Premera Blue Cross HMO Provider Reference Manual

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061594 (12-01-2024)

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Introduction

This manual is an important resource developed to help you work with us and our members. We will share information about programs, tools, and resources available to our providers.

About Premera Blue Cross HMO

Premera Blue Cross HMO offers personalized healthcare with seamless and simplified experiences for providers and members. Premera Blue Cross HMO is available to small and large Washington employers with employees who live or work in King, Pierce, Thurston, and Spokane counties.

Our network consists of committed provider partners in specific regions throughout the state. These partners will work collaboratively to deliver better member experiences and health outcomes. Our members select a primary care provider (PCP) who has a complete picture of their health. Their PCP coordinates their care and submits referrals to specialty care as needed.

Key information for providers

The information in this section highlights key HMO policies and procedures.

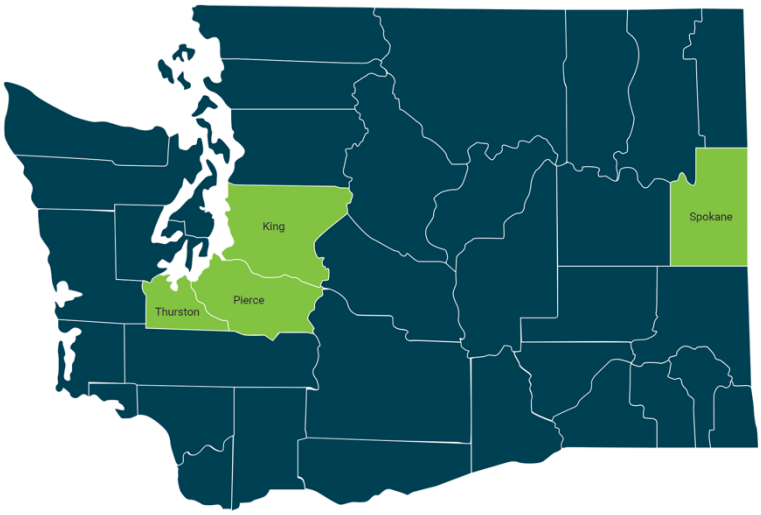
Sherwood HMO network

The Sherwood HMO network is built from committed providers who are focused on providing the best care possible at the lowest cost. The HMO Core Plus plan is available to members who live or work in King, Pierce, Spokane, and Thurston counties.

Partial provider list as of September 2024*:

Western Washington

- EvergreenHealth
- Good Samaritan Hospital
- Kinwell Medical Group
- Mary Bridge Children's
- Multicare Health System
- Optum***
- **New for 2025!** Overlake Hospital and Medical Clinics
- Peninsula Family Medical Center
- Sound Family Medicine
- Virginia Mason Medical Center**
- Yelm Family Medicine



Eastern Washington

- Centennial Pediatrics of Spokane
- Deer Park Family Clinic
- Jamison Family Medicine
- The Kids Clinic
- Kinwell Medical Group
- Multicare Health System
- The Native Project
- New Health Lake Spokane Medical
- Northwest Spokane Pediatrics
- Simplicity Direct Care

*This is not an exhaustive list of all practices and hospitals participating in the Sherwood HMO network throughout Washington. This list is subject to change.
**Does not include Franciscan Health system.
***Only includes obstetrical or transplant services if obstetrician or transplant surgeon has admitting privileges at a hospital in the Sherwood HMO network.

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Primary care providers

A key part of the Premera Blue Cross HMO is that each member has a primary care provider (PCP). By having a designated PCP, a member knows that they're working with someone who is informed of their medical history and can refer them to a specialist when needed. Members are matched to an in-network PCP once their enrollment has been processed. PCP assignments are based on recent claims history (if available), or proximity to the member's home address. Members have the choice to change their PCP at any time during their plan to best suit their needs. The PCP selection process is important so that members receive care from someone who knows their health history to avoid gaps in their care plan.

How does Premera Blue Cross HMO choose a PCP for a member?

