PREMERA BLUE CROSS

Premera Blue Cross Medicare Advantage Provider Reference Manual

Introduction to Premera Blue Cross Medicare Advantage Plans

Premera Blue Cross offers Medicare Advantage (MA) plans in Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Spokane, Stevens, Thurston, Walla Walla, and Whatcom, counties.

Medical providers:

Premera Blue Cross Medicare Advantage Plans are required to meet the Centers for Medicare & Medicaid Services (CMS) requirements for Medicare Advantage. Medical providers who provide services and supplies to Premera Blue Cross Medicare Advantage plan members must have Medicare certification and not be excluded from participating in or have opted out of the original Medicare program.

Dental providers:

Those who have opted out of the original Medicare program, cannot receive payment from CMS for *medical* services provided to a Medicare member. CMS also limits MA health plans' ability to reimburse providers who opt out of Medicare.

- Services Covered Under Original Medicare (Part A or Part B) If a dental provider has opted out of Medicare, Premera is not allowed to pay for any service that is considered medical and covered under original Medicare (Part A or Part B). For dentists who have opted out of Medicare, Premera can only reimburse claims for supplemental services, or for Part A or Part B medical services provided in urgent or emergent situations. Original Medicare pays for dental services that are an integral part either of a covered procedure, such as reconstruction of the jaw following accidental injury, or for extractions done in preparation for radiation treatment for neoplastic diseases involving the jaw. Original Medicare will also make payment for oral examinations, but not treatment, preceding kidney transplantation or heart valve replacement, under certain circumstances. Such an examination would be covered under Part A if performed by a dentist on the hospital's staff or under Part B if performed by a physician.

- If a dentist who has opted out of Medicare intends to provide non-urgent or non-emergent medical services to a Premera MA member, it's critical to know:
    - Your office will need to enter into a written agreement directly with the member.
    - Members will need to pay for these services entirely out of their own pocket and they cannot receive reimbursement from CMS or Premera. Therefore, it is imperative to have a clear discussion with your patient and our member to discuss their care options and these costs.
    - Claims for these services cannot be submitted to Premera for reimbursement.

- The above information applies only to dentist(s) in your practice who have opted out of Medicare. Claims for Part A and Part B services provided by dentists who have not opted out of Medicare will process normally.

- Supplemental Services Covered by Premera: For supplemental dental services covered by the plan and provided by dentists, regardless of opt out status, Premera will process claims normally with reimbursement to occur under the terms and rates identified in our contract.

- Dental care includes items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth. Structures directly supporting the teeth mean the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth, and alveolar process.

Online Tools

Medical

Visit the Premera Blue Cross Medicare Advantage medical provider landing page at premera.com/wa/provider/medicare-advantage to access the following tools:

- Find a Doctor - Quickly find physicians and other providers in our networks
- Eligibility & Benefits - Check eligibility and benefit information for members, including deductible and benefit limit accumulators
- Claims & Payment - Check claims status
- Referral and Prior Authorization - Manage referrals and prior authorizations online
- PCP Roster - Quickly identify your assigned patients
- Resources - Access medical and pharmacy Part B policies, clinical practice guidelines, and forms

- Training guides – Learn how to use secure online tools to submit your prior authorizations and referrals.

