be listed in our provider directory in the specialty requested, the provider must meet one of the following requirements:

- Recognized board certification, or
- Practitioners: Successful completion of residency or fellowship in the applied specialty.
  - *Fellowship training will only be recognized for those specialties where there is not a residency program for the specialty. Completion of a fellowship program in a specialty for a limited time period will not be recognized if the applicant has not completed the full residency program for that specialty. Recognition of fellowship training will be made in the sole discretion of BCBST.
- Other health care professionals: Licensure and additional certification, if applicable in the field of specialty.

American Board of Medical Specialties (ABMS)

I. American Board of Allergy and Immunology
- A. Allergy and Immunology

II. American Board of Anesthesiology
- A. Adult Cardiac Anesthesiology
- B. Anesthesiology
- C. Critical Care Medicine
- D. Health Care Administration, Leadership, and Management
- E. Hospice and Palliative Medicine
- F. Neurocritical Care
- G. Pain Medicine
- H. Pediatric Anesthesiology
- I. Sleep Medicine

III. American Board of Colon and Rectal Surgery
- A. Colon and Rectal Surgery

IV. American Board of Dermatology
- A. Dermatopathology
- B. Micrographic Dermatologic Surgery

C. Pediatric Dermatology

V. American Board of Emergency Medicine

A. Anesthesiology Critical Care Medicine
B. Emergency Medical Services
C. Health Care Administration, Leadership, and Management
D. Hospice and Palliative Medicine
E. Internal Medicine – Critical Care Medicine
F. Medical Toxicology
G. Neurocritical Care
H. Pain Medicine
I. Pediatric Emergency Medicine
J. Sports Medicine
K. Undersea-Hyperbaric Medicine

VI. American Board of Family Medicine

A. Adolescent Medicine
B. Family Medicine
C. Geriatric Medicine
D. Health Care Administration, Leadership, and Management
E. Hospice and Palliative Medicine
F. Pain Medicine
G. Sleep Medicine
H. Sports Medicine

VII. American Board of Internal Medicine

A. Adolescent Medicine
B. Adult Congenital Heart Disease
C. Advanced Heart Failure and Transplant Cardiology
D. Cardiovascular Disease
E. Clinical Cardiac Electrophysiology
F. Critical Care Medicine
G. Endocrinology, Diabetes, and Metabolism
H. Gastroenterology
I. Geriatric Medicine
J. Hematology
K. Hospice and Palliative Medicine
L. Infectious Disease
M. Internal Medicine
N. Interventional Cardiology
O. Medical Oncology
P. Nephrology
Q. Neurocritical Care
R. Pulmonary Disease
S. Rheumatology
T. Sleep Medicine
U. Sports Medicine
V. Transplant Hepatology

VIII. American Board of Medical Genetics and Genomics, Inc.

A. Clinical Biochemical Genetics
B. Clinical Genetics and Genomics (MD)
C. Laboratory Genetics and Genomics
D. Medical Biochemical Genetics
E. Molecular Genetic Pathology

IX. American Board of Neurological Surgery

A. Neurological Surgery
B. Neurocritical Care

X. American Board of Nuclear Medicine

A. Nuclear Medicine

XI. American Board of Obstetrics and Gynecology

A. Complex Family Planning
B. Critical Care Medicine
C. Gynecologic Oncology
D. Gynecology
E. Maternal Fetal Medicine
F. Obstetrics
G. Obstetrics and Gynecology
H. Reproductive Endocrinology and Infertility
I. Urogynecology and Reconstructive Pelvic Surgery

XII. American Board of Ophthalmology

A. Ophthalmology

XIII. American Board of Orthopedic Surgery

A. Orthopedic Surgery
B. Orthopedic Sports Medicine
C. Surgery of the Hand

XIV. American Board of Otolaryngology

A. Complex Pediatric Otolaryngology
B. Neurotology
C. Otolaryngology – Head and Neck Surgery
D. Plastic Surgery within the head and neck
E. Sleep Medicine

XV. American Board of Pathology

A. Pathology - Anatomic / Pathology - Clinical
B. Pathology - Anatomic
C. Pathology - Clinical
D. Blood Banking Transfusion Medicine
E. Clinical Informatics
F. Cytopathology
G. Dermatopathology
H. Hematopathology
I. Neuropathology
J. Pathology – Chemical
K. Pathology – Forensic
L. Pathology – Medical Microbiology
M. Pathology – Molecular Genetic
N. Pathology – Pediatric

XVI. American Board of Pediatrics

A. Adolescent Medicine
B. Child Abuse Pediatrics
C. Developmental-Behavioral Pediatrics
D. Hospice and Palliative Medicine
E. Medical Toxicology
F. Neonatal-Perinatal Medicine
G. Pediatrics
H. Pediatric Cardiology
I. Pediatric Critical Care Medicine
J. Pediatric Emergency Medicine
K. Pediatric Endocrinology
L. Pediatric Gastroenterology
M. Pediatric Hematology-Oncology
N. Pediatric Hospital Medicine
O. Pediatric Infectious Disease
P. Pediatric Nephrology
Q. Pediatric Pulmonology
R. Pediatric Rheumatology

S. Pediatric Transplant Hepatology
T. Sleep Medicine
U. Sports Medicine

XVII. American Board of Physical Medicine and Rehabilitation

A. Brain Injury Medicine
B. Neuromuscular Medicine
C. Pain Management
D. Pediatric Rehabilitation Medicine
E. Physical Medicine and Rehabilitation
F. Spinal Cord Injury Medicine
G. Sports Medicine

XVIII. American Board of Plastic Surgery, Inc.

A. Plastic Surgery
B. Plastic Surgery within the head and neck
C. Surgery of the Hand

XIX. American Board of Preventive Medicine

A. Aerospace Medicine
B. Addiction Medicine
C. Clinical Informatics
D. Health Care Administration, Leadership, and Management
E. Medical Toxicology
F. Occupational and Environmental Medicine
G. Public Health and General Preventive Medicine
H. Undersea and Hyperbaric Medicine

XX. American Board of Psychiatry and Neurology

A. Addiction Psychiatry
B. Brain Injury Medicine
C. Child And Adolescent Psychiatry
D. Clinical Neurophysiology
E. Consultation – Liaison Psychiatry
F. Epilepsy
G. Forensic Psychiatry
H. Geriatric Psychiatry
I. Neurocritical Care
J. Neurodevelopmental Disabilities
K. Neurology
L. Neurology with special qualification in Child Neurology
M. Neurodevelopmental Disabilities
N. Neuromuscular Medicine
O. Pain Management
P. Sleep Medicine
Q. Vascular Neurology

XXI. American Board of Radiology

A. Diagnostic Radiology
B. Interventional Radiology and Diagnostic Radiology
C. Medical Physics (Diagnostics, Nuclear, Therapeutic)
D. Neuroradiology
E. Nuclear Radiology
F. Pain Medicine
G. Pediatric Radiology
H. Radiation Oncology
I. Radiology

XXII. American Board of Surgery

A. General Surgery
B. Complex General Surgical Oncology
C. Pediatric Surgery

D. Surgery
E. Surgery of the Hand
F. Surgical Critical Care
G. Vascular Surgery

XXIII. American Board of Thoracic Surgery
A. Thoracic and Cardiac Surgery
B. Congenital Cardiac Surgery

XXIV. American Board of Urology, Inc.
A. Urology
B. Pediatric Urology
C. Urogynecology and Reconstructive Pelvic Surgery

American Osteopathic Association Boards (AOA)

I. American Osteopathic Board of Anesthesiology
A. Anesthesiology
B. Critical Care Medicine
C. Pain Management
D. Pediatric Anesthesiology

II. American Osteopathic Board of Dermatology
A. Dermatology
B. Dermatopathology
C. MOHS-Micrographic Surgery
D. Pediatric Dermatology

III. American Osteopathic Board of Emergency Medicine
A. Emergency Medical Services
B. Emergency Medicine
C. Hospice and Palliative Medicine
D. Medical Toxicology
E. Sports Medicine
F. Undersea and Hyperbaric Medicine

IV. American Osteopathic Board of Family Practice
A. Addiction Medicine
B. Correctional Medicine
C. Hospice and Palliative Care Medicine
D. Family Medicine
E. Geriatric Medicine
F. Pain Medicine
G. Sports Medicine
H. Undersea and Hyperbaric Medicine

V. American Osteopathic Board of Internal Medicine
A. Addiction Medicine
B. Cardiology
C. Clinical Cardiac Electrophysiology
D. Correctional Medicine
E. Critical Care Medicine
F. Endocrinology
G. Gastroenterology
H. Geriatric Medicine
I. Hematology
J. Hematology/Oncology
K. Hospice and Palliative Care Medicine
L. Infectious Disease
M. Internal Medicine
N. Interventional Cardiology
O. Nephrology
P. Oncology

Q. Pain Medicine
R. Pediatric and Adult Allergy & Immunology
S. Pulmonary Disease
T. Rheumatology
U. Sleep Medicine
V. Sports Medicine
W. Undersea and Hyperbaric Medicine

VI. American Osteopathic Board of Neurology and Psychiatry

A. Addiction Medicine
B. Child And Adolescent Neurology
C. Child And Adolescent Psychiatry
D. Geriatric Psychiatry
E. Hospice and Palliative Medicine
F. Neurology
G. Neurophysiology
H. Psychiatry
I. Sleep Medicine

VII. American Osteopathic Board of Neuromusculoskeletal Medicine

A. Neuromusculoskeletal Medicine
B. Osteopathic Manipulative Medicine
C. Sports Medicine

VIII. American Osteopathic Board of Nuclear Medicine

A. In Vivo and In Vitro Nuclear Medicine
B. Nuclear Cardiology
C. Nuclear Imaging and Therapy
D. Nuclear Medicine

IX. American Osteopathic Board of Obstetrics and Gynecology

A. Female Pelvic Med/Reconstructive Surgery
B. Gynecologic Oncology
C. Gynecology
D. Maternal And Fetal Medicine
E. Obstetrics
F. Obstetrics And Gynecology
G. Reproductive Endocrinology & Infertility

X. American Osteopathic Board of Ophthalmology and Otolaryngology

A. Ophthalmology
B. Otolaryngology / Facial Plastic Surgery
C. Otolaryngic Allergy
D. Sleep Medicine

XI. American Osteopathic Board of Orthopedic Surgery

A. Orthopedic Surgery
B. Hand Surgery
C. Orthopedic Sports Medicine

XII. American Osteopathic Board of Pathology

A. Anatomic Pathology
B. Chemical Pathology / Laboratory Medicine
C. Dermatopathology
D. Forensic Pathology

XIII. American Osteopathic Board of Pediatrics

A. Neonatology
B. Pediatric Allergy and Immunology
C. Pediatrics
D. Sports Medicine

XIV. American Osteopathic Board of Physical Medicine & Rehabilitation

A. Physical Medicine & Rehabilitation

B. Hospice and Palliative Medicine
C. Pain Medicine
D. Sports Medicine

XV. American Osteopathic Board of Preventive Medicine
A. Aerospace Medicine
B. Correctional Medicine
C. Occupational Medicine
D. Public Health/Community Medicine
E. Undersea and Hyperbaric Medicine

XVI. American Osteopathic Board of Proctology
A. Proctology

XVII. American Osteopathic Board of Radiology
A. Diagnostic Radiology
B. Neuroradiology
C. Pediatric Radiology
D. Radiation Oncology
E. Radiology
F. Vascular & Interventional Radiology

XVIII. American Osteopathic Board of Surgery
A. Cardiothoracic Surgery
B. General Surgery
C. Neurological Surgery
D. Plastic and Reconstructive Surgery
E. Surgery
F. Surgical Critical Care
G. Urological Surgery
H. Vascular Surgery

American Board of Dental Sleep Medicine
A. Dental Sleep Medicine

American Academy of Pediatrics (AAP)
A. Pediatric Heart Surgery
B. Pediatric Neurosurgery
C. Pediatric Orthopedics
D. Pediatric Urology

American Board of Oral and Maxillofacial Pathology
A. Oral Pathology

American Board of Oral and Maxillofacial Surgery
A. Oral and Maxillofacial Surgery
B. Oral Pathology

American Board of Orthodontics
A. Orthodontics

American Board of Pediatric Dentistry
A. Pediatric Dentistry

American Board of Periodontology
A. Periodontology

American Board of Podiatric Orthopedics & Primary Podiatric
A. Podiatry (DPM)

American Board of Podiatric Surgery
A. Podiatry (DPM)

American Board of Prosthodontics
A. Prosthodontics

American Chiropractic Neurology Board, Inc.
A. Chiropractic Neurology

Other Health Care Professionals:

I. Acupuncturist
II. Audiology
III. Addictionologist (Non-Psychiatrist)
IV. Associate Behavior Analyst
V. Certified Behavior Analyst
VI. Certified Registered Nurse Anesthetist (CRNA)
VII. Chiropractor (DC)
VIII. Chiropractor Neurologist
IX. Dietitian
X. Employee Assistance Professional Counselor
XI. Endodontist
XII. Family Practice with Obstetrical Fellowship
XIII. General Dentistry
XIV. General Practice
XV. Licensed Clinical social Worker (LCSW)
XVI. Licensed Professional Counselor
XVII. Licensed Senior Psychological Examiner (LSPE)
XVIII. Marriage and Family Therapist
XIX. Mental Health Counselor/Licensed Substance Abuse Treatment Professionals
XX. Midwife (CNM)
XXI. Neuropsychology (Ph.D.)
XXII. Nurse (RN)
XXIII. Nurse Clinician
XXIV. Nurse Practitioner
XXV. Nurse Practitioner, Acute Care
XXVI. Nurse Practitioner, Adult Health
XXVII. Nurse Practitioner, Family Practice
XXVIII. Nurse Practitioner, Gerontology and Adult Health
XXIX. Nurse Practitioner, Neonatal
XXX. Nurse Practitioner, Pediatrics
XXXI. Nurse Practitioner, Psychological/Mental Health
XXXII. Nurse Practitioner, Women's Health
XXXIII. Nutrition
XXXIV. Occupational Therapy (OT)
XXXV. Optometry
XXXVI. Pastoral Counselor
XXXVII. Pediatric Anesthesiology
XXXVIII. Pediatric Genetics
XXXIX. Pediatric Ophthalmology
XL. Pediatric Plastic Surgery
XLI. Pharmacist - Clinical
XLII. Pharmacist – Immunizing
XLIII. Physical Therapist (PT)
XLIV. Physician Assistant (PA)
XLV. Physician Assistant – Surgical Assist
XLVI. Professional Counselor

XLVII. Prosthetist/Orthotist
XLVIII. Psychiatrist
XLIX. Psychologist or Psychoanalyst
L. Psychology (Ph.D.)
LI. Speech Pathology/Speech Therapy (ST)
LII. Therapeutic Optometry

5. Accrediting Bodies We Recognize

- Accreditation Association for Ambulatory Health Care (AAAHC)
- Accreditation Commission for Health Care, Inc. (ACHC)
- American Academy of Nurse Practitioners (AANP)
- American Academy of Pain Management (AAPM)
- American Academy of Sleep Medicine (AASM)
- American Accreditation HealthCare Commission/URAC (AAHCC/URAC)
- American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF) Now QUAD A
- American Association for Marriage and Family Therapy (AAMFT)
- American Association of Critical-Care Nurses (AACN)
- American Board of Medical Specialties (ABMS)
- American Board of Certification in Orthotics, Prosthetics, and Pedorthics (ABCOP)
- American Board of Professional Psychology (ABPP)
- American College of Nurse – Midwives Certification Council
- American Medical Association (AMA)
- American Nurse Credentialing Center (ANCC)
- American Osteopathic Association (AOA)
- American Speech-Language-Hearing Association (ASHA)
- Board of Certification/Accreditation (BOC)
- Certified Urgent Care Program (CUC)
- Commission for the Accreditation of Birth Centers (CABC)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Commission on Ambulatory and Urgent Care Quality (CAUCQ)
- Community Health Accreditation Program (CHAP)
- Comprehensive Outpatient Rehabilitation Facilities (CORF)
- Council on Accreditation (COA)
- Council on Social Work Education (CSWE)
- Det Norske Veritas Germanischer Lloyd (DNV GL)
- Division of TennCare or Centers for Medicare & Medicaid Services (CMS)
- Food and Drug Administration (FDA)
- Healthcare Facilities Accreditation Program (HFAP)
- HealthCare Quality Association on Accreditation (HQAA)
- International Board of Certification of Lactation Consultants (IBCLC)
- National Association of Boards of Pharmacy
- National Certification Commission for Acupuncture and Oriental Medicine (NCCAOM)
- National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties (NCC)
- National Commission on Certification of Physician Assistants (NCCPA)
- National Committee for Quality Assurance (NCQA)
- Pediatric Nursing Certification Board
- Substance Abuse and Mental Health Services Administration (SAMHSA)
- The Center for Improvement in Healthcare Quality (CIHQ)
- The Joint Commission (TJC)
- The National Board of Accreditation for Orthotic Suppliers (NBAOS)
- Tricare
- Urgent Care Association of America (UCAOA)

D. Practice Site /Medical Record Standards

Practice Site Standards

BlueCross BlueShield of Tennessee has adopted practice site standards for all credentialed practitioners that provide ambulatory care to our members. These standards were developed to ensure members have access to care in a clean, safe, organized and physically accessible environment.

Clinical Risk Management (CRM) will review all practitioner office site quality complaints/referrals to ensure practitioner offices meet these standards. Main sources for Office Site Quality referrals may include member complaints, onsite auditors (e.g., credentialing, clinical quality assurance, internal audit) or other internal or external sources. Credentialed practitioners will be advised in writing about specific complaints received concerning the quality of the office site. Credentialed practitioners with two office quality complaints within a six-month period, including, but not limited to complaints about physical accessibility, adequacy of waiting area and cleanliness of site, will be referred to the Clinical Quality Assurance Department to request an onsite review for compliance with the standards listed below within 60 days of the second member complaint. CRM will investigate the severity of all complaints received. We may also act on only one complaint if determined necessary.

Primary care provider (PCP) practice sites, and OB/GYN sites not previously reviewed and currently occupied by a network practitioner, will be evaluated prior to or within 60 days of initial credentialing.

Practitioners will receive site review results with suggestions for improvement, if applicable, at the conclusion of the audit. Non-compliant sites will be reported to the Clinical Risk Management Committee and re-audited within approximately six months. Sites non-compliant on re-audit will be reviewed by Clinical Risk Management for placement on a Practice Improvement Plan and a 2nd re-audit planned within approximately six months.

We have adopted the current established site review standards listed below. Compliance with all required elements noted with an asterisk (*), <u>and</u> an overall score of 80% is required to meet these site review standards.

These standards are subject to change and revisions will be posted in quarterly updates.

*Appropriate procedures should be in place for after-hours coverage. Voice mail messaging/answering machines should include instructions for reaching the practitioner on call. Review of after-hours coverage is documented by Clinical Quality Assurance on a separate tool.

1. *The office must be wheelchair accessible.
2. *The office must be clean and organized, with adequate exam room and waiting room space.
3. *The office must have adequate lighting in all patient areas such as the entry way, waiting room, restrooms, and treatment areas.
4. *Exam rooms must be designed for patient privacy.
5. There should be evidence of compliance with our appointment availability standards for routine and urgent care.
6. *There must be an individual medical record for each patient.
7. *Current medical records must be available at the site where services are provided and readily accessible.
8. *Medical records must be kept in a secure location. Sites with electronic medical records should provide evidence of a secure off-site record retention/recovery process.
9. *There must be evidence of a medical record confidentiality plan/policy that includes Protected Health Information (PHI).
10. *There must be evidence of a fire safety/emergency action plan with evidence of staff education. In locations with 10 or more employees, the plan must be documented in writing.
    - At a minimum, the fire safety/emergency plan should include:
      - Well-marked evacuation routes that are clear and unobstructed
      - Working fire extinguishers and smoke detectors
      - Compliance with local fire codes
11. *Emergency supplies and procedures must be available for scope of practice.
    - At a minimum, the emergency supplies and procedure requirements should include:
      - Epinephrine and oxygen

- Delivery kit in addition to epinephrine and oxygen for obstetrical sites and family practice sites who provide care for pregnancy.
- Crash cart and oxygen at sites that perform stress tests or services that require sedation.

12. *The office must have infection control procedures that include appropriate disposal of bio-hazardous material. Hand washing facilities must be in/near treatment rooms and Occupational Safety and Health Administration (OSHA) standards and Material Safety Data Sheet (MSDS/SDS) information must be available to staff.
13. *There must be a process for the appropriate disposal of needles and other sharps.
14. There should be a process for inventory control of all stock and sample medications including evidence of regular monitoring of expiration dates.
15. *There must be evidence of an inventory control process for dispensing controlled substances and disposal of expired or unused portions of drugs.
16. *Controlled substances must be maintained in a locked area.
17. *Evidence of CLIA registration with a site-specific address is required for any practice where labs are performed.
18. *If radiology services are provided, a current state inspection compliance notice must be posted with the date of the last inspection.
19. Radiology technique should be posted near the radiology equipment if not generated by radiology equipment.
20. There should be a sign posted that physician extenders may provide care, where applicable.
21. Professional staff should be licensed appropriately with evidence of licensure on file.
22. Member rights and responsibilities should be posted or otherwise made available to members.

Comprehensive Medical Record Standards

Network practitioners are expected to maintain medical records in detail consistent with good medical/professional practice, which permits effective internal/external review and/or medical audit and facilitates appropriate care and treatment by any health care practitioner.

Practitioner performance will be evaluated against the standards listed below through random solicitation of records for review, and evaluation of records obtained as part of routine health plan operations and quality of care reporting processes.

Clinical staff will schedule onsite medical record reviews for no less than five% of credentialed primary care practitioners annually to evaluate against published standards. Suggestions for improvement will be documented and shared with the practitioner or practitioner representative if applicable. In addition, medical record reviews will be performed during the annual Healthcare Effectiveness Data and Information Set (HEDIS®) project and analysis performed to identify practitioners with educational needs.

Random comprehensive medical record reviews may also be performed for any credentialed practitioner upon request of the Clinical Risk Management Department.

Practitioners with illegible records and those with appropriateness of care or potential utilization of care concerns noted during review will be referred to the Clinical Risk Management Department for further review.

Medical record data is utilized to evaluate potential coordination of care concerns and to provide supplemental data for internal/external quality reports.

Medical Record Keeping Practices

1. Medical records should be legible.
2. Member identification must be on each page of the record.
3. Each recorded chart entry must be dated and identified by the author. Stamped signatures aren't acceptable.
4. The medical records should be readily accessible to the practitioner during normal office hours.

Documentation

5. All medical records must contain a current member problem list, which addresses chronic and significant recurrent/acute conditions.
6. All medication allergies, absence of allergies, and/or adverse reactions must be consistently documented and prominently displayed in all medical records.

7. An initial history and physical exam should be documented for new patients within 12 months of the member first seeking care, or within three visits, whichever occurs first. Past medical history that includes behavioral health history, serious accidents, illnesses and surgeries, and gestational and birth history for pediatric patients under age six should be documented.
8. Each medical record must contain an updated list of medications the member is taking, or documentation that the member isn't currently taking any medications.
9. Each medical record must contain tobacco, alcohol, and/or substance use history (for members 12 years and over and seen three or more times).
10. The medical record of all members age 18 years and older should contain documentation of whether a medical advance directive has been executed for Medicaid/Medicare members.
11. If the member has executed an advance directive, a copy should be on file within the office.

Appropriateness of Care

12. Each visit should include documentation of member's chief complaint or purpose for the visit. Clinical assessment and a physical exam should be documented and correspond to the member's stated complaint or visit purpose and/or ongoing care for chronic illnesses.
13. Working diagnosis or medical impressions that logically follow from the clinical assessment and physical exam should be recorded.
14. Rationale for treatment decisions should be medically appropriate and substantiated by documentation in the record, with lab tests performed at appropriate intervals.
15. Records should substantiate the member's clinical problems and treatment so another practitioner can determine the member's overall clinical course under the reviewed practitioner's management.

Continuity and Coordination of Care

16. There should be documentation of unresolved problems from past visits, and abnormal consults or diagnostic tests through follow-up phone calls or return office visits.
17. Medical records should contain documentation of appropriate use of consultants, which includes behavioral health providers, and documentation of medical services performed by a referral specialist/practitioner.
18. If diagnostic and/or therapeutic ancillary services were performed, there should be a copy of the written report of the service in the record.

Education and Preventive Care

19. Each medical record should contain evidence that age/sex appropriate preventive screenings/immunizations are offered in accordance with the *U.S. Preventive Services Task Force Guide to Clinical Preventive Services or the American Academy of Pediatrics,* as applicable.
20. Care for high-risk conditions should be documented in accordance with our *Clinical Practice Guidelines (CPG's*).
21. There should be documentation of member education/instructions.

TennCare Kids Medical Record Standards

Clinical personnel review medical records of primary care providers that provide preventive care to members under the age of 21 to evaluate compliance with Early and Periodic Screening, Diagnostic and Treatment (EPSDT) requirements and share additional education and resources. Reviews are performed every two years but may also be requested anytime by the Clinical Risk Management Department.

Reviews are conducted according to the Tennessee Chapter of the American Academy of Pediatrics EPSDT Manual unless more current published American Academy of Pediatrics (AAP) guidelines are available. The manual provides detailed information for each of the elements listed below and is available at http://tnaap.org.

Results and suggestions for improvements, if applicable, will be shared with the practitioner, or their representative at the conclusion of the review. Practitioners that fail to meet the 88% threshold required for compliance with TennCare Kids standards shall receive a letter requesting information about actions taken to improve performance and documentation because of this review. A re-audit will be scheduled within 12 months of receiving the practitioner response.

Practitioners that fail to meet the minimum compliance standard on re-audit will receive additional education about deficiencies and a re-audit planned within 12 months. Failure to meet the compliance threshold with a second re-audit will result in a referral to Clinical Risk Management Committee for evaluation and communication of a Practice Improvement Plan.

Age-appropriate elements, identification of risk factors and periodicity for procedures and immunizations should be provided at each TennCare Kids encounter **based on the most current American Academy of Pediatrics Recommendations for Pediatric Health Care**. Documentation should provide reasons for not performing any element, or member refusal of any or all elements of this exam.

1. There should be comprehensive health and development history. This should be updated with documentation of an interval history, developmental/behavioral surveillance and screenings as appropriate for age and risk factors.
2. There should be evidence of a comprehensive unclothed physical examination.
3. There should be evidence of age-appropriate subjective/objective hearing exam.
4. There should be evidence of age-appropriate subjective/objective vision exam.
5. Immunizations should be provided as appropriate for age and risk factors. Documentation of immunizations administered by other providers should be requested and available in the medical record (record entry or photocopy) with the antigen and date of administration noted.
6. Procedures and tests should be performed as appropriate for age and risk factors, including lead screening, which is required at age 12 and 24 months of age.
7. Anticipatory guidance and health education should be provided as appropriate for age.
8. There should be evidence of an oral/dental screening with a referral for dental health care starting at age three or earlier as medically necessary.
9. There should be evidence of appropriate referrals to other health care practitioners, including behavioral health providers, or for ancillary care because of problems identified.

Facility Site Standards

Non-accredited facilities applying for initial credentialing with BlueCross BlueShield of Tennessee networks must meet and maintain compliance with the site standards listed below.

Noncompliant sites for currently credentialed providers will be referred to the BlueCross BlueShield of Tennessee Clinical Risk Management Committee for review. The credentialing process will be halted for all non-credentialed providers until BlueCross BlueShield of Tennessee facility site standards are met.

Physical Assessment

1. The facility must be wheelchair accessible.
2. The facility should be clean and organized with adequate lighting throughout, and space in treatment rooms to conduct patient exams effectively.

After Hours Coverage

3. Appropriate procedures should be in place for after-hours coverage, where applicable.

Medical Record Keeping

4. There should be an individual medical record for each member.
5. Medical records should be kept in a secure location.
6. There should be evidence of a medical record confidentiality plan/policy that includes Protected Health Information (PHI).
7. Medical records should be legible and maintained in detail consistent with good medical/professional practice, which permits effective internal/external review and/or medical audit and facilitates follow-up treatment.

Safety

8. Emergency supplies and procedures should be available for the scope of practice.
9. Policy and procedures should be available and reviewed annually regarding administrative, operational, safety and disaster management and infection control.
10. There should be evidence of staff education to include safety, disaster management, and infection control.

11. There should be infection control measures consistent with Occupational Safety and Health Administration (OSHA) guidelines.
12. There should be a Quality Improvement plan monitoring all aspects of performance of care/services with evidence of staff review.
13. Evidence of CLIA registration is required if labs are performed in the facility.
14. If radiology services are provided, a current state inspection compliance notice should be posted with the date of the last inspection.
15. Radiological techniques should be posted near the radiology equipment.
16. There should be a process for inventory control of all stock and sample medications and medical supplies with evidence of regular monitoring of expiration dates.
17. There should be evidence of an inventory control process for dispensing controlled substances and disposal of expired or unused portions of drugs.
18. Controlled substances must be maintained in a locked area.
19. The facility should maintain equipment in a safe manner consistent with the manufacturer recommendations.
20. Member Rights and Responsibilities should be posted, or available in the facility.
21. Professional staff should be licensed appropriately, with evidence of licensure on file.
22. The facility should have a defined process to ensure professional performance of its staff by:
    a. Completing the credentialing process for independent practitioners.
    b. Completing credentialing functions according to state, federal and NCQA standards.
    c. Utilizing the current license, relevant training and experience, current competence, and privileges at a hospital in the credentialing process.
23. A Credentialing Representative will audit the facility's files to ensure the credentialing process meets the above criteria.

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XIII. PROVIDER NETWORKS

Participation in BlueCross provider networks requires satisfaction of applicable network participation and credentialing requirements.

Providers interested in expanding their participation in our provider networks or needing to communicate any changes in their practice should review the contact list located at https://provider.bcbst.com/contact-us/my-contact and contact their local provider representative.(See Section II. BlueCross BlueShield of Tennessee Quick Reference Guide, for specific contact numbers.) For all other changes see below.

Providers can access a copy of their contract in Docusign and/or Availity Document Viewer or initiate a request for a copy of their own contract by calling our Provider Service line at **1-800-924-7141**. Say "Contracts" when prompted.

By affiliating with a contracted, in-network group, individual practitioners are required to enroll in and maintain participation in every network in which that group participates, except where participation in one or more of the contracted group's networks would be prohibited by law for such individual practitioner.

If you or your patients submit a claim to us but you aren't currently interested in network participation, and you are not affiliated with any contracted, in-network group, we recommend registering with us by completing an Out of Network Provider Form in Availity in the BlueCross Payer Space. The purpose of registering with us is to identify key information about you and ensure accurate distribution of payments, remittance advices (Explanation of Payments), and 1099 forms. This registration does not constitute or imply participation in any of our networks.

If you are a provider seeking to enroll in our networks, please refer to the application section below.

A. Application Process and Changes in Practice

Submission of an application does not constitute or guarantee participation in any BCBST network. Approval for network participation is contingent upon satisfying all requirements set forth in this section, including, but not limited to, the Network Participation Criteria detailed below. Network availability may be limited or restricted depending on participation needs.

Getting Started

There are a few requirements and steps you must take before you can begin the Enrollment Process.

Note: To alter an existing contract, please contact your provider contracting representative before submitting an application.

Facility and Ancillary Organizational Providers:

- Must have an NPI registered through NPPES at https://nppes.cms.hhs.gov/login
- Set up electronic fund transfer (EFT), as well as electronic claims and remittance, through Payer Enrollment Services at https://payerenrollservices.com/
- Must have an account with Availity®. To register, access https://provider.bcbst.com, select Log in to Availity and Create an account.

Practitioners (Medical, Dental and Behavioral Health):

Must have all of the above requirements and:

- Must register with the Council for Affordable Quality Healthcare, Inc. (CAQH) at CAQH ProView to get an ID number, give us access to your data and attest that it's correct no more than 90 calendar days prior to giving us access.

Application Process – Practitioners

If you're an individual practitioner joining a group practice that's already contracted with us, you must be eligible to participate in all the networks in which the group is contracted.

CAQH Provider ID

BlueCross BlueShield of Tennessee partners with CAQH Solutions, which offers providers a single point of entry for information. By applying for network participation via this request, you agree to be included in our roster with CAQH.

You'll need a valid and current CAQH profile. Next, you'll enroll for Electronic Funds Transfer (EFT) with Payer Enrollment Services https://payerenrollservices.com/. If your group practice participates in our BlueCare and TennCare*Select* networks, you'll also need a Medicaid ID from TennCare before applying with us.

Having all of these items complete at the time you submit your online application through Availity ensures we have what we need to process your enrollment timely and smoothly, and allows you to fill out only one application with us for all networks in which your group participates.

The provider submits a Group Enrollment and/or Practitioner Enrollment Form (GEF/PEF) through Availity to start the Enrollment Process.

Existing CAQH Providers

If you have already registered and have an active CAQH Provider ID, verify that:

- Information is current and matches the information submitted on enrollment request.
- Have completed a CAQH ProView online application; and
  - All supporting documents are current and attached to your CAQH profile.
  - Attest that it's correct no more than 90 calendar days prior to giving us access.
  - Must have "authorized" BlueCross BlueShield of Tennessee (BCBST) to access your credentialing information. (If you selected "global authorization," then BCBST already has access to your data.)
  - If BCBST has not been authorized to access your credentialing information, you can complete your authorization by using the four easy steps below:

To allow BlueCross BlueShield of Tennessee access to your data:

- Go to https://proview.caqh.org and enter your username and password.
- Select the Authorize tab.
- Scroll down and select BlueCross BlueShield of Tennessee or you may select "Release my data to ANY organization that requests access".
- Accept the disclosure and select "Save" to submit your changes.

If you have questions about the CAQH Provider ID, you can contact:

- CAQH Helpdesk: 1-888-599-1771
- CAQH Email: providerhelp@proview.caqh.org
- Website: https://proview.caqh.org

BlueCross Enrollment Process

Our goal is to complete these steps in the enrollment process within 45 business days.

To check a Group Enrollment Form and/or Individual Enrollment Form visit the payor space on Availity: For instructions on using this tool see: Provider Updates and Changes Application.

This tool only allows the user to track Group Enrollment Form and/or Individual Enrollment Form progress. Direct questions to: Contracts_Reqs_GM@bcbst.com.

1. INTAKE AUDIT

Our teams confirm that we've received all your information and will contact you for additional documentation if needed.

- We may send a notification asking for additional information needed to complete the review of your application.

  Please Note: These communications require a response. Failure to respond within 30 calendar days will cause your application to be delayed or discontinued.

- You will receive a notice of discontinuation if we aren't able to process your request.

2. **CREDENTIALING**
   - We verify all information (see Credentialing section) received from providers applying to be in network with BlueCross. We may send a letter asking for additional credentialing criteria we need to complete your application.
   - We'll send a credentialing acceptance letter when our reviews are complete.

     Please Note: the date listed is the credentialing approval date not your network participation date, which you'll receive during Provider Enrollment.

   - If we're unable to credential a provider, we'll send a credentialing denied letter.
3. **CONTRACTING**

   At this step, we approve or deny requests for participation in various BlueCross networks and send out the appropriate contracts.

   - We'll send a denial notice if the network applied for isn't available to the provider.

     Please Note: Approved contracts, amendments and other related communications will be sent through Docusign or emailed from us.
4. **ENROLLMENT AUDIT**

   Our teams review documentation to make sure all enrollment requirements are met, that you're credentialed or pre-approved, and that contracts are completed.
5. **PROVIDER ENROLLMENT**

   We add the approved networks to your records and configure your information in our systems to make sure claims are paid correctly and that all information is displayed correctly in our directory.

   - We'll send applicable acceptance letters with effective dates for all contracted networks.
6. **ECOMMERCE**

   Our team will set up your EFT, electronic remittance advice, and electronic claims submission.

   - You'll receive a notification confirming that the provider has been approved to transmit claims through our vendor.
   - We'll send another notification letting you know that EFT is set up, and payments will be made electronically through the account you set up with Payer Enrollment Services at https://payerenrollservices.com/

Application Process for Facility and/or Ancillary Medical and Behavioral Health Providers

Facility and/or Ancillary organizations interested in participating in our networks should review the contact list located at Find My BlueCross Contact and contact their local provider representative. (See Section II. BlueCross BlueShield of Tennessee Quick Reference Guide, for specific contact numbers.)

If network participation is approved, Provider Networks & Contracting (PNC) will send an **Organizational Application** to provider within two business days.

Participation in BlueCross facility and ancillary provider networks requires satisfaction of applicable network participation and credentialing requirements (see Credentialing section). Network availability may be limited or restricted depending on participation needs.

Changes in Practice

Certain federal and state regulations may require our contracted providers to timely notify us of any changes to their street address, telephone number(s), office hours, and any other changes that impact availability.

If you've moved, acquired an additional location, changed your status for accepting patients, or made other changes to your practice, please refer to the following:

- Updates for individual practitioner profiles must be made on the Council for Affordable Quality Healthcare (CAQH) website at CAQH®ProView Profile. Updates to information not collected at CAQH® for practitioners, that are more specific to BlueCross, can be submitted through the online Change Request application within the BlueCross Payer Space in Availity at this link: Network Verification Form.

- Updates for group, facility, and ancillary providers are through the online Change Request application within the BlueCross Payer Space in Availity at this link: Provider Change Form
- Questions regarding changes to provider profile can be sent to us at Contracts_Reqs@bcbst.com.

The Consolidated Appropriation Act (CAA) is a federal law passed in December 2020. The law requires us to implement processes for the verification and update of certain provider information. The CAA requires us to implement a quarterly verification of provider data and make updates to the information in our Provider Directory within two business days of receiving updated information from a provider. This would include updates to their name, address, specialty, phone number and digital contact. Effective January 1, 2022, we're also required to establish a procedure to remove from our directory providers who don't validate their data information at least every 90 days.

We require individual practitioners to update and/or attest to their information in CAQH within 90 days of the notification to validate their data information. For facilities and ancillary providers, we require the return of every data verification form (DVF) received (even if there are no updates) every quarter. Depending on specialty and practice location, some providers may receive multiple attestation requests; providers must attest to each request for verification they receive. If an attestation isn't made in CAQH within a timely manner or if a DVF isn't signed, dated, and returned every quarter, the provider may be removed from our provider directory until they update and/or attest that their information is accurate. Removal from the directory won't impact network participation or claim processing. Taking these steps will confirm that all information for contracting and credentialing is correct and help ensure provider directories used by members contain the most current and correct information about your practice.

The following changes may require reconsideration for continued participation of a currently contracted provider, immediate termination of a contracted provider, review of the initial application by a non-contracted provider, or re-application for participation by a non-contracted provider.