The process starts with a review of a member's claims history to identify if the member has received care from a particular PCP in the past. If the review does not suggest an existing PCP relationship, a PCP will be assigned based on these factors:

- Location (nearest to member's home address)
- Type of provider*
- Specialty

Premera Blue Cross HMO will auto assign PCPs in the Sherwood HMO network who are accepting new patients based on available data at the time of assignment.

The PCP will be the member's main point of contact for care. Members can choose from different provider specialties for their PCP selection:

- Family medicine
- Geriatric medicine
- General practice
- Gynecology
- Internal medicine
- Adolescent medicine
- Naturopathy
- Pediatrics

*PCP provider types can be an Advanced Registered Nurse Practitioner (ARNP), Doctor of Osteopathic Medicine (DO), Doctor of Medicine (MD), Naturopathic Doctor (ND), Nurse Practitioner (NP), and Physician's Assistant (PA).

Referrals

Referrals from in-network PCPs are required for specialty services.

Certain services are direct access and do not require a referral. There is a listing of those services here: **Direct Access Services**.

If an approved referral is not obtained and a member chooses to receive services from a provider or facility, those services will not be covered under this plan. The member will be responsible for 100% of the cost for these services and any amount will not apply to their out-of-pocket maximum, except for services required by federal or state law.

A referral may be denied by Premera Blue Cross HMO if the provider who placed the referral is not in-network.

If an HMO PCP refers a member to an out-of-network provider when there is an in-network provider available who can provide the service, the referral will be denied. The member will instead be referred to an in-network provider or specialist by their provider. If there is not an in- network provider available to provide medically necessary care, an out-of-network referral may be approved. Refer to the **HMO Plus team** customer service experts for referral support or search **Find Care** for in-network providers.

Note: Premera Blue Cross HMO will accept retrospective requests for referrals up to six months after the date of service through Availity.

For more information about submitting a referral, see the **Availity** section on the tools for referrals and prior authorization.

Note: Most referrals will be auto-approved if the requesting and servicing providers are Sherwood HMO network providers.

Direct Access Services (do not require a referral)

Alternative medicine

- Acupuncture
- Chiropractic care
- Naturopathic services
- Outpatient physical, occupational and speech therapy, massage therapy (benefit limits apply)
- Spinal manipulations

Hospital-based services

- Anesthesia (regardless of location)
- Blood bank services

Preventive services

- Preventive services

Other services

- Ambulance/Air ambulance (emergent/urgent care only)
- Ancillary services (X-ray, lab, pathology)
- Behavioral health (includes hypnosis and gender-affirming care)
- DME purchases / rentals / supplies (certain supplies require authorization)
- Emergency services / Urgent care
- Eye exam (adult and pediatric)
- Family planning services
- Hearing hardware
- Inpatient hospital ancillary professional fees
- Newborn care (up to 31 days)
- Pediatric dental
- Reproductive sterilization
- Obstetric care
- Urgent care centers
- Vision hardware (includes contacts)

*The Direct Access Services list is subject to change. For a complete and updated list, please view the Direct Access Services list available on the website.

Prior authorizations

A service may require prior authorization and/or medical necessity review (unlisted codes, cosmetic procedures, and investigative procedures, are examples that may not require prior authorization but may be reviewed for medical necessity). If the provider doesn't get a prior authorization, it could result in a payment penalty to the provider. When a service does not require prior authorization but does require a medical necessity review, there isn't a penalty, but Premera Blue Cross HMO will hold the claim and request medical records. Prior authorizations can be submitted through **Availity** or by fax to 888-704-2091. Prior authorizations can't be submitted by phone. Premera Blue Cross HMO typically responds to electronically submitted requests within one or two days, but it can take up to three days. Check your Auth/Referral dashboard in Availity after submitting the authorization request for status.