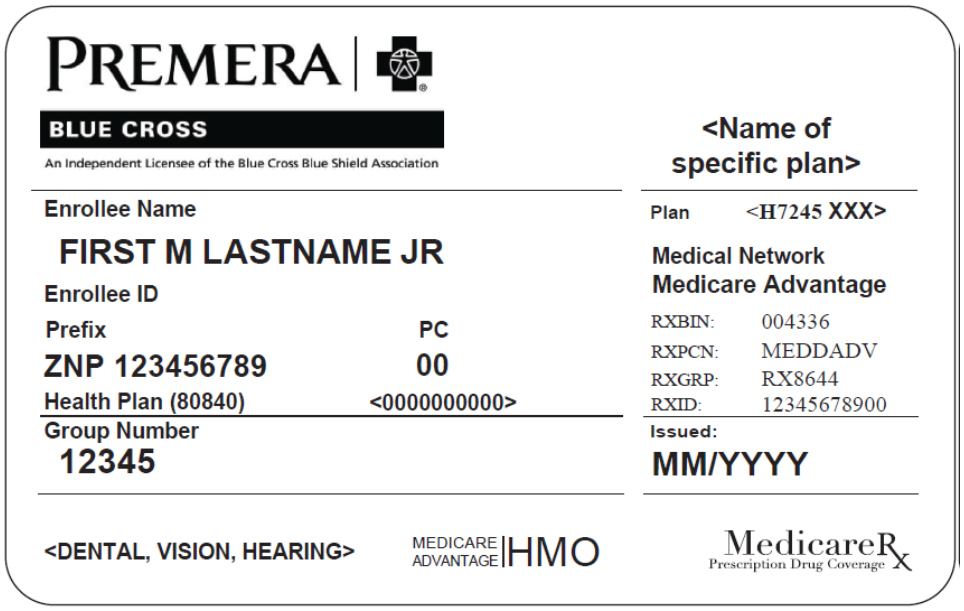
Dental

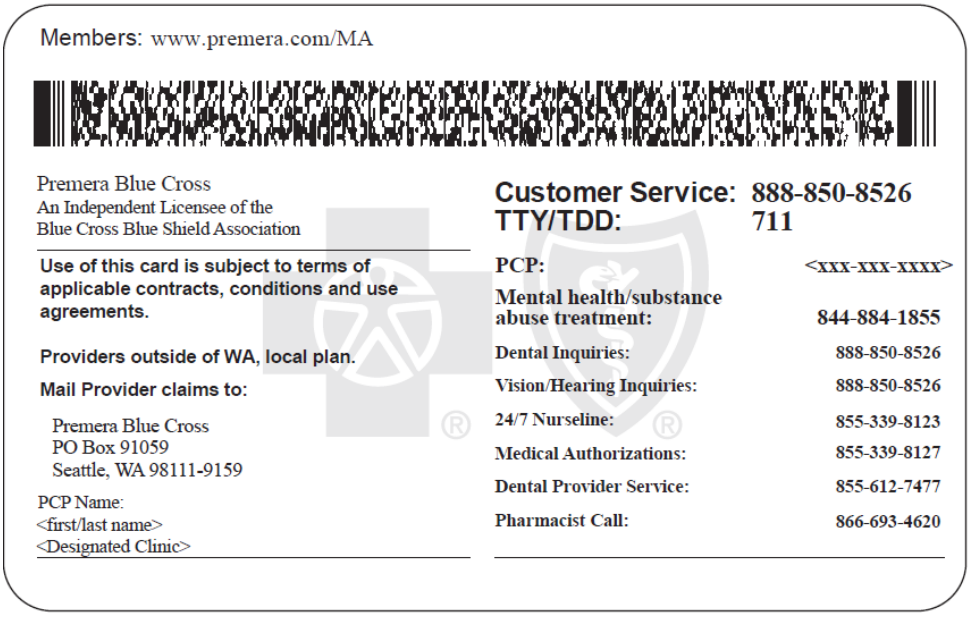
Visit the Premera Blue Cross Medicare Advantage dental provider landing page at premera.com/medicare-advantage-dental. The following tools are available:

- Find a Doctor - Quickly find physicians and other providers in our networks
- Eligibility & Benefits - Check eligibility and benefit information for members, including deductible and benefit limit accumulators
- Claims Search – Find status of claims
- Explanation of Payment Search – See claim payments

Member Identification and Eligibility Verification: Medical

Here's an example of a Premera Medicare Advantage member ID card.





Member Identification and Eligibility Verification: Dental

ID cards for Medicare Advantage patients with dental coverage are the same. All Premera Medicare Advantage plans have embedded dental benefits.

Please remember that the member ID card is not a guarantee of eligibility. To check eligibility and benefits, use our online MA dental eligibility and benefits tools, or call the number on the back of the member ID card.