Changes to Practitioner

Practitioners must report to us within 30 days prior to any changes in their practice, including but not limited to:

- Change in practice location
- Change in practice specialty
- Change in hospital privileges
- Change in insurance coverage
- Disciplinary or corrective action by licensing agency, federal agency (DEA, Medicare, Medicaid, State Children's Health Insurance Program, etc.) or peer review committee
- Malpractice claim(s) and/or judgment(s); Indictment, arrest, conviction or moral turpitude
- Adversarial relationship with BlueCross
- Any material change, which affects the practitioner's ability to perform its obligations to members and/or BlueCross; and
- Any material changes to the information submitted to CAQH or on our application for network participation

These types of changes require a new GEF/PEF application and must be reported to us within 30 days prior to:

- Change in practice specialty
- A particular practitioner entering an existing contracted group practice
- Change in tax or group NPI

Changes to Institutions, Ancillary Providers or Group Practices

Institutions, Ancillary Providers, and group practices must report to us within 30 days prior to any changes to their practice via the Provider Change Form located under Provider Change Form, including but not limited to:

- Provider Name
- Provider Type
- Address (Physical, Remit, Corporate or Mailing)
- Telephone or Fax Number

- Tax Identification Number
- Corporate Contact
- State License Number
- Contract Type
- Specialty
- Email Address
- Malpractice claim(s) and/or judgment(s)
- Change in insurance coverage
- Disciplinary or corrective action by licensing agency, federal agency (DEA, Medicare, Medicaid, etc.) or peer review committee. Disciplinary action includes (without Limitation) any change in license status, such as probation or any extraordinary conditions or training mandated by any licensing agency, federal agency or peer review committee beyond those normal educational requirements for all providers to maintain a license.
- Adversarial relationship with BlueCross
- Any material change which affects the organization's ability to perform its obligations to member(s) and/or BlueCross; and
- Any material changes in the information submitted on our application for network application.

In the event of a Change of Ownership or Control (CHOW), including a change to or addition of a tax identification number or NPI, providers are required to adhere to the CHOW policy (see section XXIII/Attachment I of this Provider Manual) and submit a Change of Ownership or Control Notification Form.

We reserve the right to interpret and apply these criteria in our sole discretion and judgment. Any provider adversely affected by our application of these criteria will be entitled to the appropriate appeals process set forth in Provider Dispute Resolution Procedure section of this Provider Manual.

B. Network Participation Criteria

We've established network participation criteria that details the terms and conditions for participation in our provider networks. These terms and conditions will be consistently applied to all providers regardless of participation status.

Our network participation criteria is governed by the Provider Participation Status Committee (PPSC), which evaluates and oversees provider participation and takes appropriate actions that aren't quality of care issues. Quality of care issues are governed by the Clinical Risk Management Committee and the Credentialing Committee.

Network participation criteria apply to any provider who:

- Is a network provider, as defined in the applicable provider network participation agreement with us;
- Is recruited by us;
- Requests participation or re-applies for participation;
- Re-applies following voluntary or involuntary termination of the provider's participation;
- Has a significant change in practice; or
- Has another intervening event or activity, which initiates a re-application and/or reconsideration of the provider's current participation status.

Note: Specific specialty participation requirements for practitioners, institutions and ancillary providers can be found within the Credentialing section of this Provider Manual, and are in addition to and supplement, where applicable, these network participation criteria.

The following are our minimum network participation criteria:

Member Access Standards:

- Agree to provide care to members within BlueCross standards for all networks.
- Demonstrates a practice history, which BlueCross deems consistent and comparable with the provider's ability to comply with these standards.
- Seven-day; 24 hour coverage through participating providers required for all networks
- Medical appointment and wait time standards: refer to Member Access-to-Care section.

- Behavioral Health appointment and wait time standards: refer to Member Access to Behavioral Health section

Credentialing: Ability to pass all credentialing requirements refer to Credentialing section for full details

- Must have a state medical license that's current, valid and unrestricted.
    a. If the provider's medical license is revoked, suspended or not renewed by any jurisdiction for cause - or if the provider voluntarily gives up their license to avoid revocation – they may be considered for participation, at a minimum of one year after the date that the provider's license was re-instated.
    b. If a revocation is still pending or has just started, the provider won't be considered for participation unless the charges are dismissed or resolved and the license remains valid.
- Malpractice insurance – BlueCross requires malpractice coverage in the amounts of not less than $1,000,000 per occurrence and $3,000,000 aggregate.
- Successfully pass site evaluation for PCP and OB/GYN
- Not revoked from a BCBST approved Advocacy program.

Quality Improvement/Utilization Review/Medical Management Program – Refer to Quality Improvement Program section

- Cooperate with our Quality Improvement (QI) and Utilization Management (UM) programs.
- Maintain a QI/UM plan.
- Demonstrate practice style and history, which we deem consistent and comparable with our quality management program standards and practices.
- Meet our acceptable practice pattern analysis performance parameters related to quality of care, patient satisfaction and cost efficiency.

General Provisions:

2. Provider must have a physical practice location or be employed by a group practice that has a physical practice location in Tennessee or Catoosa, Dade, or Walker counties in Georgia.
3. Signed contract for network participation; network participation is dependent on the business needs of BlueCross and its affiliates.
4. Meet member satisfaction standards – based on member complaints, grievances, and satisfaction survey(s).
5. Demonstrate willingness to cooperate with other providers, hospitals, and healthcare facilities.
6. Admitting privileges or an appropriate arrangement as defined by Credentialing with a BlueCross Network Hospital – exception must be approved by the Credentialing Committee.
7. Must have network specific 24-hour coverage.
8. Agree to participate in an exclusive arrangement that's required or negotiated.
9. Satisfactory record on fraud and abuse and billing practices.
10. Must have a valid NPI number.
11. Enrolled in Original Medicare (if participating in Medicare Advantage networks and required by CMS)
12. Practice style consistent with current standards of medical delivery.
13. Prescribing pattern consistent with our quality management program.
14. Abide by the terms of our Provider Dispute Resolution Procedure.
15. Must be actively engaged in our networks at our discretion (Actively engaged means personally rendering services to our members).
16. If a provider has established an adversarial relationship with us, members or participating providers that might reasonably prevent the provider from acting in good faith and in accordance with applicable laws or the requirements of our agreements with that provider, other providers, members, or other parties, the provider may not be considered for initial or continued participation in our networks.

    Such adversarial relationships may include, but aren't limited to:

    - Credible evidence of making defamatory statements about BlueCross;
    - Initiating legal or administrative actions against BlueCross in bad faith;
    - Our prior or pending termination of the provider's participation agreement for cause; and
    - Prior or pending collection actions against members in violation of an applicable hold harmless requirement.

- This participation criteria isn't intended to prevent the provider from fully and fairly discussing all aspects of a patient's medical condition, treatment or coverage (i.e., to "gag" the provider from discussing relevant matters with members).
- Involving members or third parties in disputes with BlueCross prior to receiving a final determination of that dispute in accordance with our Provider Dispute Resolution Procedure may be deemed, however, to constitute an adversarial relationship with us.

17. Provider's network participation agreement hasn't been terminated, for other than administrative reasons, within the past year. Examples of administrative terminations include failure to complete the credentialing/recredentialing process, failure to maintain hospital privileges at a network hospital, or no claims activity in the previous 18 months. For administrative terminations, the provider may reapply when the deficiency is resolved.
18. Providers are subject to restrictions on when they may charge members fees for concierge services, which are defined as "enhanced services or access to services and amenities." We consider concierge services fees to include the fees associated with a practice model under which a provider charges a patient a monthly, annual or periodic fee in exchange for enhanced services that aren't covered under the patient's health benefit plan or a fee before agreeing to provide access to covered services or amenities. We don't cover such concierge services fees.
    - A provider may not charge concierge services fees for a member to access covered services (as defined in our standard contracts, policies and procedures) and/or for standard administrative services, such as referrals, medical record maintenance or returning phone calls. This means a provider may not charge a member an annual fee to join or remain in provider's practice.
    - Provider must be accessible to members consistent with our network participation requirements and ensure that the quality and comprehensiveness of care won't be adversely impacted if a member chooses not to participate in provider's concierge services program.
    - A provider may charge a member concierge services fees only when the concierge services consist of non-covered services for which there are no member benefits.
    - Any requirement or price charged for concierge services by provider must be applied equally to all patients.
    - A member's decision to participate in concierge services must be voluntary and provider may not pressure a member to join.
    - Concierge services fees must comply with all applicable state and federal laws and regulations.
19. Provider or its owner, board member or managing partner has not:
    - Been indicted
    - Been convicted of a crime
    - Committed fraud
    - Been accused or convicted of any offense involving moral turpitude in any jurisdiction; or
    - Been currently excluded from Medicare, Medicaid or Federal Procurement and Non-Procurement Program(s), and/or CMS Preclusion List.
20. Provider must maintain compliance with BCBST Contract Address requirements (refer to BCBST Contract Quick Reference Guide).
21. Accept Electronic Funds Transfer (EFT) for all payments.
22. Electronic Claims Submission required.

Additional criteria for Institutional Providers:

23. Medicare Certification Requirements - Refer to Credentialing section.
24. Accreditation Requirements - Refer to Credentialing section.
25. Hospitals contracted in counties contiguous to our exclusive service area must meet the minimum criteria to justify commercial network participation. Minimum criteria includes but isn't limited to, satisfaction of minimum claim volumes and membership thresholds as well as market impact analysis.

C. Removal of Providers from Our Provider Network

The Provider Participation Status Committee (PPSC) will review and take action on requests for removal of providers from our provider networks including, but not limited to, lack of minimum participation criteria, no malpractice insurance, unacceptable billing practice, pattern of out of network referrals, or providers that have been arrested or indicted, been convicted of a crime, committed fraud or accused or convicted of any offense involving moral turpitude in any jurisdiction, in addition to the other reasons for immediate termination set forth in the Provider's Agreement. If PPSC determines a provider falls within any of these termination reasons, a provider may be immediately terminated from our Networks or we may refuse participation in any of our networks.

The PPSC may also address any breach of contracts that can lead to terminating a network provider.

Providers who do not meet the required criteria may be immediately terminated from network participation or denied participation. Unless otherwise specified in the termination notice, and except as otherwise provided by applicable law, such providers may not be reconsidered for network participation, at our discretion, for a minimum of two years form the date the failed requirement is resolved. In cases involving an arrest or indictment, a provider's initial or continued participation may be denied or considered, at our discretion, unless the charges are dismissed or otherwise resolved in the provider's favor. Providers denied participation in a BlueCross network for reason other than network need may not reapply for participation for a least one year from the date of denial. Providers will be notified of the reason for denial and the applicable timeframe for reapplication, as determined by the Provider Participation Status Committee. This requirement may be waived by BlueCross in its sole discretion.

The PPSC delegated the responsibility for initiating certain administrative terminations to the Provider Network Operations (PNO) Department. Administrative terminations refer to the removal of a provider from the BlueCross provider networks due to compliance-related, or procedural reason. These are immediate terminations. If the PNO staff confirms all BlueCross policies and procedures were followed related to such administrative terminations, notice of termination may be sent to a provider without PPSC review. If the PNO staff identifies unique circumstances that warrant a committee level review, the termination action may be brought to the PPSC. A list of delegated terminations includes, without limitation:

- Loss of License
- Loss of DEA registration, if applicable
- Lack of appropriate malpractice/general liability insurance
- Revoked from a BCBST approved Advocacy program
- Loss of credentialing
- Medicare, Medicaid or SCHIP sanctions
- Retired/deceased/moved out of our exclusive service area
- Excluded from participation in the Medicare/Medicaid and/or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act and 42 CFR 455.101 or otherwise not in good standing with the Division of TennCare
- Debarred from receiving federal contract by the General Services Administration and listed on the System for Award Management (SAM) database
- Debarred or suspended by the Federal Employee Program/Postal Service Health Benefits Office of Personal Management
- No claims activity within 18 consecutive months at our discretion (no claims activity means the provider's NPI doesn't appear on any claims)
- Inclusion on CMS's Opt-Out List (applicable to Medicare Advantage network)
- Inclusion on CMS's Preclusion List
- Not enrolled in Original Medicare (applicable to Medicare Advantage network)
- Lack of a valid NPI
- Deactivated NPI or no NPI

If a provider is removed from our networks, their credentials will be suspended on the effective date of the contract termination. Upon exhaustion of the contract termination appeal process, credentials will be discontinued.

D. Provider Termination Appeal Process

Providers whose network participation has been terminated pursuant to the terms of their contract may be entitled to the procedural remedies set forth below (except as set forth in Quality Improvement Program section or Provider Dispute Resolution Procedure section).

Termination notices sent to providers will include instructions on appealing the termination decision.

All notices concerning network participation contract terminations, whether with cause or without cause, are communicated to the provider according to the provisions in the contract.

Providers (except as set forth in paragraph 3 below) whose network participation has been terminated without cause, may take any dispute concerning this termination to binding arbitration pursuant to Section XI (II)(C) – Provider Dispute Resolution Procedure.

Providers should consult the section on Reporting Corrective Actions (Section XI (D)(IV) concerning our reporting obligations to regulatory agencies.

1. APPEAL: WITH CAUSE TERMINATION OF A PARTICIPATING PROVIDER

a. Reconsideration
   i. The provider may request a reconsideration of our decision by submitting a request in writing within 30 days of the date of the notice of termination. Failure to meet this requirement will result in a waiver of the right to appeal the termination. The PPSC will send a response to the provider after receiving a request for reconsideration.

b. Appeal
   i. If a provider isn't satisfied with our responses to their reconsideration request, they may request an appeal by telephonic hearing. Providers must request in writing a telephonic hearing no later than 14 days after receiving our decision on their request for reconsideration. Failure to meet this requirement will result in a waiver of the right to a telephonic hearing.
   ii. Following receipt of a written request for a telephonic hearing from a provider (pursuant to section 1.b.i), we'll contact them to establish a mutually acceptable date and time for the telephonic hearing, which generally will be conducted within the 30-day period following receipt of the written request. If the provider fails to appear at the hearing without good cause, the right to schedule another hearing is forfeited.
   iii. For Practitioners, telephonic hearings shall be conducted by a panel chosen by BlueCross.
   iv. For institutional and ancillary providers, telephonic hearings shall be conducted by a hearing officer chosen by BlueCross.
   v. Formal rules of evidence or legal procedure will not be applicable during any telephonic hearing.
   vi. In addition to any procedure adopted by the panel/hearing officer for telephonic hearings:
      - The provider has the right to be represented by an attorney or other representative. If the provider elects to be represented, such representation shall be at his or her own expense.
      - The hearing may be recorded by a court reporter at our discretion.
      - The provider and BlueCross must provide the other party with a list of witnesses expected to testify on their respective behalf during the hearing and any documentary evidence that it expects to present during the hearing, as soon as possible following issuance of the notice of hearing. Either party may amend that list at any time (not less than 10 working days) before the date of the hearing.
      - Each party has the right to inspect and request copies of any documentary information that the other party intends to present during the hearing (at the inspecting party's expense) upon reasonable advance notice.
      - During the hearing, each party has the right to call witnesses and cross-examine opposing witnesses.
      - Following the hearing, each party may obtain copies of any record of the hearing, upon payment of the charges for that record.
   vii. The panel/hearing officer will send BlueCross and the provider a written response within 60 days of the date of the telephonic hearing. The decision will be reviewed by the PPSC and our final decision will be sent to the provider.

c. Binding Arbitration

i. If the provider isn't satisfied with our final decision, the next and final step is binding arbitration. The provider may make a written demand that the matter be submitted to binding arbitration (pursuant to Section XI (II) (C) Provider Dispute Resolution Procedure).

2. APPEAL: DENIAL OF APPLICATION

a. Written Appeal
   i. A provider may appeal by submitting a written statement of their position within 30 days of receipt of the notice of the application denial. The written appeal will be reviewed by the PPSC. A written response will be sent to the provider within 60 days of our receipt of the written appeal.

b. Binding Arbitration
   i. If the provider isn't satisfied with the PPSC's decision, the next and final step is binding arbitration. The provider may make a written demand that the matter be submitted to binding arbitration (pursuant to Section XI (II) (C), Provider Dispute Resolution Procedure).

3. APPEAL: TERMINATION BY A PARTICIPATING PHYSICIAN IN MEDICARE ADVANTAGE NETWORKS

a. Physicians terminated with or without cause from our Medicare Advantage networks will be afforded the procedural rights set forth in subsection 1 above.

E. Federal Exclusion Screening Requirements

The following definitions apply for the purpose of the Exclusion Screening Requirements:

- Exclusion Lists
  - The U.S. Department of Health and Human Services' Office of Inspector General's List of Excluded Individuals/Entities (LEIE) and the General Services Administration's (GSA) System for Award Management (SAM) and applicable state Medicaid exclusion list.
- Ineligible Persons
  - Any individual or entity who:
    - Is excluded, debarred, suspended or otherwise ineligible to participate in federal healthcare programs or in federal procurement or non-procurement programs (as of the date such exclusion lists are accessed by the provider); or
    - Has been convicted of a criminal offense that falls within the ambit of 42 U.S.C. § 1320(a)-7(a), but hasn't yet been excluded, debarred, suspended or otherwise declared ineligible.

Providers are reminded of their obligation to screen all employees, agents, and contractors (Exclusion Screening Process) against the Exclusion Lists. They also need to conduct criminal background checks and registry checks and exclusion checks in accordance with federal and state laws and regulations to determine whether any employees, agents, and contractors have been determined to be Ineligible Persons (making them excluded from participation in the Medicare or Medicaid programs). At minimum, registry checks must include a check of the Tennessee Abuse Registry, Tennessee Felony Offender Registry, National and Tennessee Sexual Offender Registry. The screenings should be conducted prior to hiring employees or contracting with individuals and entities, and monthly thereafter. Providers are also required to have employees and contractors disclose whether they're Ineligible Persons prior to providing any services on behalf of the provider. The Exclusion Screening Process is a CMS requirement and a condition of the provider's enrollment as a BlueCross provider and is also a continuing obligation during contractual term.

Providers and their subcontractors must comply with all federal requirements (42 CFR § 1002) on exclusion and debarment screenings. Provider entities that bill and/or receive federal funds must screen their owners, board members, agents and employees against the Exclusion Lists. Any unallowable funds made to excluded individuals as full or partial wages and/or benefits must be refunded to and/or recouped by BlueCross.

BlueCross providers must immediately report any exclusion information discovered. (See Introduction section for a listing of appropriate contact numbers.)

If a provider determines that an owner, board member, employee or contractor is an Ineligible Person, they'll need to take the appropriate action to remove the owner, board member, employee or contractor from responsibility for, or involvement with the provider's operations related to federal healthcare programs. In such event, the provider must take all appropriate actions to ensure that the responsibilities of such owner, board

member, employee or contractor haven't and won't adversely affect the quality of care rendered to any BlueCross member of any federal healthcare program.

EXCLUDED PROVIDER

If we discover a provider has been excluded, precluded, or debarred, we'll remove the provider from all our participating networks in accordance with the administrative termination provisions in Section D.

EXCLUDED PRACTITIONER IN A GROUP

If we discover a practitioner who is the owner of a group practice is excluded, precluded, or debarred, we'll remove the group from all our participating networks in accordance with the administrative termination provisions in Section D.

If we discover a practitioner who is part of a group practice is excluded, precluded, or debarred, we'll remove that practitioner from all our participating networks in accordance with the administrative termination provisions in Section D.

A provider may present documentation to support that the practitioner wasn't hired or affiliated with them on or after the exclusion effective date for us to adjust the claims recovery period. In addition to the supporting documentation, an attestation must be obtained from BlueCross to indicate the dates that practitioner was employed by or associated with the provider. The supporting documentation and attestation must be received within 30 days of the date of the termination notice.

EXCLUDED OWNER, BOARD MEMBER, OR EMPLOYEE

If we discover that an owner, board member, or employee of a provider has been excluded, we'll remove the provider from all our participating networks in accordance with the administrative termination provisions in Section D.

A provider may present documentation to support that the owner, board member, or employee wasn't hired or affiliated with them on or after the exclusion effective date for us to adjust the claims recovery period. In addition to the supporting documentation, an attestation must be obtained from BlueCross to indicate the dates that the owner, board member, employee or contractor was employed by or associated with the provider. The supporting documentation and attestation must be received by BlueCross within 30 days of the date of the termination notice.

RECOUPMENT OF CLAIMS PAID TO OR FOR THE BENEFIT OF EXCLUDED PROVIDERS

If a provider or group is removed from our participating networks under this section as an excluded provider, we'll reprocess claims for all dates of service after the exclusion effective date. Some plans or products prohibit payment to excluded providers; BlueCross will recover any payments for these plans or products previously made to or for the benefit of an excluded provider during the exclusion period.

If the excluded provider is the owner of a group, claims for the group are not eligible for payment, and BlueCross will recover any payments for these plans or products previously made to the group during the exclusion period.

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XIV. BLUECARD® PROGRAM

The BlueCard Program links participating healthcare providers and the independent BlueCross and/or BlueShield plans across the country and around the world through a single electronic network for claims processing and reimbursement.

The BlueCard Program also allows members away from (traveling or living) their Home Plan's* service area to receive medical care from participating providers wherever services may be required, and, in many instances, to receive the same level of benefits they would receive if the services were rendered in their Home Plan's service area.

The program allows providers to submit claims for BlueCross and/or BlueShield plan members from other BlueCross and BlueShield plans, including international BlueCross and BlueShield plans, directly to the provider's local plan (Host Plan)**. That plan will be the provider's contact for claims filing, claims payment, adjustments, inquiries, and problem resolution.

*Home Plan is the plan that "owns" the member's coverage

**Host Plan is the practitioner's local BlueCross BlueShield Plan – for Tennessee practitioner's treating members of other Blue Plans, it's BlueCross BlueShield of Tennessee.

A. How the Program Works

- A BlueCross and/or BlueShield member is outside their Home Plan's service area and needs health care services.
- The member locates a participating provider* by calling the BlueCard Provider Finder at **1-800-810-BLUE (2583)** or by accessing the BlueCard Provider Finder website at: www.bcbs.com/healthtravel/finder.html.
- The member presents their BlueCross and/or BlueShield ID card. The member's identification number should begin with a three-character alpha prefix, which may only contain alpha characters or a combination of alpha and numerical characters.
- The provider should verify the member's eligibility and benefits by calling BlueCard Eligibility at **1-800-676-BLUE (2583)**, the member service number on the back of the member's ID card, or online via the secure Availity ® link at www.bcbst.com.
  - If you're not registered, go to http://Availity.com and click on "**Register**" in the upper right corner of the home page, select "**Providers**", click "**Register"** and follow the instructions in the Availity registration wizard. (See subsection B. "How to Identify a BlueCard member" to determine the member's BlueCross BlueShield Plan.) Note: A BlueCard member's coverage and utilization management requirements may differ from those of BlueCross BlueShield of Tennessee. The facility is responsible for obtaining any necessary inpatient prior authorizations; however, the practitioner may elect to confirm a prior authorization has been obtained. See subsection L. "Prior Authorization Requirements").
- If services are rendered in Tennessee, the provider should submit claims to BlueCross BlueShield of Tennessee. If services are rendered outside of Tennessee by a contiguous provider who may be participating with BlueCross BlueShield of Tennessee, the claim should be filed to the provider's local plan (state where services are rendered). If the services are rendered in one of the three overlapping service areas located in Georgia (Walker, Catoosa, or Dade County), and the member isn't an Anthem member, the claim should be filed to BlueCross BlueShield of Tennessee. If the services are rendered in one of the three overlapping service areas located in Georgia (Walker, Catoosa, or Dade County), and the member is an Anthem member, the claim should be filed to Anthem Georgia.
- BlueCross BlueShield of Tennessee will electronically forward the claim to the member's Home Plan with the provider's network participation status and the maximum allowable based on the provider's agreement with BlueCross BlueShield of Tennessee.
- The member's Home Plan will determine the benefits provided based on their eligibility, contract provisions, the provider's network status, and the maximum allowable. The Home Plan will transmit the finalized adjudication information back to BlueCross BlueShield of Tennessee (e.g., reason for denial, amount applied to deductible, amount paid, etc.).

- BlueCross BlueShield of Tennessee will notify the provider via the Explanation of Payment (EOP) of the final adjudication results.
- The member's Home Plan will notify them of their benefits via a claim summary (sometimes called an Explanation of Benefits).

*If the member receives services from a non-participating provider, the member is responsible for:

- Paying the charges at the time the services are rendered;
- Submitting the claim to BlueCross BlueShield of Tennessee; and
- Any amounts not paid by their benefit plan, including amounts exceeding the maximum allowable.

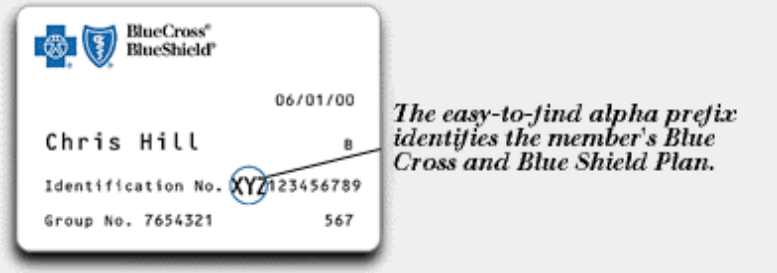
B. How to Identify a BlueCard Member

BlueCard members will carry BlueCross and/or BlueShield identification cards that include one or more of the following identifiers:

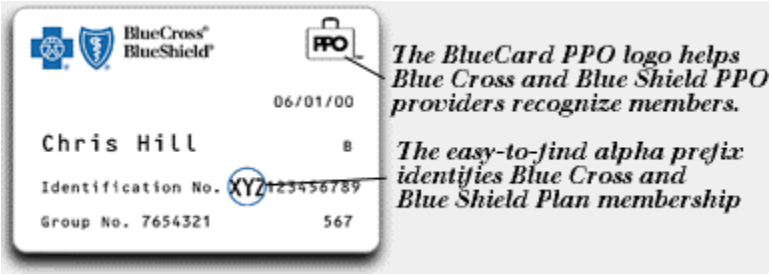
- Subscriber identification number begins with an alpha-prefix, which may only contain alpha characters or a combination of alpha and numerical characters.
- Suitcase icon (empty or PPO inside)
- Member's plan name other than BlueCross BlueShield of Tennessee reflected on the back the of ID card

Sample copies of the BlueCard ID cards below:

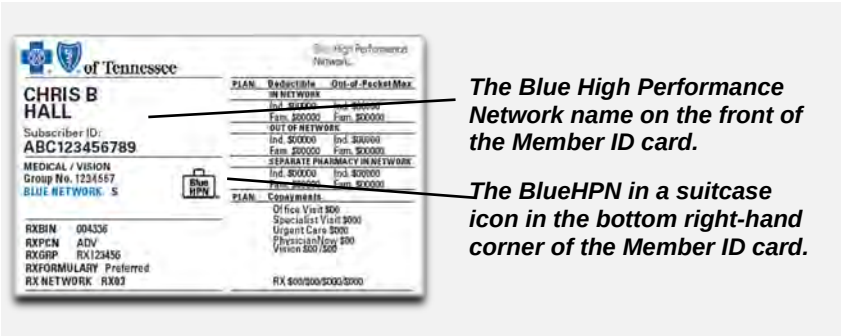
BlueCard Traditional ID Card



BlueCard PPO ID Card



BlueHPN ID Card



C. BlueCard Traditional

- BlueCard Traditional members have identification cards with either no suitcase icon or an empty suitcase icon.
- They're often required to use a participating provider within their Home Plan's service area. Therefore, providers should verify the level of benefits (in-network vs. out-of-network) they'll receive for services provided these members.
- For dates of service prior to Jan. 1, 2009, the maximum allowable was based on Blue Network C. For dates of service Jan. 1, 2009, and after, the maximum allowable is based on Blue Network P.

D. Blue High Performance Network (BlueHPN)

- Benefits are provided at the in-network level (if the provider is participating in the local BlueCross and/or BlueShield's designated BlueHPN Network.
- BlueHPN Network members don't have access to a Wrap Network in Tennessee.
- The maximum allowable is based on Blue Network S.

E. BlueCard PPO

- BlueCard PPO members have identification cards with PPO inside the suitcase icon.
- Benefits are provided at the in-network level if the provider is participating in the local BlueCross and/or BlueShield Plan's BlueCard PPO Network.
- The maximum allowable is based on Blue Network P.

F. BlueCard Alternative PPO Network

- Alternative PPO Network members have identification cards that include the local BlueCross and/or BlueShield's alternative PPO Network name listed.
- Benefits are provided at the in-network level if the provider is participating in the local BlueCross and/or BlueShield's designated Alternative PPO Network.
- Alternative PPO Network members don't have access to a Wrap Network.
- The maximum allowable is based on Blue Network S.

G. Medicare Advantage Private-Fee-for-Service (PFFS)

The Medicare PFFS plan is offered by an organization that pays physicians and providers on a fee-for-service basis. This isn't a specific network that providers sign up for to service PFFS members. Members can obtain services from any licensed physician or provider in the United States who is qualified to be paid by Medicare and accepts the plan's terms of payment.

The maximum allowable for covered services will be equivalent to the current Medicare payment amount.

Please refer to the member identification card for instructions on how to access terms and conditions. Providers may also locate this information at http://www.bcbst.com/providers/BenefitHighlights.shtml.

H. Medicare Advantage PPO

Effective Jan. 1, 2010, Medicare Advantage PPO network sharing is available in all Centers for Medicare & Medicaid Services (CMS)-approved Medicare Advantage PPO (MAPPO) BlueCross and/or BlueShield Plans local service areas.

This network sharing allows MA PPO members from Blue Plans to obtain in-network benefits when traveling or living in the service areas of other plans if the member receives care from a contracted MA PPO provider.

The maximum allowable is based on the Blue Advantage PPO Network. If you aren't a contracted Blue Advantage PPO Network Provider and you provide services for any Blue Medicare Advantage out-of-area member, the maximum allowable will be based on the Medicare allowed amount for covered services.

I. BlueCard Claim Filing

Claims for the following services should be submitted to BlueCross BlueShield of Tennessee unless the provider contracts directly with the member's Home Plan:

- Medical services (including secondary claims)
- Routine hearing and vision

Claims for the following services should be submitted directly to the member's Home Plan:

- Stand-alone dental
- Prescription drug

Effective Oct. 14, 2012 all Blue Plans implemented new claims filing procedures for **ancillary providers. It's very important that all providers understand the impact of this change.**

File a claim for an ancillary provider as outlined below:

- **Independent Clinical Lab** – Lab providers should file claims to the Blue Plan in the state the specimen was drawn, which will be determined by which state the referring provider is located.
- **Durable Medical Equipment (DME)/Home Medical Equipment (HME**) – DME/HME providers should file claims to the Blue Plan in the state the equipment was shipped or purchased at a retail store.
- **Specialty Pharmacy** –Specialty pharmacies should file the claim to the Blue Plan in the state the ordering physician is located.
- **Home Infusion Therapy (HIT)** – HIT claims should be filed to the Plan in whose service area the member's home, or equivalent setting, is located as this is where services were rendered.

Overlapping Service Area

An overlapping service area is formed when multiple plans share the same service area.

Effective Nov. 1, 2022, we entered an overlapping service area for the following three Georgia counties – Walker, Catoosa, and Dade. Our service area includes the state of Tennessee and Walker, Catoosa and Dade counties in Georgia.

If the provider and member's plan are in an overlapping servicing area, the claim must be filed to the member's plan. Each plan can't host each other's members (Anthem can't accept a claim for a Tennessee member for these three counties and we can't accept a claim for an Anthem member within these three counties.)

Image Analysis by Providers

File to Tennessee if provider who is performing the analysis or interpretation of the image is sitting in Tennessee/overlapping service area when reading the image.

Contiguous Providers

A contiguous area is generally a border county in another plan's service area that's the greater of one county over or a Metropolitan Statistical Area (MSA) from the plan's own service area.

Note: Contiguous county and overlapping service area providers should file claims according to these guidelines regardless of network status.

If a provider contracts with more than one Blue plan in a state for the same product type (i.e., PPO or Traditional), the provider should file based on the member and where services were rendered:

File to Tennessee if:

- BlueCross BlueShield of Tennessee member – Tennessee provider or contiguous provider - contracted with both plans
- BlueCross BlueShield of Tennessee member – overlapping service area county provider. Note: It doesn't matter if the provider is contracted with both BlueCross BlueShield of Tennessee and Anthem Georgia. The claim should be filed to Tennessee
- Host member – Tennessee provider contracts with Tennessee and services were in Tennessee
- Non-Anthem host member – overlapping service area county provider – provider contracts with BlueCross BlueShield of Tennessee

File to Georgia if:

- Non-Anthem host member – overlapping service area county provider – provider doesn't contract with BlueCross BlueShield of Tennessee but is contracted with Anthem Georgia
- Anthem host member – overlapping service area county provider
- Host member services were rendered outside of Tennessee and out of the overlapping service area, even if the provider is contracted with Tennessee (e.g., Whitfield, Chattooga counties), claim should be filed where services were rendered
    - Contiguous county doesn't apply for host members. These claims would be considered out of state.
        - Example: Provider is located in Dalton, GA. Whitfield County is contiguous to BlueCross BlueShield of Tennessee. However, this is a host member and the claim should be filed to Anthem Georgia.

File to either plan if:

- Non-Anthem host member - overlapping service area county provider – par or non-par with both BlueCross BlueShield of Tennessee and Anthem Georgia

File to the provider's local plan (where services were rendered) if:

- Host member services were rendered outside of Tennessee and out of the overlapping service area, even if the provider is contracted with Tennessee (e.g., Jackson County (Alabama), Crittenden County (Arkansas)), claim should be filed where services were rendered
    - Contiguous county doesn't apply for host members. These claims would be considered out of state. Example: Provider is located in Crittenden County in Arkansas. Crittenden County is contiguous to BlueCross BlueShield of Tennessee. However, this is a host member, and the claim should be filed to Arkansas Blue Cross and Blue Shield.

Providers using outside vendors to provide services (sending blood specimen for special analysis that can't be done by the lab where the specimen was drawn) should use the in-network participating ancillary providers to reduce the possibility of additional member liability for covered benefits. A list of in-network participating providers may be obtained by contacting your Provider Network Manager (See Section II. BlueCross BlueShield of Tennessee Quick Reference Guide in this Manual) or by calling BlueCard at **1-800-705-0391**.

Claims should be filed with the identification number as it appears on the member's ID card, omitting any dashes or spaces within the identification number. Additionally, Ancillary provider claims must include the name of the referring physician, or the claim will be rejected.

When submitting electronically, follow the guidelines found in this Manual (Section VI. Billing and Reimbursement – Filing Electronic Claims). If you have questions about electronic claims filing, call our eBusiness Solutions line at **(423) 535-5717**.

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

When submitting paper claims, mail to:

BlueCross BlueShield of Tennessee
Claims Service Center
1 Cameron Hill Circle, Ste 0002
Chattanooga, TN 37401-0002

When submitting paper claims for secondary benefits (secondary to a commercial carrier or Medicare), please include the primary carrier's Explanation of Payment.

J. BlueCard and Medicare Crossover Claims

Each BlueCross and/or BlueShield Plan independently contracts with CMS for crossover claims, and only the member's plan can accept crossover claims.

Since the CMS Coordination of Benefits Agreement allows insurance carriers to select which claims cross over automatically, providers may see some variation in crossover processes, (i.e., type of bill, Provider location state, Medicare Administrative Contractor for Jurisdiction C (DME MAC), and Medicare payment versus beneficiary liability) among the BlueCross and/or BlueShield Plans.

Providers are encouraged to review their Medicare Summary Notice (MSN) to determine if Medicare crossed over a specific claim to the member's Home Plan. If the MSN indicates the claim was crossed over, the member's Home Plan will process the claim directly. If the MSN doesn't indicate a claim cross over, and the services were rendered in Tennessee or an overlapping services area, the provider should file the claim as indicated in the "How to File a Claim" section. If services were rendered outside of Tennessee or overlapping service area, the claim should be filed to Plan in which services were done, which is the provider's local plan.

Providers may request a status update for Medicare crossover claims in Availity.

K. BlueCard Program Reimbursement

BlueCross BlueShield of Tennessee will reimburse providers for BlueCard Program claims submitted according to BlueCross BlueShield of Tennessee claims filing guidelines when:

- The member is eligible for benefits.
- The services are covered under the member's plan.*
- The provider hasn't already been paid for the services.

*The Home Plan determines what services are considered eligible under the member's plan including all medical policy determinations (e.g., medical necessity, investigational, routine, etc.).

L. Medical Records

BlueCross BlueShield of Tennessee will forward requests for medical information and/or copies of records as requested by the member's Home Plan. The medical information and/or records should be returned to BlueCross BlueShield of Tennessee as quickly as possible to reduce any delays in claims processing. We want to service you as efficiently as possible, so please submit medical records using the following guidelines:

- Submit any request letters from us as the first page of your medical record.
- Providers are encouraged to fax the requested information to the number listed on the request letter. This allows for direct storage into our image repository.
- Submit only the requested information.
- Claim copies aren't necessary when submitting requested medical records. Any claim copies submitted must be behind the medical record. If attached to the front, it'll be mistaken for a claim needing adjudication rather than a medical record needing review.

Note: Medical record requests are based on the Home Plan's medical policies and may differ from those of BlueCross BlueShield of Tennessee.

M. Prior Authorization Requirements

Each BlueCross and/or BlueShield Plan determines its medical policies related to prior authorization requirements. Home Plans may require prior authorization based on the type of service or location of service. The services requiring prior authorization may vary from those determined by BlueCross BlueShield of Tennessee.

Providers may elect to verify any prior authorization requirements via telephone or by utilizing Availity.

N. Inquiries

The following grid lists examples of specific inquiries and provides direction to the appropriate contact:

Inquiry	Contact	Description
Verification of eligibility/benefits	Home Plan	**1-800-676-BLUE (2583)** or by accessing BlueCard within Availity
Prior Authorizations	Home Plan	See back of member's ID card
Electronic claims submissions	Host Plan (BlueCross BlueShield of Tennessee)	eBusiness Solutions **(423) 535-5717**
General questions	Host Plan (BlueCross BlueShield of Tennessee)	BlueCard Host Service **1-800-705-0391**
Processed claims	Host Plan (BlueCross BlueShield of Tennessee)	BlueCard Host Service **1-800-705-0391**
Status requests	Host Plan (BlueCross BlueShield of Tennessee)	BlueCard Host Service **1-800-705-0391** or by accessing BlueCard in Availity
Claim rejected "Home Plan will handle direct"	Home Plan	Customer service number located on the back of the member's ID card
Claim rejected "Additional information needed"	Host Plan (BlueCross BlueShield of Tennessee)	BlueCard Host Service **1-800-705-0391**
Overpayments	Host Plan (BlueCross BlueShield of Tennessee)	BlueCard Host Service **1-800-705-0391**
Appeals	Host Plan (BlueCross BlueShield of Tennessee)	Follow guidelines found in this Manual (Section XIII. Provider Dispute Resolution Procedure)

If you have questions about the BlueCard Program, call our BlueCard Service Department at **1-800-705-0391**.