If a prior authorization or review for medical necessity is denied, Premera Blue Cross HMO will send the provider written notification with instructions on next steps. If the provider believes that a member's condition meets the medical policy criteria, the provider may request a Medical Director Call to discuss the denial. They may call Premera Blue Cross HMO Physician Reviewers at 877-835-5672 to schedule a time block for that discussion. The discussion is not a formal appeal or specialist review. Medical Director Calls are optional and available prior to appeal requests. The next step would be to request an appeal. If the provider appeals the decision, the request must be received within 180 days of the date of the denial letter.

For more information about submitting a prior authorization see the **Availity** section on the tools for referrals and prior authorization.

Find Care tool

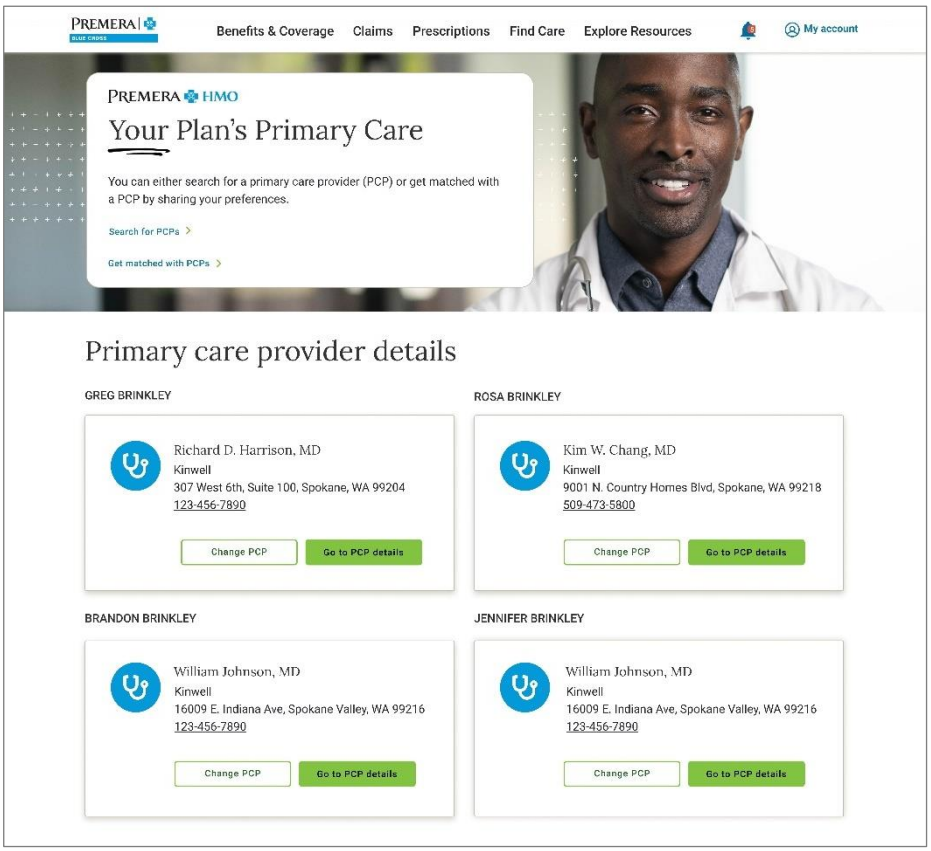
What you need to know about the Find Care tool

HMO members and their dependents can choose an in-network PCP using the Find Care tool. They can use the Find Care tool to change their PCP at any time. To access this tool, a member needs to sign up or sign in to their account or member portal.

Network:
Sherwood HMO - Find Care tool
Sherwood HMO and Dental Choice – Find Care tool

Member PCP Selection tool

Members will land on this page after clicking the PCP notification call to action within their member portal. From here, members may “Change PCP” or “Go to PCP details.”

