PREMERA | BLUE CROSS

Premera Blue Cross Medicare Advantage

PROVIDER REFERENCE MANUAL

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An Independent Licensee of the Blue Cross Blue Shield Association

Contents

Introduction to Premera Blue Cross Medicare Advantage Plans

Premera Blue Cross offers three Medicare Advantage HMO plans: HMO $0, Classic (HMO), Total Health (HMO). We offer plans in Cowlitz, Island, King, Kitsap, Lewis, Pierce, San Juan, Skagit, Snohomish, Spokane, Stevens, Thurston, Walla Walla, and Whatcom, counties.

Medical Provider Requirements

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 appropriate Medicare certification and not be excluded from participating in or have opted out of the original Medicare program.

Member appointment wait times

These are the expected wait times for primary care and behavioral health providers in the Medicare Advantage network.

- Urgently needed services or emergency—immediately.
- Services that are not emergency or urgently needed, but the enrollee requires medical attention—within seven business days.
- Routine and preventive care—within 30 days.

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.

Provider marketing

CMS prohibits provider marketing of a Medicare Advantage organization without the permission of the 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.

Primary care provider (PCP) patient 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.

PCP selection

- Members are encouraged to select a PCP as soon as they enroll. The PCP is responsible for communicating and arranging care with specialists. It's the members choice who they select, and they can change their PCP at any time.
- Members who don't select a PCP are auto-assigned one based on their home address.
- Provider types who can be a member's PCP:
    - Geriatric physician
    - Internal medicine
    - Pediatrician
    - General practice
    - Family practice
    - ARNP or PA

Delegated providers

- Some provider groups are delegated to provide utilization and claims management services for our members.
- For patients who've selected a PCP associated with a delegated provider group, we expect you to contact the group before providing services that require referral, authorization, or admission.
- Delegated providers are also responsible for the payment of the member's claims. Submit billing for medical services to the delegated provider group.
- All member ID cards have the name of the delegated organization, and billing information on the back of the card.

Dental Provider Requirements

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 organ transplants, surgery, heart valve replacement, valvuloplasty procedures, head and neck cancer, chemotherapy, chimeric antigen receptor (CAR) T-cell therapy, and the administration of high-dose bone-modifying agents when used in the treatment of cancer. Original Medicare will also cover treatment to address dental complications after radiation, chemotherapy, and/or surgery, and for head and neck cancer. 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 patients and our members 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.

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 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 request to transfer a member to a different provider

Premera understands that there may be times when the provider/patient relationship can become compromised. When this occurs, it may be necessary to transition a member's care to another provider. Some of these circumstances may include unruly or abusive behavior by the member, or a breakdown in the relationship. To initiate the transfer process, the provider

must be assigned to the member for at least 30 days and the reason for the transfer may not be solely for financial reasons. If these conditions are met, the following procedure must be followed:

- Send written communication to Premera with details about the behavior or circumstances leading to the request to transfer the patient to another provider or group.
- Dates of the occurrence.

Once received, Premera will review the information and make the final determination for the transfer. If Premera approves of the transfer, Premera will reach out to the member to help them select a new provider.

Online Tools and Training Guides

Medical

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

- Provider directory: To quickly find physicians and other providers in our network.
- Eligibility and benefits: To check eligibility and benefit information for members, including deductible and benefit limit accumulators.
- Claims and payment: To check claims status.
- Referrals and prior authorizations: To manage and enter referrals and prior authorizations online.
- PCP roster: To identify your assigned patients.
- Resources: To find medical and pharmacy Part B policies, clinical practice guidelines, and forms.
- Training guides: To 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:

- Provider directory: To quickly find physicians and other providers in our network.
- Eligibility and benefits: To check eligibility and benefit information for members, including deductible and benefit limit accumulators.
- Claims search: To find status of claims.
- Explanation of payment search: To review claim payments.
- Training guide: To learn more about our MA dental benefits and how to access and use online tools.

Member Identification

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

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.

Plan Benefits

Basic medical health benefits

Benefits are provided in the following broad 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.

To learn more about a plan's benefits, visit the member Medicare Advantage website.

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 deciding whether emergency medical treatment is needed. A prudent layperson will be considered to have acted reasonably if other similarly situated laypersons believed, based on 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:

- 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)
- Serious impairment to bodily functions
- 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.

Dental Benefits

All Premera Medicare Advantage plans include preventive and comprehensive benefits.

Plans	Annual Maximum Allowed and Comprehensive Deductibles
HMO $0	$1,000 with $25 deductible
Classic (HMO) and Total Health (HMO)	$1,500 with $25 deductible

- Eligible preventive and comprehensive services paid at 100% up to the annual maximum with an in-network provider.
- Routine comprehensive services have a $25 annual deductible on all plans.
- 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.