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XV. VISION CARE

A. VisionBlue

VisionBlue is a network-based routine vision care product offered in partnership with EyeMed Vision Care.

Benefits for services due to illness or injury aren't covered under this routine vision plan. However, the member's medical plan may include benefits for those services.

The following ID card identifies a members also subscribing to vision coverage:

Front

Back

Providers holding a contract with EyeMed provide services at the in-network benefit level and file claims directly with EyeMed. Members who seek services from out-of-network providers (those not having a contract with EyeMed) must file their claim directly to EyeMed to receive the out-of-network benefits.

The following summary of benefits reflects examples of standard vision benefits offered by BlueCross BlueShield of Tennessee. **Benefits vary plan by plan, therefore, providers should always check eligibility and benefits prior to rendering services**.

Vision Summary of Benefits

Benefit	In-Network Member Cost	Out-of-Network Reimbursement	Benefit Frequency
Vision Examination			
Comprehensive Eye Exam	$0, $10, $20 or $25 copay	up to $35	One exam within a 12-month period For each member covered under the plan
Plans with materials coverage also include benefits listed below			
Contact Lenses Fit and Follow-Up			One exam within a 12-month period for each member covered under the plan
Standard	$40 or $55 copay	up to $0	
Premium	10% off retail	up to $0	
Vision Materials			
Standard Plastic Lenses			One set of lenses within a 12-month period For each member covered under the plan

Benefit	In-Network Member Cost	Out-of-Network Reimbursement	Benefit Frequency
Single vision	$0, $10 or $25 copay	up to $30	
Bifocal	$0, $10 or $25 copay	up to $45	
Trifocal	$0, $10 or $25 copay	up to $60	
Frames	$0 copay up to ($100 - $250) allowance, 20% off balance over allowance	Up to 50% of In-Network allowance	One pair of frames within a 12- or 24- month period for each member covered under the plan
Contacts			One set of lenses within a 12-month period for each member covered under the plan (instead of eyeglass lenses)
Conventional	$0 copay up to ($100 - $250) allowance, 15% off balance over allowance	Out of network up to 80% of In-Network allowance	
Disposable	$0 copay up to ($100 - $250) allowance	Out of network up to 80% of In-Network allowance	
Medically Necessary	Paid in Full	Up to $200	
Lens Options			One set of lenses within a 12-month period for each member covered under the plan
Standard Polycarbonate	$40 copay	Up to $0	
Standard Polycarbonate (For covered Dependent children under 19 years of age)	$0 copay	Up to $5	
UV Treatment	$15 copay	Up to $0	
Tint	$15 copay	Up to $0	
Standard Plastic Scratch Coating	$15 copay	Up to $0	
Standard Progressive Lenses (add on to Bifocal)	$65 copay	Up to $45	

Benefit	In-Network Member Cost	Out-of-Network Reimbursement	Benefit Frequency
Premium Progressive Lenses (add on to Bifocal)	$65 copay, 20% off retail price less $120 allowance **or** fixed tiered price list	Up to $45	
Standard Anti-Reflective Coating	$45 copay	Up to $0	

Note:

- This document serves as a summary of the benefits that are detailed in the member's evidence of coverage. These benefits are subject to the covered services, exclusions from covered services, and schedule of benefits sections of the member's evidence of coverage.
- Members with diabetes may be eligible for additional services detailed in the schedule of benefits section of the evidence of coverage.
- Members may see any vision care provider. However, contracted providers in our network have agreed to limit certain charges and provide additional discounts once the allowance has been reached. Members are responsible for all charges that exceed the out-of-network reimbursement.

Vision Frequently Asked Questions

Why was EyeMed Vision Care chosen to administer the BlueCross Vision product?

By choosing EyeMed, we're able to allow members a variety of private practitioners, as well as retail outlets.

Will I submit Vision claims to BlueCross or EyeMed?

To determine if claims should be submitted to BlueCross or EyeMed, simply flip the member's card over.

If it's a VisionBlue member, the back of the card will read "Vision: EYEMED **1-877-342-0737**." All other vision claims should be sent to BlueCross. In addition, if a claim is sent to BlueCross in error, it'll be returned to the provider with instructions to resubmit to EyeMed.

How can I contact EyeMed directly?

EyeMed has dedicated a customer service line for our members and providers. The number to call is **1-877-342-0737**.

Who do I contact to verify eligibility and check claim status for members that have routine benefits provided through EyeMed?

You'll need to contact EyeMed Customer Service at **1-877-342-0737.**

If the services rendered are medical and not considered routine, where should I submit the claim?

Claims of medical services should be filed directly to the member's medical insurance carrier.

I'm interested in becoming a provider with EyeMed. Who should I contact?

You'll need to contact EyeMed directly by calling **1-877-342-0737**.

B. Essential Health Benefits (EHB) Medical Plan

Our new Health Care Reform plans have pediatric vision benefits built into the medical plan. The Affordable Care Act (ACA) mandates certain additional services be covered, including, but not limited to pediatric vision care services for members under 19 years of age.

A sample copy of the EHB ID card is below:

Adults aren't covered for vision services under the EHB medical plan. Adult coverage is available as a separate vision supplemental plan providing coverage to individuals 19 years and older. Benefits vary; so providers should always check eligibility and benefits prior to rendering services.

A sample copy of a Vision Supplemental plan ID card is below:

Essential Health Benefits Medically Necessary and Appropriate Routine Vision Care Services

Covered Services

- Routine vision services, including services and supplies to detect or correct refractive errors of the eyes.

Limitations

- Vision exams are covered once every annual benefit period.
- Eyeglass frames are covered once every annual benefit period.
- Eyeglass lenses or contact lenses are covered once every annual benefit period.
- Prescription sunglasses are handled as any other lens.
- Benefits aren't available more frequently than specified in Attachment C: Schedule of Benefits.
- Discounts don't apply for benefits provided by other group benefit plans or promotional offers.

Exclusions:

- Medical and/or surgical treatment of the eye(s), or supporting structure, including surgeries to detect or correct refractive errors of the eyes.
- Eye exercises and/or therapy.
- Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses.
- Charges for lenses and frames ordered while insured but not delivered within 60 days after Coverage is terminated, or vision testing exams that occur after the date of termination.
- Charges for photosensitive, anti-reflective or other optional charges when the charge exceeds the amount allowable for regular lenses.
- Charges filed for procedures determined by the plan to be special or unusual, (i.e. orthoptics, vision training, subnormal vision aids, aniseikonic lenses, tonography, corneal refractive therapy, etc.)

- Charges for lenses that don't meet the Z80.1 or Z80.2 standards of the American National Standards Institute.
- Charges more than of the covered benefit established by the plan.
- Oversized lenses.
- Corrected eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the plan.
- Non-prescription lenses and frames, and non-prescription sunglasses (except for 20% discount).
- Services or materials provided by any other group benefit providing vision care.
- Two pairs of glasses instead of bifocals.
- Charges for replacement of broken, lost, or stolen lenses, contact lenses, or frames.
- Charges for services or materials from an Ophthalmologist, Optometrist or Optician acting outside the scope of their license.
- Charges for any additional service required outside basic vision analyses for contact lenses, except fitting fees.

The EHB Summary of Benefits can be viewed below:

EHB Pediatric Vision		
Benefit	**EyeMed Network**	**Out-of-Network**
Exam with Dilation as necessary	$0 Copayment	Not Covered
Contact Lens Fit and Follow-Up:		
(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)		
Standard Contact Lens fit and follow-up:	$0 Copayment	Not Covered
Premium Contact Lens fit and follow-up:	$0 Copayment	Not Covered
Frames:		
Designated available frame at provider location	100% Coverage for provider designated frames	Not Covered
Standard Lenses (Glass or Plastic):		
Single vision	$0 Copayment	Not Covered
Bifocal	$0 Copayment	Not Covered
Trifocal	$0 Copayment	Not Covered
Lenticular	$0 Copayment	Not Covered
Standard progressive lens	$0 Copayment	Not Covered

EHB Pediatric Vision		
Benefit	**EyeMed Network**	**Out-of-Network**
Lens Options:		
UV treatment	$0 Copayment	Not Covered
Tint (fashion, gradient & glass-grey)	$0 Copayment	Not Covered
Standard plastic scratch coating	$0 Copayment	Not Covered
Standard polycarbonate	$0 Copayment	Not Covered
Photochromic/transitions plastic	$0 Copayment	Not Covered
Standard polycarbonate	$0 Copayment	Not Covered
Photochromic/transitions plastic	$0 Copayment	Not Covered
Contact Lenses:		
(Contact lens includes materials only)	100% Coverage for Provider designated contact lenses	
Extended wear and extended wear disposables	Up to six months supply of monthly or two week disposable, single vision spherical or toric contact lenses	Not Covered
Daily wear/disposables	Up to three months supply of daily disposable, single vision spherical contact lenses	Not Covered

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XVI. DENTAL PROGRAM

Note: We've written policies and procedures for both the initial and re-credentialing process of practitioners and organizational providers. Dentists must be able to meet these credentialing and re-credentialing requirements. For questions, see Section XIV. Credentialing, in this manual.

A. Standard Dental Covered Services and Limitations

The standard Dental Program provides a wide range of benefits to cover most services associated with dental care.

If more than one procedure or course of treatment can be used to accomplish the same treatment goal, meets generally accepted standards of professional dental care, and offers a favorable prognosis for the patient's condition, then benefits may be based on the lowest cost procedure or treatment. This will be at our sole discretion.

If a member transfers from the care of one dentist to another during treatment, or if more than one dentist renders services for one dental procedure, benefits won't exceed those that would have been provided had one dentist rendered the service. Benefits won't be paid for incomplete treatment.

The examples of covered services listed below are intended to be a summary of our standard benefits. Coverage can vary from contract to contract. We encourage you to always review the member's specific benefits prior to rendering services.

Exams

Covered

Two periodic exams in any 12 month period. One limited oral evaluation in any 12-month period. One comprehensive, detailed/extensive, or periodontal exam in any 36- month period.

X-Rays

Covered:

One full mouth set of x-rays in any 36-month period. A full mouth set of x-rays is defined as either an intraoral complete series or panoramic x-ray. Benefits provided for either include benefits for all necessary intraoral and bitewing films taken on the same day. Up to four bitewing films in any 12-month period. All bitewing films must be taken on the same date of service.

Exclusions:

Extraoral, skull and bone survey, sialography, temporomandibular joint dysfunction (TMJ), and tomographic survey x-ray films, cephalometric films, diagnostic photographs and cone beam CT capture, unless otherwise stated in this Dental EOC.

Cleanings, Fluoride Treatment

Covered

Two prophylaxis in any 12-month period, except when replaced as described below in Basic Periodontics. One fluoride treatment in any 12-month period for members 18 and under.

Sealants, Space Maintainers

Covered

One sealant or preventive resin restoration per lifetime on first and second permanent molars for members 15 and under. Space maintainers for members 13 and under. One recementation per space maintainer in any 12-month period.

Basic Restorative Services

Covered

One amalgam or resin restoration per tooth surface in any 12-month period. Replacement of existing amalgam and resin composite restorations are covered only after 12-months from the date of the initial restoration. Stainless steel crowns. Replacement of stainless steel crowns is covered after 36-months from the date of the initial restoration. One sealant, preventive resin restoration, or resin infiltration per first or second permanent molar tooth per lifetime, for members 15 and under. Sealant/preventive resins are subject to additional limitations listed under Preventive Services, and may be subject to a different coverage level under Attachment C: Schedule of Benefits. Palliative (emergency) treatment for the relief of pain. One repair per denture in any 24-month period. General anesthesia or intravenous (IV) sedation in connection with major oral surgery procedures and implants when provided by a dentist licensed to administer such agents.

Exclusions

Gold foil restorations.

Major Restorative Services – Single Tooth Restoration

Covered

Crowns, inlays and onlays only for the treatment of severe carious lesions or severe fracture on permanent teeth, and only when teeth can't be adequately restored with an amalgam or resin composite restoration (filling).Replacement of single tooth restorations or fixed partial dentures (bridges) after 60-months from the date of the initial placement. Veneers for anterior permanent teeth.

Exclusions

Provisional restorations and crowns. Crowns, inlays, onlays or laminate veneers for members 11 and under.

Prosthodontic Services – Fixed Bridges

Covered

Fixed partial dentures (bridges), including pontics, retainers, and abutment crowns, inlays, and onlays (resin, porcelain, ¾ and full cast) for permanent teeth only. Replacement of fixed partial dentures or single tooth restorations after 60-months from the date of the initial placement.

Exclusions

Provisional or interim restorations. Bridges for members 15 and under.

Prosthodontic Services – Removable Dentures

Covered

Complete, immediate and partial dentures using standard techniques and materials determined by the plan. Personalized restorations, special techniques or materials are covered up to the amount allowed for standard techniques and materials. Replacement of removable dentures after 60-months from the date of the initial placement.

Exclusions

Interim (temporary) dentures. Dentures for members 15 and under.

Other Major Restorative & Prosthodontic Services

Covered

Core build-up covered separately from restoration only in circumstances where benefits are provided because severe carious lesions or fractures are so extensive that retention of the restoration wouldn't be possible. Crown inlay, onlay, veneer and bridge repair and re-cementation after 12-months from the date of the initial placement. One denture adjustment in any 6-month period and only after 6-months from the

date of the initial placement. One denture re-line, rebase, or tissue conditioning in any 36-month period. One implant per tooth per lifetime. One bone graft for implant per tooth per lifetime. One implant debridement per tooth per lifetime. Initial placement or replacement of implant supported prosthesis after 60 months from the date of any corresponding major restoration.

Exclusions

Provisional and interim restorations. Other major restorative services including protective restoration and coping. Other prosthodontic services including overdenture, precision attachments, connector bars, stress breakers and coping metal. Crown preparation, temporary or prefabricated crowns, impressions and cementation. Post and core services not performed in conjunction with a covered crown or bridge.

Basic Endodontics

Covered

Pulpotomy, pulpal therapy for primary teeth but not when performed in conjunction with major endodontic treatment.

Exclusions

Pulpal debridement. Pulp vitality tests. Protective restorations.

Major Endodontics

Covered

One root canal treatment (root canal, re-treatment, apexification, pulpal regeneration, hemisection, pulp cap or root amputation) per tooth in any 60-month period. One apicoectomy per root per lifetime. Retrograde filling if done on same date of service as apicoectomy.

Exclusions

Guided tissue regeneration. Intentional re-implantation (including necessary splinting). Canal preparation. Incomplete endodontic therapy. Pulp vitality test. Protective restorations.

Basic Periodontics

Covered

One periodontal scaling and root planing per quadrant in any 24- month period. One full mouth debridement per lifetime. Periodontal maintenance no sooner than 90 days after completion of any one of the Basic Periodontic covered services above. Periodontal maintenance will replace a prophylaxis or scaling. Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth, once per lifetime. Scaling will replace a prophylaxis or periodontal maintenance procedure.

Exclusions

Provisional splinting, antimicrobial medication and dressing changes. Periodontal scaling and root planing, full mouth debridement, periodontal maintenance and prophylaxis when more than one of these procedures is performed on the same date of service.

Major Periodontics

Covered

One major surgical periodontal procedure, including gingivectomy, gingivoplasty, gingival flap procedure or osseous surgery, per quadrant in any 36-month period. One crown lengthening per tooth in any 36-month period. One bone and tissue grafting per site in any 36-month period.

Exclusions

Tissue regeneration and apically positioned flap procedure.

Basic Oral Surgery

Covered: Non-surgical or simple extractions (pulling teeth).

Major Oral Surgery

Covered

Surgical extractions (including removal of impacted teeth), coronectomy, and other oral surgical procedures typically not covered under a medical plan.

Exclusions

Oral surgery typically covered under a medical plan, including but not limited to, excision of lesions and bone tissue, treatment of fractures, suturing, wound and other repair procedures, temporomandibular joint dysfunction (TMJ) and related procedures. Orthognathic surgery and treatment for congenital malformations. Harvesting of bone for use in autogenous grafting.

Orthodontic Services (Many Plans Don't Provide Orthodontic Coverage)

Covered

Exams, photographic images, diagnostic casts, cephalometric x-rays, installation and adjustment of orthodontic appliances and treatment to reduce or eliminate an existing malocclusion.

Exclusions

Replacement or repair of any lost, stolen or damaged appliance. Surgical procedures to aid in orthodontic treatment.

B. Other General Exclusions

Our dental plan doesn't provide benefits for the following services, supplies or charges including, but not limited to:

- Dental services received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trustee or similar person or group.
- Services or supplies not listed as covered services under Attachment A, Covered Services and Limitations on covered services.
- Charges for services performed by the member or member's spouse, or member's or member's spouse's parent, siblings or child.
- Services rendered by a dentist beyond the scope of their license.
- Free dental services, or services when a member isn't required or legally obligated to pay, or when no charge would be made if the member had no dental coverage.
- Dental services to the extent that charges for such services exceed the charge that would have been made and collected if no coverage existed hereunder.
- Dental services covered by any medical insurance coverage, or by any other non-dental contract or certificate issued by BlueCross or any other insurance company, carrier, or plan.
  - For example, removal of impacted teeth, tumors of lip and gum, accidental injuries to the teeth, etc.
- Any court-ordered treatment of a member unless benefits are otherwise payable.
- Courses of treatment rendered before a member became covered under this program.
- Any services performed after a member ceases to be eligible for coverage, except as shown under the Payment for Services Rendered After Termination of Coverage section.
- Dental care or treatment not specifically listed in Attachment C: Schedule of Benefits.
- Any treatment or service that the plan determines isn't necessary dental care that doesn't offer a favorable prognosis that doesn't t meet generally accepted standards of professional dental care, or that's experimental in nature.
- Services or supplies for the treatment of work-related illness or injury, regardless of the presence or absence of workers' compensation coverage.
  - This exclusion doesn't apply to injuries or illnesses of an employee who:
    - Is a sole-proprietor of the Group;
    - Is a partner of the Group; or
    - Is a corporate officer of the Group, provided the officer filed an election not to accept workers' compensation with the appropriate government department.

- Charges for any hospital or other surgical or treatment facility and any additional fees charged by a dentist for treatment in any such facility.
- Dental services for congenital malformations or primarily for cosmetic or aesthetic purposes
  - This doesn't exclude services provided under orthodontic benefits (if applicable.)
- Replacement of tooth structure lost from wear or attrition.
- Dental services resulting from loss or theft of a denture, crown, bridge or removable orthodontic appliance.
- Diagnosis for, or fabrication of, adjustment or maintenance and cleaning of maxillofacial prosthesis, appliances or restorations necessary to correct bite problems, restore the occlusion, correct TMJ or associated muscles.
- Diagnostic dental services such as diagnostic tests, image capture only and oral pathology services (except as stated elsewhere in this EOC).
- Adjunctive dental services including all local and general anesthesia, sedation, and analgesia (except as stated elsewhere in this EOC).
- Charges for the treatment of desensitizing medicaments, drugs, occlusal guards and adjustments, mouthguards, microabrasion, behavior management, and bleaching.
- Charges for the treatment of professional visits outside the dental office or after regularly scheduled hours of operation.
- Charges for the inhalation of nitrous oxide/analgesia, anxiolysis.
- Dental consultations including but not limited to re-evaluations, nutritional and tobacco counseling and oral hygiene instruction.

C. Clinical Criteria Requirements

The following criteria are based on procedure codes defined in the American Dental Association's (ADA) Current Dental Terminology (CDT) manual.

These criteria were formulated from information gathered from practicing dentists, dental schools, ADA clinical articles and guidelines, insurance companies, and other dental related organizations. They're designed as guidelines for consideration of payment and payment decisions and are not intended to be all-inclusive or absolute.

Requests for information about treatment using these codes, such as radiographs, periodontal charting, or descriptive narratives, are determined by generally accepted dental standards for consideration of payment. Additional narrative information is appreciated when there may be a special situation.

Unspecified codes (e.g., D0999, D1999, D2999, D3999, D4999, D5899 D5999, D6999, D7999, D8999, D9999) will be clinically reviewed and considered for payment if a narrative and/or appropriate radiographs are included with the claim. In some instances, the State legislature will define the requirements for dental procedures.

The following grid lists CDT codes and the required documentation that should accompany claims to BlueCross for review. Only attach the required documentation for the codes listed; Attaching documentation to claims for procedures not listed will result in claims processing delays.

CDT Code	Description	Documentation Required with Claim
D2510; D2520; D2530	Inlays	Preoperative radiographs Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio; whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.
D2542 – D2544	Onlays	Preoperative radiographs Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio; whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.

CDT Code	Description	Documentation Required with Claim
D2610; D2620; D2630	Inlays	Preoperative radiographs Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio; whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.
D2642 – D2644	Onlays	Preoperative radiographs Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio; whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.
D2650 – D2652	Inlays	Preoperative radiographs Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio; whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.
D2662 – D2664	Onlays	Preoperative radiographs Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio; whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.
D2710; D2712; D2720 – D2723; D2740; D2750 –D2752; D2780 – D2783; D2790 – D2792; D2794	Crowns	Preoperative radiographs^ Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio; whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.
D2960 – D2962	Veneers	Preoperative radiographs Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio; whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.
D6600 – D6615; D6624; D6634	Inlays/Onlays	Preoperative radiographs and Perio Charting Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio; whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.
D4341, D4342	Scaling and Root Planing	Radiographs and Perio Charting Pocket depth measurements and evidence of bone loss; periodontal prognosis
D0999 – D9999	Unspecified Procedures	Narrative, Preoperative radiographs Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio; whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.

^ Radiographs required when filing more than one specific procedure.

Note: To help ensure claims process in a timely manner, please don't attach radiographs or perio charting unless submitting a claim for one of the above listed procedures. We don't return X-rays to the

provider. Because X-rays are considered part of the patient's clinical record, the dentist office should retain the original image and only submit a copy of the X-ray with the claim.

We accept electronic attachments, such as X-rays or perio charts, through National Electronic Attachment (NEA). Currently we're not able to accept claim summaries from other insurance carriers electronically. If you have questions, please call NEA at **1-800-782-5150, ext. 2**.

D. Essential Health Benefits (EHB) Medical Plan

New Health Care Reform plans from BlueCross have pediatric dental benefits built into the medical plan. The Affordable Care Act (ACA) mandates that certain additional services be covered, including, but not limited to pediatric oral care services for members under 19.

Adults aren't covered for dental services under the EHB medical plan. Adult coverage is available as a separate dental supplemental plan providing coverage to individuals 19. Benefits vary; therefore, providers should always check eligibility and benefits prior to rendering services.

A sample copy of an EHB ID card follows:

The following grid lists pediatric dental benefits included in our Essential Health Benefits plan:

Pediatric Dental Benefits included in the BlueCross EHB Medical Plan		
Covered Services	**Network Dentist**	**Out-of-Network Dentist**
Coverage A Diagnostic and preventive services; exams; cleanings; X-rays	100%	100% of the Maximum Allowable Charge after Deductible
Coverage B Basic and restorative services; basic restorative; basic endodontics; oral surgery; basic periodontics	80%	80% of the Maximum Allowable Charge after Deductible
Coverage C Major restorative and prosthodontic services; major restorative; major endodontics; major periodontics; implants	50%	50% of the Maximum Allowable Charge after Deductible
Coverage D Medically necessary orthodontia for members under 19. Prior authorization is required.	50% after Deductible*	50% of the Maximum Allowable Charge after Deductible*

Members with pediatric dental benefits on non-group or individual medical plans no longer have any out-of-network benefits. Members are responsible for 100% of the maximum allowable charge on individual medical plans when out-of-network pediatric dental benefits are used. Group plans provide out-of-network benefits as listed above.

Dental Services – Pediatric Dental

This section provides a wide range of benefits to cover most services associated with dental care for members through the end of the month when they turn 19.

If a member transfers from the care of one dentist to another during treatment, or if more than one dentist renders services for a dental procedure, benefits won't exceed those that would've been provided had one dentist rendered the service.

When more than one treatment alternative exists, meets generally accepted standards of professional dental care, and offers a favorable prognosis for the member's condition. We reserve the right to provide payment for the least expensive covered service alternative.

I. Diagnostic Services

A. Exams

1. Covered Services

a. Two periodic, limited oral evaluation, comprehensive, detailed/extensive or periodontal exam in any 12-month period.

B. X-rays

1. Covered Services

a. One full mouth set of x-rays in any 60-month period. A full mouth set of x-rays is defined as either an intraoral complete series or panoramic x-rays. Benefits provided for either include benefits for all necessary intraoral and bitewing films taken on the same day.

b. Up to four bitewing films in any 6-month period. Bitewing films must be taken on the same date of service.

c. Intraoral periapical x-rays.

2. Exclusions

a. Extraoral, skull and bone survey, sialography, and tomographic survey x-ray films, cephalometric films and diagnostic photographs.

II. Preventive Services

A. Prophylaxis (Cleanings)

1. Covered Services

a. Two cleanings in any 12-month period, except when replaced as described below in Basic Procedures.

B. Fluoride Treatment

1. Covered Service

a. One fluoride treatment in any 6-month period

C. Other Preventive Services

1. Covered Services

a. One sealant or preventive resin restoration per 36 months on first and second permanent molars.

b. Space maintainers.

c. One recementation per space maintainer in any 12-month period.

d. Palliative (emergency) treatment for the relief of pain.

III. Basic Restorative Services

A. Fillings and Stainless Steel Crowns

1. Covered Services

a. One amalgam or resin restoration per tooth surface in any 12-month period.

b. Replacement of existing amalgam and resin composite restorations covered only after 12 months from the date of the initial restoration.

c. Stainless-steel crowns.

d. Replacement of stainless-steel crowns covered only after 60 months from the date of the initial restoration.
e. One sealant, preventive resin restoration, or resin infiltration per first or second permanent molar tooth per 36 months. Sealant/preventive resins are subject to additional limitations listed under Preventive Services, and may be subject to a different coverage level under “Attachment C: Schedule of Benefits”.

2. Exclusions
a. Gold foil restorations.

B. Other Basic Restorative Services

1. Covered Services
a. Crown and inlay re-cementation.
b. General anesthesia and IV sedation in connection with a covered surgical procedure when provided by a dentist licensed to administer such agents.
c. One repair per denture or bridge in any per 24 month period.
d. One denture adjustment in any six month period and only after six months from the date of the initial placement.
e. One denture reline, rebase or tissue conditioning in any 36 month period.

IV. Major Restorative & Prosthodontic Services

A. Single Tooth Restorations

1. Covered Services
a. Crowns (resin, porcelain, ¾ cast, and full cast), inlays and onlays (metallic, resin and porcelain), only for the treatment of severe carious lesions or severe fracture on permanent teeth and only when teeth cannot be adequately restored with an amalgam or resin composite restoration (filling). Replacement of a single tooth restoration or fixed partial dentures (bridges) after 60 months from the date of the initial placement.
b. Veneers for anterior permanent teeth.

2. Exclusions
a. Provisional restorations and crowns.

B. Multiple Tooth Restorations – Bridges

1. Covered Services
a. Fixed partial dentures (bridges), including pontics, retainers, and abutment crowns, inlays, and onlays (resin, porcelain, ¾ and full cast) for permanent teeth only.
b. Replacement of fixed partial dentures or single tooth restorations after 60 months from the date of the initial placement.

2. Exclusions
a. Provisional or Interim restorations.

C. Removable Prosthodontics (Dentures)

1. Covered Services
a. Complete, immediate and partial dentures for permanent teeth using standard techniques and materials as determined by the plan.
b. Personalized restorations, special techniques or materials are covered up to the amount allowed for standard techniques or materials.
c. Replacement of removable dentures after 60 months from the date of the initial placement.

2. Exclusions
a. Interim (temporary) dentures.

D. Other Major Restorative & Prosthodontic Services

1. Covered Services

a. Core build-up covered separately from restoration only in circumstances where benefits provided because of severe carious lesions or fractures so extensive that retention of the restoration wouldn't be possible.
b. Crown, inlay, onlay, and veneer and bridge repair and re-cementation after 12 months from the date of the initial placement.
c. One implant per tooth per 60 months.
d. One bone graft for implant per tooth per 60 months.
e. One implant debridement per tooth per 60 months.
f. Initial placement or replacement of implant-supported prosthesis after 60 months from the date of any corresponding major restoration.
g. Occlusal guards by report for extreme bruxism (grinding) and other occlusal factors once every 12 months for members ages 13 to 19.

2. Exclusions

a. Provisional and interim restorations.
b. Other major restorative services including protective restoration and coping.
c. Other prosthodontic services including overdenture, precision attachments, connector bars, stress breakers and coping metal.
d. Crown preparation, temporary or prefabricated crowns, impressions and cementation.
e. Post and core services not performed in conjunction with a covered crown or bridge.

V. Endodontics (treatment of the dental pulp or root canal)

A. Basic Endodontics

1. Covered Services

a. Pulpotomy and pulpal therapy for primary teeth, but not when performed in conjunction with major endodontic treatment.

2. Exclusions

a. Pulpal debridement.
b. Pulp vitality tests.
c. Protective restorations.

B. Major Endodontics

1. Covered Services

a. Root canal treatment (root canal, re-treatment, apexification, pulpal regeneration, root amputation, hemisection and pulp cap).
b. Apicoectomy
c. Retrograde filing if done on same date of service as apicoectomy.

2. Exclusions

a. Guided tissue regeneration.
b. Intentional re-implantation (including necessary splinting).
c. Canal preparation.
d. Incomplete endodontic therapy.
e. Pulp vitality tests.
f. Protective restorations.

VI. Periodontics

A. Basic Periodontics

1. Covered Services

a. One periodontal scaling and root planing per quadrant in any 24 month period.
b. One full mouth debridement per lifetime.
c. Periodontal maintenance no sooner than 90 days after completion of any one of the Basic Periodontics covered services above. Periodontal maintenance will replace a cleaning or scaling.

d. Scaling in the presence of generalized moderate or severe gingival inflammation – full mouth, once per lifetime. Scaling will replace a cleaning or periodontal maintenance procedure.
e. Up to four of any cleaning or periodontal maintenance procedure in any 12 month period.

2. Exclusions

a. Provisional splinting, antimicrobial medication and dressing changes.
b. Periodontal scaling and root planning, full mouth debridement, periodontal maintenance and prophylaxis when more than one of these procedures is performed on the same date of service.

B. Major Periodontics

1. Covered Services

a. One major surgical periodontal procedure per quadrant including gingivectomy, gingivoplasty, gingival flap procedure or osseous surgery in any 36 month period.
b. One crown lengthening per tooth in any 36 month period.
c. One bone and tissue grafting per site in any 36 month period.

2. Exclusions

a. Tissue regeneration and apically positioned flap procedure.

VII. Oral Surgery

A. Basic Oral Surgery

1. Covered Services

a. Non-surgical or simple extractions (pulling teeth).

B. Major Oral Surgery

1. Covered Services

a. Surgical extractions (including removal of impacted teeth), coronectomy, and other oral surgical procedures typically not covered under a medical plan.

2. Exclusions

a. Oral surgery typically covered under a medical plan including, but not limited to, excision of lesions and bone tissue, treatment of fractures, suturing, wound and other repair procedures.
b. Harvesting of bone for use in autogenous grafting.

VIII. General Pediatric Dental Exclusions

Pediatric dental coverage doesn't provide benefits for the following services, supplies or charges:

- Services rendered by a dentist beyond the scope of their license.
- Free dental services or services a member isn't required or legally obligated to pay for or when no charge would be made if the member had no dental coverage.
- Dental services covered by any medical insurance coverage, or by any other non-dental contract or certificate issued by BlueCross or any other insurance company, carrier, or plan.
  - For example, removal of impacted teeth, tumors of lip and gum, accidental injuries to the teeth, etc.
- Dental care or treatment not specifically listed in Attachment C: Schedule of Benefits.
- Any treatment or service that the plan determines:
  - Isn't necessary dental care;
  - Doesn't offer a favorable prognosis;
  - Doesn't meet generally accepted standards of professional dental care;

    or

  - Is experimental in nature.
- Charges for any hospital or other surgical or treatment facility and any additional fees charged by a dentist for treatment in any such facility, except as otherwise covered in this dental section.

- Dental services for congenital malformations or primarily for cosmetic or aesthetic purposes including cosmetic orthodontia.
- Replacement of tooth structure lost from wear or attrition.
- Dental services resulting from loss or theft of a denture, crown, bridge or removable orthodontic appliance.
- Diagnosis for, or fabrication of, adjustment or maintenance and cleaning of maxillofacial prosthesis, appliances or restorations necessary to correct bite problems or restore the occlusion.
- Diagnostic dental services such as diagnostic tests and oral pathology services.
- Adjunctive dental services including all local and general anesthesia, sedation, and analgesia (except as provided under a covered surgery).
- Charges for the treatment of desensitizing medicaments, drugs, occlusal adjustments, mouthguards, micro abrasion, behavior management, and bleaching.
- Charges for the treatment of professional visits outside the dental office or after regularly scheduled hours or for observation.
- Charges for the inhalation of nitrous oxide/analgesia, anxiolysis.
- Dental consultations including, but not limited to re-evaluations, nutritional and tobacco counseling and oral hygiene instruction

IX. Dental Services - Orthodontia - Pediatric Only

Medically necessary and medically appropriate orthodontia for members through the end of the month in which they turn 19.

1. Covered Services
   a. Medically necessary and medically appropriate non-cosmetic orthodontia for members through the end of the month in which they turn 19.
2. Exclusions
   a. Orthodontia for members after the end of the month in which they turn 19.
   b. Cosmetic orthodontia.

Dental Supplement Plan Options

The following grid reflects basic options for Dental Supplement Plans for members ages19 or older who may be added to an EHB medical plan. These members will have “MEDICAL/DENTAL/VISION” reflected on their ID card.

Basic Options for Dental Supplement Plans **Benefits for Individuals Over Age 18**			
COINSURANCE	**DEDUCTIBLE**	**ANNUAL MAXIMUM**	**Cosmetic ORTHO***
100%/80%/50%	$50	$1,000	No
100%/80%/50%	$50	$1,000	Child (1K)*
100%/80%/50%	$50	$1,500	No
100%/80%/50%	$50	$1,500	Child (1.5K)*
100%/80%/50%	$50	$2,000	No
100%/80%/50%	$50	$1,000	Child & Adult (1K)*
100%/80%/0%	$25	$1,000	No

Basic Options for Dental Supplement Plans Benefits for Individuals Over Age 18			
COINSURANCE	**DEDUCTIBLE**	**ANNUAL MAXIMUM**	**Cosmetic ORTHO***
100%/70%/70%	$250	$2,500	No
100%/90%/60%	$50	$1,000	No
100%/90%/60%	$50	$1,000	Child (1K)*
100%/70%/70%	$250	$2,500	Child (1K)*
100%/80%/50%	$50	$2,000	Child (1.5K)*
100%/90%/60%	$50	$2,000	Child (1K)
100%/80%/50%	$0	$2,500	No
100%/80%/50%	$0	$3,000	Child & Adult (1.5K)
Personal Dental Schedule Plan	$50	$1,000	No

*Cosmetic orthodontia is also payable to those under age 19 on these plans

E. Predeterminations

The Predetermination of Benefits program allows the dentist and the member to know exactly what kinds of treatment are covered. If a treatment will exceed $200.00, the treatment plan and estimated charges should be submitted to BlueCross for review before the treatment starts. To review, the predetermination must be on an ADA dental claim form and “Dentist’s Pre-Treatment Estimate” box should be checked with a description of each service and charge submitted along with all supporting aids such as preoperative X-rays and/or photographs. Don’t include the date(s) that the treatment will be started.

We’ll review the claim and other information submitted and notify the member and the dentist via the Dental Pre-Determination of Benefits form of our decision and estimated dental benefits available.

F. ADA/BlueCross Dental Claim Form

Dental claims must be completed on one of the three most current standard ADA claim forms or BlueCross claim form using the most appropriate ADA CDT codes. To help avoid processing delays, claim forms should be completed with special attention given to the critical fields listed below. If the format or data inserted in these fields isn’t valid, the claim will be returned for correction or resubmission.

- Member name
- Member date of birth
- BlueCross subscriber ID number* (Not Social Security Number)
- Date of service
- Procedure code
- Total charges
- Tooth number (as appropriate)
- Tooth surface (as appropriate)
- Area of oral cavity (as appropriate)

- Provider tax ID number/NPI number
- Signature of treating dentist (or authorized representative for the treating dentist)

*Enter the subscriber identification number exactly as it is listed on the member's ID card.

Note: We phased in non-Social Security Number (SSN) identification numbers in 2004 to help protect member privacy.

Some claim form fields may request the member's Social Security number. However, because we moved to non-SSN identification numbers, it may not be able to identify the member by the SSN. This is particularly true for new groups, which don't require members to provide their SSN.

When submitting the subscriber ID number, don't include data in front of the ID number, such as ID#, SSN or #. The imaging equipment will read this extra data as part of the number, which may result in a rejection.

> **Note**: The Tennessee Board of Dentistry Code of Professional Conduct Section 5; 5.B.4 states the date of completion is the treatment date. The revised ADA claim form doesn't take into consideration individual state laws or specific contracting agreements.

Links to the ADA Dental Claim Form and Claim Form Instructions can be found at https://www.bcbst.com/docs/providers/dental/dentalclaimform.pdf

Note: When submitting charges on an ADA Dental Claim Form, please include the assigned Individual Provider Identification Number and/or NPI number. This provider-specific number is located in the upper right-hand corner of the assigned BlueCross Dental Remittance Advice and may be listed on the dental claim form in Fields 49 and 54. Some dental practices choose to obtain a group provider number and/or NPI for payment purposes. In these cases, the remittance advice will reflect the group provider number and/or NPI. The group number is used to report payments and shouldn't be used when submitting claims. If there's a question on the individual provider number, dentists may contact Dental Customer Service at **1-800-523-1478**.

Tips for Completing a Dental Claim Form

Tips to help ensure claims are processed timely and accurately:

- Type all letters in Upper Case (capital letters).
- Use black ink (if typed) or block letters (if handwritten) to reflect a clear impression.
- Enter the member's ID number as shown on the ID card.
- We request that providers use an eight-digit format for all dates (MM_DD_CCYY)
  - Example: January 1, 2005 would be written as 01/01/2005.
- Some paper dental forms will only allow a two-digit year in the date of service. In these cases, use the format MMDDYY (01/01/05).
- Review each claim to ensure all required fields have been provided.
- Send only original claims and supporting documentation.
- Securely staple any attachments, receipts, etc.
- Be sure to include the designated Individual Provider Identification Number or NPI in Fields 49 and 54.
- File corrected claims hardcopy and clearly mark **"Corrected Billing"** in the Remarks section of the claim form**;** Don't use correction tape or white out. Draw a line through the original information and list the new information above, below or beside the original information. (the original information must be visible).

G. Orthodontic Claims Processing Guidelines

Effective Jan. 1, 2021, orthodontic claims filed with date of service on or after Jan. 1, 2021, will be reimbursed per the provider's network status and group's reimbursement option.