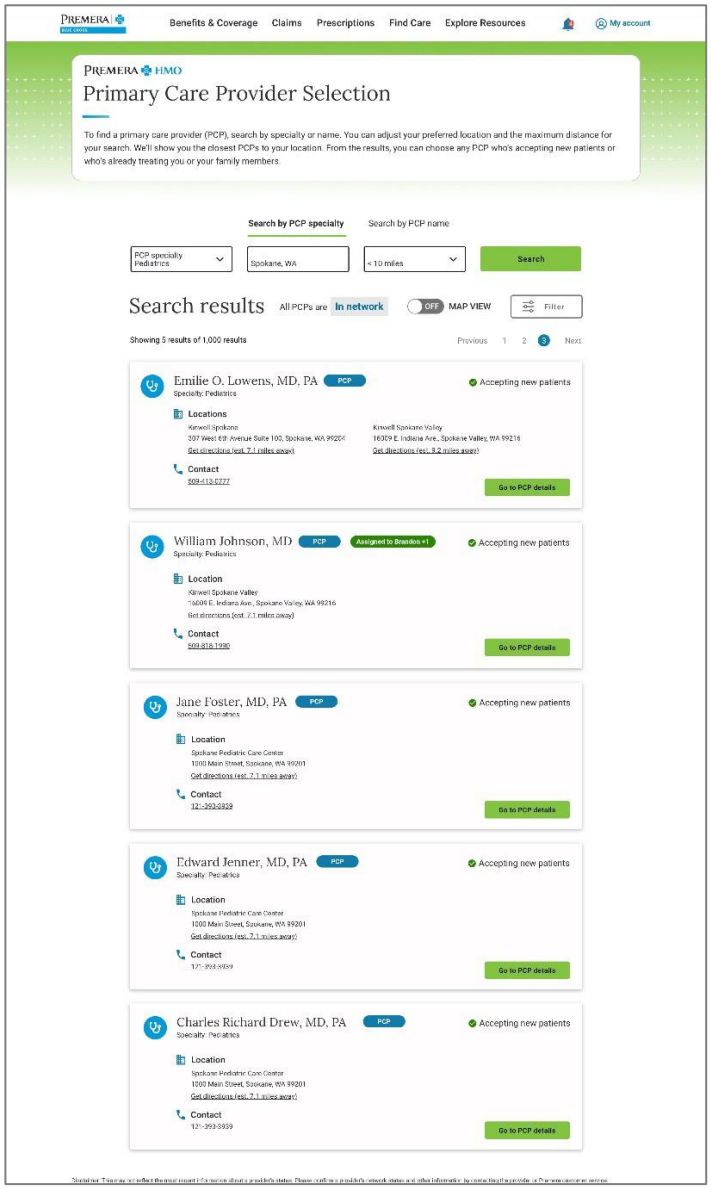


Sherwood HMO provider directory

HMO members have access to the **Sherwood HMO network provider directory** to help them pick the right PCP for their needs. Providers can use the directory to find in-network specialists to refer patients.

Providers can check the **Direct Access Services list** before submitting a request to confirm if a service does not require a referral.