- Review our Medicare Advantage dental utilization review document prior to delivering dental services.

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.

Coverage and Payment

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.

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 broad 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)

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 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, such as 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.

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.

Health Management

Premera Medicare Advantage Health 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:

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.

- 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 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*.
- 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.
- 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.
- Member: A Medicare Advantage–eligible individual who has enrolled in or elected coverage through the Medicare Advantage product offered by the plan.
- Organization determination: Any determination made by the plan with respect to payment for service(s), denial of service(s), or discontinuation of service(s).
- Prior authorizations: Clinical review of select services and maintenance of medical review criteria.

Utilization Management

Referrals

- The PCP is responsible for patient referrals.
- Referrals to any in-network provider do not need to be submitted to Premera. Only referrals to an out-of-network provider require a submitted referral to Premera.
- As a courtesy, providers can submit referrals to an out-of-network provider with a retroactive date, no greater than 60 days after the date of care.
- Premera Medicare Advantage plans are HMO plans. Members don't have out-of-network benefits unless it's emergency care or is prior approved by the plan.
- Referrals can be submitted online by signing in to tools and resources on the Medicare Advantage provider home page.
- Referrals can also be faxed by completing a referral form and faxing 866-809-1370. The MA referral form is located on the Medicare Advantage provider home page under forms.

Prior authorizations

Services that require prior authorization:

- Acute: Acute hospital admissions, elective inpatient surgeries
- Post-acute: Skilled nursing facility admissions, long-term acute care hospital admissions, inpatient rehabilitation
- Outpatient: Select Part B drugs, select outpatient surgeries and durable medical equipment (DME).

Submitting reviews. You can submit a request three ways.

- Access electronically the prior authorization and referral tool through OneHeatlhPort or the Premera MA website. For information about how to use our online prior authorization and referral tool, log in to our secure MA website where you'll find tool training guides available.

- Fax a filled-out request form located on our MA provider home page. Fax to 866-809-1370. When submitting service requests, please select and complete the appropriate prior authorization form and attach all necessary clinical information to avoid delays.
- Call the Utilization Management (UM) department at 855-339-8127. If you call in a request, you need to follow up by submitting all necessary clinical documentation.

Decision timelines:

Premera Blue Cross Medicare Advantage will process 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.

Decision timeline medical

Type of Request	Decision	Initial Notification	Written Notification
Expedited pre-service	Within 72 hours from receipt of request	Within 72 hours from receipt of request	Within 3 days of verbal notification
Standard pre-service	Within 14 days of receipt of request	Within 14 days of receipt of request	Within 14 days of receipt of request
Retrospective review	Within 14 days of receipt of request	N/A	Within 14 days of receipt of request

Decision timelines: Part B drugs

Type of Request	Decision	Initial Notification	Written Notification
Expedited pre-service	Within 24 hours from receipt of request	Within 24 hours from receipt of request	Within 3 days of verbal notification
Standard pre-service	Within 72 hours from receipt of request	Within 72 hours from receipt of request	Within 3 days of verbal notification

Review process

Service requests are submitted under either standard or expedited time frames. 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.

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 anytime a Medicare Advantage member is sent a denial letter.** See CMS.gov regarding denial notice instructions.

Questions and assistance: Call Utilization Management at **855-339-8127**. If you call in a request, you must also follow up and submit your clinical documentation.

Escalation:

- If you're having any issues getting your request escalated on the phone, ask to *speak to the UM supervisor for Premera*. This is the quickest way to escalate a prior authorization issue.
- The UM team is available for provider assistance 24/7 and automatically converts over to the on-call nurse when the call center isn't open.

Appeals

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.

Care Management Programs

Complex conditions management

Assesses, plans, implements, coordinates, monitors, and evaluates members' health status.

Types of conditions managed include:

- Complex conditions such as Parkinson, ALS, advanced liver disease, cancer
- Chronic conditions such as diabetes, congestive heart failure, kidney disease including end stage renal disease, ischemic heart disease.
- Catastrophic conditions such as motor vehicle accident, loss of limb, multiple burns
- Transplants

Chronic conditions management

Condition-specific education and management. This may also include coordination of a patient's care with the patient's providers. Types of conditions managed:

- Chronic obstructive pulmonary disease (COPD)
- Coronary artery disease (CAD)
- Diabetes
- Chronic kidney disease (CKD)
- Congestive heart failure (CHF)

Contact

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:

- Phone: 855-339-8125
- Fax: 800-431-3981
- Email: MABXCMPremera@bcbsm.com

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 (888-850-8526) or in writing (Premera Blue Cross Medicare Advantage Plans Attn: Appeals and Grievances Department PO Box 21481, Eagan, MN 55121.

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.