Our Dental Preferred Providers agree to accept reimbursement in accordance with the terms of their provider contract, referenced in the Balance Billing subsection.

Providers no longer need to file a claim for monthly adjustments. Instead, providers were notified they should file one (1) claim for the total charge of the orthodontic treatment plan indicating the initial placement date.

The allowed amount for the initial placement is 25% of the allowed charge(s) for the orthodontic treatment plan. Monthly adjustments will automatically be processed each month until the member's orthodontic lifetime maximum is met or the provider or member advises that the member is no longer in treatment. The maximum allowed amount for monthly adjustments is $200 payable to the treating dentist listed on the initial orthodontic treatment plan claim.

Note: In addition to the above reimbursement guidelines, some group plans allow payment for the orthodontic services to be paid in a single claim up to the member's lifetime maximum or until BlueCross' portion of the charges have been paid. Payment made depends on the group's benefit structure.

H. Filing a Dental Claim Form

Dental claims may be faxed or mailed to us.

Billing Requirements for Faxed Paperwork (PWK) Attachments

When paper documentation is necessary to support an electronically submitted claim, you can use the PWK06 (paperwork) segment (Loop 2300) to indicate that documentation will be sent to us separately from the electronic claim. The actual supporting documentation would be faxed with a PWK fax cover sheet. We'll match the documentation to your electronic claim using the information supplied from the PWK06 segment and PWK fax cover sheet and use that documentation during claims processing and payment. To ensure we match the documents to an electronic claim for processing; the documentation and fax sheet should be submitted no later than the day of claims submission.

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

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

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

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

- Only include your attachment control number (ACN) reported in the PWK06 segment of the claim.
- Complete **one** fax cover sheet for each electronic claim for which documentation is being submitted.

Note: The PWK Fax cover sheet can be found at http://www.bcbst.com/docs/providers/PWK-Coversheet.pdf. Complete the form and fax with documentation to (423) 591-9481.

Mail dental claims to:

BlueCross BlueShield of Tennessee
Claims Service Center
1 Cameron Hill Cr, Ste 0002
Chattanooga, TN 37402-0002

I. Dental Professional Remittance Advice

The Dental Professional Remittance Advice is an explanation of payments and deductions. It's necessary for the provider's office staff to understand the remittance advice thoroughly in order to make all billing adjustments accurately. A copy of your remittance advice may be viewed in Availity.

The following instructs providers how to read a BlueCross dental remittance advice when overpayment recovery activity is reflected.

Credit Balance Activity

We use the credit balance process (automatic payment recovery) to recover overpayment of charges. Credit balances are the result of a credit (amount to be taken back) which exceeds actual payments on a given dental remittance advice (RA). A credit balance will carry forward and be applied against future RA. Depending on the amount of the credit balance, it may take more than one future RA to deplete the entire balance.

A credit balance carried forward and applied against a subsequent RA should be applied to the member's account where the original overpayment occurred. The following steps should be taken to resolve a credit balance:

Step 1

Locate the prior RA and identify where the credit balance originally occurred.

Step 2

Determine if this credit balance is the result of an online adjustment or a manual credit adjustment.

Online Adjustment

This type of adjustment occurs when a provider or eligible member initiates an adjustment request. The adjustment will appear on Page 1 of the RA in the claim detail section and is identified by a negative (-) indicator in the "Amount Paid" column. Page 2 of the RA reflects the credit balance due, the remittance total amount, the credit amount applied to the check and the check amount (the final dollar amount printed on the check). At the bottom Page 2 of the RA, the Adjustment Reference No., the current balance due and the specific claim numbers involved in the online adjustment are listed.

Manual Adjustment

This type of adjustment is initiated by BlueCross via a refund request letter to the provider outlining specific claims-overpayment information. Once the provider returns the overpaid amount will be entered manually and the overpaid claim will be adjusted.

Step 3

Post claim payment and/or credit adjustment (amount BlueCross took back) to the member's account.

J. Provider Overpayments

If a provider identifies that a payment made by BlueCross results in an overpayment, it's the provider's responsibility to reimburse BlueCross the overpaid amount. The provider should return the overpayment with a copy of the RA and a cover letter explaining why the payment is being refunded.

Mail to: BlueCross BlueShield of Tennessee

Receipts Department
1 Cameron Hill Circle, Ste.40

Chattanooga, TN 37402

If a provider receives an overpayment notification, no action is required unless records conflict with the findings. We'll recover the overpayment through an offset to the remittance advice within 30 days from the date of the notification. Please don't send a check for the overpayment. Checks received for solicited overpayments will be returned to the payee.

Overpayment Notifications

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

K. Electronic Funds Transfer

We execute the July 2013 electronic claims filing requirement pursuant to the BlueCross Minimum Practitioner Network Participation Criteria, which requires all network providers to enroll in the Electronic Funds Transfer (EFT) process. EFT is a free service that sends payments directly to the provider's financial institution and increases the speed they receive payment.

Key advantages to receiving payments electronically are:

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

We accept EFT enrollment through Change Healthcare, who offers a universal enrollment tool for providers that provides a single point of entry for adopting EFT and Electronic Remittance Advice (ERA). The Change Healthcare process facilitates compliance with CAQH Core III requirements, eliminates administrative redundancies and creates significant time and cost savings. Enrollment information is available on the Change Healthcare website at payerenrollservices.com.

To view/print a copy of your RAs, ensure you have access to Availity®.

If you have questions about the EFT program process, or need help with Availity, call eBusiness Service at **1-800-924-7141**, **option 3** Monday through Thursday, 8 a.m. to 6 p.m. ET, Friday 9 a.m. to 6 p.m. ET, or e-mail eBusiness_Service@bcbst.com.

Payer Enrollment Services™ is the name for the new EFT and ERA enrollment tool.

Phone: 1-800-956-5190, available Monday through Friday 8 a.m. to 5 p.m. CT

Website: payerenrollservices.com

Note: Vendor and BlueCross are bound by the National Automated Clearing House Association rules for corporate trade payment entries (the "Rules") in the administration of these ACH Credits.

L. Balance Billing

Our Dental Preferred providers agree to accept reimbursement made in accordance with the terms of their provider contract, plus any applicable member copayment/deductible and coinsurance amounts as the maximum amount payable to the provider for covered services rendered to members.

Dental Preferred Providers should not seek payment from a BlueCross member when:

- The provider failed to comply with our medical management policies and procedures or provided a service that doesn't meet our standards for medical necessity or doesn't comply with our medical policies.
- The provider failed to submit or resubmit claims for payment within the time periods required (timely filing guidelines); or services rendered are considered investigational and are therefore non-reimbursable, unless **prior** to rendering such services to the member, the provider has entered a

procedure-specific written agreement with the member, which advised the member of their payment responsibilities.

Dental Preferred Providers may bill the BlueCross members for:

- Non-covered services*,
- Any applicable deductible/copay amounts; and
- Any applicable co-insurance amounts.

When seeking payment from a BlueCross member, please refer to the Patient Owes column on your Provider Remittance Advice. This column includes the non-covered total, deductible/copay total, and coinsurance total. It may also reflect the other insurance total, which is the amount paid by the member's other insurance carrier.

Before billing the member, check both the deductible/copay and the other insurance columns to ensure any applicable copayment or other insurance payments haven't been received.

*When billing a member for non-covered services due to benefit limitations (i.e., dollar maximums), network providers should only bill the member the difference between the maximum dollar limit amount and the allowed amount. The difference between the billed amount and the allowed amount is considered a provider write-off.

Example: Dollar Limit

The member has a $1,000 annual maximum. The member has already used $800 of their annual maximum. This leaves a remaining benefit of $200.

Claim billed amount of $450 and all services would be a covered services

Claim allowed amount of $325

Remaining annual maximum benefit $200

Since this claim meets the member's annual maximum and all services were eligible for benefits, the member would receive the benefit of the discounted amount on the entire claim. The member liability would be $125 (difference between allowed amount on the claim and remaining benefit). Provider write-off $125 (difference between billed amount and allowed amount)

However, on any subsequent claims after the member has met their annual maximum, the Dental Preferred provider doesn't have to take a provider write-off for the remainder of the benefit period/calendar year.

M. Financial Responsibility for the Cost of Dental Services

If a Dental Preferred Provider renders a service which is investigational or doesn't meet medically necessary and appropriate criteria, the provider must obtain a written statement from the member prior to the service(s) being rendered, acknowledging that the member understands they may be responsible for the cost of the specific service(s) and any related services. Providers may also use this form in the event a member requests non-emergency, cosmetic or elective services specifically excluded under the member's health plan. It's essential the signed statement be kept on file, as it may be necessary to provide a copy of the signed statement to us verifying the member's agreement to the financial responsibility.

To make this process easier, we developed the Acknowledgement of Financial Responsibility for the Cost of Dental Services form for provider use. This form meets the contractual obligations of Dental Preferred Provider Agreements. Providers are strongly encouraged to use this form.

Providers using their own form should ensure their form includes:

- The name of the specific service/procedure the provider will perform;
- The reason why the provider believes that BlueCross won't provide benefits for the service/procedure; (i.e., BlueCross considers the service/procedure to be investigational, cosmetic or not medically necessary and appropriate);
- The approximate cost of the service/procedure and associated costs;

- A statement acknowledging the member understands that BlueCross won't provide benefits for the service/procedure;
- A statement acknowledging the member has been advised why BlueCross won't cover the service/procedure and that they understand and agree that they'll be responsible for the costs and any associated costs;
- A statement indicating the form is only valid for one service/procedure; and
- A specific expiration date.

A sample copy of the Acknowledgement of Financial Responsibility for the Cost of Dental Services form can be found below or online at https://www.bcbst.com/docs/providers/Dental_Acknowledgement_Financial_Responsibility_Form.pdf.

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BlueCross BlueShield of Tennessee
Acknowledgement of Financial Responsibility
for the Cost of Dental Services
(For use with BCBST Dental Preferred)

To: _____;

Re: (Identification of Prescribed Service)

I have been informed that my dental health care benefits insurer or administrator, BlueCross BlueShield of Tennessee, may determine that the above referenced dental service(s) may be an investigational service, cosmetic, may not be a covered services or may not be medically necessary or medically appropriate as those terms are defined in my member dental health care benefits plan from BlueCross BlueShield of Tennessee. Therefore, the dental service would be excluded from coverage by my dental health care benefits plan. My dentist has also informed me about alternative treatments, if any, that may be covered by BlueCross BlueShield of Tennessee.

I understand that my dentist may request that BlueCross BlueShield of Tennessee reconsider that determination by presenting evidence that the referenced dental service(s) is not an investigational service, is a covered service or the dental service is considered to be medically necessary or medically appropriate. I also understand that I have the right to request reconsideration of that determination, as described in the member grievance section of my dental health care benefits plan, either before or after receiving the service(s).

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

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

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

Signature of Patient or Responsible Person

_____

Date: _____

N. Disclaimer

Each member has their own group-specific benefits. To help ensure correct benefits, please contact our Provider Service Line at **1-800-523-1478** to determine specific member benefits prior to performing services.

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XVII. PHARMACY

A. Pharmacy Programs

Drug List/Prescribing Guidelines

BlueCross BlueShield of Tennessee commercial pharmacy benefits currently cover most legend drugs for The Food and Drug Administration (FDA) indicated use. Non-FDA approved drugs are considered experimental and aren't covered. Appropriate "off-label" use of FDA-approved medications may be approved if they're recognized in standard compendia and/or there's supporting evidence listed in a peer-reviewed journal.

Practitioners prescribing controlled substances to BlueCross members are expected to comply with all existing federal and state laws governing this activity, including checking a patient's drug use in the State's Controlled Drug Database. The "Controlled Substance Prescribing Documentation Standards" may be monitored through Practitioner site reviews and medical record audits of members receiving controlled substances upon request from the Clinical Risk Management Department. These adopted standards can be viewed at https://www.bcbst.com/docs/pharmacy/Controlled-Substance-Prescribing.pdf.

Practitioners who are non-compliant with these documentation standards are monitored by the Pharmacy and Therapeutics Committee and may be referred to the Clinical Risk Management Committee (CRMC) for further review and action.

The BlueCross Corporate Pharmacy Directors (CPD) conduct personal visits with prescribing practitioners to supply information designed to assist the practitioner in the provision of quality, cost-effective health care to BlueCross members. Timely clinical information is presented around specific high incidence medical conditions and is intended to inform the Practitioner of potential gaps in care, compliance and adherence issues as well as opportunities for cost-effective therapeutic options. Data is presented as an aid in the overall management of our members.

B. Plan Exclusions

A member's particular health care plan may exclude certain drug classes or individual drugs (e.g., oral contraceptives, products for hair loss, drugs considered for cosmetic purposes, et al.). A provider or member may check with a customer service representative for help in determining covered benefits. The member service phone number is listed on the back of the member's identification card.

C. Member Drug Co-pay/Co-insurance

There are many varieties of co-pay/co-insurance structures for our members. These may range from 10% or 20 % co-insurance to a two-tiered drug card co-pay of $10 or $20 (or other variations) to a six-tiered co-pay of perhaps $10/$20/$35/$45/$100/$150 (or other variations). Generic drugs are in tiers one and two; brand name products are in tiers three and four; and specialty drugs occupy tiers five and six. Select plans require co-payment (usually $100) for provider-administered specialty drugs obtained at a physician's office.

D. Pharmacy Network

Most Tennessee pharmacies are in the pharmacy network. Members can locate their plan's pharmacy network information on their ID card. These pharmacies are listed in our Referral Directory of Network Providers, which can be viewed at https://bcbst.vitalschoice.com. Additionally, we use a national network, which allows members to obtain prescriptions outside of Tennessee.

E. Claims Submission

Claims for provider-administered drugs administered in a practitioner's office should be submitted electronically on a CMS-1500 claim form using the most appropriate CPT® or HCPCS code and the specific drug's National Drug Code (NDC) number, which is printed on the drug container. The strength of the drug

and the number of units administered must also be submitted. Claims for self-administered drugs (oral, topical and self-administered injectables) should be electronically submitted through a network pharmacy to the member's pharmacy benefits manager (PBM). Claims for self-administered drugs won't process through our medical claims system.

F. Drug List (Formulary)

The Preferred Formulary, Essential Formulary, Essential Plus Formulary, Choice Formulary, and Control Formulary are lists of the top therapeutic classes of drugs, which are therapeutically sound and offer a cost advantage for the member and the member's sponsoring plan.

- The Preferred Formulary is updated monthly and can be viewed at https://www.bcbst.com/docs/providers/2026-preferred-formulary-prescription-drug-list.pdf
- The Essential Formulary is updated monthly and can be viewed at https://www.bcbst.com/docs/providers/2026-essential-formulary
- The Essential Plus Formulary is updated monthly and can be viewed at https://www.bcbst.com/docs/providers/2026-essential-plus-formulary.pdf
- The Choice Formulary is updated quarterly and can be viewed at https://www.bcbst.com/docs/providers/2026-Choice-Formulary.pdf
- The Control Plus Formulary is updated quarterly and can be viewed at https://www.bcbst.com/docs/providers/2026-Control-Formulary.pdf
- The Prior Authorization Criteria for the Preferred, Essential, and Essential Plus Formularies can be viewed at https://client.formularynavigator.com/Search.aspx?siteCode=7323916982
- The Prior Authorization Criteria for the Control and Choice Formularies can be view at https://info.caremark.com/dig/bcbst

Prior Authorization

Certain drugs with special indications require authorization prior to dispensing by a pharmacy. The prescribing Practitioner is responsible for obtaining the necessary authorization from us.

Drugs requiring prior authorization can be found in the applicable formulary guidebook and can be accessed at the links listed above. They're also available through your Provider Network Manager. (See Section II. Quick Reference Telephone Guide in this Manual for appropriate phone numbers.) Requests for prior authorization can be made by submitting the claim digitally through CoverMyMeds or SureScripts (**covermymeds.com** or through the link in Availity), calling **1-800-924-7141**, or by faxing it to **1-888-343-4232**. Please only use fax if you're unable to submit digitally.

Find Upcoming Prior Authorization Changes

You can find the latest changes to select prior authorizations under the Upcoming Prior Authorization Changes section in the Pharmacies & Prescriptions section of our Documents and Forms page. You can access prior authorization changes 45 days before the effective date.

Requests for prior authorization can be made by submitting the claim digitally through CoverMyMeds or SureScripts (**covermymeds.com** or through the link in Availity), calling **1-800-924-7141,** or by faxing it to: **1-888-343-4232.** Please only use fax if you're unable to submit digitally.

Reconsideration for denied requests should be faxed directly to our Pharmacy Management Department at **1-888-343-4232.** Often, additional supportive clinical information is necessary for approval of a request for a prior authorization drug.

G. Reconsideration

If a prior authorization request has been denied, a prescribing physician may file a Reconsideration by faxing any pertinent clinical documentation/notes and a brief written statement giving medical justification supporting the request. Reconsiderations can be completed by calling **1-800-924-7141**, or faxing to **1-888-343-4232.** If following the reconsideration process and the prior authorization continues to be denied, the member may pursue the request through the normal grievance process outlined in the Member Handbook.

H. Quantity Limits or Maximum Drug Limitation

Some medications have a quantity limit for a given time. All specialty drugs are limited to a one-month supply. A list of these products can be found in the applicable formulary guidebook and can be accessed at the links listed above. They're also available through your Provider Network Manager. Requests for exceptions to these limits may be submitted digitally via CoverMyMeds or SureScripts along with rationale for why an exception is needed. You may also fax exception requests to **1-888-343-4232**. You can find the form at https://www.bcbst.com/docs/pharmacy/Non-Covered_Rx_Exception_Request.pdf.

Please only fax if you're unable to use the digital submission process.

I. Pharmacy and Therapeutics Committee

All policies and procedures affecting the pharmacy programs are reviewed and approved by the Pharmacy and Therapeutics Committee, or its delegate, a panel of pharmacists and physicians, some of whom are community practitioners. Any comments or suggestions for the commercial pharmacy program may be directed to:

BlueCross BlueShield of Tennessee
Pharmacy and Therapeutics Committees – CH 2.3
1 Cameron Hill Circle
Chattanooga, TN 37402

J. Specialty Pharmacy Program

The Specialty Pharmacy Program is available for Commercial and Medicare Advantage members who use certain high-cost/high-risk drugs for serious, chronic conditions. Specialty pharmacy medications require complex care, including special handling, patient education, and continuous monitoring.

We have a network of specialty pharmacies for members and providers to call to obtain specialty medications. A listing of the network specialty pharmacies can be viewed at https://www.bcbst.com/docs/pharmacy/specialty-pharmacy-network.pdf.

The specialty pharmacy will call the member to collect the required copayment or coinsurance. This amount is typically paid by credit card. The medication is shipped directly to the member's home or other designated location. After shipping, the specialty pharmacy will call the member to verify the medication was received and to answer any questions the member may have about the medication or its administration.

The specialty pharmacy may contact the prescribing practitioner for specific medication orders, or the practitioner may contact the specialty pharmacy with drug orders. With the added pharmacy support services available through each vendor, members have access to:

- Patient care coordinators;
- Pharmacists and nurses;
- Help optimizing drug usage, and
- Monitoring and management of complex drug regimens.

Certain specialty pharmacy medications administered in any setting other than an inpatient hospital may require prior authorization by either the member's medical benefits plan or their pharmacy benefits plan.

A complete listing of self and provider-administered specialty pharmacy medications can be viewed at:

https://provider.bcbst.com/tools-resources/documents-forms

To obtain a prior authorization for a self-administered medication being billed under the member's pharmacy benefits plan and filed through a pharmacy, the network Practitioner should submit the request digitally through CoverMyMeds (**covermymeds.com**), SureScripts (surescripts.com) through the CoverMyMeds or SureScripts link in Availity, calling **1-800-924-7141,** or faxing **1-888-343-4232**. Specialty pharmacies may also call this number on behalf of the practitioner to obtain prior authorization.

Please only fax or call if you're unable to use the digital submission process.

K. Specialty Pharmacy Billing Information

- Self-administered claims must be electronically submitted through a network pharmacy to the member's pharmacy benefits manager.
- Self-administered claims taken "on assignment" by the specialty pharmacy should be faxed to the BlueCross claims department at **(423)-535-3741.**
- Claims for provider-administered medications should be electronically submitted as a medical claim. Please see Sections L and M for information on billing claims for members enrolled in the Advanced Specialty Benefit Management program.
- The RC Claims Assist tool in Availity can help when in converting HCPCS codes to NDCs and vice versa. It can also translate HCPCS billable units to NDC billable units and vice versa.
- Medical billing information:
  - Bill at contracted rate
  - Medi-Span as source of AWP
  - Medications billed with unlisted, miscellaneous, non-specific and Not Otherwise Classified (NOC) codes should be billed with a unit of one and require submission of the drug name, NDC and dosage administered in appropriate form as ordered by the practitioner. Failure to submit this information may result in delay of reimbursement. (See Section VI. Billing and Reimbursement in this Manual for further information.)
  - Medical claims require the most appropriate HCPCS or CPT® code. When filing medical claims please include the following information:
    - NPI (more than one of your subsidiaries may share the same code)
    - Tax ID (more than one of your subsidiaries may share the same code)
    - **Appropriate taxonomy code must be in Block 33b** (taxonomy code should be specific for specialty pharmacy, home infusion therapy (HIT), etc.)
    - Name of drug
    - Strength of drug
    - NDC
    - Number of units being billed
    - Amount of days for supply (if billing an ambulatory drug on a medical claim) for example when accepting Assignment of Benefits for members who have to pay 100% up front
  - Medical claims delivered to the member for self-administration - use place of service 12 (home) in Block 24b on CMS-1500 claim form
  - Medical claims delivered to physician's office for office administration use place of service 11 (office) in Block 24b on CMS-1500 claim form
  - Medical claims coming to BlueCross as the home plan should follow the billing guidelines for the Specialty Pharmacy Program.
- Policy for Quarterly Reimbursement Changes
  - **This policy will be applicable when referenced in the Provider Agreement or our Reimbursement Policy**. Reimbursement changes applicable to this policy will be made according to the following schedule:

Date Reimbursement Data is Published by Source	Date Change will be Applied by BlueCross
Jan. 1 to March 31	July 1
April 1 to June 30	Oct.1
July 1 to Sept. 30	Jan. 1
Oct. 1 to Dec. 31	April 1

- Pharmacy Pricing Appeal
  - Pharmacy pricing appeals should be submitted directly to our pharmacy benefit manager at the following link:

    https://www.caremark.com/portal/asset/MAC_Portal_Access_Appeals_Process.pdf

  - Medical claims pricing appeals for specialty pharmacies contracted in our specialty network should be submitted to us using the standard appeal process listed above.
- BlueCard billing for medical claims (provider-administered)
  - **Note:** Host claims (i.e., claims filed out of state by out-of-state Provider) will process through the Blue Card system.
  - The BlueCross BlueShield Association's BlueCard program requires provider-administered (medical claims) specialty drugs to be billed through the Host Plan as determined by the state in which the prescribing physician resides and is providing services to the member.
  - ***Example 1***: BlueCross member is being treated by a physician residing in Little Rock, Arkansas. The physician orders a provider-administered a specialty pharmacy drug (medical claim) from specialty pharmacy. The specialty pharmacy must bill the drug through the Host Plan (Arkansas). The member is subject to out-of-network benefits, if that specialty pharmacy isn't in the BCBS Arkansas network. Therefore, it may be in the member's best interest to have their physician order the specialty drug from a specialty pharmacy participating in the BCBS Arkansas plan.
  - ***Example 2:*** BCBS Arkansas member seeks medical attention in Nashville, Tennessee. The treating physician in Tennessee orders a provider- administered specialty pharmacy drug. The specialty pharmacy ships the drug to the physician's office in Nashville for administration as a medical claim and bills the drug through the Host Plan (e.g., BlueCross BlueShield of Tennessee).
  - ***Example 3:*** BlueCross member visits a physician whose office is in West Memphis, Arkansas, just across the river from Memphis, Tennessee (but in a contiguous county). The Arkansas physician orders a provider- administered drug from a specialty pharmacy in the BlueCross BlueShield of Tennessee preferred specialty pharmacy network. Even though West Memphis, Arkansas is in a contiguous county to Tennessee, and the physician is our network, the specialty pharmacy must file this medical claim to BCBS of Arkansas.
  - Rules of the Tennessee Board of Pharmacy require all pharmacies doing business in Tennessee, which includes the shipping of drugs to a member or physician residing in Tennessee, to be licensed by the Tennessee Board of Pharmacy.

The above BlueCard policy applies only to provider-administered drugs being filed as a medical claim unless the drug appears on the list as being both self and provider-administered. This may be billed as a medical claim depending on the site of service.

If you disagree with your compensation for a specialty product, please refer to the Provider Appeal Process.

To obtain a prior authorization for a provider-administered drug being billed as a medical claim, the provider should call our Pharmacy Management Department at **1-800-924-7141** or submit a digital request in Availity. You can follow the prompts for specialty pharmacy.

In addition to the member information, the following is required when requesting prior authorization for provider -administered specialty drugs:

- Provider NPI (more than one of your subsidiaries may share the same number)
- Tax ID (more than one of your subsidiaries may share the same number)

- Appropriate taxonomy code in Block 33b (taxonomy code should be specific for specialty pharmacy, HIT, etc.)
- HCPCS code (J, Q or S code)
- Drug name
- Drug Strength
- NDC
- Number of units being billed
- Frequency of dosing
- Dosage
- Days' supply if billing an ambulatory drug on a medical claim (for example, when accepting Assignment of Benefits for members who have to pay 100% up front)
- Clinical Information to support the request (Reference the BlueCross BlueShield of Tennessee Medical Policy Manual)

Note:

- New drugs may be periodically added to the specialty pharmacy list and those products requiring authorization are subject to change. Changes will be communicated via BlueAlert newsletter or updates to this Manual. Current and archived BlueAlert issues can be viewed at http://www.bcbst.com/providers/newsletters/index.page.
- The specialty medication section of our Medical Policy Manual includes clinical criteria for provider-administered drugs to help providers considering use of these medications. Providers can select the appropriate drug from the manual at http://www.bcbst.com/mpmanual/!SSL!/WebHelp/mpmprov.htm.
- Claims for provider-administered medications should be electronically submitted as a medical claim. Please see sections L and M for information on billing claims for members enrolled in the Advanced Specialty Benefit Management Program.

L. Advanced Specialty Benefit Management Program

The Advance Specialty Benefit Management (ASBM) Program is available in response to the escalating cost of provider-administered specialty drugs. Members with this benefit must obtain their provider-administered specialty medications from a BlueCross preferred specialty pharmacy.

We have a network of preferred specialty pharmacies for members and providers to call to obtain provider-administered specialty medications. A listing of the preferred specialty pharmacies can be viewed at https://www.bcbst.com/docs/pharmacy/specialty-pharmacy-network.pdf.

The preferred specialty pharmacy may contact the prescribing practitioner for specific medication orders, or the practitioner may contact the preferred specialty pharmacy with drug orders. The provider and preferred specialty pharmacy will also coordinate submission of any required prior authorization requests.

The preferred specialty pharmacy must always verify member benefits for provider-administered specialty drugs through the Availity portal or by calling Customer Service. The verification process should be completed each time a medication is dispensed, because self-funded groups can elect or remove the ASBM program at any time. The preferred specialty pharmacy may also request a prior authorization through the portal.

The preferred specialty pharmacy must submit claims for provider-administered specialty medications for members with the ASBM program through our PBM. The preferred specialty pharmacy will then call the member to collect the required copayment or coinsurance and coordinate shipping. The medication may be shipped directly to the provider's office or directly to the member's home.

M. ASBM Billing Information

- This benefit doesn't apply to our Medicare Advantage, BlueCare or CoverKids plans; please continue to process claims for these members as you do today.
- Provider-administered claims for members with the ASBM program must be electronically submitted through our PBM, CVS Caremark(CVS).
- Preferred specialty pharmacies must bill claims at the contracted rate.
- Medi-Span as source of AWP.

- Provider-administered claims for out-of-state BlueCross members with the ASBM program billed through BlueCard Host Plans will be denied.
- Provider-administered claims for members with the ASBM program billed through the members medical benefit will be denied.
- Provider-administered claims for members with the ASBM program billed through a different BlueCross contract will be denied.
- Provider-administered claims for members with the ASBM program billed through the member's carved out PBM may be recouped.
- Billing information will be listed on the member's ID card.
- Billing information for members that do not have pharmacy coverage through BlueCross should be entered as:
  - Member identification number
  - RXBIN = 004336
  - PCN = ADV
  - Pharmacy Group Number = RX56AM

If you disagree with your compensation for a specialty product, please refer to the Provider Appeal Process.

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XVIII. BEHAVIORAL HEALTH SERVICES

A. Introduction

BlueCross BlueShield of Tennessee is committed to providing safe and effective treatment at the most clinically appropriate and least restrictive level of care necessary to meet a member's behavioral health needs. Our commitment begins with providing a credentialed network of behavioral health providers to meet the access and availability needs of our members.

Providers of behavioral health services will adhere to all standards and regulations set forth by their licensing and accreditation entities. Providers of behavioral health services will also adhere to all contractual guidelines including all guidelines in the Provider Administration Manual. Treatment record standards for all behavioral health providers can be found in the Provider Administration Manual, and treatment records will comply with those standards. All applicable Tennessee state mandated requirements for Autism Spectrum Disorders are also followed by BlueCross BlueShield of Tennessee.

Additional resources that provide specific treatment expectations and best practices can be found below.

0940 - Mental Health and Substance Abuse Services

MCG Cite Guideline Transparency

B. Prior Authorization Guidelines

A complete list of services that require prior authorization can be found in the provider section of BCBST's website and at the following link: https://www.bcbst.com/docs/providers/Commercial-Prior-Auth-Requirements.pdf

Note: Always check member benefits for final determination on authorization requirements as these may vary per plan. Depending on the specific member health care plan, benefits for non-prior authorized care may be reduced or may not be available.

Any prior authorization changes will be published in the prior authorization section of www.bcbst.com.

> Emergency behavioral health services should be authorized at the time of admission or within two business days from the time of admission. Non-urgent services must be authorized at least one business day prior to admission or no later than one business day post admission. Behavioral Health authorizations requested outside of regular business hours should be submitted via Availity.com or via telephone during regular business hours. For questions about using Availity, please call (423) 535-5717, option 2, or contact your eBusiness Regional Marketing Consultant. For general Commercial UM information, please refer to section VII. Utilization Management Program.

C. Access to Services

Telephone Access for Referral and Authorization

BlueCross members can call **1-800-924-7141** during normal business hours to arrange routine behavioral health services. Medical or behavioral health providers or their office staff can also use this number to assist members in setting up appointments for required behavioral health evaluations or treatment.

Members should **call or text 988** in the event of a behavioral health crisis outside of normal business hours.

Treatment Access to Facilities and Professionals

We maintain standards to provide access to licensed and approved psychiatric and substance use disorder facilities and treatment programs, as well as licensed behavioral health care professionals.

Facilities must be licensed by the State and may require accreditation by the Joint Commission or the Commission Accreditation of Rehabilitation Facilities, or other recognized accrediting body to be approved for network participation.

Behavioral health care professionals must be state licensed or certified at the highest level of independent practice in the state where practice occurs.

Additional details about network eligibility requirements can be found in Section XIV. Credentialing, in this Manual.

D. Member Access to Behavioral Health Care

Medical and Behavioral Health

Emergency Care for Adult and Child Standard

Immediate evaluation by an appropriate provider – these services may be provided by facility-based providers. Emergency Care is defined as an emergency condition is defined 'by a prudent layperson' who possesses an average knowledge of health and medicine, as a medical condition that develops itself by symptoms of sufficient severity, including severe pain. Failure to provided such treatment could reasonably result in the following: serious impairment of bodily functions, serious dysfunction of any body organ or part, could reasonable be expected to place the person's health in serious jeopardy; threat to the health and safety of a pregnant woman who is having contractions or to an unborn child; danger to self (including psychiatric conditions and intoxication). It is understood that in those instances where a physician makes emergency care determinations, the physician shall use the skill and judgement of a reasonable physician in making such determinations.

Appointment Type: Non-life-threatening emergency

Standard: Within six hours

Definition: An emergency situation where clinical evidence shows that a person requires immediate care, but the lack of care wouldn't lead to death

Appointment Type: Urgent care

Standard: Within 48 hours

Appointment Type: Initial Visit for Routine Care

Standard: Within 10 business days

Definition: Doesn't include follow-up care for an existing problem

Appointment Type: Follow-up Routine Care

Standard: Within 10 business days for non-prescriber and within 30 business days for prescriber

Definition: Visits at later, specified dates to evaluate patient progress and other changes that have taken place since a previous visit, within clinically reasonable timeframes.

Appointment Type: After-Hours Care

For after-hours phone calls where the member leaves a message with an answering service/machine, the provider or their designated call coverage provider (unless otherwise approved by BlueCross, the call coverage provider shall be a BlueCross participating provider) will return the phone call to the member within the following time frames:

- In less than or equal to 30 minutes from when the member calls and leaves a message for urgent calls, and

- In less than or equal to 90 minutes from when the member calls and leaves a message for routine calls

Seven-day; 24-hour coverage through participating providers required for all networks. BlueCross may ensure compliance by calling provider's offices after hours to see if return phone calls are received within the above time frames.

E. Behavioral Health Specific Billing Guidelines

The following information will be helpful when billing behavioral health professional and facility claims. For general claims filing instructions, please refer to Section VI. Billing and Reimbursement, in this Manual.

1. Health and Behavior Assessment/Intervention

Performance of a health and behavior assessment may include a health-focused clinical interview, behavioral observations, psychophysiological monitoring, use of health-oriented questionnaires and interpretation of assessment data. Elements of a health and behavior intervention may include cognitive, behavioral, social, and psychophysiological procedures designed to improve the patient's health, improve specific disease-related problems, and improve overall well-being.

The following CPT® codes should be billed with a medical diagnosis and are most frequently billed by medical providers: (Please refer to the current International Classification of Diseases [ICD] Codes manual for the most appropriate diagnosis code in effect for the date of service.)

CPT® Code	Description
96156	Health behavior assessment, or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making)
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96170	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes
96171	Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)

2. Psychiatric Consultation Guidelines in a Medical Setting

When psychiatric consultation services are required, providers should call BlueCross to verify member eligibility and benefits. The following guidelines apply:

If consultation is in:	service may be:
Emergency Room	performed **only** by psychiatrist and billed according to contract fee schedule

Hospital Bed	performed by psychiatrist and/or psychologist and billed according to contract fee schedule
Nursing Home	performed by all behavioral health professionals and billed according to contract fee schedule

Psychiatric consultation services must be billed with the appropriate Place of Service code for the medical treatment setting and the CPT® code provided at the time the service was authorized. Claims must be billed on a CMS-1500 claim form or ANSI-837P transaction.

3. Facility and Program Services Revenue Codes

As a result of the code set requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), behavioral health facility claims must be filed with the appropriate Revenue Codes. A listing and contract descriptions follow:

Revenue Code	**Contract Description**
0114, 0124, 0134, 0144, 0154, 0204, 0116, 0126, 0136, 0146, 0156, 0118, 0128, 0138, 0148, 0158	Hospitalization for Psychiatric and Substance Use Disorders
0762	Observation, up to 23 hours
1001	• Non-Acute, Residential Treatment, Psychiatric • Non-Acute, Residential Treatment, Eating Disorder
1002	Non-Acute, Residential Treatment, Substance Use Disorder
0901	ECT Inpatient and Outpatient
0905	• Intensive Outpatient, Psychiatric • Intensive Outpatient, Eating Disorder
0906	Intensive Outpatient, Substance Use Disorder
0913, 0915	• Partial Hospital, Psychiatric • Partial Hospital, Substance Use Disorder • Partial Hospital, Eating Disorder
0944, 0945	Ambulatory Detox

Note: Certain Revenue Codes must also be accompanied by an appropriate CPT®/HCPCS code in order for claims to pay. Please refer to standard billing resource materials for additional information.

4. Applied Behavior Analysis

When the Board Certified/Licensed BCBA is physically present with the member (with or without the Registered Behavior Technician (RBT) being present) then the procedure code for the claim would be the applicable service the BCBA provides. If the RBT was alone with the member carrying out the service plan, then the code would be for the applicable service the RBT provides.

The RBT service codes can be used by Registered Behavior Technicians, Board Certified Assistant Behavior Analysts (BCaBA) or by a provider who has completed their training in Applied Behavior Analysis and is waiting to take the exam to become a Board Certified Behavior Analyst (BCBA).

Providers should bill in a manner consistent with the CPT code descriptions. In addition, if the BCBA is directing an RBT, the client is present, and one or more protocols have been modified then 97155 may be billed concurrently with the RBT codes.

2019 CPT® Code	2019 Duration	Description
0362T	per 15 minutes	Behavior identification supporting assessment, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: •administered by the physician or other qualified healthcare professional who is on site; •with the assistance of two or more technicians; •for a patient who exhibits destructive behavior; •completed in an environment that is customized to the patient's behavior.
0373T	per 15 minutes	Adaptive behavior treatment with protocol modification, each 15 minutes of technicians' time face-to-face with a patient, requiring the following components: • Administered by the physician or other qualified healthcare professional who is on site; • with the assistance of two or more technicians; • for a patient who exhibits destructive behavior; • an environment that is customized to the patient's behavior.
97151	per 15 minutes	Behavior identification assessment, administered by a physician or other qualified healthcare professional, each 15 minutes of the physician's or other qualified healthcare professional's time face-to-face with patient and/or guardian(s)/caregiver(s) administering assessments and discussing findings and recommendations, and non-face-to-face analyzing past data, scoring/interpreting the assessment, and preparing the report/treatment plan.
97152	per 15 minutes	Behavior identification supporting assessment, administered by one technician under the direction of a physician or other qualified healthcare professional, face-to-face with the patient, each 15 minute.
97153	per 15 minutes	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face with one patient, each 15 minutes
97153HO	per 15 minutes	Adaptive behavior treatment by protocol, administered by a physician or other qualified healthcare professional, face-to-face with one patient, each 15 minutes (effective for dates of service 9/1/2019 and forward)
97154	per 15 minutes	Group adaptive behavior treatment by protocol; administered by technician under the direction of a physician or other qualified healthcare professional, face-to-face with two or more patients, each 15 minutes
97155	per 15 minutes	Adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, which may include simultaneous direction of technician, face-to-face with one patient, each 15 minutes.
97156	per 15 minutes	Family adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (with or without the patient present), face-to-face with guardian(s)/caregivers, each 15 minutes
97157	per 15 minutes	Multiple-family group adaptive behavior treatment guidance, administered by physician or other qualified healthcare professional (without the patient present), face-to-face with multiple sets of guardians/caregivers, each 15 minutes
97158	per 15 minutes	Group adaptive behavior treatment with protocol modification, administered by physician or other qualified healthcare professional, face-to-face with multiple patients, each 15 minutes

As a reminder for the FEP/PSHB program, ABA is a medical benefit.