Interpreter Services

Premera Blue Cross Medicare Advantage will cover American Sign Language for Premera Blue Cross Medicare Advantage members when a provider's office or Premera Blue Cross staff orders the services.

Basic Medical Health Benefits

Benefits are provided in the following general categories of care:

- Inpatient and outpatient professional services
- Preventive care, including medically necessary immunizations
- Inpatient hospital and skilled nursing facility care

To check specific benefits, use our online MA eligibility and benefits tools, or call the number on the back of the member ID card.

Dental Benefits

- Each 2022 Premera Medicare Advantage plan has an annual member benefit allowance for preventive and comprehensive services.
    - Classic HMO, Total Health HMO, and Alpine HMO: $1,500
    - Sound + Rx HMO, Classic Plus HMO, and Charter + Rx HMO: $1,300
    - HMO $0 and Peak + Rx HMO $0: $1,000
- Eligible preventive and comprehensive services paid at 100% up to the annual maximum with an in-network provider.
- Routine comprehensive services have $75 annual deductible on all plans except Alpine, which is $25.
- Review our MA dental enhanced benefit document for details about what's covered.

- Visit our MA dental landing page for additional resources.
- See our training guide to learn how to use our online tools to check your patient's benefits or search for claims.
- Prior to delivering dental services, review our Medicare Advantage dental utilization review document.

Services Not Covered by Premera Blue Cross Medicare Advantage Plans

Services that aren't medically or dentally necessary generally aren't covered. Certain services are covered only for specific diagnoses. If you're uncertain whether a service or specific treatment is covered, or if you'd like more information, call the number listed on the back of the member ID card.

Emergency and Urgent Care Management

- Prudent Layperson Rationale
  Premera Blue Cross Medicare Advantage Plan applies the "prudent layperson" concept when reviewing whether the use of an urgent care facility or emergency room service was appropriate. A prudent layperson is a person without medical training who draws on his/her practical experience when making a decision regarding whether emergency medical treatment is needed. A prudent layperson will be considered to have acted reasonably if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was necessary.

- Emergency
  Medicare defines an emergency medical condition as a medical condition brought on by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that not getting immediate medical attention could result in one of the following:
    1) Serious jeopardy to the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child)
    2) Serious impairment to bodily functions
    3) Serious dysfunction of any bodily organ or part

- Urgent Care
  Urgently needed services are defined as services needed immediately as a result of an unforeseen illness, injury, or condition; and it isn't reasonable given the circumstances to get the services through a PCP or other plan providers. Ordinarily, these services are provided when members are out of the service area. In extraordinary cases, these are services provided when members are in the service area, but plan providers aren't available.

  Regulatory language prohibits the denial of urgent care or emergency room services for failure to obtain an authorization. Premera Blue Cross Medicare Advantage denies payment to both plan and non-plan hospitals when emergency room treatment is delivered inappropriately. Members are notified of denials.

Surgical Second Opinions

If you advise surgery for a Premera Blue Cross Medicare Advantage Plan member, the member has the right to a second opinion. Refer the member to another participating specialist at the member's request, or a third participating provider if the first and second opinions regarding surgery contradict each other.

Coordination of Benefits

Sometimes charges for a member's healthcare services are the responsibility of a source other than Premera Blue Cross Medicare Advantage, for example:

- Other group health insurance
- Workers' compensation
- Liability auto insurance
- Third-party payer

When a member is eligible for more than one health plan at the same time, the health plans coordinate their payments to avoid overpayment of claims. Premera Blue Cross

Medicare Advantage collects information about other insurance coverage that members may have. If our records indicate that a member has a primary insurance other than Premera Blue Cross Medicare Advantage, we must receive a copy of the EOP from the primary carrier with your billing. Members shouldn't receive a bill for remaining balances unless the services weren't a covered benefit or until both the primary and secondary have processed and paid the claim.

If you're unsure of primary coverage, call Customer Service at 888-850-8526.