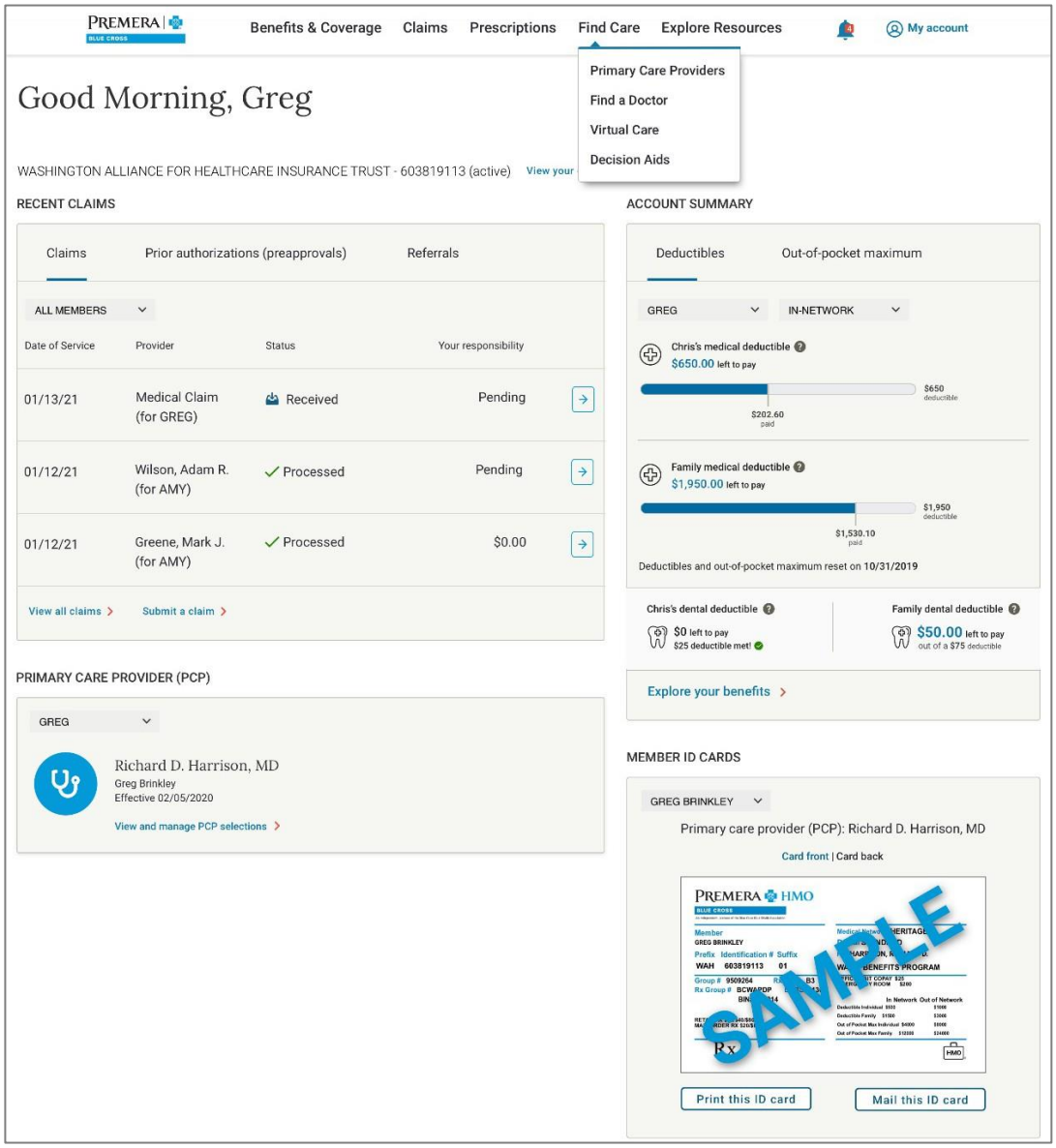
Members can use the directory to pick the right Sherwood HMO PCP for their needs.



Member dashboard

Members can select their PCP from their member dashboard that is accessible through premera.com or the Premera mobile app. The dashboard has additional information for members on their HMO plan.