5. Neuropsychological and Psychological Testing

Check member benefits for prior authorization requirements. The following codes were developed by the APA and AMA. **Note**: As a reminder, neuropsychological testing is a medical benefit. A listing and description follow:

CPT® Code	Units	Description
96130	1	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96131	1	Each additional hour (List separately in addition to code for primary procedure)
96132	1	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96133	1	Each additional hour (List separately in addition to code for primary procedure)
96136	1	Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method, first 30 minutes
96137	1	Each additional 30 minutes (List separately in addition to code for primary procedure)
96138	1	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes
96139	1	Each additional 30 minutes (List separately in addition to code for primary procedure)

For psychologists using Licensed Psychological Examiners (LPE), these practitioners require supervision according to their state licensure. If the actual provider of the service needs the direction or supervision of a psychologist to legally perform the service and is ineligible to bill under their own NPI pursuant to the terms and conditions of their license or certification, then such supervising practitioner will be allowed to bill those services under their name and NPI. Supervising practitioners must perform all requirements and follow all regulations set forth by the applicable medical licensing or certification board for this specialty.

6. Single Psychological or Neuropsychological Automated Test with Automated Result

No prior authorization is required when billing for this service. A listing and description follow:

CPT® Code	Description
96146	Psychological or neuropsychological test administration, with single automated instrument via electronic platform, with automated result only

7. Residential Treatment Facility – Federal Employee Program (FEP) and Postal Service Health Benefits (PSHB)

- Residential Treatment Facility claims for Federal Employee Program (FEP) and Postal Service Health Benefits (PSHB) members must be billed following the CMS-1450 format.
- Residential Treatment Facility claims for Federal Employee Program (FEP) and Postal Service Health Benefits (PSHB) members must be billed with a Type of Bill 86x in Form Locator 4.

F. Provider/Member Complaints/Grievances

Providers and members can register complaints or grievances by calling BlueCross BlueShield of Tennessee Customer Service number, which is listed on the member ID card (see Provider/Member Complaint section for additional details).

G. Covered Behavioral Health Services

Benefits are available for clinical assessment, diagnosis, referral, as well as inpatient and outpatient services for treatment of Behavioral Health Disorders (mental health and substance use).

Behavioral health services are covered when received from a contracted provider or a non-contracted provider depending upon the member's health care benefits plan. Providers should check member benefits and prior authorization requirements using the Availity portal. Members should consult their health care benefits plan or call the Customer Service number listed on their ID card for prior authorization requirements, benefit coverage, and information about the Mental Health Parity and Addiction Equity Act of 2008.

Program Services

Program services are covered when received in a licensed behavioral health facility program, or unit for mental health disorders or substance use disorders and when prior authorized (as necessary) by the member's health care benefits plan. For all inpatient, residential and partial hospitalization admissions, a verbal or written MD order is required. Program services include acute care (psychiatric and withdrawal management), residential care, partial hospitalization, intensive outpatient programs, and inpatient and outpatient electroconvulsive therapy (ECT) defined as follows:

- **Acute Care**

  Acute care is provided in a facility licensed by a state to provide treatment for psychiatric or substance use disorders and is accredited by an acceptable accrediting body. Acute care includes 24-hour psychiatric and substance use withdrawal management (medically managed or medically monitored) care for adults, adolescents and children with distinct criteria for each service. It may also include co-occurring disorders, eating disorder, and other services targeted to treat specific behavioral health disorders.

- **Residential**

  Residential care includes psychiatric and substance use disorder treatment in an accredited program. Residential care is 24-hour-a-day care.

- **Partial Hospitalization and Intensive Outpatient Programs**

  Partial hospitalization and intensive outpatient programs must be provided in licensed facilities that have been accredited by an acceptable accrediting body and/or have passed a structured site visit.

  Effective 1/1/24 dually eligible beneficiaries (those enrolled in both Medicare and Medicaid) who received Medicaid coverage of services furnished by MFTs or MHCs, or IOP services furnished by hospital outpatient departments, community mental health centers (CMHC), rural health clinics (RHC), federally qualified health centers (FQHC), or opioid treatment programs (OTP), Medicare will become the primary payer for these services provided by Medicare enrolled practitioners or providers.

- **Inpatient and Outpatient Electroconvulsive Therapy**

  Electroconvulsive therapy (ECT) is covered when performed in a hospital setting.

- **Transcranial Magnetic Stimulation**

  Transcranial Magnetic Stimulation (TMS) has been approved as a treatment for major depressive disorder for all BlueCross lines of business. TMS is a non-invasive method of delivering electrical stimulation to the brain. TMS is not approved for treatment of other diagnoses or conditions.

  The therapy is administered in an inpatient, outpatient, or office setting. If needed, a treatment course may be repeated after a 3-month cessation period. All TMS services must be performed by staff with

device specific training and performed under the supervision of a licensed and trained Psychiatrist. The supervising Psychiatrist must be available on site or readily available.

TMS is not allowed for pregnant women or for children under age 18.

Services provided in an outpatient setting must be preauthorized and requests must include a physician's order.

The following CPT® codes are used for billing TMS services:

CPT® Code	Description
90867	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management
90868	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session
90869	Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management

Note: Use revenue codes 0510, 0513, and 0920 in conjunction with appropriate CPT® codes when services are initiated in an inpatient setting. Please note that charges for TMS filed by a facility during inpatient care are included in the inpatient reimbursement and aren't paid separately.

- **Psychological Testing and Neuropsychological Testing**

  All providers are required to submit a psychological or neuropsychological testing request in order to obtain prior authorization for this service. Automatic authorizations can be obtained on www.Availity.com. Authorization request form is located at https://www.bcbst.com/providers/forms/Psychological-Testing-Authorization.pdf

  Testing request should include:

  - General information about the member
  - Reported difficulties the member is experiencing
  - History of treatment and assessment
  - Diagnostic and treatment implications
  - Specific names of tests should be listed, with only the most common test acronyms used
  - Specific number of units the provider anticipates for: 1) administration and scoring, and 2) integration of patient data, interpretation, clinical decision making, treatment planning reports, and interactive feedback based on codes and units listed in the Neuropsychological and Psychological Testing grid. (See Subsection D.5 this Section.)

  Providers should be aware that educational testing is considered an excluded benefit under BlueCross. Educational testing is to be provided by the school system under federal Mandate PL 94-142. (According to the Child Find mandate of the Individuals with Disabilities Education Act, schools are required to locate, identify, and evaluate all children with disabilities from birth through age 21. (20 U.S.C. 1412(a)(3)).) There are also restrictions regarding the use of testing for vocational and legal purposes.

  Psychological, Neuropsychological or psychiatric evaluations of patients with psychiatric disorders that may reasonably be completed through clinical interview and other routine assessment tools (e.g., self-administered or self-scored evaluations or screening cognitive tests) are considered standard evaluation and management services and aren't categorized as psychological testing services.

  Generally, in depth psychological testing will not be considered medically necessary if the diagnostic questions can be addressed through medical, neurological, or psychiatric examination.

  Psychological testing should be administered by a trained qualified professional.

- **Applied Behavior Analysis (ABA)**

Applied behavior analysis is covered by the Federal Employee Program (FEP) as of 1/1/2017, by Postal Service Health Benefits (PSHB) as of 1/1/2025, and BCBST fully insured plans as of 1/1/2018. Coverage of ABA services for self-funded plans may vary and it is the provider's responsibility to verify coverage.

ABA has been approved for the treatment of Autism Spectrum Disorder and has a significant focus on identifying the function of unwanted behavior and development and implementation of a structured treatment plan to decrease undesirable behaviors and increase desirable behaviors. ABA is not: psychological testing, neuropsychology, psychotherapy, cognitive therapy, psychoanalysis, hypnotherapy or long-term counseling.

ABA providers using Registered Behavior Therapists (RBT) are expected to demonstrate compliance with the supervision guidelines outlined by the Behavior Analyst Certification Board, Inc. ® (BACB®) located at https://www.bacb.com/supervision-and-training/

- **Medication for Opioid Use Disorder (MOUD) Treatment**

  Effective 1/1/2020, Opioid Treatment Programs (OTPs) can provide treatment for Opioid Use Disorder as a Covered Service, to include Methadone, Buprenorphine, and Naltrexone Medication Assisted Treatment (MAT). BlueCross follows Medicare coding and billing guidance for OTP services, which is available at MLN8296732 Opioid Treatment Programs (OTPs) Medicare Billing & Payment Booklet (cms.gov)

- **Buprenorphine Medications for Opioid Use Disorder Outside of an OTP**

  Due to the evolution of billing codes that are available to providers, both bundled and unbundled, for the delivery of MOUD services, BCBST is phasing out its Buprenorphine Medication Assisted Treatment Program and its specific codes for Commercial and MedAdvantage lines of business.

  Current participating prescribers can continue to bill these or other available codes in their agreements, within their scope of licensure and practice, but new prescribers will not be added for this program. BCBST will provide additional communications regarding this change via Blue Alert and an FAQ and will notify participating providers per the agreement when the codes will no longer be available for use.

  All network providers who prescribe Buprenorphine for the treatment of Opioid Use Disorder must still meet State and federal requirements including those specific to nurse practitioners and physician assistants outlined by PC 771, PC 761 and PC 857 or successor regulations.

- **Traditional Outpatient Services**

  Professionals delivering these services must be licensed at the independent practice level in the state in which the services are provided and meet other requirements as formulated by State of Tennessee law, BlueCross BlueShield of Tennessee, and the behavioral health services covered under the member's health care benefits plan.

H. Treatment Record Requirements

Providers are expected to develop an initial treatment plan within thirty (30) days of the start date of service and update it every six (6) months or more frequently, as clinically appropriate for outpatient programs. Evidence of an individualized treatment plan includes, but is not limited to, the following documentation:

- A Case Formulation Statement that hypothesizes the member's primary problem(s), states the desired treatment outcomes, describes the therapeutic approach to treatment, and proposes interventions toward desired outcomes;
- Identified problems for which the member is seeking treatment;
- DSM diagnoses, primary and secondary;
- Measurable, attainable, age-appropriate goals and objectives related to the identified problems;
- Target dates for completion of goals/objectives;
- Information regarding the member's strengths used to develop strengths-based plan;
- Services to be used for each goal or objective (e.g., medication management, therapy, community-based treatment services);

- Evidence of member's involvement in treatment planning (Fulfilling this requirement means that each initial treatment plan and subsequent treatment plan review is signed by a member, family member, or legally appointed representative.);
- Progress notes for each service contact documenting the date and time of service, duration/end time of service, the type of service provided, a summary of treatment interventions used, the treatment plan goals and objectives addressed in the session, and the name and credentials of service provider;
- Documentation of coordination of care efforts and communications with PCPs, other outside providers, agencies, judicial system, member support system, or any other person or entity involved in the member's treatment;
- Evidence of discharge planning activities to include discharge plans, dates of follow-up appointments, and referrals to other providers;
- A discharge summary is completed and documented following discharge from service, (see program descriptions for time frame requirements; and
- For providers of multiple services, one comprehensive treatment plan is acceptable as long as at least one goal is written and updated as appropriate, for each of the different services provided to the member.

All treatment records must be legible, maintained in a detailed and organized manner, and available at the site where covered services are rendered. Treatment records for ALL LEVELS OF CARE must contain:

Identifying Member Information:

- Member name and at least one other piece of identifying information on every page or electronic screen of treatment record. (date of birth, member ID#, address);
- Member contact information including address and phone number;
- Employment or school information;
- Marital status;
- Legal status (including state custody);
- Guardianship and/or conservatorship, if applicable;
- Declaration for Mental Health Treatment form status

Consent Forms Signed by Member/Parent/Guardian:

- Consent for treatment;
- Informed consent for prescribed medications;
- Release of information forms, updated annually, for member's PCP, for other behavioral health providers, and for any other providers or agencies relevant to coordination of care
- For members with no PCP, documentation must reflect efforts to help a member to obtain a PCP;
- Release of information form for MCO or payer, communicating to member that provider will share service participation and treatment progress with MCO;
- For adolescents ages 16 and older, a consent or refusal to discuss behavioral health issues with a parent/guardian; and
- Acknowledgement of review of patient rights and responsibilities.

To equip members with the information they need to provide informed consent, when residential treatment is being considered for children and adolescents BlueCross BlueShield of Tennessee expects providers to inform children and adolescents and their parent(s) or legally appointed representative of all their options for residential and/or inpatient placement, alternatives to residential and/or inpatient treatment, and the benefits, risks, and limitations of each.

Likewise, when voluntary inpatient treatment is being considered for adults, BlueCross expects providers to inform them or their legally appointed representative of all their options for residential and/or inpatient placement, alternatives to residential and/or inpatient treatment, and the benefits, risks, and limitations of each.

Medication Information Documenting:

- All medications prescribed (psychotropic medications as well as medications for other physical health conditions), the dosages of each, and the dates of initial prescription and refills;
- If medications are prescribed by an outside provider, the prescriber is identified;

- Any medication allergies or adverse reactions are clearly noted; and
- For members being considered for psychotropic treatments, documentation must reflect evidence of informing the member and parent or guardian of the benefits, risks, and side effects of the medication, alternate medications, and other forms of treatment.

Current Medical Information and Medical History:

- A health assessment that includes medical history, screening for current medical problems, currently prescribed medications, and medication history;
- Medication allergies, adverse reactions, and relevant medical conditions are clearly documented as present or absent; and
- Documentation for Children/Adolescents regarding prenatal and perinatal events along with a complete developmental history (physical, psychological, social, intellectual, and academic).

Psychiatric Information and Psychiatric History:

- Identification of previous providers and treatment services;
- Approximate dates of service for previous providers and treatment services;
- Information regarding outcomes of previous treatment services;
- A mental status evaluation to be completed that includes, at a minimum, as assessment of appearance, affect/mood, speech, thought content, judgement/insight, attention/concentration, and memory;
- A DSM diagnosis consistent with current symptoms;
- Information addressing member-specific cultural considerations;
- Information regarding the member's list of strengths;
- A substance use assessment that screens for frequently used over-the-counter medications, alcohol, tobacco, and other drugs and history of prior alcohol and drug treatment episodes (recommended screening tools are available at https://provider.bcbst.com/working-with-us/behavioral-health);
- Current risk assessment (imminent risk of harm, suicidal or homicidal ideation/intent, elopement potential) clearly documented and updated according to written protocols; and
- A crisis plan relevant to member's risk potential that includes individualized steps for prevention or resolution of crisis. This plan should include, but is not limited to:
- Identifying crisis triggers
- Steps to prevent, de-escalate, or defuse crisis situations
- Names and phone numbers of contacts who can assist member in resolving crises
- The member's preferred treatment options in the event of a crisis.

Policies and Procedures

Note: The provider must have a policy regarding CFR-42, Part 2 protection of substance use information as well as a policy regarding ongoing training for non-licensed staff.

Clinicians

- It is the expectation that ongoing supervision will be provided by Mental Health/Substance Use facilities who employ non-licensed clinical staff that complete clinical activities, such as psychoeducational groups. The facility should ensure that all non-licensed clinicians are regularly supervised by a licensed clinician. The supervising clinician will have regular, in-person, one-on-one supervision with the non-credentialed clinician to review the services provided to members.
- Non-licensed master's level clinicians should not render outpatient behavioral health professional services.

Additional record requirements apply to SPECIFIC LEVELS OF CARE.

Child/Adolescent Residential Treatment Centers:

- An intake, initial evaluation, and diagnostic assessment completed within 2 hours of admission;
- An initial treatment plan completed within the first 72 hours of admission, and an updated treatment plan at least every 30 days or upon completion of the stated goals/objectives;
- Progress notes to be documented daily for each therapeutic contact and the member's individual progress;
- Documentation of consent by parent/guardian or member (if 16 years of age or older) to all medication changes;

- Documentation of seclusion/restraint events, notifications, and debriefings with member and staff;
- Medication administration record (MAR);
- Documentation of coordination with aftercare providers (including education providers) throughout the residential stay, and particularly coordination with providers as the discharge date approaches that includes aftercare appointments and sharing of relevant clinical information for continuity of care; and
- Discharge summary completed within five business days of member discharge which includes member's condition at time of discharge or transfer, the reason for discharge or transfer, aftercare appointments, and signature of person preparing the summary.

Intensive Outpatient Program (mental health and substance use disorders):

- An intake, initial evaluation, and diagnostic assessment and an initial individualized treatment plan must be completed and documented within three days of treatment;
- Updated treatment plan at least every eight treatment sessions;
- Progress notes for each therapeutic contact, including group sessions, to include date, start and finish times, level of member participation, daily risk assessment, and signature of service provider;
- Documentation of evaluation for mental health and substance use disorder services as medically necessary and evidence of the provision of needed services with appropriate behavioral health follow-up services planned.

Outpatient Service Providers:

- An intake, initial evaluation, or diagnostic assessment completed within the first 30 calendar days of initiation of services and to be updated as needed, and annually at minimum;
- An initial treatment plan completed within the first thirty (30) calendar days of initiation of services, and an updated treatment plan at least every six months;
- A progress note completed for each service contact;
- Documentation of communication with member's PCP and other behavioral health providers within two weeks of the intake/diagnostic assessment; annual updates to those providers, and notification of discharge from services to those providers; all communication to other providers must include a summary of treatment services, including medications, and any changes to treatment since the previous communication. Communication with the PCP or other medical provider must include a request for information to be sent back, to include at a minimum, a medication list;
- A discharge/transfer summary that includes member's condition at the time of discharge/transfer, the reason for discharge/transfer, aftercare recommendations or appointments as applicable, and the signature of person preparing the summary.

Substance Use Disorder Services Providers (Inpatient, Residential, & Outpatient):

- For Withdrawal Management services, documentation of supervision by a Tennessee-licensed physician with a minimum of daily re-evaluations by a physician or a registered nurse.

I. Behavioral Health Quality of Care and Adverse Occurrences

Complaints and Quality of Care Concerns

One method of identifying opportunities for process improvement is to collect and analyze the content of member complaints and other reported quality of care concerns. These will be reviewed per BlueCross Clinical Risk Management (CRM) Department processes. See CRM section of the Provider Administrational Manual for details.

Reporting Adverse Occurrences

Participating providers are required to report all adverse incidents involving members to BlueCross BlueShield of Tennessee. Providers must report adverse incidents to BlueCross within twenty-four (24) hours of detection or notification. Adverse occurrences are defined as incidents that represent actual or potential serious harm to the well-being of members or to others by a member who is in behavioral health treatment. Report all adverse occurrences to BlueCross using the Adverse Occurrence report form found on the company website at http://www.bcbst.com/providers/forms/Behavioral-Health-Adverse-Occurrence-Report.pdf.

Examples of reportable adverse occurrences include, but aren't limited to the following:

- Suicide death
- Non-suicide death that occurs in a residential or inpatient treatment setting. Non-suicide deaths of members receiving outpatient behavioral health treatment services should be reported only if there would be reasonable suspicion that the death was related to behavioral health treatment (e.g., overdose, potential medication error or reaction.)
- Death-cause unknown
- Homicide
- Homicide attempt with significant medical intervention*
- Suicide attempt with significant medical intervention*
- Allegation of abuse or neglect including peer-to-peer (physical, sexual, verbal)
- Accidental injury with significant medical intervention*
- Self-injurious behavior with significant medical intervention*
- Use of restraints/seclusion (physical, chemical, mechanical) requiring significant medical intervention*
- Treatment complications, including (medication errors and adverse medication reactions)
- Other occurrences representing actual or potential serious harm to a member not listed above
    - *Significant medical intervention: An event requiring medical intervention that cannot be provided in the behavioral health treatment facility (for example, a myocardial infarction requiring treatment in an emergency department or medical hospital).

BlueCross may undertake an investigation based on the circumstances of each occurrence, or on any identified trend of adverse occurrences. As a result, providers may be asked to furnish records, and/or to engage in corrective action to address quality of care concerns and any identified or suspected deviations from a reasonable standard of care. Providers may also be subject to disciplinary action through BlueCross Clinical Risk Management or the BlueCross Credentialing Committee, or both.

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XIX. BCBST.com

Our website, www.bcbst.com, is an award-winning, easy-to-use service that enables providers and members with internet capabilities to link to a compilation of informative health care information.

A. Availity

Availity enables providers to view information in a secure online environment. If you aren't registered, go to http://www.Availity.com and click on **New to Availity? Get Started** in the upper right corner of the home page and follow the instructions in the Availity registration wizard.

Using Availity providers can:

- Check claim status;
- Verify benefits, eligibility and coverage details;
- Submit claims (RTCA);
- View/print remittance advice; and
- Submit/update prior authorizations.

National Consumer Cost Tool

Providers can view their cost data in the National Consumer Cost Tool (NCCT) on Availity prior to the information being made available to members. This information is available for a 60-day review period.

The NCCT presents an opportunity for Blues Plans to offer a secure, interactive environment where consumers can evaluate cost-related information, become knowledgeable about the estimated costs of future procedures, and participate more effectively in their health care decisions.

B. Other Online Reference Materials

Provider Administration Manuals, Medical Policy Manual and a List of Clinical Practice Guidelines (CPGs)

A number of reference manuals are available at https://provider.bcbst.com/tools-resources/manuals-policies-guidelines giving you access to current administrative processes, and medical policies.

Click on the manual you wish to reference. To search for a specific topic, simply:

- Click on the **find** button (magnifying glass);
- Type in a word or number of words that most describe the topic you wish to find; and
- Hit **enter** on your keyboard

You'll be taken to the first mention of your search. To continue searching, just click on the **find again** button (magnifying glass with forward arrow).

C. Network Directories

Referring your patients to other participating providers isn't only contractual, but will also save substantial out-of-pocket costs for your patients.

The information listed in this online directory is updated daily. As is the case with any directory, the listed providers' participation in the network is verifiable only up to the date the directory was updated. Providers join and, leave the networks. It's very important to verify health care professionals' and facilities' continued participation in a network before referring a patient.

Although it's the provider's obligation to notify their BlueCross patients of any intent to terminate participation in a network, we'll also display future termination dates beside the provider's name once notice is received. It is our intent to publish these termination dates 30 days prior to the actual termination effective date.

We invite you to visit our website often. Information and new features are added on a regular basis.

XX. PROVIDER AUDIT GUIDELINES

A. Overview

All claims submitted to us and any of our affiliates and/or subsidiaries for reimbursement are subject to audit for the purpose of verifying the information submitted is correct, complete, in accordance with provider contract requirements, and supported by established coding guidelines.

Claims are routinely analyzed for potential billing and coding irregularities, as well as known areas of potential fraud and abuse. Audit of specific providers or provider groups may also be requested by any vested party.

All records requested must be provided; claims payments involved with records not received are subject to immediate recovery as unsubstantiated by documentation.

Audits are based on recognized coding and billing guidelines such as, but not limited to, the UB Coding Editor, ICD Manual and CPT® Manual as well as specific provider contractual language, medical policy and medical necessity review.

Audit rights are defined in this manual and any of their affiliates and/or subsidiaries' Provider Agreement. Claims found with errors, both overcharges and undercharges, will be submitted for adjustment.

B. Audit Process

Audit Scheduling

All providers are given advance notice of scheduled audit dates. Once an audit is scheduled, it shouldn't be changed or cancelled except for extenuating circumstances, and must be agreed upon by Provider Audit. If scheduled audits are continually delayed, or denied by the provider, payment for those claims selected for audit will be retracted until the audit is allowed.

Medical Record Request Process

When requested by BlueCross or a designated vendor, providers are required to furnish, in a timely manner, medical records and encounter data in electronic or hardcopy format. Medical records may be submitted via our secure file transfer portal (SFTP) that's fully compliant with HIPAA and requires minimal set up. All complete medical records must be provided by the beginning of the audit to help ensure a timely audit schedule. Any additional documentation requested during the audit must be provided in a timely manner. Medical records not provided at the audit start date may result in retraction of payment. Electronic Health Records (EHR) must contain a system generated permanent date and time record for all entries as required by HIPAA.

Audit Process

All claims are reviewed for correct coding and billing, contract compliance and accurate reimbursement based on applicable regulatory governing agencies and BlueCross guidelines as published in this manual, medical policies, and as well as medical necessity.

Analysis is performed to identify the need for additional frontend edits. While it is possible to implement a new edit to reduce overpayments going forward, Provider Audit will continue to identify and recover overpayments retrospectively. The effective date of a new front-end edit will only communicate to providers when they will apply to claims processing going forward. This notice doesn't preclude retrospective audit findings for dates of service prior to the edit effective date, or claims that bypass editing for other reasons.

Facility Audit Process

Facility Audit schedules audits in advance and medical records are requested a minimum of eight weeks before the scheduled audit date. This provides ample time to compile and submit medical records, I-bills and invoices, and ER tools, as applicable. Audits begin on the scheduled date and it's expected that all documentation is received prior to the actual start date of the audit. Audit staff will be available during the audit period to discuss audit concerns and findings and will conduct an exit interview with designated staff at

the conclusion of the audit to provide a general overview of all audit outcomes. Facilities **shouldn't** file corrected claims for issues identified during audit unless instructed to do so by the auditors. Corrections/changes to claims audited should be handled via reconsideration/appeal process as advised during the audit.

Audit Accommodations

We reserve the right to conduct on-site audits. Adequate and reasonable accommodations will be required during the audit. These accommodations include but aren't limited to adequate desk space, location compatible for wireless internet service, lighting, environment with minimal noise or distraction for the auditors, temperature, seating, etc. A single location for the entire audit team without relocation during the audit is expected.

If auditors are expected to connect to the provider's system for access to medical records, providers are responsible for ensuring connectivity, communicating instructions, and providing training on computer systems prior to the audit. E-mail communications outline the requirements for remote access given to auditors, but the testing process and validation of access is expected **two weeks prior to the begin date** of the scheduled audit.

Audit Findings

The provider will receive a Final Audit Report detailing the results of each audited claim at the audit conclusion, normally within 30 days. The claims found in error may be submitted for adjustment and/or re-adjudication. Providers are expected to correct identified issues immediately.

Subsequent Audits

A decision may be made to expand the audit scope based on audit findings.

Additional follow-up audits may be performed to substantiate the provider has made any necessary corrections to billing and/or documentation practices according to the billing and coding guidelines cited on a previous audit.

Vendor Audits

BlueCross, or a designated vendor, is allowed to perform on-site, desk, or remote audits and inspections of financial and/or medical records, and Utilization Management covering treatment of any BlueCross member. Such audits and inspections must be permitted without charge to us or its designated vendor, who shall be provided copies of records involving the audit or inspection without charge.

We've contracted with claims audit vendors to perform pre and post-payment coding, utilization and medical necessity audits. Our claim audit vendors follow CMS auditing procedures like those practiced by the Medicare claims audit vendor where Clinical Review Judgment (CRJ) is used to determine if the services provided were medically necessary, coded at the appropriate level and/or billed according to recognized utilization standards. CRJ is used on all complex audits and involves a thorough review of all submitted medical documentation for the reviewer to develop a complete clinical picture of the patient as part of the evaluation. In addition to the complex reviews, our claims audit vendors also perform automated audits using proprietary algorithms to identify potential overpayments as a result of billing and coding errors.

Submission of Outpatient Claims Following an Audit

In accordance with CMS ruling 1455-R issued on March 13, 2013, we'll accept outpatient claims from facilities for outpatient services (ER room visits, observation services, etc.) performed prior to an inpatient admission when our recovery audit vendor or Provider Audit has determined that the inpatient admission wasn't medically necessary, or did not meet contractual terms. We'll process the outpatient claims according to our normal processing and reimbursement rules.

To prevent delays in reimbursement, hospitals should mark the outpatient claim to indicate that it's the result of an audit and submit it within 120 days of the date of our remittance advice reflecting recovery of the inpatient claim. If a facility has appealed an audit decision and received a denial, the outpatient claim should

be submitted within 120 days of the date of the appeal decision. A copy of the appeal decision should also be submitted to help ensure proper handling of the claim. Additionally, hospitals must maintain documentation to support the services billed on the outpatient claim.

C. Data Mining and Claims Auditing

Claims Data Analysis is performed using algorithms that analyze claims data prospectively and retrospectively. Claims are evaluated, both individually and against other claims using edits developed from recognized standards of coding, billing and reimbursement. Claims will be adjusted according to the results of the application of these principles when overpayments are identified.

The overpayment adjustments may take place simultaneously with a facility audit, as well as periodically when identified. BlueCross and any of our affiliates and/or subsidiaries reserve the right to periodically evaluate and modify these edits.

D. Reconsideration Process

If you wish to dispute Provider Audit findings, you may submit a written request for reconsideration and state why you disagree. Additional supporting documentation and medical records applicable to your dispute should be included. Claims audited are subject to the Provider Dispute Resolution Process. See Section XI. Provider Dispute Resolution Procedure in this manual for detailed information.

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XXI. MEDICARE ADVANTAGE

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A. Introduction

Preferred Provider Organization

BlueCross offers seven Medicare Advantage Preferred Provider Organization (PPO) products, which we commonly refer to as BlueAdvantage products: Sapphire, Garnet, Ruby, Diamond, Extra, Freedom, Total Heart and Diabetes, and Plus (Group). PPO plans have a network of contracted providers who have agreed to care for plan members for a contracted payment amount. PPO plans must allow all covered benefits whether they're received from network or non-network providers. Member cost-sharing may be higher when care is received from non-network providers.

Sapphire, Garnet, Ruby, Diamond, Extra, Freedom, Plus (Group) PPO, BlueAdvantage Total Heart and Diabetes products and benefits are described in subsection B.

For covered services, contracted providers may collect no more than the applicable cost-sharing amount and, if the provider doesn't accept Medicare assignment, the Medicare limiting charge. Members may get covered services from out-of-network providers if they participate in Medicare. If a provider mistakenly collects more from the member than the designated cost-sharing amount, the provider must refund the difference to the member.

B. Medicare Advantage Products

1. Product Descriptions

BlueAdvantage Sapphire, Garnet, Ruby, Diamond, and Extra

These Medicare Advantage plans combine the benefits of Medicare Part A and B and includes additional services not covered by Original Medicare, such as a yearly routine physical, routine vision care, an eyewear allowance, preventive and comprehensive dental benefits, and a hearing aid benefit provided through TruHearing. Plus it offers Medicare Part D prescription drug coverage, an over-the-counter benefit, and more.

BlueAdvantage Freedom

BlueAdvantage Freedom combines the benefits of Medicare Part A and B and includes additional services not covered by Original Medicare, such as a yearly routine physical, routine vision care, an eyewear allowance, preventive and comprehensive dental benefits, and a hearing aid benefit provided through TruHearing. This product doesn't include Medicare Part D prescription drug coverage, however, there's an over-the-counter (OTC) benefit for this plan.

BlueAdvantage Plus (Group)

BlueAdvantage Plus is a group plan that combines the benefits of Medicare Part A and B and includes additional services not covered by Original Medicare, such as a yearly routine physical. Plus it offers Medicare Part D prescription drug coverage.

BlueAdvantage Total Heart and Diabetes

BlueAdvantage Total Heart and Diabetes combines the benefits of Medicare Part A and B with a focus on helping members with heart disease and diabetes. These plans include additional services not covered by Original Medicare, such as dental and vision. It also provides special copays and other benefits for diabetic supplies, drugs, and support. This plan also provides Part D drug coverage.

2. Benefit Highlights

A summary of benefits for our members can be found on Availity®.

3. ID Card

Each of our members receive an ID card that includes the following information:

- Member name
- Member ID number
- Group number
- Member copayment amount
- Drug coverage indicator*

**Not applicable to BlueAdvantage Freedom*

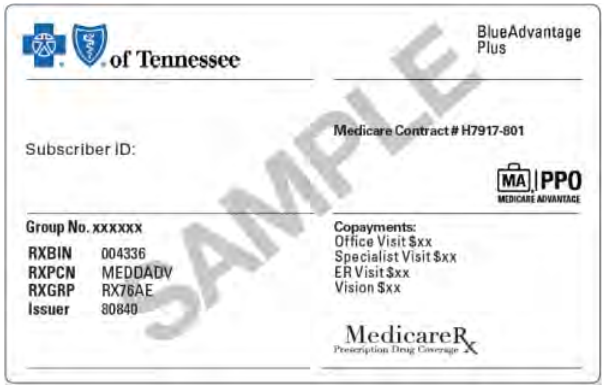
You can verify the member's plan by simply checking their member ID card. When a member presents the card into your office, please take a moment to look at the card to help prevent them from being denied services incorrectly.

Sample copies of the BlueAdvantage cards follow:

BlueAdvantage (PPO)

BlueAdvantage Freedom

BlueAdvantage Plus (PPO)



C. Reimbursement Methodology

When billing for services rendered to our Medicare Advantage members, providers should refer to the most current federal, state, or other payer instructions for specific requirements applicable to the CMS-1500 professional/ANSI-837P and CMS-1450 facility/ANSI-837I health insurance claim forms. Medical /clinical

codes including modifiers should be reported in accordance with the governing coding organization. Refer to your BlueAdvantage contract for reimbursement specifics.

Note: Unless specified differently in this section, all other Commercial billing guidelines apply for our members (see Section VI. Billing and Reimbursement, of this Manual).

1. General Provisions

Eligible services not priced by the Centers for Medicare & Medicaid Services (CMS) will be based on a reasonable allowable fee as determined by us.

We reserve the right to request documents submitted to or issued by the Medicare Fiscal Intermediary or Carrier necessary to determine an appropriate fee under Medicare-based reimbursement methods.

Should payments to managed care organizations participating in federal health care programs, such as BlueCross or the applicable payor, be adjusted other than through the payment method for the applicable federal health care program, we or the applicable payor may implement the same or a similar adjustment to payment rates and/or payments for covered services. An example of an adjustment to payment rates for federal health care programs would be the application of the Medicare Sequestration provision (part of the Budget Control Act of 2011) that went into effect April 1, 2013.

You have a right to appeal our reimbursement. If you have information that Original Medicare would pay more for a service, documentation (e.g. copy of a remittance advice or other official notice of payment for the same service from the Medicare Fiscal Intermediary or Carrier as proof of Medicare payment) may be submitted to us. See subsection K. Provider Appeals Process in this section for additional information regarding our appeal processes including submission instructions.

Details regarding Medicare reimbursement methods can be found on the CMS website, www.cms.gov. Links to the CMS website for specific provider and service types are in the following grid. If CMS changes one or more of the links, refer to CMS website, www.cms.gov.

If there's a conflict between the following information and information published by CMS, the information published by CMS will prevail.

Provider or Service Type	CMS Link for Detailed Information
Acute Inpatient Service	http://www.cms.gov/AcuteInpatientPPS/
Ambulance Services	http://www.cms.gov/AmbulanceFeeSchedule/
Ambulatory Surgical Center (ASC)	http://www.cms.gov/HospitalOutpatientPPS
Anesthesia	http://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html
Clinical Lab	http://www.cms.gov/ClinicalLabFeeSched/
Critical Access Hospitals	http://www.cms.gov/center/cah.asp
Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS)	http://www.cms.gov/DMEPOSFeeSched/
End Stage Renal Disease (ESRD) Center	http://www.cms.gov/center/esrd.asp
Federally Qualified Health Centers (FQHC)	http://www.cms.gov/center/fqhc.asp
Home Health	http://www.cms.gov/HomeHealthPPS/
Hospice	http://www.cms.gov/Center/Provider-Type/Hospice-Center.html

Provider or Service Type	CMS Link for Detailed Information
Hospital - Outpatient Services	http://www.cms.gov/HospitalOutpatientPPS/
Hospitals	http://www.cms.gov/center/hospital.asp
Inpatient Rehabilitation Facility	http://www.cms.gov/InpatientRehabFacPPS/
Inpatient Psychiatric Facility (IPF)	http://www.cms.gov/InpatientPsychFacilPPS/
Long-Term Care Hospital	http://www.cms.gov/LongTermCareHospitalPPS
Medicare Diabetes Prevention Program (MDPP)	https://www.cms.gov/priorities/innovation/files/mdpp-cy26-billingclaims-cheatsheet.pdf https://www.cms.gov/priorities/innovation/files/fact-sheet/mdpp-ma-fs.pdf
Part B Drugs	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/CompetitiveAcquisforBios https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice
Physicians and Other Healthcare Professionals	http://www.cms.gov/center/physician.asp
Rural Health	http://www.cms.gov/center/rural.asp
Skilled Nursing Facilities	http://www.cms.gov/SNFPPS/

a. Quarterly Policy for Carrier Priced and Based Wholesale Acquisition Cost (WAC) fee schedules

All Carrier Priced codes will reimburse at the local WAC fee schedule for Tennessee. Changes to the Carrier Priced fee schedule will be implemented using the below Quarterly Reimbursement table. For example, if a change to a Carrier Priced code is published Feb. 14, 2023, the new fee will be in effect July 1, 2023. Changes to the Base WAC fee schedule will be implemented using the below Quarterly Reimbursement Table. For example, if a change to a Base WAC code is published Feb. 14, 2023, the new fee will be in effect July 1, 2023.

Date Reimbursement Data is Published by Source	Date Change Will Be Applied by Us
January 1 to March 31	July 1
April 1 to June 30	October 1
July 1 to September 30	January 1
October 1 to December 31	April 1

b. Right of Reimbursement and Recovery (Subrogation)

The Right of Reimbursement and Recovery (Subrogation) is a provision in a Medicare Advantage (MA) plan to conditionally pay the provider when a third party causes the member's condition. We follow Medicare policy where by law, 42 U.S.C. Section 1395y(b)(2) and Section 1862(b)(2)(A)/Section and Section 1862(b)(2)(A)(ii) of the Social Security Act, Medicare may not pay for a beneficiary's medical expenses when payment "has been made or can reasonably be expected to be made under a workers' compensation plan, an automobile or liability insurance policy or plan (including a self-insured plan), or under no-fault insurance."

Pursuant to 42 U.S.C. Section 1395y(b)(2(B)(ii)/Section, Section 1862(b)(2)(B)(ii) of the Act and 42 C.F.R. 411.24(e) & (g), CMS may recover from a primary plan or any entity, including a beneficiary, provider, supplier, physician, attorney, state agency or private insurer that's received a primary payment. Likewise, we may recover in the same manner as CMS.

Like Medicare, if responsibility for the medical expenses incurred is in dispute and other insurance won't pay promptly, you may bill us as the primary payer. If the item or service is reimbursable under MA and Medicare rules, we may pay conditionally on a case-by-case basis and will be subject to later recovery if there's a subsequent settlement, judgment, award, or other payment. In situations like this, the member may choose to hire an attorney to help recover damages.