Third-Party Liability

If the diagnosis or treatment on a billing suggests that a third party may be liable for the charges, we'll investigate this prior to claims payment. You'll need to provide accident information with your billing.

Timely Claims Submission

Claims must be submitted on a timely basis. Providers are encouraged to submit all claims within 60 days. Claims for services must be submitted within 12 months of the date of service. The member can't be billed for these services if the provider doesn't file within Premera Blue Cross Medicare Advantage guidelines.

Quality Improvement Standards

CMS has developed quality improvement standards and a Five-Star Quality Rating System that measures a plan's performance. You can read more about CMS's quality initiatives here.

Payment and Risk Structure

Refer to your Participating Provider Agreement for details regarding payment and risk structure issues specific to the Premera Blue Cross Medicare Advantage Plans.

Coverage Issues

It's very important that providers know whether a service is covered by Premera Blue Cross Medicare Advantage. If a Medicare Advantage member receives services under the direction or authorization of a Premera Blue Cross Medicare Advantage Plan provider and the member hasn't been informed in writing that he/she is liable for the cost of the services, the provider must pay for the services. Providers can't overturn a Plan physician's decision that a service is medically reasonable and necessary.

The only exceptions to the above instructions are:

1) The presence of written evidence that the provider advises the Premera Blue Cross Medicare Advantage member before each and every service is received that the service isn't covered, or
2) Cases where the member should be expected to know that the services aren't covered by Premera Blue Cross Medicare Advantage, e.g., acupuncture services and cosmetic procedures.

See CMS regulations and guidelines on organizational determinations.

Dual Eligible Members

Some members are eligible for both Medicaid and Medicare health benefits. They are referred to as "dual eligible." A dual eligible member has Medicaid and a Medicare Advantage plan and receives benefits from both types of coverage. Doing so often relieves the member's Medicare Part B premium. It also allows greater coordination of care. A person who doesn't have Part A and Part B of Medicare may not enroll in a Medicare Advantage plan.

Full benefit dual eligible members (aka QMB beneficiary) aren't responsible for paying Premera Blue Cross Medicare Advantage copayments, coinsurance, or deductibles. The Washington State Medicaid program may pay providers for deductibles, coinsurance, and copayments. Medicare providers must accept Premera Blue Cross Medicare Advantage payment and Medicaid payment (if any) as payment in full for services rendered to a QMB beneficiary.

Medicare is the primary insurance. Dual members have appeal rights under both coverages.

If you have any questions about dual eligible benefits, billing, or denials, see this CMS Medicare Learning Network article, or contact Premera Medicare Advantage plan Customer Service at 888-850-8526.

Health Management

Premera Medicare Advantage Medical Management program promotes the provision of cost-effective, medically appropriate services. This comprehensive approach employs key interactive medical management activities so that Premera Blue Cross can achieve its goals for Premera Medicare Advantage members.

Health Management Services Include:

- Care Management
    - Care coordination activities
    - Discharge planning
    - Case management activities
    - Chronic condition management programs
    - Health risk assessments
- Utilization Management
    - Clinical review of select services and maintenance of medical review criteria
    - Provider Appeal Process

Care Management

A care coordinator is available to support you to identify high-risk members, address healthcare needs, and provide a plan of care for chronic, medically fragile, or high-utilizing patients. Additionally, the care coordinator can assist members in accessing Premera Blue Cross Medicare Advantage Plan's specialized clinical resources as well as community resources. To refer a member to Care Management, contact us via phone (855-339-8125), fax (800-431-3981), or email (MABXCMPremera@bcbsm.com) .

Definitions

- Appeal -- Any of the procedures that deal with the review of adverse organization determinations on the healthcare services the enrollee believes he or she is entitled to receive, including delay in providing, arranging for, or approving the healthcare services (such that a delay would adversely affect the health of the enrollee), or on any amounts the enrollee must pay for a service as defined in CFR 422.566(b).
- Authorized Representative -- An individual authorized by an enrollee, or under state law, to act on his or her behalf in obtaining an organization determination or in dealing with any of the levels of the appeal process, subject to the rules described in 20 CFR part 404, subpart R, unless otherwise stated in this subpart.
- Member -- a Medicare Advantage–eligible individual who has enrolled in or elected coverage through the Medicare Advantage product offered by Plan.
- Grievance -- Any complaint or dispute other than one involving an organization determination, for example, a complaint regarding the services or quality of care provided by the Plan or Plan providers.
- Expedited Review -- Per CMS, expedited requests should ONLY be requested when the health care provider believes that waiting for a decision under the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function. Please be mindful of this definition

when submitting your requests so that we can prioritize and process all requests appropriately. *The expedited process doesn't apply to claims denials*.

- Organization Determination -- Any determination made by the Plan with respect to payment for service(s), denial of service(s), or discontinuation of service(s).
- MAXIMUS Federal Services – An independent appeals review expert contracted by CMS to review coverage decisions made by a health plan. Its decisions are binding on the health plan.

Utilization Management

- Submitting Reviews- When submitting service requests, please submit the appropriate clinical information with the completed prior authorization form to avoid delays. Requests can be submitted through the provider secure website, fax, or phone. Phone requests must be followed up with the submission of clinical documentation. For medical management prior authorizations, please submit requests through the provider secure website, by fax (866-809-1370), or by phone (855-339-8127). To learn how to submit requests online, checkout our referral and prior authorization tool guide.

- Review Process—Service requests are submitted under either standard or expedited timeframes. Per CMS, expedited requests should ONLY be requested when the health care provider believes that waiting for a decision under the standard review time frame may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function. Please be mindful of this definition when submitting requests so that we can prioritize and process all requests appropriately.

  Premera Blue Cross Medicare Advantage processes standard requests within 14 days, or sooner if possible. If Premera Blue Cross Medicare Advantage or a PCP decides, based on medical criteria, that the member's situation is time-sensitive and requests an expedited review, Premera Blue Cross Medicare Advantage will issue a decision no later than 72 hours after receiving the request. If additional information is needed, Premera Blue Cross Medicare Advantage may extend the decision by 14 days if the extension benefits the member.

  If Premera Blue Cross Medicare Advantage requests clinical documentation from a provider, the request should be honored as quickly as possible. No extension of time will be permitted if network providers fail to submit the requested information.

- Denial Letter Language -- CMS has developed specific language that must be used in all denials. Premera Blue Cross Medicare Advantage is required to submit model letters to CMS for approval. The language for the letters has been approved and can't be altered without submitting changes to CMS for review and approval. This

language must be used any time a Medicare Advantage member is sent a denial letter. See subsection 27 for a copy of the required CMS denial language.

- Standard Appeal Process -- If Premera Blue Cross Medicare Advantage denies services or payment, a Medicare Advantage member has 60 days from the date of denial to request an appeal. Premera Blue Cross Medicare Advantage has 30 days, with a possible 14-day extension (preservice), 7 days for Part B Medication, or 60 days (claims), to make a determination as to whether to pay for services or claims. Other than for prescription denials, if on appeal Premera Blue Cross Medicare Advantage upholds the original denial, the appeal is automatically sent by Premera Blue Cross Medicare Advantage to MAXIMUS for review and final decision.

- Expedited Appeal/Determination Process -- CMS requires that Premera Blue Cross Medicare Advantage review "time-sensitive" appeals within 72 hours. A time-sensitive situation results when waiting for a decision to be made within the standard time frame could jeopardize the member's life, health, or ability to regain maximum function. The member may request an expedited appeal verbally or in writing. Examples of service decisions that may prompt a member to request an expedited appeal are:

    - Denial of service the member thought was needed (e.g., referral to specialist)
    - Discontinuation of services such as home healthcare, discharge from a skilled nursing facility, or discharge from a hospital and the member has missed the deadline for a peer review organization review.