2. Specific Provisions

a. Self-Administered Drugs and Revenue Code 0637

Self-administered drugs billed with revenue code 0637 are not covered and will deny as a contractual write-off. Certain high dollar self-administered drugs may be billed with revenue code 0636 if eligible per the UB editor to be considered for reimbursement.

b. Hospital Based Clinic Visits

1. When one of our members receives Evaluation & Management (E&M) professional services with a procedural service or services on the same date of service by the same provider of care in a provider-based office or clinic setting, whether on-campus or off-campus of the provider or facility, payment for provider-based clinic professional services includes any technical or facility fees;
2. The technical or facility fee associated with a provider-based clinic visit using Revenue Code 510 and associated with an office/clinic visit where our member receives an E&M service or services with a procedural service or services on the same date of service from the same provider won't be paid and will be identified on provider remittances/evidence of benefits as provider responsibility or provider liability;
3. Providers and facilities may not bill our members for the above noted technical or facility fees associated with provider-based clinic visits; and
4. The 'same provider' means any physician or other healthcare practitioner and/or the provider or facility who owns and/or operates the provider-based clinic, whether on-campus or off-campus.

c. Dialysis Clinic Claim Reimbursement for Completed CMS-2728-U03 Form)

Initial dialysis clinic claims filed with Type of Bill 072X will require the submission of a completed CMS-2728-U03 form. The online fillable form is located at: https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms2728.pdf. Reimbursement won't be considered for dialysis clinic claims if a completed CMS-2728-U03 form isn't on file with us. The initial and subsequent claims will be denied requesting that the provider submits the completed form.

More information one ESRD may be found in subsection D (Risk Adjustment) in this section. Providers may submit the applicable CMS-2728-U03 form by fax to **(423) 535-5498**, or by mail to BlueCross, Attn: BlueAdvantage Revenue Reconciliation, 1 Cameron Hill Cr, Ste 0002, Chattanooga, TN 37402-0002.

d. Organ Acquisition Costs

Certified Transplant Centers (CTC) that submit any claims for organ acquisition costs must be accompanied by the following documents:

- Form CMS-2252-10
- Worksheet D4, Parts I-IV:V Computation of Organ Acquisition Cost and Charges for Hospitals which are Certified Transplant Centers

Facility claims submitted without a CMS-2252-10 form or the appropriate D4 Worksheet will be denied.

See the Medicare Provider Reimbursement Manual, Part 1, Chapter 31- Organ Donation and Reimbursement for additional assistance.

e. Radiopharmaceuticals and Contrast Materials

For radiopharmaceuticals and contrast materials billed on a CMS-1500/ANSI-837P, refer to Section VI. Billing and Reimbursement of this Manual - Policy for Radiopharmaceuticals and Contrast Materials for appropriate reimbursement.

f. Home Health Services

All Home Health services require prior authorization with the exception of Medical Social Services and Home Health Aide; this includes the initial evaluation and treatment to prevent delay in patient care. Authorization request should be submitted prior to services being rendered or no later than 24hrs after initial evaluation and treatment visit. Start of care visits will be approved based on care type and clinical needs.

All Home Health services for our members should be billed on the CMS-1450 claim form using CMS-1450 Type of Bill 032X. When submitting ANSI-837 electronic claims, the Institutional format must be used.

HCPCS codes are required for all MA outpatient physical, occupational, and speech therapy services. Skilled nursing, medical social services and home health aide services also require the appropriate HCPCS codes that correspond with the Revenue Code being billed.

Note: Please use the appropriate therapy evaluation revenue code for services related to an evaluation.

Description	Revenue Code	Procedure Code	
Home Health Physical Therapy	0421	G0151 G0157 G0159	
Home Health Physical Therapy Evaluation	0424	G0151 G0157 G0159	
Home Health Occupational Therapy	0431	G0152 G0158 G0160	
Home Health Occupational Therapy Evaluation	0434	G0152 G0158 G0160	
Home Health Speech Therapy	0441	G0153 G0161	
Home Health Speech Therapy Evaluation	0444	G0153 G0161	
Home Health Skilled Nursing (RN or LPN)	0551	G0493 G0494 G0495	G0496 G0299 G0300
Home Health Medical Social Services	0561	G0155	
Home Health Home Health Aide	0571	G0156	

Home Health services not billed with the indicated revenue codes and/or procedure codes may be rejected or denied.

To facilitate claims administration, a separate line item must be billed for each date of service and for each service previously indicated. (This includes drug codes for the drugs provided with Home Infusion Therapy [HIT] per diem.)

Supplies on our Home Health Agency Non-Routine Supply List should be billed using the indicated revenue codes and HCPCS codes. Units should be billed based on the HCPCS code definition in effect for the date of service. HCPCS code definitions can be found in the HCPCS manual.

Supplies not billed with the indicated Revenue Codes and HCPCS codes will be rejected or denied.

Reimbursement for supplies not indicated on our Home Health Agency Non-Routine Supply List used in conjunction with the above services are included in the maximum allowable for the service and won't be reimbursed separately.

Prior authorization is required for any non-routine supplies used in conjunction with skilled nurse care rendered either in the patient's home or in a facility. Charges for non-routine supplies won't be reimbursed if they're not included and reviewed within the authorization. Supplies not used in conjunction with a Home Health visit aren't billable by the Home Health Agency Provider. Charges for routine supplies not billed with associated services may be subject to review prior to claim payment. Third party reimbursement is only allowed when there's absence of an associated skilled nursing care within the patient's home or in a skilled nursing facility.

The following codes should be used when billing Home Health Agency Non-Routine Supplies with Revenue Code 0270:

A4212	A4331	A4357	A4375	A4390	A4407	A4422	A4455	A5056	A5112	A7502	A7526	T4531
A4248	A4333	A4358	A4376	A4391	A4408	A4423	A4456	A5057	A5113	A7503	A7527	T4532
A4310	A4334	A4360	A4377	A4392	A4409	A4424	A4459	A5061	A5114	A7504	T4533	T4534
A4311	A4338	A4361	A4378	A4393	A4410	A4425	A4461	A5062	A5120	A7505	S8210	T4535
A4312	A4340	A4362	A4379	A4394	A4411	A4426	A4463	A5063	A5121	A7506	T4521	T4537
A4313	A4344	A4363	A4380	A4395	A4412	A4427	A4481	A5071	A5122	A7507	T4522	T4540
A4314	A4346	A4364	A4381	A4396	A4413	A4428	A4623	A5072	A5126	A7508	T4523	T4541
A4315	A4349	A4366	A4382	A4397	A4414	A4429	A4625	A5073	A5131	A7509	T4524	T4542
A4316	A4351	A4367	A4383	A4398	A4415	A4430	A4626	A5081	A6413	A7520	T4525	T4543
A4320	A4352	A4368	A4384	A4399	A4416	A4431	A5051	A5082	A6531	A7521	T4526	
A4321	A4353	A4369	A4385	A4400	A4417	A4432	A5052	A5083	A6532	A7522	T4527	
A4326	A4354	A4371	A4387	A4404	A4418	A4433	A5053	A5093	A7045	A7523	T4528	
A4328	A4355	A4372	A4388	A4405	A4419	A4434	A5054	A5102	A7047	A7045	T4529	
A4330	A4356	A4373	A4389	A4406	A4420	A4435	A5055	A5105	A7501	A7524	T4530	

The following codes should be used when billing Home Health Agency Non-Routine supplies with Revenue Code 0623:

A6010	A6203	A6214	A6232	A6243	A6256	A6412	A6451
A6011	A6204	A6215	A6233	A6244	A6258	A6441	A6452
A6021	A6205	A6220	A6234	A6245	A6259	A6442	A6453
A6022	A6206	A6221	A6235	A6246	A6261	A6443	A6454
A6023	A6207	A6222	A6236	A6247	A6262	A6444	A6455
A6024	A6208	A6223	A6237	A6248	A6266	A6445	A6456
A6154	A6209	A6224	A6238	A6251	A6402	A6446	A6457
A6196	A6210	A6228	A6239	A6252	A6403	A6447	A6545
A6197	A6211	A6229	A6240	A6253	A6404	A6448	A7040
A6198	A6212	A6230	A6241	A6254	A6407	A6449	A7041
A6199	A6213	A6231	A6242	A6255	A6410	A6450	A7048

Note: In the event the Home Health Agency is not able to provide needed Non-Routine supplies a third party vendor, such a medical supply company, may bill for any eligible non-routine supplies on a CMS-1500 professional claim form/ANSI-837P.

g. Oxygen Equipment

As required by CMS, Tennessee LCD and the supporting policy article, reimbursement for oxygen equipment is limited to 36 monthly rental payments. Payment for accessories, delivery, back-up equipment, maintenance and repairs is included in the rental allowance.

The supplier who provides oxygen equipment for the first month must continue to provide any necessary oxygen equipment and all related items and services through the 36-month period. Contents will only continue to be reimbursed beyond 36 months.

After 36 monthly rental payments have been made there's no further payment for oxygen equipment during the five-year reasonable use lifetime of the equipment. The supplier who provided the equipment during the 36-month rental is required to continue providing the equipment during the five-year reasonable use lifetime of the equipment.

Exceptions and additional information can be found on the CMS website at https://www.cms.gov/medicare-coverage-database/view/lcd.aspx?lcdid=33797.

h. Readmissions

Submitting a corrected bill or combining the services from a readmission with those of the initial (index) admission will result in all services on the claim being disallowed. Also, billing with a "leave of absence" revenue code (018X) for the interval period and combining all the dates of service in a single claim will lead to a disallowed claim. Similarly, submitting a corrected bill or other alternate outpatient resubmission for these services isn't appropriate without a Condition Code 44 appended, and services will be disallowed.

D. BlueCard Program – Medicare Advantage

When providing services to MA members from Blue Plans (see Section XIV. BlueCard Program of this manual), network providers must follow the member's Home Plan procedures/requirements, including obtaining the appropriate prior authorization for services. Failure to secure a prior authorization will result in a denial of payment. In such instances, CMS guidance prescribes that MA members cannot be held financially liable.

E. Risk Adjustment

Risk adjustment is the process where CMS reimburses MA plans, such as us, for the health status and demographic characteristics of their enrollees. CMS uses the Hierarchical Condition Category (HCC) payment model (the ICD Code version required by CMS at the time the service is provided) and encounter data submitted by MA plans to establish risk scores. The primary source of encounter data or ICD codes routinely submitted to CMS is extracted from claims with additional conditions being identified during retrospective chart review and prospective health assessments.

CMS looks to you to code identified conditions accurately using the ICD coding guidelines with supporting documentation in their medical records.

Your role in risk adjustment includes:

- Accurately reporting the ICD Code version required by CMS at the time the service is provided to the **highest level of specificity** (critical as this determines disease severity).
- Documentation should be complete, clear, concise, consistent and legible.
- Documentation of all conditions treated or monitored at the time of the face-to-face visit in support of the reported diagnoses codes.
- Use of standard abbreviations.
- Medical records should be signed with physician's credentials present.
- Medical records should identify a treatment plan for conditions present.
- Submitting claims data in a timely manner, generally within 30 days of the date of service (or discharge for hospital inpatient admissions).

Risk Adjustment Data Validation (RADV) Audits conducted by CMS

Annually, CMS selects (both random and targeted) MA organizations for a data validation audit. CMS uses medical records to validate the accuracy of risk adjustment diagnoses submitted by MA organizations. The medical record review process includes confirming appropriate diagnosis codes and level of specificity were used, verifying the date of service is within the applicable data collection period, and ensuring the provider's signature and credentials are present. If CMS identifies discrepancies and/or confirms there isn't adequate

documentation to support a reported diagnosis in the medical record during the data validation process, financial adjustments will be imposed on the MA organization.

Medical Record Documentation Tips for Meeting CMS requirements for Submission of Encounter Data and RADV Audits:

- Progress Note Requirements:
  - Progress notes must contain patient name and date of service on each page.
  - If the progress note is more than one page or two-sided, the pages must be numbered, (i.e., 1 of 2). If pages aren't numbered, the provider must sign each page of the progress note.
  - Progress notes should follow the standard subjective, objective, assessment and plan (SOAP) format.
- Provider Signature Requirements on Progress Note:
  - All progress notes must be signed by the provider rendering services.
  - Provider credentials must either be pre-printed on the progress notes as a stationary or the provider must sign all progress notes with their credentials as part of their signature.
  - Dictated notes and consults must be signed by the provider.
  - Provider signature must be legible, (i.e., John Smith Doe, M.D. or JSD, MD. If a provider's signature is missing or illegible, an attestation must be completed by the physician or physician extender.
  - Stamped signatures aren't acceptable for risk adjustment.
  - Electronic Medical Record (EMR) progress notes must have the following wording as part of the signature line:
    - Electronically signed
    - Authenticated by
    - Signed by
    - Validated by
    - Approved by
    - Sealed by
  - The signed EMR record must be closed to all changes.
  - Sign off on medical records should be completed timely.
  - Medical records must be signed by a Medical Doctor (MD), Physician Assistant (PA), Nurse Practitioner (NP), or Doctor of Osteopathic Medicine (DO).
- Diagnosis Documentation Requirements on Progress Note:
  - Documentation should include evaluation of each diagnosis on the progress note, not just the listing of chronic conditions (e.g., DM w/Neuropathy – meds adjusted, CHF-compensated COPD – test ordered, HTN – uncontrolled, Hyperlipidemia – stable on meds). CMS considers diagnoses listed on the progress note without an evaluation or assessment as a "problem list", which isn't acceptable for risk adjustment submission.
  - Avoid using "history of" for conditions the member still has or is being treated.
    - For example, indicating a history of diabetes isn't correct. While the member has diabetes in their history, it's still a current condition. Use the words "history of" cancer, stroke, etc., to indicate the condition is no longer a current health concern.
  - Each progress note must be able to "**stand alone.**" Don't refer to diagnoses from a preceding progress note, problem list, etc.
  - Avoid documentation of diagnosis as probable, suspected, questionable, rule out or working. Rather, document or code to the highest degree certainty known for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Releasing Medical Records

We have the right to request medical records without charge to ensure appropriate coding and/or identify additional diagnoses for risk adjustment data submission to CMS – refer to your Medicare Advantage Provider Agreement and/or the Model Terms and Conditions of Payment.

Confidentiality and General Consent

Confidentiality of patient information is important to us. Any information disclosed by you in response to medical record requests for risk adjustment will be treated in accordance with applicable privacy laws. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 C.F.R. § 164.502, you are permitted to disclose the requested data for purpose of treatment, payment and health care operations after you have obtained the “general consent” of the patient. A general consent form should be an integral part of your patient’s medical records file.

Requests for medical records from our Risk Adjustment Department will be like the sample letter on the following page:

Balance this Page
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To:	<Contact Person>
Fax:	<Recipient Fax #>
From:	BlueCross BlueShield of Tennessee
Re:	Medical Record Retrieval for Medicare Advantage Risk Adjustment Review
Pages:	<Insert # Pages>

FAX

Request for Medical Records

<Date>

<Office Address>
<City, State Zip>

Dear Practice Manager or Health Information Department:

We are requesting medical records for your BlueCross BlueShield of Tennessee Medicare Advantage patients for **dates of service between Jan. 1, 2023, and now**. Because we are a Medicare Advantage Organization, the Centers for Medicare & Medicaid Services (CMS) requires us to verify that our members' medical records contain documentation supporting diagnoses and related acuities for risk adjustment reasons. Please know this is a medical record review and not a claims payment audit.

To minimize the effort needed to fulfill this CMS requirement, we have technology to support remote access to electronic medical record (EMR) systems. This would allow BlueCross to access the necessary records with minimal administrative support from your medical records staff. If you are interested in making remote EMR arrangements, please call us at **1-855-413-8776**. Sites with 25 or more records requested may qualify for this option.

This is a time-sensitive request. We need these medical records, progress or hospital notes, and any clinical correspondence for the patients in the attached list **within six weeks** of the date of this letter. You may also use one of these alternative options to send your records:

- Upload records through our Secure File Transfer Protocol (SFTP). SFTP lets you upload records in batch to our secure location. Instructions are included with this packet.
- Fax directly to our secure **fax line at 1-833-605-5210**.
- Have a Medical Record Technician **visit your office** to collect medical records. Call **1-855-413-8776** to schedule an appointment. Sites with 100 or more records requested may qualify for this option.
- As a last resort only please, mail to:

  BlueCross BlueShield of Tennessee
  Risk Adjustment Department
  1 Cameron Hill Circle, Building 1.4F61
  Chattanooga, TN 37402

We greatly appreciate your attention to this important request. **If you have questions about any of these options, please call us at 1-855-413-8776 Monday through Friday from 8 a.m. to 5 p.m. ET.**

Thank you for your help and your continued partnership.

Sincerely,

J. Todd Ray
Senior VP Government Programs
BlueCross BlueShield of Tennessee

Provider Assessment Forms

In 2025 physicians are eligible to receive payments for completing and submitting a Provider Assessment Form (PAF) for their attributed BCBST MA members. **This form is in the Quality Care Rewards (QCR) application in Availity®**. The form may be completed online within the application. **Office visit notes and retired, standard blank forms are not accepted**.

We'll reimburse the service as E/M Code 96161. Providers must bill for their full expected payment for the PAF; billing for less than the full expected payment will result in a considered reimbursement limited to billing charges. Reimbursement is limited to one PAF per calendar year per member. If multiple providers bill a PAF for the same member in a calendar year, only the first claim will be considered for payment. Subsequent claim submissions will be disallowed. BlueCard Host MA members aren't included in the PAF program as BCBST isn't permitted to submit risk adjustment data to CMS for these members. Any PAF claims received for BlueCard Host MA members will default to CMS pricing.

To receive reimbursement, you must complete the form in its entirety and submit electronically or upload in the Quality Care Rewards application in Availity within 90 days of the date of service or fax it to **1-877-922-2963**.

The PAF is **required** to be included in your patient's chart as part of their permanent record. More information about the PAF program can be found in our Medicare Advantage Quality+ Partnerships Program Information Guide located at: https://www.bcbst.com/docs/providers/quality-initiatives/Quality_Partnerships_Program_Guide.pdf.

Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD) Patient Registration Form

You have access to a case management program, designed to identify when members are in Stage 4 or Stage 5 of CKD.

Early detection of CKD and proper management to prevent or slow the progression of the disease improves the overall health and clinical outcomes of our members while reducing health care costs. The case management program offers education and support for members identified with CKD and ESRD. It provides members with tools and support to promote knowledge and self-management of their CKD along with other chronic conditions to resolve barriers to care.

The CMS-2728-U3 form (End Stage Renal Disease Medical Evidence Report Medicare Entitlement and/or Patient Registration) can be accessed on the CMS website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms2728.pdf. Fax a completed copy of the members' CMS-2728-U3 form to us at **(423) 535-5498**, Attn: Medicare Advantage Revenue Reconciliation.

Ensure that you've submitted the CMS-2728-U3 form into the CROWNWeb Data Management system and mailed a hard copy of the form to the Social Security Administration.

Forms must be submitted within 45 days for:

- All patients who initially receive a kidney transplant instead of a course of dialysis
- Patients for whom a regular course of dialysis has been prescribed because they've reached the stage of renal impairment where a kidney transplant or regular course of dialysis is necessary to maintain life.
- Beneficiaries who've already been entitled to ESRD Medicare benefits and those benefits were terminated because their coverage stopped three years post-transplant but now are again applying for Medicare ESRD benefits because they returned to dialysis or received another kidney transplant.
- Beneficiaries who stopped dialysis for more than 12 months and have had their Medicare ESRD benefits terminated and now returned to dialysis or received a kidney transplant.
- A patient that's received a transplant or trained for self-care dialysis within the first three months of the first date of dialysis and initial form was submitted.

Note: You must complete all the mandatory fields for your form to be considered "complete". Failure to do so will result in an "Incomplete" form. If your form is incomplete, we'll contact you to gather any missing information.

F. Quality Measures for 2026 Provider Quality Program

Our MA plans include Provider Quality Amendments that reward providers for achieving 4 Star or greater performance on select measures included in the Star Ratings Program for Medicare Advantage Plans. Below is the list of measures included in the 2026 program. Contact your Provider Quality Outreach Consultant if you have any questions about the program or these measures.

Note: Measures and cut points for the Star Ratings Program for Medicare Advantage Plans are determined by CMS and are based on prior year performance of all MA plans. To adjust for industry continuous improvement in the current year, we retain the right to adjust the cut points based on statistical analysis of industry trends from prior years' performance. BlueCross follows CMS rounding methodology in which measure scores are rounded using traditional, standard "round to the nearest" rounding rules.

2026 Performance Measures

Measure Description	Data Source	Weight
Breast Cancer Screening (BCS)	HEDIS	1
Colorectal Cancer Screening (COL)	HEDIS	1
Controlling High Blood Pressure (CBP)	HEDIS	3
Eye Exam for Patients with Diabetes (EED)	HEDIS	1
Follow-Up After Emergency Department Visit for People with Multiple High-Risk Chronic Conditions (FMC)	HEDIS	1
Glycemic Status Assessment for Patients With Diabetes (GSD)	HEDIS	3
Kidney Health Evaluation for Patients with Diabetes (KED)	HEDIS	1
Medication Adherence for Cholesterol (Statins)	PDE	3
Medication Adherence for Hypertension (RASA)	PDE	3
Medication Adherence for Diabetes Medications (OAD)	PDE	3
Member Experience (CAHPS)	CMS Member Survey	2
Member Experience (HOS)	CMS Member Survey	2
Osteoporosis Management in Women Who Had a Fracture (OMW)	HEDIS	1
Polypharmacy: Use of Multiple – Anticholinergic Medications in Older Adults (POLY-ACH)	PDE	1
Plan All-Cause Readmissions (PCR)	HEDIS	3
Statin Therapy for Patient with Cardiovascular Disease (SPC)	HEDIS	1
Statin Use in Persons with Diabetes (SUPD)	PDE	1
Transitions of Care (TRC)	HEDIS	1

G. Claims Information

Network providers are required to submit claims electronically rather than by paper format. Submitting claims electronically will ensure compliance with the terms of the Minimum Practitioner Network Participation Criteria as well as lower costs and streamline adjudication. This effort is consistent with the health care industry's movement toward more standardized and efficient electronic processes.

Key advantages to submitting electronically are:

- Earlier payments
- More secure submission process
- Reduced administrative costs
- Less paper storage

More information about submitting electronic claims can be found at https://provider.bcbst.com/tools-resources/digital-resources/. If you need help with Availity, contact eBusiness Service at **(423) 535-5717, option 2**, Monday through Thursday, 8 a.m. to 6 p.m. ET and, Friday 9 a.m. to 6 p.m. ET, or via e-mail at eBusiness_Service@bcbst.com.

Tennessee providers should submit claims on a CMS-1500 or CMS-1450 (UB-04) claim form for our members directly to us, using their National Provider Identifier (NPI) number.

- If a provider currently submits claims electronically, they can submit MA claims using the same process.
- MA paper claims, which will only be accepted when technical difficulties or temporary circumstances exist and can be demonstrated, may be mailed to:

  BlueCross BlueShield of Tennessee
  Attn: BlueAdvantage Operations
  1 Cameron Hill Cr, Ste 0002
  Chattanooga, TN 37402-0002

Providers outside of Tennessee should review Chapter XIV. BlueCard Program, Section I. BlueCard Claim Filing in this Manual, for claim filing instructions and more.

Note: Claims for all our MA products should be filed using the same CMS billing guidelines, forms and codes as Original Medicare.

1. Timely Filing

Our timely filing period when we are primary is one year from the date of service for providers or within one year from the date of discharge for inpatient facilities.

Our timely filing period when we are secondary is one year from the date of service for providers or within one year from the date of discharge for inpatient facilities, or 60 days from the date of primary insurer's notice of payment, determined by whichever is greater.

If you have documented evidence that the member didn't provide insurance information, the timely filing provision will begin when the insurance information was received, subject to the limitations of your contract or the member's benefits.

Concerning claims returned to you for additional information, you must send back the form that was attached as proof of timely filing.

2. Qualified Medicare Beneficiary Program

The Qualified Medicare Beneficiary (QMB) Program is a State Medical benefit that assists low-income Medicare beneficiaries with Medicare Part A and Part B cost-sharing. The program helps to pay certain BCBST Medicare Advantage (MA) members' copays and coinsurance amounts.

MA Providers must not collect any copay, coinsurance, or deductible from QMB eligible members. Providers should submit claim for any copay or coinsurance amount to the State Department of Medicaid in which the member resides for possible reimbursement.

QMB Members can be identified by a QMB indicator in the Note field on your Remittance Advice (RA). Additionally, a reminder text is added to any RA processed with an eligible QMB member.

Reminder – Qualified Medicare Beneficiaries (QMB) should not be billed for cost-sharing amounts. These amounts may be billed for the appropriate Medicaid payer.

H. Electronic Funds Transfer (EFT)

The BlueCross Minimum Practitioner Network Participation Criteria requires all network providers to enroll in the EFT process. EFT is a free service that sends payments directly to the provider's financial institution and increases the speed they receive payment.

- Key advantages to receiving payments electronically are:
  - Earlier payments
  - More secure payment process
  - Reduced administrative costs
  - Less paper storage

We accept EFT enrollment through Change Healthcare, who offers a universal enrollment tool for providers that uses a single point of entry for adopting EFT and Electronic Remittance Advice (ERA). The Change Healthcare process facilitates compliance with Council for Affordable Quality Healthcare (CAQH) Core III requirements, eliminates administrative redundancies and creates significant time and cost savings. Enrollment information is available on the Change Healthcare website at payerenrollservices.com.

To view/print a copy of your remittance advice, ensure you have access to Availity.

If you have questions about the EFT program process, or need help with Availity, contact eBusiness Service at **1-800-924-7141, Option 2**, Monday through Thursday, 8 a.m. to 6 p.m., Friday 9 a.m. to 6 p.m. ET, or e-mail eBusiness_Service@bcbst.com.

Payer Enrollment Services™ is the name for the EFT and ERA enrollment tool.

Phone: 1-800-956-5190 available Monday through Friday 8 a.m. to 5 p.m. CT

Website: payerenrollservices.com

Note: Vendors and BlueCross are bound by the National Automated Clearing House (ACH) Association rules for corporate trade payment entries in the administration of these ACH Credits.

I. CMS Star Ratings

CMS uses a five-star quality rating system to measure Medicare beneficiaries' experience with their health plans and the health care system. This rating system applies to all MA lines of business: PPO and Health Maintenance Organization Special Needs Plan (HMO SNP). It also applies to MA plans that cover both health services and prescription drugs (MA-PD).

The program is a key component in financing health care benefits for MA and MA-PD plan enrollees. In addition, the ratings are posted on the CMS consumer website, www.medicare.gov, to give beneficiaries help in choosing among the MA and MA-PD plans offered in their area.

You should understand the metrics included in the CMS rating system as some of them are part of our Physician Quality program, in which you may be eligible to participate in. This program is designed to promote improvement in quality and recognize primary care providers for demonstrating an increase in performance measures over a defined time period.

CMS Goals for the Five-star Rating System

- Implement provisions of the Affordable Care Act
- Clarify program requirements
- Strengthen beneficiary protections
- Strengthen CMS' ability to distinguish stronger health plans for participation in Medicare Parts C and D and to remove consistently poor performers

How Are Star Ratings Derived?

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

- Staying healthy, screenings, tests and vaccines
- Managing chronic (long-term) conditions
- Member experience with the health plan
- Member complaints, problems getting services and improvement in the health plan's performance
- Health plan customer service

A Medicare drug plan's rating is based on measures in four categories:

- Drug plan customer service
- Member complaints, problems getting services and improvement in the health plan's services
- Member experience with the drug plan
- Patient safety and accuracy of drug pricing

Measures in both groups of these categories are used to rate MA health plans. Annually, CMS sets the thresholds for each measure.

Benefits to Providers

- Improved patient relations
- Improved health plan relations
- Increased awareness of patient safety issues
- Greater focus on preventive medicine and early disease detection
- Strong benefits to support chronic condition management
- Supports value-based contracting efforts

Benefits to Members

- Improved relations with their providers
- Greater health plan focuses on access to care
- Increased levels of customer satisfaction
- Greater focus on preventive services for peace of mind, early detection and health care that matches their individual needs

Our Commitment

We're strongly committed to providing high-quality Medicare health plans that meet or exceed all CMS quality benchmarks. The structure and operations of the CMS star rating system ensures funding is used to protect or, in some cases, to increase benefits and keep member premiums low.

We encourage members to become engaged in their preventive and chronic-care management through outreach, screening opportunities, and member rewards.

Tips for You

- Encourage patients to obtain preventive screenings annually or when recommended by the U.S. Preventive Services Task Force (USPSTF).
- Create office practices to identify and intervene with noncompliant patients at the time of their appointment.
- Submit complete and correct encounters/claims with appropriate codes.
- Submit clinical data such as lab results to us.
- Communicate clearly and thoroughly; ask, "What questions do you have?"
- Understand each measure you impact.
- Incorporate Health Outcomes Survey (HOS) questions into each visit. Find out more about HOS at https://www.hosonline.org/en/survey-instrument/
- Review the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey to identify opportunities for you or your office to have an impact: https://ma-pdpcahps.org/en/survey-instruments-and-specifications/
- We'll make the data available to you of services each patient hasn't yet received via the Provider Quality Care Rewards application in Availity. Review this information and the patient's medical record to determine if services have been completed or scheduled.

- If a service isn't completed, flag or contact the member to schedule the service.
- If a service is completed, submit an electronic attestation via the Provider Quality Care Rewards application in Availity. Supporting documentation from the medical record is required to be uploaded for all attestations for measure exclusions as well as some attestations for measure compliance. Supporting documentation from the medical record is recommended to be uploaded for all attestations for measure compliance.

Questions?

For Program-Related Support

Contact a member of our Provider Quality Team or your Provider Relations Consultant (see Section II. BlueCross BlueShield of Tennessee Quick Reference Guide in this Manual for appropriate phone numbers).

Online Resources

https://provider.bcbst.com/working-with-us/quality-initiatives

For Technical Support with Availity

Contact eBusiness Service at:

Phone: 1-800-924-7141, **Option 2**

- Monday through Thursday: 8 a.m. to 6 p.m.
- Friday: 9 a.m. to 6 p.m. ET

Email: ebusiness_service@bcbst.com

Helpful Websites

To learn more about the CMS quality rating measures, visit:

http://www.cms.gov
http://www.hosonline.org
https://ma-pdpcahps.org/en/survey-instruments-and-specifications/

J. Health Management

Population Health (PH)

Our Population Health Programs are managed by the Population Health Department, which provides the following services:

- Lifestyles Condition Management
- Discharge Care Coordination
- Transplant Care Management
- Social Work
- Nutritional Management/Dietitian
- Behavioral Health Management

Referrals and Triage

PH referrals may originate from our internal departments, any agency or practitioner in the provider community, a designated representative for an account and/or, any member or member representative. Participation in PH program offerings is voluntary. Referrals can be received both internally and externally via fax, telephone, e-mail, or QCR. Members, family and/or caregivers, practitioners and providers are encouraged to initiate referrals for any of the above listed programs. A PH team member, such as a nurse, dietitian, or social worker will contact the designated person upon receipt of the program referral.

Lifestyles

This program is designed to work collaboratively with members with complex health care needs, health equity needs, unstable multi-disease states, and multiple chronic conditions where frequent care manager contact is required. This includes but isn't limited to severe depression and mood disorders, frequent ER visits, and

frequent inpatient admissions. Education, resources and support to members are provided to empower members to navigate through the health system by promoting self-management skills. These cases are intensively managed through consistent assessment, planning, coordinating, implementing and evaluating care. By using this approach, multiple health and psychosocial needs of the member are met.

The PH team works with the member, treating practitioners, family members or designees by member, and other members of the health care team to coordinate and facilitate an individualized plan of treatment, evaluate the member's progress towards mutually established goals and facilitate referrals to a less intensive health management program as applicable.

The chronic conditions being managed within this program (subject to change based on analysis of "at risk" members) include but aren't limited to:

- Anxiety
- Depression
- Diabetes
- Chronic obstructive pulmonary disease
- Chronic heart failure
- Coronary artery disease and other cardiovascular diseases
- Hypertension
- Musculoskeletal conditions with chronic pain
- Transplants

The primary goal of the program is to stabilize the member's health condition and help them with tools, education and care necessary for self-management. The program promotes the member's and caregiver's active participation in management of their chronic condition and/or complex condition resulting in an increased knowledge of the disease process, maintenance, prevention and treatment.

Additionally, the member increases their knowledge of healthy lifestyle changes and co-morbid management. The treating physician's involvement is an integral part of the program and development of an individualized plan of care and desired outcomes. The program supports the physician by reinforcing education, monitoring and reporting.

Services involve the full spectrum of care coordination, as applicable. Care coordination is intended to quickly stabilize the members' health condition/disease through connection with needed services, promote self-management by providing tools and education to allow them to make informed decisions about their health care, and encourage and provide tools for active participation in managing their condition(s).

The PH team helps to identify members' needs, find solutions to those needs, and reduces barriers to healthcare. Interventions can improve quality of life, make effective use of available healthcare and community-based resources, and improve health outcomes.

Discharge Care Coordination

The Discharge Care Coordination Intervention is a post hospital discharge follow-up. Members are called based on certain triggers within 24 business hours after they're dismissed/discharged from acute care or post-acute care facilities to verify:

- Understanding of discharge instructions
- Appointments made with the member's physician for post discharge follow-up
- Transportation is available to get to the appointment.
- Post discharge medications obtained and the member understands their prescriptions; what the medication is for, and whether to continue previous prescribed medications
- If home health was ordered following an acute care episode, confirm start of care in the member's home setting
- Understanding of dietary instructions and needs, including available food on hand to meet those needs
- Post-discharge services such as DME delivered/initiated
- Caregiver availability
- Safety concerns or needs

If needed, an additional call will be made within one week to help ensure all discharge services/plans are in place.

Transplant Care Management

The coordination of transplant-related care is managed as necessary based on complexity of members' needs pre and post procedure. Transplants must be performed in a Medicare-approved facility. Attention is given to assisting and educating the members about acquisition and use of needed drugs prescribed by their physician, with special emphasis on the Part B benefit for anti-rejection drugs. The Care Management team educates and helps the members with chronic condition management as needed to remain healthy prior to transplant; and helps with benefit navigation such as travel, meals, and lodging reimbursement requests for members that qualify.

It's critically important, to both the practitioner and member, that PH be contacted as soon as the provider identifies the member may need an evaluation for a transplant.

Social Worker

The Social Worker Case Manager assists members and/or caregivers with economic/financial and social/community resources available to help with health care needs collaborating with other health care disciplines to improve health outcomes and member experience. In addition, the Social Worker Case Management team collaborates with facilities, practitioners, agencies, members, and caregivers as designated by member to ensure smooth transition of care from inpatient setting to community or inpatient to inpatient setting as applicable.

Nutritional Management/Dietitian

The Registered Dietitian will educate members about diet, nutrition and the relationship between eating habits and preventing/managing chronic conditions. Nutritional assessments, care plans, and diet education will be provided for members and/or caregivers to evaluate nutritional needs and address any barriers to meeting those needs.

Behavioral Health Management

Behavioral Health (BH) case managers help members with primary BH disorders. They work closely with medical case managers to ensure the member's physical health needs are also addressed. The BH case manager may also serve as a consultant on medical cases for psychosocial needs, environmental barriers, and community support services.

BH case managers closely monitor members to identify immediate and ongoing needs and plan a course of care in collaboration with treating physicians, BH counselors, medical case managers, family members, and other members of the health care team.

BH case managers educate members about medication adherence, recognition of symptoms, and appropriate times to contact a physician or seek emergency treatment. They work with members and their families to identify triggers that exacerbate symptoms and develop strategies for avoiding or responding to these triggers. BH case managers also work closely with members who have substance use disorders, connecting them to the supports they need, and facilitating appropriate alternatives to in-patient hospital treatments, such as partial hospitalization, intense outpatient programs, or individual or group outpatient treatment.

Providers are key to identifying potential BH issues and referring their patients to treatment. BH management supports providers by offering tools and patient education, monitoring and reporting.

CareTN Digital Chronic Condition Management Programs

Members have access to digital care management through the free CareTN mobile app. CareTN offers our members a digital platform to manage their wellness and health needs through an app that can be downloaded onto their personal cell phone or tablet device. Members enroll in a care program according to their specific health needs, and these programs allow the member to have one-on-one personal care with a

BlueCross nurse, social worker, health navigator, pharmacist, behaviorist health case manager, and/or dietitian who guides them through the program and assists them along the way.

A few of the programs available include, but aren't limited to:

- Diabetes
- Prediabetes Support Program
- Medication Reminders
- Wellness and Prevention
- Coronary Artery Disease
- Heart Failure
- Weight Loss
- Smoking Cessation
- Stress Management
- Oncology
- Chronic Obstructive Pulmonary Disease
- Caregiver Support

Contact/Referrals for Population Health Programs

Practitioners/providers are encouraged to initiate referrals for any of the population health programs available for our members via QCR which became effective 3/8/2024 or Case Management lines listed below.

Phone: 1-800-611-3489
Fax: 1-800-727-0841

Referral requests should include:

- Requesting provider's name and telephone number
- Contact person and telephone number (if different from requesting provider);
- Member name
- Member ID number and telephone number
- Diagnosis and current clinical information
- Current treatment setting (e.g., hospital, home health, rehabilitation, etc.)
- Reason for referral
- Level of urgency

A Case Manager will contact the requesting provider upon receipt of the program referral.

1. Care Management

Our Health Management programs adhere to CMS' MA rules and regulations published in 42 CFR § 422 and CMS' Internet Only Medicare Managed Care Manual. CMS' requirements for MA vary from the requirements for Original Medicare. Chapter 13 of the Medicare Managed Care Manual is a significant resource used to implement our Care Management programs.

Care management includes services that require prior authorization, notification, advance determinations and retrospective review that may be requested by a member, practitioner or provider. CMS' MA reconsideration process is available in cases of dissatisfaction with the review decision. Provider reimbursement appeals are handled through the CMS mandated Provider Payment Dispute Process. Additional provider appeals are handled through our Provider Dispute Resolution Procedure. (Refer to the Provider Appeal section of this Manual for these processes).

These utilization management strategies are additional ways of identifying members who may benefit from Health Management programs outlined above.

Criteria Hierarchy

Medical Necessity is described in CMS' hierarchy for determining medical necessity prospectively or retrospectively. Medical necessity reviews are performed without regard to age, gender, creed, religion or race/nationality. All guidelines/criteria used to determine medical necessity are accessible on our website at https://provider.bcbst.com/tools-resources/manuals-policies-guidelines#three-up-links.

The hierarchy of decisions the requested service must:

- Be a covered benefit in the member's health plan
- Be a benefit that isn't otherwise excluded
- Be appropriate and medically necessary

The hierarchy of references includes:

- The Law (Title 18 of the Social Security Act)
- The Regulations (Title 42 Code of Federal Regulations (CFR))
- National Coverage Determinations (NCD) (Pub 100-03 of the Internet Only Manual (IOM)

  https://www.cms.gov/medicare-coverage-database/search.aspx

- MA Benefit Policy Manual (IOM 100-02)
- Local Coverage Determinations (LCD)

  https://www.cms.gov/medicare-coverage-database/search.aspx

- Coverage guidelines in Interpretive Manuals (Internet Only Manual (IOM), Pub 100-04 Claims Processing, Pub 100-08 Program Integrity Manual, Pub 100-10 QIO manual, Pub 100-16 Medicare Managed Care Manual
- Durable Medical Equipment Medicare Administrative Contractor (DMEMAC)

  https://www.cms.gov/medicare-coverage-database/reports/local-coverage-mac-contacts-report.aspx?ContractType=4&stateRegion=all#

- Program Safeguard Contractor (PSC) local coverage determinations
- Milliman Care Guidelines (MCG)
  These nationally recognized guidelines are updated annually by a panel of consultants including, but not limited to practitioners and registered nurses. An MCG Care Guideline used in a specific medical decision can be obtained by submitting a written request to the Medicare Advantage UM Department. We'll supply, via mail, at no charge, up to three MCG Care Guidelines as they pertain to a specific medical decision.
- BlueCross Utilization Guidelines (http://www.bcbst.com/providers/UM_Guidelines/)
- BlueCross Medical Policy
- Supplemental Benefits and Limitations as outlined in the member's Evidence of Coverage
- U.S.F.D.A. Approved Indications for Medications
- Other major payer policy and peer reviewed literature

a. Advance Beneficiary Notice (ABN)

An ABN is a document used by Original Medicare to inform members that an item or service is unlikely to be considered for coverage under Medicare rules and regulations. MA plans don't recognize ABNs. When informing a member that a service isn't covered or excluded from their health benefit plan, it's considered an Organization Determination under C.F.R. 422.566(b), and requires a formal Organization Determination denying coverage.

An ABN waiver isn't sufficient documentation of this notification. Please complete a pre-determination on the member's behalf before you provide any non-covered services/supplies. This includes network providers referring a patient/member to a non-network provider for services and supplies.

b. Advance Determination

A member or provider can seek a determination of coverage before receiving or providing services by requesting an Advance Determination. Providers can obtain an Advance Determination for select services from us for our members. Advance Determinations are performed to render coverage, medical necessity and appropriateness determinations before services are rendered rather than during claims processing. However, claims submitted for services that weren't reviewed prospectively will be reviewed retrospectively for medical appropriateness to determine coverage and reimbursement.

You can obtain an Advance Determination by phone, fax, or online (see "Contact Information" at end of this section). Advance determinations are good for a period of 6 months from the date of the approval. Requests not rendered before then will need to be resubmitted with updated supporting clinical for consideration.

A reference number is issued with each request. Advance Determinations are also made available to members when the service doesn't require a prior authorization.

c. Prior Authorization

Prior authorization is required before certain services are provided to our members.
Prior authorization for coverage and medical necessity is required for the following services including but not limited to:

- All acute care facility, skilled nursing facility (including non-routine supplies), rehabilitation, and long-term acute care
- All inpatient professional services related to an inpatient care facility admission
- Behavioral health facility inpatient stays, partial hospitalization, intensive outpatient program, psychiatric residential, electroconvulsive treatment, and transcranial magnetic stimulation.
  Note: Effective 7/1/2024 psychological testing and neuropsychological testing no longer require prior authorization.
- Certain Part B and Part D medications (reference authorization list and drug list on https://provider.bcbst.com/tools-resources/documents-forms/
- Durable Medical Equipment, rental or purchase, listed on the Master Authorization List found at MA Master Prior Auth List
- Prosthesis and Orthotics listed on the Master Authorization List
- Outpatient rehabilitation services:
  - Speech therapy
  - Occupational therapy
  - Physical therapy (initial evaluation doesn't require prior authorization)
  - Phase II cardiac rehab services
  - Pulmonary rehab
  - Chiropractic care
- All Home Health services including all therapies and/or nursing visits (non-routine supplies) and psychiatric visits
  - Note: Authorization isn't required for initial evaluation for therapies, routine supplies, Aides, or social worker visits.
- Diagnostic tests, non-routine lab services and cardiac echo.
- All genetic testing
- Radiation therapy including proton beam therapy, elective interventional radiology and standard radiation treatment
- Advanced imaging services (MRIs, CT and PET scans) and some cardiac diagnostic and therapeutic radiology services
- Non-emergency ambulance transportation (routine doctor's office visit or dialysis)
- Diabetic supplies and services (diabetic monitoring supplies and self-management training)
- Certain outpatient procedures or services (potential cosmetic or investigational procedures and outpatient sleep studies) refer to MA Master Authorization list for specific codes
- Transplant services (solid organ, bone marrow, stem cell, and cornea)
- Acupuncture services
- Opioid treatment program services

An authorization/reference is issued regardless of the decision and providers will be notified by fax or letter of the determination. See bcbst.com or the web submission platform for more information about which services require prior authorization and how to complete a prior authorization.

Vendor Authorization Partnerships

Our Blue Advantage products partner with vendors to assist with handling the following services:

- High-Tech Imaging and some cardiac diagnostic services
  In addition to Medicare Medical Policies for some services, providers can review medical criteria online at: RADMD | Clinical Guidelines & Other Resources
- Durable Medical Equipment authorizations coming 2nd quarter 2026
- Home Health Services (Skilled Nursing Visits and Home Therapies) coming 2nd quarter 2026

- Post-Acute Care authorizations (Skilled Nursing Facilities, Long Term Acute Care Hospital, Inpatient Recovery Facilities) - coming 2nd quarter 2026
- Oncology related services (Oncology Part B drugs and Oncology related radiation therapy – Coming 4th quarter 2026

Authorization requests can be initiated by phone, available from 8 a.m. to 8 p.m. ET, at **1-888-258-3864 and when prompted select the option for type of request to be directed to the vendor**, or online through Availity 24/7. Request for High-Tech Imaging cannot be submitted via fax.

d. Organizational Determinations

Organizational determinations review medical necessity and appropriateness for the payment of services. They include both advance determinations and retrospective reviews. An organization determination for an advance determination request will be reviewed as expeditiously as the member's health condition requires, but no later than 7 calendar days after receiving the request for a standard Organization Determination.

An expedited Organization Determination will be performed when requested or supported by a physician indicating that applying the standard time for deciding could seriously jeopardize the life or health of the member or the member's ability to regain maximum function. The physician doesn't need to be appointed as the member's authorized representative to make this request. When an expedited review is requested, an attestation form will be provided. The expedited timeframe will start when the signed form is received. A decision will be rendered as expeditiously as the member's health condition requires, but no later than 72 hours after receiving the request for expedited review. The time frame will be extended by up to 14 calendar days if the member requests the extension or if the need for additional information and documents are delayed and is in the best interest of the member. Expedited Organization Determinations may not be requested for cases when the only issue involves a claim for payment, or for services that the member has already received.

Retrospective reviews are completed within 30 Calendar days after receiving the request for a standard Organization Determination.

e. Peer-to-Peer and Re-Evaluation Processes

In accordance with guidance from CMS and our accreditation through the Utilization Review Accreditation Commission (URAC) the following peer-to-peer and appeal processes are applicable for our MA products.

For Medicare Advantage products, Peer to Peer (P2P) reviews are optional clinical discussions between the requesting provider and a Plan Medical Director that occur **prior to the issuance of an organization determination**. The purpose of a pre-determination P2P is to allow clarification of clinical information or submission of additional documentation that may not have been included with the original request. A P2P review is not an appeal, is not specialty matched, and does not guarantee approval.

Pre-determination P2P reviews may be requested for applicable pre-service and concurrent review cases when a determination is pending. Information discussed during a pre-determination P2P will be considered as part of the ongoing clinical review and may be used in making the organization determination.

Post determination Peer to Peer (P2P) reviews are not permitted for Medicare Advantage products. Once an organization determination has been issued—whether pre-service, concurrent, or retrospective, the decision cannot be changed through informal mechanisms, including P2P discussions. Any request to reconsider or overturn a determination must proceed through the formal Medicare Advantage appeals (reconsideration) process or, when applicable, a reopening as defined by CMS.

f. Inpatient DRG Outlier Program Management Program

Consistent with the criteria in MCG, we'll reimburse acute inpatient hospitalization costs outside of the DRG approval as follows:

- MCG will be used with the clinical information provided to determine if the care and services are consistent with an intensity of services that can only be safely and appropriately furnished in an acute inpatient setting. This review is performed by a Plan Medical Director. If criteria aren't met,

the additional hospital costs may be denied for benefit coverage as not meeting acute inpatient level of care criteria per MCG. This review will occur after the claim has been identified for outlier payment. Please note that MA DRGs are dollar threshold triggered and any denied days will only apply to the outlier payment calculations (if applicable) and not to the base DRG payment due to the facility.

- Clinical information to support outlier payment is requested by sending the provider an Additional Documentation Request (ADR) letter. The supporting clinical can be submitted to the Plan by fax or phone at the numbers provided in the letter. The provider has 45 days to submit the supporting clinical. Clinical that isn't submitted timely will result in the outlier payment being recouped. Any clinical received will be reviewed for medical necessity. The provider may follow the Provider Appeal process for any decisions with which they disagree.

Note: The member can't be held liable for payment of services received when not authorized.

g. Readmission Quality Program

CMS recognizes the growing challenge of readmissions for the Medicare population. In Original Medicare, CMS guidance provides for readmission review under Chapter 4 of the Medicare Quality Improvement Organization Manual. Because of this, we've developed a readmissions review program.

31-Day Same or Similar-Cause Readmission Quality Program

We'll reimburse for a readmission within 31 days from an index admission as follows:

- For the purposes of this program, the date of discharge from the original acute inpatient admission (called the **Index Admission**) is the start of the 31-day window.
- This readmission program is limited to same or similar diagnoses between the Index Admission and the Readmission as determined by a Plan Medical Director, even though we're held to an all-cause readmission standard.
- Only readmissions that occur as an acute inpatient admission to the same or similar facility, or facility operating under the same contract are included in this program.
- Readmissions in the 31-day window should also have a **modifiable cause** leading to the readmission. Because readmissions are a multi-stakeholder concern, the modifiable cause doesn't have to only be for direct illness related complications, but also issues that arose from the discharge plan. These include, but aren't limited to, the member not receiving new prescriptions, home health not showing up on time at the member's residence or lack of transportation to make outpatient appointments after discharge, etc.
- All readmissions in this program are reviewed by a Plan Medical Director as part of a medical necessity review. This isn't an automated claims-based adjudication. So, you have your normal medical necessity-based denial appeal rights.
- For readmissions on or after May 1, 2025, the facility reimbursement under this Same or Similar Cause Readmission Quality program allows reimbursement for the index admission, but not the readmission. The index admission will be paid at normal contracted rates.
- Readmissions that occur in an observational (outpatient) setting are exempt from this program and are reimbursed as per the facility agreement.
- Readmissions for members undergoing active chemotherapeutic treatment or in the immediate post-transplant period (30 days) are also excluded from this program.
- Readmissions occurring within the original 31-day window from the original index admission discharge, will be bundled into the original admission if the above parameters are met. A new index readmission isn't set until a full 31 days has elapsed.

Note: The member can't be held liable for payment of services received when not authorized.

48 Hour Readmission Quality Program

Medicare specifically identifies short term readmissions as a likely deviation in quality of care in the original discharge plan or discharges occurring before the member was stable for transition of care.

Therefore, we will not reimburse for a readmission within 48 hours from an index admission. This is not a matter of medical necessity, it is based on contract and payment. Our policy is as follows:

- For the purposes of this program, the date of discharge from the original acute inpatient admission (called the **Index Admission**) is the start of the 48-hour window.
- Only readmissions that occur as an acute inpatient admission to the same or similar facility, or facility operating under the same contract, are included in this program.
- Because of the proximity to the index discharge, there's no modifiable cause component of this program.
- Also, because this readmission program has a denial of the readmission, the medical necessity of the readmission isn't evaluated.
- The provider may file a provider appeal by following the steps in the denial letter.
- Readmissions that occur in an observational (outpatient) setting are exempt from this program and are reimbursed as per the facility agreement.
- Readmissions for members undergoing active chemotherapeutic treatment or in the immediate post-transplant period (30 days) are also excluded from this program.

Note: The member can't be held liable for payment of services received when not authorized.

h. Contact Method According to Type of Service

The following grid is intended to help providers determine the appropriate contact method according to the type of service requested:

Type of Service	Submit via:
Advanced Imaging & Cardiology Diagnostic Testing	Advanced Imaging Vendor Phone: 1-888-258-3864 eHealth Web submission via Availity
Home Health Services (Skilled Nursing and rehabilitation therapies) *After vendor implementation target date 2nd quarter 2026	BlueCross BlueShield of Tennessee Phone: 1-800-924-7141 Fax: 1-888-535-5243 e-Health Web Submission via Availity Home Health Vendor Phone: 1-888-258-3864 eHealth Web submission via Availity
Home Infusion Therapy	BlueCross BlueShield of Tennessee Phone: 1-800-924-7141 Fax: 1-888-535-5243 e-Health Web Submission via Availity
Behavioral Health Services	BlueCross BlueShield of Tennessee Phone: 1-800-924-7141 (After Hours) 1-800-836-1660
Durable Medical Equipment (DME) Orthotic/Prosthetic (O & P) *After implementation – target 2Q 2026 request should be routed to vendor. Additional details forthcoming	BlueCross BlueShield of Tennessee Phone: 1-800-924-7141 Fax: 1-888-535-5243 e-Health Web submission via Availity DME Vendor Phone: 1-888-258-3864 eHealth Web submission via Availity

Type of Service	Submit via:
Inpatient (Medical) Observations Conversions	BlueCross BlueShield of Tennessee Phone: 1-800-924-7141 Fax: 1-888-535-5243 e-Health Web Submission via Availity
Inpatient Rehabilitation Long Term Acute Care Skilled Nursing Facilities (See Section VIII in this Manual for details) *After vendor implementation target date 2nd quarter 2026	BlueCross BlueShield of Tennessee Phone: 1-800-924-7141 Fax: 1-888-535-5243 e-Health Web submission via Availity Post-Acute Care Vendor Phone: 1-888-258-3864 eHealth Web submission via Availity
Musculoskeletal Procedures (MSK) – Joint and spine surgery and pain management	BlueCross BlueShield of Tennessee Phone: 1-800-924-7141 e-Health Web submission via Availity Note: Inpatient form is for inpatient admission related requests only. All other outpatient procedures should be submitted via the Outpatient Surgery form
Part B Pharmacy	BlueCross BlueShield of Tennessee Phone: 1-888-258-3864 e-Health Web submission via Availity
Outpatient Therapies – Speech, Physical and Occupational, Chiropractic Services	BlueCross BlueShield of Tennessee Phone: 1-800-924-7141 Fax: 1-888-535-5243 e-Health Web submission via Availity

i. Compliance with Prior Authorization Requirements

Prior authorization reviews can be initiated by the member, designated member advocate, practitioner, or facility. However, it's your responsibility to contact us to request an authorization and to provide the clinical and demographic information that's required to complete the authorization. Scheduled admissions/services must be authorized up to 24 hours prior to admission. Notification of emergency admissions (unplanned) is required within 24 hours or the next business day after services have started. Behavioral health utilization review services are available 24-hours-a-day, seven-days-a-week. Prior authorization for all behavioral health services is required prior to admission.

When prior authorization isn't obtained on time by a network provider, only the following exceptions will be considered for retrospective review/consideration:

- Member didn't provide Medicare Advantage insurance information at the time of service.
- Member ID card wasn't issued.
- There was a coverage issue.
- You submit a valid copy of fax transmittal as evidence that an attempt to meet prior authorization timeframe requirements was made.

A request for retrospective authorization review must be received within 180 days of the date of service or the date eligibility is confirmed by CMS. Peer-to-Peer (P2P) reviews are not available as part of retrospective review and may not be used to reconsider or revise an issued organization determination.

When a request for an authorization of a procedure, an admission/service or a concurrent review of the days is denied, the penalty for not meeting authorization guidelines will apply to both the facility

and the practitioner rendering the care for the day(s) or service(s) that have been denied. Our non-payment is applicable to both the facility and practitioner rendering the care. The member isn't held liable if they're eligible at the time services are rendered and the covered services are received from a network provider.

j. Non-Compliance with Prior Authorization Requirements

Services provided without obtaining approval are considered "non-compliant" when prior authorization is required. You must obtain authorization prior to scheduled services. Non-compliance applies to the initial review, as well as concurrent review for ongoing services beyond dates previously approved and retrospective review requests that weren't received on time. Failure to comply within specified authorization timeframes will result in a contractual denial or reduced benefits due to non-compliance. Network providers can't bill members for covered services denied due to non-compliance by the provider.

There's no reconsideration of a non-compliance denial. If a party is dissatisfied with a non-compliance denial, they may appeal through the provider appeal process. Provider appeals of non-compliance denials must be submitted within 60 days of the initial denial. Failure to comply within the specified 60-day timeframe will result in a contractual denial due to non-compliance. The request should include a copy of any pertinent information, a copy of the medical records relevant to the admission or services, along with the face sheet, if applicable, and a statement from the practitioner indicating the reasons for the appeal and a copy of the denial letter, to the Care Management Appeals Department. A determination will be sent to the provider and/or member within 30 days of the receipt of the request for appeal. If the party is still dissatisfied with the decision, they can proceed to arbitration as outlined within the provider appeal denial letter.

k. Mandated Notices (Additional information about these notices, including a copy, can be found in Chapter 30 of the Medicare Claims Processing Manual)

i. **Important Message from Medicare:** Any facility providing care at an inpatient hospital level is responsible for delivering advance written notice of a member's rights as a hospital inpatient including discharge appeal rights to the member or the authorized member representative in accordance with applicable CMS regulations. CMS requires the Important Message from Medicare be distributed no later than two calendar days following the member's admission to the hospital and follow-up notice as far in advance of discharge as possible, but no more than two calendar days before discharge.

ii. **Detailed Notice of Discharge:** CMS requires a Detailed Notice of Discharge (DN) be distributed to a member or authorized representative requesting an appeal of discharge from an inpatient facility or when BlueCross no longer intends to continue coverage of an authorized hospital inpatient admission. BlueCross delegates to providers the responsibility for developing and delivering the DN for provider discharge determinations and for the delivery of a DN for BlueCross discharge determinations. CMS requires the DN to be delivered as soon as possible, but no later than noon of the day after the Quality Improvement Organization's (QIO's) notification or BlueCross's request for delivery. Providers are required to fax a signed copy of the DN to the BlueCross UM Department at **1-888-535-5243** or **1-423-535-5243**. Providers must be able to demonstrate compliance with the delivery of the DN in accordance with applicable CMS regulations.

iii. **Notice of Medicare Non-Coverage:** Home Health Agencies (HHA), Skilled Nursing Facilities (SNF), and Comprehensive Outpatient Rehabilitation Facilities (CORF) are responsible for delivering Medicare Notices of Non-Coverage (NOMNC) to the member or the authorized member representative in accordance with applicable CMS regulations. Per CMS regulations, HHAs are responsible for both completing the NOMNC form and issuing this to the member or authorized representative.

CMS requires the NOMNC be delivered **at least two days prior** to the member's HHA, SNF, or CORF authorized services ending. Days won't be extended due to untimely delivery of the NOMNC by the facility. A signed NOMNC must be submitted with any appeal. If the member's services are expected to be fewer than two days, the HHA, SNF or CORF must provide the NOMNC to the member at the time of admission to the provider.

The NOMNC must be faxed to BlueAdvantage no later than noon the day following receipt of the NOMNC. A model NOMNC form can be found at http://www.bcbst.com/docs/providers/bcbst-

medicare/forms/NOMNC.pdf. Providers are required to fax a signed copy of the NOMNC to our Medicare Advantage Care Management Department at **1-888-535-5243**.

iv. **Detailed Explanation of Non-Coverage:** CMS requires a Detailed Explanation of Non-Coverage (DENC) be distributed to a member or authorized representative requesting an appeal of discharge from a SNF, HHA, or CORF or when BlueCross no longer intends to continue coverage. BlueCross delegates to providers the responsibility for developing and delivering the DENC for provider discharge determinations and for delivery of the DENC for BlueCross discharge determinations. CMS requires the DENC to be delivered as soon as possible, but no later than close of business the day of the QIO's notification or BlueCross's request for delivery. Providers must be able to demonstrate compliance with the delivery of the DENC in accordance with the applicable CMS regulations. Providers are required to inform members that a request for denial notice must be submitted to BlueCross by the member, if they believe they're being denied service.

l. Retrospective Claims and Clinical Record Review

Retrospective claims reviews are conducted on certain targeted requests to determine medical necessity and to verify eligibility and benefits. Claims are targeted for review based on National Coverage Determinations, Local Coverage Determinations, MCG and BlueCross Medical Policy. Reviews are performed pre or post claims payment using CMS' processing guidelines (i.e. post-acute care transfer policy, low utilization payment adjustments, outlier payments, etc.).

Retrospective clinical record reviews may be conducted to meet our CMS contractual requirements. Record review results support CMS and other regulatory agencies audits, applicable accreditation audits, quality improvement activities, QIO and Independent Review Entity (IRE) review processes, and CMS' risk-adjusted payment processes.

Care Management Contact Information:

Phone: 1-800-924-7141
Fax: 1-888-535-5243

Mailing Address:

BlueCross BlueShield of Tennessee
Medicare Advantage Care Management Department
1 Cameron Hill Circle, Ste 0005
Chattanooga, TN 37402-0005

m. Acute Care Facility

For the services to be covered care, and treatment must be medically necessary and appropriate in an inpatient setting. Scheduled inpatient stays begin on the morning of a procedure in nearly all instances. Clinical information needed for processing an advance determination/prior authorization request includes:

- Procedure/operation to be performed, if applicable
- Diagnosis with supporting signs/symptoms
- Treatment plan
- Vital signs and abnormal lab results
- Elimination status
- Ambulatory status
- Hydration status
- Comorbidities that impact the patient's condition
- Complications
- Prognosis or expected length of stay
- Current medications
- Discharge plans*

*Discharge information should be sent daily to us to help ensure appropriate follow-up and coordination of care for members. Discharge dates may be entered for all lines of business via Availity or faxed to **(423) 591-9501.** Providers may fax one member listing for all lines of business as

long as each member listed reflects the line of business the member belongs. Provider cover sheets should include the facility name and NPI number to help ensure appropriate and efficient processing.

n. Skilled Nursing Facility (SNF)

For SNF services to be covered, care and treatment must be medically necessary and appropriate in an inpatient setting. Skilled services require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, and/or audiologists. Skilled services must be provided directly by or under the general supervision of technical or professional health care personnel. SNFs are required to follow CMS guidelines for delivery of the NOMNC. SNF days won't be extended due to untimely delivery of the NOMNC to the member by the facility. A model NOMNC form can be found at http://www.bcbst.com/docs/providers/bcbst-medicare/forms/NOMNC.pdf.The signed NOMNC must be faxed to us no later than noon the day following receipt of the NOMNC. (See details of Notice of Medicare Non-Coverage in this Manual.) Any NOMNC appeal needs to be submitted with the signed NOMNC and recent clinical documentation.

To facilitate an advance determination or prior authorization request please use the our Skilled Nursing Fax Form located at https://www.bcbst.com/providers/forms/Commercial_Skilled_Nursing_Facility_Inpatient_Rehab_Fax_Form.pdf and fax it to **1-888-535-5243**. We have dedicated Nurse Clinicians to help you with necessary services for your patients. Our Case Management team can be contacted at **1-800-924-7141** to assist with any discharge planning or transition of care needs.

We will start partnering with a vendor to assist with these reviews. After vendor implementation, targeted for 03/01/2026, all advance determinations or prior authorization requests will need to be submitted directly to them for review via phone at **1-888-258-3864** or eHealth Web submission via Availity.

Basic information needed for processing an advance determination request:

- Member's identification number, name, and date of birth
- Practitioner's name, provider number, NPI, Medicare number; address, and telephone number
- Hospital/facility's name, provider number and/or NPI, Medicare number, address and telephone number
- Admission date
- Caller's name

Clinical information required for review:

- Admitting diagnosis, symptoms, and treatment plan
- Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care influencing the medical necessity determination
- A condition requiring inpatient skilled nursing services or inpatient skilled rehabilitation services at least daily
- A practitioner's order for skilled services
- Ability and willingness to participate in ordered therapy
- Medical necessity for the treatment of illness or injury (this includes the treatment being consistent with the nature and severity of the illness or injury and consistent with accepted standards of medical practice)
- Expectation for significant reportable improvement within a predictable amount of time
- Discharge plans that include:
  - Type of residence
  - Number of home levels
  - Number of stairs to enter the home and within the home (including number of rails)
  - Who lives in the home
  - Driving status
  - Support system
  - Any known resources (CHOICES, home health, caregivers)
  - Any DME and what's needed, including ramps

- A CHOICES Pre-Admission Evaluation (PAE), if one has been initiated
- Medication review
- Follow-up appointments

Evaluation and Plan of Care

Evaluation of the member must be submitted including the following as appropriate:

- Primary diagnosis
- Circulation and sensation
- Ordering practitioner and date of last visit
- Gait analysis
- Date of diagnosis onset
- Cooperation and comprehension
- Baseline status
- Developmental delays (pediatric patients)
- Prior level of functioning
- Current functional abilities
- Functional potential
- Expected maximum level of functioning
- Other therapies or treatments
- Patient's goals
- Strength
- Medical compliance
- Range of motion
- Support system/caregiver

Plan of care must be submitted including the following as appropriate:

- Short and long-term goals
- Proposed admission date
- Discharge goals
- Frequency of treatment
- Measurable objectives
- Specific modalities, therapy, exercise
- Functional objectives
- Safety and preventive education
- Home program
- Community resources

Information for Billing Health Insurance Prospective Payment System Codes

CMS requires MA plans to bill health insurance prospective payment system (HIPPS) codes for all SNF claims.

Guidance:

- SNF claims received for processing that don't include HIPPS coding with Revenue Code 0022 will be rejected and will require re-submission with the appropriate HIPPS code.
- The HIPPS code should be billed indicating a quantity of one $0.00 charge and a date of service equal to the date of the earliest billable service on the claim.
- The claim's "From" and "Through" dates should cover the assessment* and services.

*SNFs must submit a HIPPS code from the admission assessment completed during the covered stay. If an assessment wasn't completed, refer to the following guidelines.

Stays of more than 14 days – If the admission assessment was completed prior to the covered portion of the stay, submit a HIPPS code:

- From another assessment completed during the covered portion of the stay.
- From the most recent assessment completed prior to the covered portion of the stay.
- If no assessment was completed, submit a code from the most recent assessment.

Stays of 14 days or less – If no admission assessment was completed before discharge for a covered stay, submit a HIPPS code:

- From another assessment from the stay.
- Use default code "AAA00."

Submit a default code ONLY if:

- The member was discharged prior to the completion of the initial assessment.
- No other assessment was completed during the covered stay.

For additional HIPPS code information, refer to the CMS HIPPS Codes page at

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/HIPPSCodes

Therapy Services

Therapy services appropriate for SNF include occupational therapy, physical therapy and speech therapy not possible on an outpatient basis. Specific therapy services that may be appropriate for an SNF include, but aren't limited to:

- Complex wound care requiring hydrotherapy.
- Gait evaluation and training to restore function in a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormalities.

Nursing Services

Nursing services appropriate for SNF include skilled nursing services not possible on an outpatient basis. Specific nursing services that may be appropriate for an SNF include, but aren't limited to:

- Intramuscular injections or intravenous injections or infusions;
- Initiation of and training for care of newly placed:
  - Tracheostomy
  - In-dwelling catheter with sterile irrigation and replacement
  - Colostomy
  - Levin tube
  - Gastrostomy tube and feedings
- Complex wound care involving medication application and sterile technique.
- Treatment of Grade 3 or higher decubitus ulcers or widespread skin disorder.

Nursing and Therapy Services Not Requiring SNF Placement:

SNF placement isn't necessary for services including, but not limited to:

- Administration of routine oral, intradermal or transdermal medications, eye drops, and ointments
- Custodial services (e.g., non-infected postoperative or chronic conditions)
- Activities or programs primarily social or diversional in nature
- General supervision of exercises in paralyzed extremities, not related to a specific loss of function
- Routine care of colostomy or ileostomy
- Routine services to maintain functioning of in-dwelling catheters
- Routine care of incontinent patients
- Routine care in connection with braces and similar devices
- Prophylactic and palliative skin care (i.e., bathing, application of creams, or treatment of minor skin problems)
- Duplicative services - Physical therapy services duplicative of occupational Therapy services being provided or vice versa
- Invasive procedures
- General supervision of aquatic exercise or water-based ambulation
- Heat modalities (hot packs, diathermy or ultrasound) for pulmonary conditions or wound treatment, or as a palliative or comfort measure only (whirlpool and hydrocollator)
- Hot and cold packs applied in the absence of associated modalities
- Diagnostic procedures performed by a Physical Therapist (i.e., nerve conduction studies)
- Electrical stimulation for strokes when there's no potential for restoration of functional improvement. Nerve supply to the muscle must be intact

o. Rehabilitation Facility

For rehabilitation facility services to be covered, care and treatment must be medically necessary and appropriate. Inpatient rehabilitation provides multidisciplinary, structured, intensive therapy for members both requiring and able to participate in a minimum of three hours of daily rehabilitation therapy services. Rehabilitation goals are to prevent further disability, to maintain existing ability, and to restore maximum levels of functioning within the limits of the member's impairment. Potential inpatient rehabilitation admissions include members with recent cerebrovascular accident, head trauma, multiple trauma, spinal cord injury or recent amputation.

We've dedicated Nurse Clinicians available to assist you with necessary services for your patients. Our Care Management team can be contacted at **1-800-924-7141**.

We will start partnering with a vendor to assist with these reviews. After vendor implementation, targeted for 2nd quarter 2026, all advance determinations or prior authorization requests will need to be submitted directly to them for review via phone at **1-888-258-3864** or eHealth Web submission via Availity.

Basic information needed for processing an advance determination or prior authorization request:

- Member's identification number, name, and date of birth
- Practitioner's name, provider number, NPI, Medicare number; address and telephone number
- Hospital/facility's name, provider number, NPI, Medicare number, address, and telephone number
- Admission date
- Caller's name

Clinical information required for review:

- Admitting diagnosis, symptoms, treatment, frequency of therapies, member's ability to participate in treatment
- Member is ventilator dependent or not
- Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care that would influence the medical necessity determination
- Discharge plans that include:
    - Type of residence
    - Number of home levels
    - Number of stairs to enter the home and within the home (including number of rails)
    - Who lives in the home
    - Driving status
    - Support System
    - Any Known Resources (CHOICES, home health, caregivers)
    - What DME they have and what is needed, including ramps
    - If a CHOICES Pre-Admission Evaluation (PAE) has been initiated

Evaluation of the member must be submitted including the following as appropriate:

- Ordering practitioner and date of last visit
- Gait analysis
- Primary diagnosis
- Circulation and sensation
- Date of diagnosis onset
- Cooperation and comprehension
- Baseline status
- Prior level of functioning
- Current functional abilities
- Functional potential
- Expected maximum level of functioning
- Other therapies or treatments
- Patient's goals
- Strength
- Medical compliance

- Range of motion
- Support system/caregiver

Plan of care must be submitted including the following, as appropriate:

- Short and long-term goals
- Proposed admission date
- Discharge goals
- Frequency of treatment
- Measurable objectives
- Specific modalities, therapy, exercise
- Functional objectives
- Safety and preventive education
- Home program
- Community resources

p. Home Health Services and Billing Guidelines

Home health services are hands-on, skilled care/services, provided by or under the supervision of a registered nurse that are needed to maintain the member's health or to treat the member's illness or injury. Services may include skilled nursing, physical therapy, occupational therapy and speech therapy. In order for the services to be covered, the member must have a medical condition making them unable to perform personal care that meets medical necessity and medical appropriateness criteria. Documentation must support the member's limitations, homebound status, and the availability of a caregiver/family and degree of caregiver/families' participation/ability in member's care.

Basic information needed for processing an advance determination request:

- Member's identification number, name, and date of birth
- Practitioner's name, provider number, NPI, Medicare number; address, and telephone number
- Hospital/Facility's name, provider number, NPI, Medicare number, address, and telephone number
- Date of service
- Caller's name
- Signed order from the ordering or treating physician indicating primary reason for home health services in addition to the requested services
- Supporting face-to-face documentation that occurred no more than 90 days prior to services or no more than 30 days after the initiation of services
- In addition to the certifying physician, the following can perform face-to-face services:
  - A nurse practitioner or clinical nurse Specialist who's working with the physician in accordance with State law.
  - A physician assistant under the supervision of the physician.

Billing of supplies including those provided by third party vendors such as medical supply companies used with a home health visit are the responsibility of the Home Health Agency. Prior authorization will be required for skilled nurse visit(s) and any non-routine supplies used with skilled nurse care rendered in the patient's home. Charges for non-routine supplies won't be reimbursed if they aren't included and reviewed within the authorization.

Supplies not used during a home health visit aren't billable by the Home Health Agency. See Reimbursement Guidelines at the beginning of the Medicare Advantage section.

Note: Please fax a copy of the Home Health form to Medicare Advantage Care Management at **1-888-535-5243** or **(423) 535-5243**. The authorization for services form is located at 508C, Home Health/Outpatient Therapies Services Request. The form is located under the Medicare Advantage Authorization and Appeals section.

We will start partnering with a vendor to assist with these reviews. After vendor implementation, targeted for 2nd quarter 2026, all advance determinations or prior authorization requests will need to be submitted directly to them for review via phone at **1-888-258-3864** or eHealth Web submission via Availity.

q. Durable Medical Equipment

Basic information needed for processing an advance determination request:

- Member's identification number and name
- Practitioner's name, provider number, NPI, Medicare number; address and telephone number
- Hospital/facility's name, provider number, NPI, Medicare number, address, and telephone number
- Date of service
- Caller's name

Clinical information/documentation required for review:

- Member's diagnosis and expected prognosis
- Signed prescription
- Estimated duration of use
- Supporting face-to-face documentation that occurred no more than 90 days prior to services or no more than 30 days after the initiation of services
- In addition to the certifying physician, the following can perform the face-to-face services:
  - A nurse practitioner or clinical nurse specialist working with the physician in accordance with State law
  - A certified nurse midwife as authorized by State law
  - A physician assistant under the supervision of the physician
- Limitations and capability of the member to use the equipment
- Itemization of the equipment components, if applicable
- Appropriate HCPCS codes for equipment being requested
- Member's weight and/or dimensions (needed to determine coverage of manual or power wheelchairs), if available

r. Chiropractic Manipulation, Acupuncture, and Outpatient Occupational, Physical Therapy and Speech Therapy

In order for therapy services to be considered for benefits, the services must be medically necessary and medically appropriate for the treatment of the member's illness or injury. You can request an advance determination by calling **1-800-924-7141** or completing the request online through Availity, using the Outpatient Therapy form.

Administrative approvals are given on **initial** requests to help ensure the member receives services needed while allowing providers time to get supporting clinical documentation for ongoing care. These approvals are as follows:

- **Outpatient Occupational and Physical Therapy** will be approved up to twelve (12) visits over a timeframe of up to 90 days. The number of visits and timeframe given doesn't need to include the initial evaluation because it doesn't require prior authorization and won't be included in the authorization total.
- **Speech Therapy** will be approved up to six (6) visits over a timeframe of up to 90 days. The number of visits and timeframe given doesn't need to include the initial evaluation because it doesn't require prior authorization and won't be included in the authorization total.
- **Chiropractic Services** are covered for manual manipulation of the spine to correct subluxation, but only when deemed medically necessary and a reasonable and necessary treatment for a neuromusculoskeletal condition. Coverage is limited to the hands-on manipulation of the spine for symptomatic subluxations, and other services like X-rays, exams, and therapies are generally not covered. Maintenance Care, which is aimed at preventing future problems or maintaining a chronic condition without expecting further improvement is not covered. Initial request will be approved up to eight (8) visits over a timeframe of up to 90 days. For additional visits, supporting clinical must be provided to establish medical necessity and provide a reasonable expectation of recovery or functional improvement.
- **Acupuncture Services for Chronic Low Back Pain (cLBP)**: CMS determined it will cover acupuncture for cLBP effective for claims with dates of service on or after Jan. 21, 2020, for up to 12 visits in 90 days if criteria are met. An additional eight sessions will be covered for members demonstrating an improvement. No more than 20 treatments may be administered annually. These services require prior authorization. Physicians, physician assistants, nurse practitioners, clinical nurse specialists, and auxiliary personnel may furnish acupuncture if they meet the criteria in the NCD. All types of acupuncture including dry needling for any condition other than cLBP are non-covered by Medicare.

If requesting more than the outlined number of visits or timeframe that can be approved on the initial request, all supporting documentation for medical necessity review should be submitted with the initial request.

Basic information needed for processing an advance determination request:

- Member's identification number, name and date of birth
- Practitioner's name, provider number, NPI, Medicare number, address and telephone number
- Hospital/facility's name, provider number, NPI, Medicare number, address and telephone number
- Date of service
- Caller's name

Clinical information/documentation required for review:

- Assessment Requirements (Evaluation and Plan of Care) Evaluation
- Ordering practitioner and date of last visit
- Primary diagnosis
- Date of diagnosis onset
- Baseline status/current abilities
- Functional potential
- Prior level of functioning
- Current functional abilities
- Functional potential
- Expected maximum level of functioning
- Strength and range of motion, if applicable
- Circulation and sensation
- Cooperation and comprehension
- Diagnostic and assessment services used to determine the type, causal factors and severity of speech and language disorders
- Support system/caregiver
- Other therapies or treatments
- Patient's goals
- Therapy compliance

Clinical information/documentation required for plan of care:

- Long and short-term goals
- Discharge goals
- Measurable objectives
- Functional objectives
- Home program, if applicable
  - Duration of therapy
  - Frequency of therapy
  - Date therapy will begin
  - Specific therapy techniques
- Safety and preventive education
- Community resources

s. Orthotics/Prosthetics

Basic information needed for processing an advance determination or prior authorization request:

- Member's identification number, name and date of birth
- Practitioner's name, provider number, NPI, Medicare number, address and telephone number
- Hospital/facility's name, provider number, NPI, Medicare number, address, and telephone number
- Date of service
- Caller's name

Clinical information/documentation required for review:

- Member's diagnosis and expected prognosis
- Limitations and capability of the member to use the equipment
- Itemization of the equipment components, if applicable

- Appropriate HCPCS codes for equipment being requested

t. Laboratory Services

Providers should use in-network options for all lab services requested unless the specific lab test isn't available from a participating lab provider. This includes genetic testing that is covered by Medicare. If the provider refers testing to a non-participating lab and the test was available through a participating provider, the cost may be the provider's and not the member's responsibility through an off-set reconciliation.

u. Retrospective Claims Review

We'll conduct Retrospective Claims Review within two years of the original claim receipt date to provide a decision based on benefit eligibility, exclusion(s), appropriateness and medical necessity of services. Specific reasons why the service wasn't requested in a timely manner apply to retrospective reviews. See the Criteria Hierarchy listed in the Care Management subsection (1) of the Health Management section (I) of this manual for more information about the references we use to determine appropriateness and medical necessity.

v. Pharmacy (Part B Drugs)

For Part B drugs to be considered for benefits, the drug must be medically necessary and medically appropriate to the treatment of the member's illness or injury according to National Coverage Determinations and/or Local Coverage Determinations. In the absence of NCD, LCD or clear Medicare guidance, BCBST drug policy, FDA approved labeling, drug compendia, authoritative medical literature and/or accepted standards of medical practice will be used to review the request.