Grievance

A grievance is a Medicare Advantage member's concern relating to the quality of care or services received from a provider or Premera Blue Cross Medicare Advantage. Concerns related to waiting times, lack of access, etc., would also be processed as a grievance. A member may file a grievance by contacting Customer Service by phone (800-889-1076) or in writing (Premera Blue Cross Medicare Advantage Plans Attn: Appeals and Grievances Department PO Box 262527 Plano, TX 75026.

Member Communications

Providers must send any proposed correspondence (other than test results, preventive health screens, or appointment reminders) for Premera Blue Cross Medicare Advantage Plan members to Premera Blue Cross's MA Compliance Department. Premera Blue Cross Medicare Advantage compliance staff will submit it to CMS for approval, as needed.

Collecting Copays

Members are instructed that the copay is due at the time of service. Members who have dual Premera Blue Cross coverage aren't responsible for a copay/coinsurance; the secondary Premera Blue Cross policy covers the copay and coinsurance, whichever is applicable.

If a member consistently refuses to pay the copay, contact Customer Service at 888-850-8626. A provider can refuse service to a member if a sign is posted in the office that states the copay is due at the time of service.

PCP Responsibilities

- Educate members at the start of the PCP-member relationship on procedures to follow in using urgent and emergency care appropriately.
- Respond immediately to emergency calls from members and related provider calls as medically indicated.
- Inform the emergency department or urgent care center of the member's presenting condition and whether you'll be arriving to coordinate care immediately upon referring a member.
- Ask for health plan intervention through Quality Medical Management to improve individual member compliance with emergency medical services procedures.
- Encourage and assist members to make an advance directive and assure that directives are honored to within the confines of state law.

Medical Plan Requirements and Coverage Changes

- Plans are required to cover dialysis treatments for members temporarily out of the plan area. Members aren't required to obtain pre-authorization for this service.
- Premera Blue Cross Medicare Advantage must provide, upon a member's request, information regarding utilization controls, a summary of provider methods of compensation and Premera Blue Cross's financial condition.
- If a Premera Blue Cross Medicare Advantage Plan member doesn't want to see a specialist recommended by a PCP, he/she has a right to request a referral to a different participating specialist.
- Premera Blue Cross Medicare Advantage is required to provide health services in a culturally competent manner, coordinate care with community and social services, assess enrollees' healthcare needs within 90 days of enrollment, and communicate information on follow-up care and training in self-care when necessary. Premera uses the Member Health Information Form to assess these needs, and Care Management staff arranges for services.

- Premera Blue Cross Medicare Advantage is required to provide information on the incentive arrangements affecting the Plan's physicians to any person receiving Medicare Advantage services (i.e., a "beneficiary") who requests the information. Premera Blue Cross Medicare Advantage must make the following pieces of information available, upon request, to current, previous, and prospective enrollees:
    - Whether Premera Blue Cross Medicare Advantage Plan's contracts or subcontracts include physician incentive plans that affect the use of referral services.
    - Information on the type of incentive arrangements used.
    - Whether stop-loss protection is provided for physicians or physician groups.
    - If Premera Blue Cross Medicare Advantage Plan is required by the regulation to conduct a customer satisfaction survey, a summary of survey results.

For further information regarding your incentive plan, please refer to your contract addendum for the Premera Blue Cross Medicare Advantage Plan.

Expansion of Provider Protections

Premera Blue Cross Medicare Advantage must include rules of notice of participation, written notice of material changes prior to implementation, a process for appealing adverse decisions and consultation with healthcare professionals on practice guidelines. This requires a 60-day written notice of appeal for denial, suspension, or termination of a healthcare professional. Premera Blue Cross Medicare Advantage must exclude providers who furnish services to Medicare members through private contracts. Premera Blue Cross Medicare Advantage must have prompt payment language in contracts with contracted providers.

As used in this guide, the term "provider" means all Medicare contracting healthcare delivery network members, e.g., physicians, hospitals, dentists. This goes beyond the Medicare regulatory definition for "provider." Refer to CMS for more guidance on this subject.

Provider Marketing

CMS prohibits provider marketing of a Medicare Advantage organization without the permission of the Medicare Advantage organization for the following reasons:

- Providers are usually not fully aware of membership plan benefits and costs.
- Providers may not be the best source of plan membership information.
- A provider outside the role of providing medical services may confuse the beneficiary when the provider is acting as an agent of the plan.

- Providers' knowledge of their patients' health status increases the potential for them to discriminate in favor of Medicare beneficiaries with positive health status when acting as a marketing agent. (Find more information here.) They might also discriminate in favor of beneficiaries with negative health status to reduce beneficiaries' out-of-pocket costs and/or increase benefits.

Read more about CMS guidelines for marketing in the healthcare setting.

Information Required for Filing Claims

To ensure timely claims processing, all claims must be submitted on a CMS 1500 form (formerly a HCFA 1500 form); or, for facilities, on a UB-04 form, or, for dentists, an ADA form. Information on the claim form must be printed in black ink with a standard 10- or 12-point type face. Place required information in the appropriate field and align the form so that each item is properly located within the box.

The list below includes general categories of information necessary for claims processing. If any of this information is missing from your claim, it could be delayed or returned to you.

- Patient's full name and date of birth
- Patient's Premera Blue Cross Medicare Advantage member ID number (including the prefix)
- Subscriber's full name and relationship to patient
- Group number or name
- Information about other insurance coverage
- ICD-10 CM codes (code to the highest level of specificity)
- Description of any accident circumstances
- CPT, HCPCS, or CDT codes for services performed (use current year codes)
- Place of service codes per CMS guidelines
- Itemized charges, by date of service (only one service per line
- Provider's name, National Provider Identifier (NPI) number, tax ID number, and remittance address (Box 33)
- Name and address of facility where services where rendered (Box 32 on CMS 1500 form)

Fraud, Waste, and Abuse

It's the policy of Premera to prevent, proactively detect, and investigate health care fraud, waste, and abuse (FWA) in the Medicare Advantage program. Premera expects employees, FDRs, Non-employees, and MA beneficiaries to report suspected noncompliance or possible FWA and has created multiple confidential methodologies to do so.

Reports of suspected FWA may be made to the Special Investigations Unit (SIU) by calling the Anti-Fraud Hotline at 1-888-844-8985; sending an email to StopFraud@premera.com; or via letter at Premera Blue Cross, SIU Medicare Advantage, 7001 220th St. SW, MS 219, Mountlake Terrace, WA 98043. If you choose to remain anonymous, you may do so by calling the hotline and following the prompts. Please provide as much detailed information as possible so that the SIU can follow up on your concerns. Any potential FWA issues are investigated by the SIU department.

In accordance with Premera's Compliance & Ethics Hotline Corporate Policy, any retribution, retaliation, intimidation, or harassment of an employee reporting concerns in good faith, or for participating in or cooperating with an investigation is prohibited. Corrective action up to and including termination of employment may occur for anyone that retaliates, intimidates, harasses, or seeks retribution against another employee. FDRs are expected to maintain similar requirements for their employees. Additionally, accusations which are intentionally false or reckless are not tolerated and will result in corrective action.

Examples of FWA include, but are not limited to:

- Billing for services not provided
- Upcoding of CPT and DRG codes to obtain a higher rate of reimbursement
- Unbundling CPT codes to obtain a higher rate of reimbursement
- Intentionally using an incorrect or inappropriate provider number to be paid
- Signing blank records or certification forms that are used by another entity to obtain payment
- Misrepresenting non-covered services as medically necessary, by using inappropriate procedure or diagnosis codes
- Providing false employer group and/or group membership information
- Obtaining benefits or services using someone else's identity
- Obtaining services under false pretenses (such as lying about a condition or injury to obtain a prescription)
- Using a more expensive technique to provide treatment when an acceptable alternative method is readily available at a reduced cost
- Purchasing enrollee lists for the purpose of submitting fraudulent claims
- Retaining duplicate payments for services
- Balance billing
- Waiving member cost share
- Billing for services grossly in excess of those needed by patients