Certain Part B drugs may be subject to Step Therapy requirements for members newly starting the medication. These drugs are identified with "ST" for Step Therapy. Lists of drugs requiring prior authorization and Step Therapy can be found at https://www.bcbst.com/docs/providers/BCBST_Part_B_Step_Therapy_Provider_Reference_Guide.pdf

and

https://www.bcbst.com/docs/providers/MA-DSNP-Specialty-Pharmacy-List.pdf

Certain drugs may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make a determination.

Part B Specialty Pharmacy authorization requests can be initiated by phone at **1-800-924-7141**, or online through Availity.

You can find the Part B prior authorization criteria search tool at: https://client.formularynavigator.com/Search.aspx?siteCode=7342549953 (bcbst-medicare.com)

Note: New drugs may be periodically added to the Specialty Pharmacy list and products requiring authorization are subject to change. Changes will be communicated in the BlueAlert newsletter or updates to this Manual. Current and archived BlueAlert issues can be viewed online under the News and Updates section at Provider News and Updates | BCBS of Tennessee

w. Reconsideration Process (Pre-Service)

The reconsideration process applies to members or member's representatives for services that haven't been received. This is the first step in a Medicare member appeal. More information is provided for members in their Evidence of Coverage.

A **standard Reconsideration** of an adverse organization determination or termination of services decision may be requested in writing by a treating physician, member or member's authorized representative. A standard Reconsideration of the denial of a request for service will be determined no later than 30 calendar days from the date the request of a standard Reconsideration is received. The timeframe may be extended up to 14 calendar days at the member's request.

A treating physician, member or member's authorized representative may submit a verbal or written request for an **expedited Reconsideration** in situations where applying the standard of procedure could seriously jeopardize the member's life, health, or ability to regain maximum function. If we

approve a request for an expedited Reconsideration, the review will be completed no later than 72 hours after receiving the request. The 72-hour timeframe may be extended up to 14 calendar days at the member's request.

As of Jan.1, 2020, provider-administered medication (Part B) member appeals are processed under the following timeframes:

- For an expedited Part B Medication Reconsideration, review will be completed no later than 72 hours after receiving the request.
- For a standard Part B Medication Reconsideration review will be completed no later than seven days from the date the request is received.
- Extensions can't be taken on Part B Medication Reconsiderations.

A request for payment of a service already provided to the member isn't eligible to be reviewed under the Reconsideration process.

x. Advanced Imaging

Prior authorization* is required for select advanced imaging radiology procedures performed in an outpatient setting. Prior authorization isn't required for imaging procedures performed during an inpatient admission, observation, or ER room visit. Procedures requiring prior authorization include, but aren't limited to:

- Computed tomography (CT)
- Computed tomography angiography (CTA)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Positron emission tomography (PET)
- Nuclear and diagnostic cardiology

CMS created "C" codes for its outpatient facility PPS payment logic to increase reimbursement when paying under a per diem basis. Accordingly, the codes weren't created by CMS to represent "base" procedure codes like CPT® or "G" or "S" HCPCS codes.

Authorizations aren't performed based on C codes but use CPT® or possibly G or S HCPCS codes. Refer to High Tech Imaging C Code Crosswalk Reference Guide on our provider website. The list can be found at: https://provider.bcbst.com/tools-resources/authorizations-appeals.

Bone Density/CT Bone Density Exclusions from Advanced Imaging Program

Bone Mass Measurements are used to diagnose osteoporosis and to assess the individual's risk for subsequent fracture and are excluded from this requirement. These measurements are considered part of Medicare's preventive services.

To request prior authorization for any of the above listed radiology procedures, call the Advanced Imaging vendor at **1-888-258-3864** or complete the request online through Availity.

y. Oxygen Authorizations

Our members no longer receive lifetime, or multi-year approval for oxygen equipment rentals. Authorizations for oxygen equipment will be reviewed to address the full 36 months rental period in accordance with CMS regulations.

Oxygen equipment rental is only covered for 36 months, in accordance with CMS regulations.

z. Fusion for Degenerative Joint Disease of the Lumbar Spine

The following documentation is required to request authorization for Fusion for Degenerative Joint Disease of the Lumbar Spine:

- Continued pain and difficulty maintaining activities of daily living despite activity modification
- A documented home exercise program or supervised physical therapy
- Anti-inflammatory medication
- Results of pertinent imaging studies, full motor and sensory exam of lower extremities
- Response to conservative treatment, such as injection therapy
- Levels planned for instrumentation

Note: Both Tennessee specific LCD criteria and MCG criteria are used to make medical necessity determinations for these services.

aa. Hemodialysis

Nephrologists and dialysis providers are required to provide a copy of CMS form 2728 once per year for each member receiving hemodialysis services. This form should be faxed to our Medicare Advantage Care Management at **1-888-535-5243**.

bb. Radiation Therapy

Prior authorization is required for all radiation therapy procedures (proton Beam, Selective interventional radiology, and standard radiation treatment).

Prior authorization can be started via Availity or by completing the MA Inpatient/Outpatient Request form and faxing it to **1-888-535-5243**. These service requests are available for submission via Availity under the outpatient form. A reference document for potential codes is located on **bcbst.com** under the **Medicare Advantage Tools and Resources** page.

K. Member Access to Care

For members to receive the quality care they need to manage their health they must have access to health care services.

Standards for Appointment Wait Times (Medicare Advantage plans)

The Appointment Wait Time Standards measure the amount of time between when an individual requests an appointment and when the first in-person appointment is available. These standards apply to appointments for both new and existing patients.

The Appointment Wait Time Standards for primary care services are:

- Urgently needed service or emergency – immediately
- Services that are not emergency or urgently needed, but in need of medical attention – within one week
- Routine and preventive care – within 30 days

L. Valuable Health Tools for Your BlueAdvantage Patients

Tool	Description	For more information…
Personal Health Manager	This customizable online tool provides patients with condition-specific information and recommendations. It also has trackers available to help them with documenting lab tests, exercise achievements and medications among many other things.	To access the Personal Health Manager, members can go to www.bcbst-medicare.com.
Blue365	This discount program is designed to offer discounts on a wide range of health and wellness related products and services. These discounts are additional perks and do not replace the patient's benefits. Discounts can't be used in conjunction with a patient's benefit.	Members can sign up through bcbst-medicare.com or www.Blue365Deals.com/bcbstn. For additional assistance your patients can: 1. Submit a completed form to us, started by clicking on the "Contact Us" link in the footer of our website 2. Send us an email directly to: support@blue365deals.com 3. Call us at **1-855-511-2583**

Tool	Description	For more information…
24/7 Nurse Line	A nurse line is available 24-hours-a-day, seven-days-a-week to help answer your patient's health concerns. This important resource can also help your patients know when to go to the ER room if they're unsure.	To access the nurse line, direct your patients to call us at **1-866-275-1660.**
Care Campaigns	To help you close your patient's preventive gaps in care, we review claims data and provide your patients with periodic reminders to get important preventive health services. Gaps in care measures include, but aren't limited to: flu/pneumonia shots, annual wellness exams, diabetic, glaucoma, breast/colorectal cancer screenings, etc.	We'll either direct members to contact their primary care physician to schedule an appointment or call the primary care physician's office to schedule an appointment on the member's behalf.
Silver & Fit	The Silver & Fit program is designed for older adults to help them exercise regularly. The program provides access to a network of fitness facilities, in-home fitness kits and an online library of fitness classes.	For more information or to join the program, direct your patients to visit http://www.silverandfit.com/ or call **1-877-427-4788 (TTY/TDD 711).**
Medication Therapy Management* (MTM*) Program	We offer a Medication Therapy Management program to members that meet the enrollment requirements. This program provides them with a comprehensive medication therapy review, personal medication record, and tools to help them manage their prescription medications, over-the-counter medications and/or herbal therapies.	Members that meet the qualifying criteria are automatically enrolled and sent a letter explaining the program.
My HealthPath® Wellness and Rewards Program	This program partners with members as they take steps toward a healthier lifestyle. Members must opt-in to participate in this program. After they're actively enrolled, they're educated about the importance of preventive screenings while being rewarded for receiving the screenings that apply to them.	For more information on the member Incentive Program, please see the member Incentive section of our Quality Program Information guide at https://www.bcbst.com/docs/providers/quality-initiatives/Quality_Partnerships_Program_Guide.pdf
Medicare Diabetes Prevention Program(MDPP)	MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle. There is no coinsurance, copayment, or deductible for the MDPP benefit.	Referrals to the MDPP program should be sent to MA Population Health by calling **1-800-611-3489** or by fax to **1-800-727-0841** **See the Quality Program Guide for MDPP eligibility requirements.** **Note**: Prediabetes can be diagnosed via oral glucose tolerance tests, fasting blood glucose tests, or an A1C test. Blood-based testing is the most accurate way to determine if a patient has prediabetes.

Tool	Description	For more information…
Telehealth	Telehealth services are provided by Teladoc. Members can access telehealth services for non-emergency medical, behavioral health, nutrition, and dietary issues 24- hours-a-day, seven-days-a-week. Consults are limited to certain conditions.	See bcbst.com for information regarding the limited conditions that Teladoc can consult on. Members can enroll at: https://www.bcbst.com

M. Pharmacy

1. Drug List

Our drug list, referred to as a formulary, is located at:

https://www.bcbst-medicare.com/docs/2026_blueadvantage_formulary.pdf

Note: Our drug list doesn't apply to the BlueAdvantage Freedom plan as this plan doesn't include Part D benefits.

2. Prior Authorizations, Quantity Limits, Exceptions and Redeterminations

Prior Authorizations

Certain drugs with special indications require authorization. These drugs are noted on the drug list. For our plans, the prescribing practitioner, member, or member's representative is responsible for requesting and obtaining the necessary authorization. Prior authorization must be obtained before the drug is dispensed.

Compound ingredients are subject to drug list rules and Medicare requirements. If one ingredient requires prior authorization, the prescribing practitioner must obtain the necessary authorization before the compound is dispensed.

Quantity Limits

Some medications have a quantity limit for a given time. Greater quantities require a practitioner supporting statement for medical necessity.

Exceptions

An exception is a type of coverage determination that's unique to the Part D benefit. A member, member's authorized representative or prescribing physician may request an exception. These types of coverage determinations require a provider's statement of support:

- Tiering Exception: Permits members to obtain a non-preferred drug at the cost-sharing amount applicable to drugs on preferred tiers.
- Non-Formulary Exception: Ensures that members have access to medically necessary Part D drugs not included on the BlueAdvantage drug list or need to be dosed outside the limitations or requirements policy.
- Quantity Limit Exception*:* Permits members to request an exception to a quantity or dosing limitation.

The physician's supporting statement must indicate that the requested drug is medically required, and other non-formulary drugs and dosage limits won't be effective because:

- All covered Part D drugs on any tier of our drug list wouldn't be as effective for the member as the non-formulary drug, and/or would have adverse effects.
- The number of doses available under a dose restriction for the prescription drug:
  - Has been ineffective in the treatment of the member's disease or medical condition; or
  - Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the member, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or

- The prescription drug alternative(s) listed on our drug list:
  - Have been ineffective in the treatment of the member's disease or medical condition; or
  - Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the member, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance; or
  - Has caused, or based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the member.

The review process for a tiering exception or drug list exception request won't begin until we receive the physician's supporting statement and can't exceed 14 days to retrieve the supporting statement.

The Physician's supporting statement will be evaluated based on:

- Comparisons of quality of the medication therapy, including safety, efficacy, effectiveness and cost, as well as comparison of the drug product within the specific therapeutic class; and
- Medical evidence, such as peer reviewed medical references, primary research, standards of practice, or relevant findings of government agencies, medical associations and national commissions.

To request an exception, complete a Medicare Part D Prescription Drug Authorization Request form. This form may be accessed at: 508C Request for Medicare Prescription Drug Coverage Determination (bcbst-medicare.com).

If an exception is granted, we can't require the member to request approval for a refill or new prescription from the prescriber to continue using the Part D drug that was approved. The exception will be approved until the specified expiration date assuming the member remains enrolled in the plan, the physician continues to prescribe the drug and it continues to be safe for treating the member's condition.

When drug list changes during the benefit year that result in a member's drug no longer being covered, the affected members will be notified by letter at least 30 days prior to the effective date of such changes. Members may request an appeal of any drug list change and we'll review the request according to the tiering exception and drug list exception process.

Redetermination

If we've denied your request for a medication or pharmaceutical product, the member or the member's physician may initiate a pharmacy redetermination. Urgent redeterminations may be initiated by phone; standard redeterminations must be submitted in writing via mail or fax.

You may request prior authorization or initiate a redetermination by contacting the following:

Phone	**1-800-831-2583**
Fax	**1-423-591-9514**

Mail to:

BlueCross BlueShield of Tennessee
Medicare Part D Coverage Determinations and Appeals
1 Cameron Hill Circle, Suite 51
Chattanooga, TN 37402-0051

Peer to Peer

At any time, prescribers may request a peer-to-peer review for Part D pharmacy reviews. To initiate a peer-to-peer review, contact provider services at **1-800-831-2583**.

Websites:
https://www.bcbst-medicare.com
https://www.bcbst-medicare.com/manage-my-plan/pharmacy/index.page
https://www.bcbst-medicare.com/docs/Request-for-Redetermination-ppo.pdf

N. Provider Appeal Process

Provider Claim Payment Dispute Resolution Procedure

The provider claim payment dispute resolution procedure has three levels, or stages:

1. Inquiry/Reconsideration Level (Written or verbal)
2. Appeal Level (Formal, Written request)
3. Binding Arbitration

Level 1 – Inquiry/Reconsideration

If you disagree or have questions about payment, you can submit a request for a provider reconsideration within 18 months of the initial claim denial (18 months from the remittance advice date in which the claim first appeared).

- Only one reconsideration is allowed per claim.
- Reconsiderations must be completed before filing a formal appeal.
- You can't use the Provider Reconsideration Form to request an appeal.

Please submit the Provider Reconsideration Form along with any supporting documentation related to your reconsideration request to:

Fax: (423) 535-1959

Mail:

BlueCross BlueShield of Tennessee
1 Cameron Hill Circle, Ste 0039
Chattanooga, TN 37402-0039

Additional information on Reconsideration processes and the fillable Provider Reconsideration Form can be viewed at: https://provider.bcbst.com/tools-resources/authorizations-appeals/

Level 2 - Appeal

If you're dissatisfied with our response to your request for reconsideration, you may submit a formal appeal. Appeal requests must be submitted within 60 days after receiving the response for a reconsideration request.

Please submit a Provider Appeal Form and along with any supporting documentation to:

Fax: (423) 535-1959

Mail:

BlueCross BlueShield of Tennessee
1 Cameron Hill Circle, Ste 0039
Chattanooga, TN 37402-0039

Additional information on Appeal processes and the fillable Provider Appeal Form is located on at:

https://provider.bcbst.com/tools-resources/authorizations-appeals/

Level 3 – Binding Arbitration

The final step in the Provider Claims Payment Dispute Resolution Procedure is Binding Arbitration. Please see Provider Dispute Resolution Procedure in this Manual for information on this process.

Additional Provider Claims Payment Dispute Resolution Procedure Information

To avoid delays in reviewing your request(s):

- Ensure the Provider Reconsideration form or the Provider Appeal form is completed accurately.
- Please attach any records or documentation to the reconsideration or appeal form. If the proper form isn't included, the records/documentation may be returned to you for clarification of your request.

Formal Care Management Provider Appeal

Typically pre-service scenarios are defined as member appeals. When requests are treated as member appeals, only the member, a representative, or treating physician acting on the behalf of the member have appeal rights per CMS regulations. When applicable, an Appointment of Representative (AOR) form on file may be required before the appeal can be reviewed. This includes third-party companies acting on

behalf of a facility for adverse determinations appealed while the member is still in the hospital. These appeals including any supporting documentation and an AOR form, if required, should be sent to:

Fax: (423) 535-5270

Mail:

BlueCross BlueShield of Tennessee
Attn: Medicare Advantage Appeals and Grievances Department
1 Cameron Hill Circle, Ste 0005
Chattanooga, TN 37402-0005

Per CMS guidelines, contract providers don't have appeal rights. However, we have a contractual Provider Appeals process if a provider disagrees with a determination post services or payment. When services were already rendered and there was no additional member financial responsibility, these will be processed as provider appeals. Once an organization determination has been issued, the appeals process is the **sole mechanism** available to request reconsideration of an adverse decision. Peer-to-Peer discussions are not available after a determination is rendered and may not be used in lieu of, prior to, or during an appeal. Written appeals including any supporting document should be sent to:

Fax: 1-888-535-5243

Mail:

BlueCross BlueShield of Tennessee
Attn: Medicare Advantage Utilization Management
1 Cameron Hill Circle, Ste 0005
Chattanooga, TN 37402-0005

Post-Service Appeal Options (services have already been received)

You have the right to ask for a provider appeal from us. Please complete the 508C Medicare Advantage Care Management Appeal and send it along with any supporting documentation to:

Fax: 1-888-535-5243

Mail:

BlueCross BlueShield of Tennessee
Attn: Medicare Advantage Care Management – Provider Appeal
1 Cameron Hill Circle, Ste 0005
Chattanooga, TN 37402-0005

We need this information within 60 days of the date on the initial decision letter. If you initiate a written appeal, we'll review the request and provide a decision within 30 days from receiving your appeals request. After the appeal review has been completed, we'll inform you and/or the member in writing of the decision. If you disagree with that decision, you can request binding arbitration. (See Provider Dispute Resolution Procedure section in this Manual for information on binding arbitration.)

Pharmacy Pricing Appeal

Pharmacy pricing appeals should be submitted directly to BCBST's pharmacy benefit manager using directions in the following link:

https://www.caremark.com/content/dam/enterprise/caremark/pdfs/MAC_Portal_Access_Appeals_Process.pdf

Medical claim pricing appeals for specialty pharmacies contracted in BCBST's specialty network should be submitted to BCBST using the Standard Appeal process referenced above.

O. Website Related Links

The following web pages contain information from CMS that you may find helpful, or supplemental, to the information provided in this manual.

CMS website

http://www.cms.gov/

Internet-Only Manuals (IOMs)

https://www.cms.gov/regulations-and-guidance/guidance/manuals/internet-only-manuals-ioms

Quarterly Provider Update

https://www.cms.gov/regulations-and-guidance/regulations-and-policies/cms-rulemaking

Medicare Coverage Home page

http://www.cms.gov/center/coverage.asp

P. Contact Us

Learn more about our Medicare Advantage plans:

Website:	www.bcbst.com www.bcbst-medicare.com
Provider Service:	Phone: 1-800-841-7434; 1-800-924-7141 Monday through Friday, 8 a.m. to 6 p.m. ET
Advance Determinations/Prior Authorizations:	Phone: 1-800-924-7141 Monday through Friday 9 a.m. to 6 p.m. ET Fax: 1-888-535-5243 or (423) 535-5243 Online Web Authorization also available via Availity or Cohere, the secure area on our website, https://provider.bcbst.com/
Medicare Part D Coverage Determinations and Appeals	Phone: 1-800-831-2583 Monday through Friday, 8 a.m. to 9 p.m. ET (Secure voicemail available after hours)
BlueCard Host Services	Phone: 1-800-705-0391 Monday through Friday, 8 a.m. to 6 p.m. ET
Medicare Part C Preservice Member Appeals	Mail: BlueCross BlueShield of Tennessee Attn: Medicare Advantage Appeals and Grievances 1 Cameron Hill Circle, Suite 0005 Chattanooga, TN 37402 Fax: (423) 535-5270

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XXII. COVER TENNESSEE

The Cover Tennessee program, CoverKids, was developed by the State of Tennessee to provide free healthcare coverage for pregnant women and children who do not have insurance and who do not qualify for TennCare.

Information on the CoverKids program can be found in the *BlueCare Tennessee Provider Administration Manual* located on the BlueCare Tennessee website at http://bluecare.bcbst.com/Providers/Provider-Administration-Manual.html.

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XXIII. ATTACHMENT I: BCBST Change of Ownership or Control (CHOW) Policy

The change of ownership or control requirements in this Policy only apply to facility and professional group provider types. It is the responsibility of the entity or person acquiring a provider to provide BCBST at least 60 calendar days advance notice of any change of ownership (CHOW) which is defined as a (a) direct or indirect sale or other disposition of all or a majority of the assets of provider; (b) any transaction resulting in a change in the beneficial owner, directly or indirectly, of more than 25% of the then-outstanding number of units, interests, or shares of the provider's voting stock (or membership interests or other equity); (c) the lease of all or part of Provider's facility or (d) any other transaction that results in a change to the NPI or Tax ID of Provider. When such advance notice is not furnished, payment to the provider may be impacted. The requirements under this policy are in addition to, and do not replace or supersede, any notice or approval requirements triggered by a CHOW, "Change of Control," or assignment that are set forth in the provider's agreement with BCBST.

The person or entity acquiring a provider or more than 25% control of a provider is required to submit a CHOW notification using the Provider Change of Ownership Notification Form on BCBST's website. The form can be found under the Document & Forms section or at this link: https://www.bcbst.com/providers/forms/Change_Ownership_Notification_Form.pdf. The buyer must also furnish a copy of the executed bill of sale or purchase document (minus the purchase price) within five (5) business days of closing. Failure to provide this documentation within this timeframe, will result in the suspension of payments to the provider following the CHOW.

A representative of the Provider Network Contracting (PNC) team will assist the person or entity that is acquiring provider in completing any applicable credentialing and contracting processes prior to the effective date of the CHOW. They will also advise the provider of any missing information or documentation.

The buyer may be given the option to assume the seller's provider agreement, enter into a new agreement, or a single case agreement at BCBST's discretion. If BCBST determines a new agreement is required, the rates of the seller are not guaranteed to transfer to the buyer.

Claims with dates of service prior to the effective date of the CHOW should be submitted using the provider's NPI and Tax Id prior to the CHOW. Once the CHOW transaction closes, all claims for dates of service after the effective date of the CHOW should be submitted using the provider's NPI and Tax ID after the CHOW reflecting any change resulting from the CHOW.

Providers that fail to notify BCBST of a CHOW at least 60 calendar days prior to the CHOW effective date may experience a gap in network participation and claims payment. If the buyer notifies BCBST at least 60 days prior to the effective date of the CHOW and BCBST agrees to maintain the seller's provider agreement or enter into a new provider agreement, the following will apply:

- The network effective date will be the CHOW effective date.
- Claims after the CHOW effective date will be reimbursed at 100% of the in-network rate subject to all applicable payment terms under the agreement.

Buyers that do not notify BCBST timely of a CHOW will be handled as follows:

- BCBST may terminate the provider's agreement.
- If credentialing or a new agreement is required, then the network effective date will be the later of the date credentialed or agreement execution, as applicable.
- If BCBST does not choose to terminate the provider's agreement, there nonetheless could be a gap in network participation for the facility or group.
- If BCBST does not choose to terminate the provider's agreement, claims for dates of service after the CHOW closing date will be reimbursed at 100% as of the network effective date instead of the CHOW effective date subject to all applicable payment terms under the agreement.

For additional change of ownership information, please review the Change of Ownership or Control (CHOW) FAQs located at https://www.bcbst.com/providers/forms/Change_Ownership_FAQ.pdf.

XXIV.GLOSSARY

These term definitions have been edited for this medium and are not as complete or detailed as some of the glossary definitions included in our contracts.

ambulance

A specially designed and equipped vehicle used only for transporting the sick and injured.

ambulatory surgical facility

A facility that:

- primarily performs surgical procedures on an outpatient basis
- doesn't provide inpatient care
- has an organized staff of practitioners and permanent facilities and equipment
- may not be primarily used as an office or clinic for a practitioner's or other professional's practice
- is a licensed Institution

benefit period

A calendar year during which benefits are available for covered services.

BlueCard®

An advantage that allows our members to "take their coverage with them" when they travel. BlueCard links Blue Plans and participating health care providers across the country and internationally through one electronic network for claims processing and reimbursement.

coinsurance

The portion of an eligible medical bill a member must pay out-of-pocket before we begin paying insurance benefits. Coinsurance amounts are usually a percentage of the total medical bill, (i.e., 20 percent). Coinsurance applies after the member meets a required deductible or copay amount is part of certain health plans.

concurrent review

A determination of whether continued inpatient care, or a given level of services being received, is medically necessary for the member's medical condition. This review can be performed by the provider's utilization review staff, our review coordinator or medical director, or any other entity or organization under contract with us. Once the case is reviewed, we'll notify the Practitioner and the member of the results.

copayment (copay)

A fixed dollar amount that a member pays to a participating network doctor, caregiver, or other medical Provider or pharmacy each time health care services are received. Members pay their copay before we pay the covered benefit amount. Copays are part of certain health care plans.

contract

The agreement between BlueCross and the Member. It includes a contract document, the signed application and any attached papers or riders. A rider is an extra provision that's added to the basic contract. We consider the statements an individual makes in the application to be representations, not warranties.

contract date (effective date)

The date coverage begins

covered service

A medically necessary service or supply shown in the contract where benefits may be available.

custodial care

Care provided primarily for maintenance designed to assist the member in activities of daily living. It is not provided primarily for its therapeutic value in treatment of an illness or injury. Custodial care includes,

but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets, and supervision of self-administration of medication not requiring constant attention of medical personnel.

deductible (deductible amount)

A deductible is a fixed-dollar amount that a member must pay for eligible services before we begin applying insurance benefits. Usually deductibles apply every calendar year and are part of certain health care benefits plans.

dependent

Another family member covered under a Member's health care benefits plan. May be a spouse and/or unmarried children who meet eligibility requirements of the plan.

diagnostic service

A procedure ordered by a practitioner or other provider to determine a specific condition or disease. Some common diagnostic procedures include:

- X-rays and other radiology services
- Lab and pathology services
- Cardiographic, encephalographic and radioisotope tests

durable medical equipment (DME)

Equipment which:

- Can only be used to service the medical purpose for which it's prescribed
- Isn't useful to the member or other person in the absence of illness or injury
- Is able to withstand repeated use
- Is appropriate for use in an ambulatory or home setting

Such equipment won't be considered a covered service, even if it's prescribed by a practitioner or other provider simply because its use has an incidental health benefit

effective date

The date that coverage begins for a member.

eligible person

A person entitled to make application for coverage.

emergency or emergency medical condition

An illness, injury, symptom or condition so serious that a reason person would seek care right away to avoid a severe harm.

emergency admission

An inpatient admission as an Inpatient in connection with an emergency.

emergency services

Health care services and supplies furnished in a hospital which are needed to determine, evaluate and/or treat an emergency medical condition until the condition is stabilized, as directed or ordered by a Practitioner or hospital protocol.

fee schedule (fee for services)

The maximum fee that we will pay for specific covered services.

freestanding diagnostic laboratory

Another provider that provides lab analysis for providers.

freestanding dialysis facility

A facility that provides dialysis treatment, maintenance, and training to members on an outpatient or home health care basis.

freestanding sleep study center

A facility that provides sleep studies on an outpatient basis.

health care professional

A podiatrist, dentist, chiropractor, nurse midwife, registered nurse, optometrist, or other person licensed or certified to practice a health care profession, other than medicine or osteopathy, by Tennessee or the state in which that health care professional practices.

home health care agency

Provider that's primarily engaged in providing home health care services.

hospital

A short-term, acute-care, general hospital which:

- Is a licensed institution
- Provides inpatient services and is compensated by or on behalf of its patients
- Provides surgical and medical facilities primarily to diagnose, treat, and care for the injured and sick; Note: A psychiatric hospital isn't required to have surgical facilities
- Has a staff of Practitioners licensed to practice medicine
- Provides 24-hour nursing care by registered graduate nurses

A facility which serves, other than incidentally, as a nursing home, custodial care home, health resort, rest home, rehabilitative facility or place for the aged isn't considered a hospital.

in-network (INN) provider

Practitioners, caregivers and medical facilities are considered "in-network" or "in network" if they participate in an agreement with us to provide services according to specific terms and rates. In network does not need to be hyphenated when the term follow the noun, ex. "The provider is in network".

inpatient

Inpatient medical care is when treatment is provided to a Member who's admitted as a bed patient in a hospital or other medical facility, and room and board charges are incurred. For behavioral health benefits, Inpatient care can refer to treatment received at a hospital, a behavioral health facility or a behavioral health program. Most benefit plans require prior authorization for Inpatient care before a member is admitted to a hospital, skilled nursing facility or rehabilitation facility.

investigational

A drug, device, treatment, therapy, procedure, or other services or supplies that don't meet the definition of medical necessity. Investigational services or supplies:

- Can't be lawfully marketed without the approval of the Food and Drug Administration (FDA) when such approval hasn't been granted at the time of its use or proposed use
- Can be the subject of a current investigational new drug or new device application on file with the FDA
- Can be provided according to a Phase I or Phase II clinical trial or the experimental or research portion of a Phase III clinical trial (participation in a clinical trial shouldn't be the sole basis for denial)
- Can be provided according to a written protocol which describes among its objectives, determining the safety, toxicity, efficacy or effectiveness of that service or supply in comparison with conventional alternatives
- Can be delivered or should be delivered subject to the approval and supervision of an Institutional Review Board (IRB) as required and defined by federal regulations, particularly those of the FDA or the Department of Health and Human Services (HHS)
- Will be marked as investigational if the Office of Health Care Technology Assessment within the Agency for Health Care Policy and Research within HHS has determined that the service or supply is investigational or that there's insufficient data to determine if it's clinically acceptable
- Can be the predominant opinion of experts, as expressed in the published authoritative literature, that usage should be substantially confined to research settings

- Can be the predominant opinion of experts, as expressed in the published authoritative literature, that further research is necessary in order to define safety, toxicity, efficacy or effectiveness of that service compared with conventional alternatives
- Can be required to treat a complication of an investigational service

The medical director has discretionary authority, in accordance with applicable Employee Retirement Income Security Act (ERISA) standards, to determine whether a service or supply is an investigational service. If the medical director doesn't authorize the provision of a service or supply, it won't be a covered service. In making such determinations, the medical director should rely on any or all the following, at their discretion:

- Member's medical records
- The protocol(s) for the proposed services or supplies that will be delivered
- Any consent document that's been executed or that the member is asked to execute, to receive the proposed service or supply
- The published authoritative medical or scientific literature regarding the proposed service or supply in connection with the treatment of injuries or illnesses
- Regulations or other official publications issued by the FDA and/or HHS
- The opinions of any entities that contract with the plan to assess and coordinate the treatment of members requiring non-investigational services
- The findings of the BlueCross and BlueShield Association Technology Evaluation Center or other similar qualified evaluation entities

maximum allowable charge (MAC)

The highest dollar amount of reimbursement for a covered service. This amount is based on the rates or fees we've negotiated with certain practitioners, health care professionals, or other providers, and whether covered services are received from a participating or non-participating provider. Reimbursement for out-of-network services will be the stated percentage of the maximum allowable charge or billed charges, whichever is less.

medical care

Professional services provided by a practitioner or other medical professional other provider to treat an illness, injury, pregnancy, or other medical condition.

medically appropriate

Services that, have been determined to be of value in the care of a specific member. To be medically appropriate, a service must be:

- Medically necessary
- Used to diagnose or treat a member's condition caused by disease, injury or congenital malformation
- Consistent with current standards of good medical practice for the member's medical condition
- Provided in the most appropriate site and at the most appropriate level of service of the member's medical condition
- Reasonable probable on an ongoing basis
  - Correcting a significant congenital malformation or disfigurement caused by disease or injury
  - Preventing significant malformation or disease
  - Substantially improving a life-sustaining bodily function impaired by disease or injury
- Provided not just solely to improve a member's condition beyond normal variation in individual development and aging including
  - Comfort measures in the absence of disease or injury
  - Improving physical appearance that's within normal individual variation
- Provided for other reasons outside of the sole convenience of the provider, member or member's family
- Something other than an Investigational service

medically necessary (medical necessity)

"Medically necessary" includes procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a patient

for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's illness, injury or disease; and not primarily for the convenience of the patient, Physician or other health care provider
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "**generally accepted standards of medical practice**" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations, and the views of medical practitioners practicing in relevant clinical areas and any other relevant factors.

Medicare

The health care program for the aged and disabled established by Title XVIII of the Social Security Act as amended.

member

Any person covered under a BlueCross health plan, including that person's eligible spouse and/or eligible, unmarried children.

mental illness

A condition characterized by abnormal functioning of the mind or emotions in which psychological, intellectual, emotional or behavioral disturbances are the dominant feature. Mental illness includes mental disorders, psychiatric illnesses, mental conditions, and psychiatric conditions, whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement. Nervous and mental disorders include alcohol, drug or chemical abuse or dependency, but don't include learning disabilities, personality disorders, or disciplinary problems.

non-participating provider

A practitioner, hospital or ambulatory surgical facility that isn't contracted with us to furnish services and to accept specified levels of payment, plus applicable deductibles and copayment amounts, as payment in full for covered services.

other provider

The following institutions are **facility other providers** which may provide covered services:

- Freestanding dialysis facility
- Ambulatory surgical facility
- Skilled nursing facility
- Substance abuse treatment facility
- Residential treatment facility
- Licensed birthing center

In order to be covered, all services rendered must fall within a specialty (as defined below) and be those normally provided by a practitioner within this specialty or degree. All services or supplies must be rendered by the practitioner who's actually billing for them and be within the scope of their licensure. The following professional other providers may provide services covered by certain contracts:

- Doctor of Osteopathic Medicine (DO)
- Doctor of Dental Surgery (DDS)
- Doctor of Dental Medicine (DDM)
- Doctor of Optometry (OD)
- Doctor of Podiatric Medicine (DPM)
- Doctor of Chiropractic (DC)
- Licensed Clinical Social Worker (LCSW)
- Licensed Independent Practitioners of Social Worker (LIPSW)

- Licensed Marriage and Family Therapist (LMFT)
- Licensed Practical Nurse (LPN)
- Licensed Professional Counselor (LPC)
- Licensed Psychological Examiner (LPE) supervised in accordance with Tennessee law
- Licensed Psychologist
- Nurse Midwife (NM), licensed as an RN and certified by the American College of Nurse Midwives)
- Registered Nurse (RN), including an RN who's a nationally-certified Nurse Practitioner (NP) Nurse Anesthetist (NA), or Clinical Specialist (CS)
- Certified Registered Nurse Anesthetist (RNA)
- Registered Physical Therapist (RPT)
- Licensed Pharmacist (D. Pharm.)
- Occupational Therapist (for services to restore functioning of the hand following trauma only)
- Registered Dietitian or Nutritionist approved by BlueCross (for nutritional counseling in connection with the treatment of diabetes only)

The following **Other Providers** may also provide services covered by certain contracts:

- Suppliers of durable medical equipment, appliances and prosthesis
- Suppliers of oxygen
- Certified ambulance service
- Hospice
- Pharmacy
- Freestanding Diagnostic Laboratory
- Freestanding Sleep Study Center
- Home Health Care Agency

out-of-network (OON) provider

A practitioner, caregiver or medical facility that isn't contracted with us to provide services according to specific terms and rates. Out of network doesn't need to be hyphenated when the term follows the noun, ex. "The provider is out of network."

out-of-pocket maximum

The dollar amount that a member owes for covered services during a benefit period (doesn't apply to psychiatric care services).

outpatient

Outpatient medical care provided to a member in a facility or setting where room and board charges aren't incurred. Outpatient medical services may be provided in a practitioner's office, the outpatient department of a hospital, or in some other medical setting. For behavioral health benefits, outpatient care refers to routine visits to a behavioral health professional. Most benefit plans require prior authorization for certain outpatient medical services.

outpatient surgery

Surgery performed in an outpatient department of a hospital, practitioner's office or facility other provider.

physical therapist

A licensed physical therapist. (In states where there is no Licensure required, the physical therapist must be certified by the appropriate professional body or accrediting organization)

participating provider

A practitioner, hospital, or ambulatory surgical facility or other health care provider that has contracted with us to furnish services and to accept payment for covered services after applicable deductibles, coinsurance or copayment amounts have been paid by the member.

practitioner

A licensed practitioner legally entitled to practice medicine and perform surgery. All practitioners must be licensed in Tennessee or in the state in which covered services are rendered.

preferred provider organization (PPO)

A PPO plan offers a network of practitioners, caregivers and medical facilities that agree to provide health care services to members at less than the usual service fees. Members receive the highest level of benefits when network providers are used. Members may seek medical care outside the network, but benefits are reduced substantially.

primary care practitioner (PCP)

A Practitioner selected by the Member to coordinate all his or her health care, including routine checkups and treatment for medical conditions. A PCP is usually a Practitioner in general practice, family practice, internal medicine or pediatrics. Certain health plans require the Member to select a PCP.

prior authorization (prior approval)

Prior authorization verifies the medical necessity of certain treatments, as well as the setting where medical services are provided. For pharmacy benefits, prior authorization helps determine cost-effective alternatives for certain prescription drugs.

provider

A provider is a practitioner, other professional caregiver, medical facility, or medical supplier that supplies health care.

referral

The process by which a member's PCP authorizes treatment from a medical specialist.

skilled nursing facility (SNF)

A facility that provides ambulatory and rehabilitative care on an Inpatient basis. Skilled nursing care must be provided by or under the supervision of a practitioner.

specialist

A specialist is a practitioner that's highly trained in a specific area. Specialists may refer to a sub-specialist in complex cases. Some examples of a specialist include:

- Cardiologist
- Dermatologist
- Neurologist
- Obstetrician/gynecologist
- Podiatrist

surgery

Surgery is defined as:

- Operative and cutting procedures, including use of special instruments
- Endoscopic examinations (the insertions of a tube to study internal organs) and other invasive procedures
- Treatment of broken and dislocated bones
- Usual and related pre-and post-operative care when billed as part of the charge for surgery
- Other procedures that have been approved

termination Date

The date a contract ends and/or benefits end.

therapy services

Services for treatment of illness or injury such as:

- Radiation therapy – treatment of disease by X-ray, radium, or radioisotopes
- Chemotherapy – treatment of malignant disease by chemical or biological agents
- Dialysis – treatment of a kidney ailment, including the use of an artificial kidney machine
- Physical Therapy – treatment to relieve pain, restore bodily function, and prevent disability following illness, injury, or loss of a body part
- Respiratory therapy – introduction of dry or moist gases into the lungs

- Home Infusion Therapy (HIT) – therapy in which fluid or medication is given intravenously, subcutaneously, intramuscularly, or epidurally, at the patient's home, including total parenteral nutrition, enteral nutrition, hydration therapy, chemotherapy, and aerosol therapy and intravenous drug administration

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