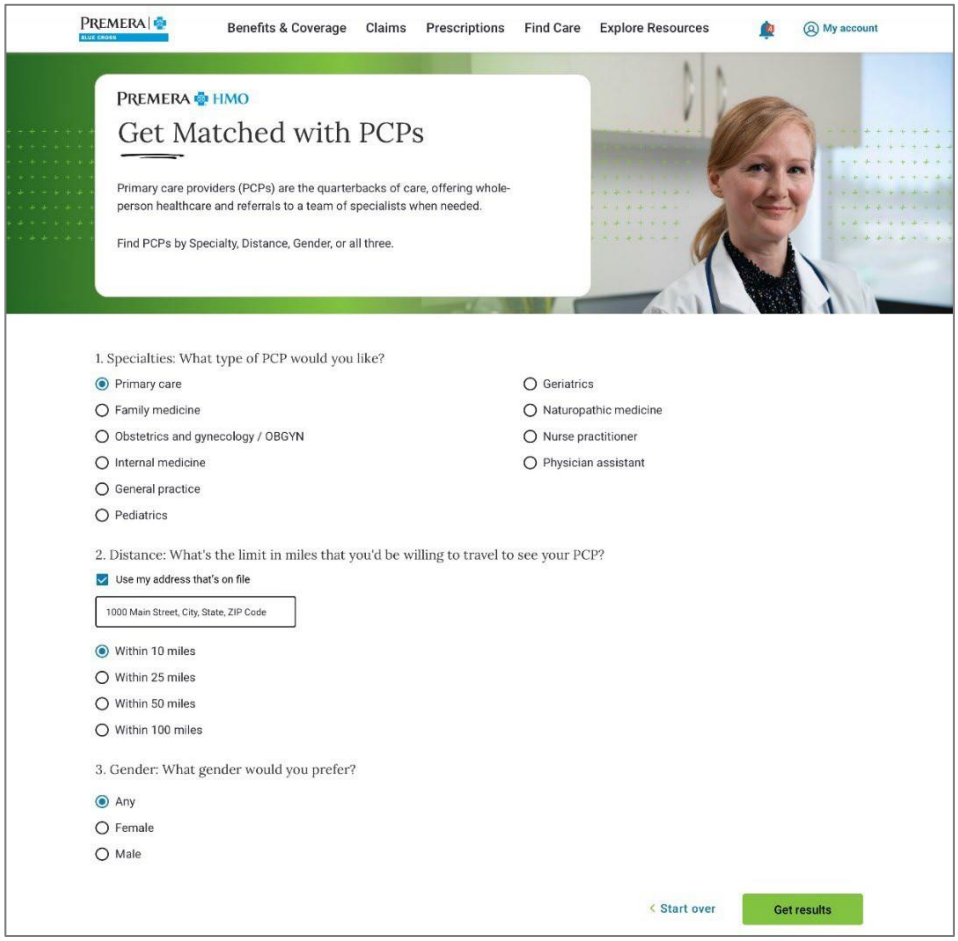
Note: This image is informational only and does not contain Personal Protected Information (PPI).



PCP selection and matching

If a member chooses to change their PCP, this is the screen that they will navigate to.

Note: This image is for reference purposes only.



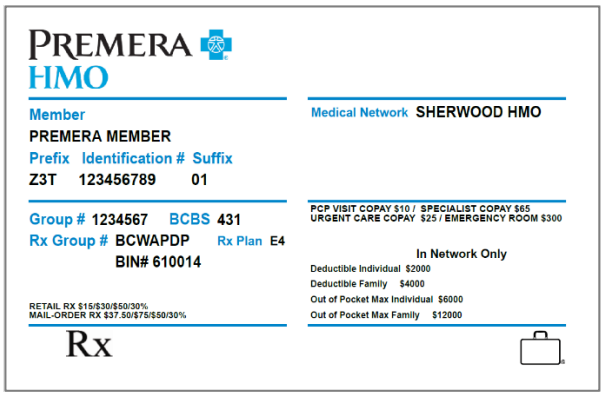
Searching for a PCP

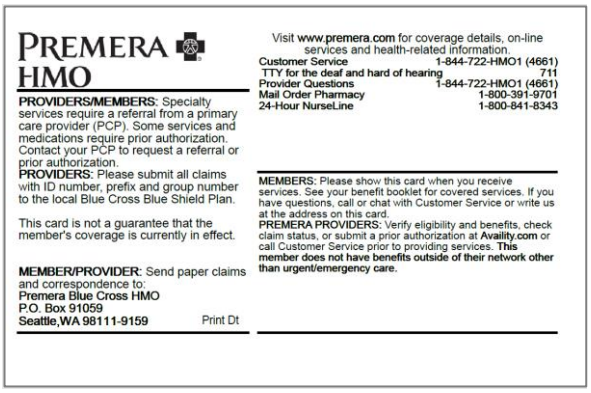
A member can easily search for a PCP or be suggested a PCP within their member portal, illustrated by the screenshot below.

ID cards

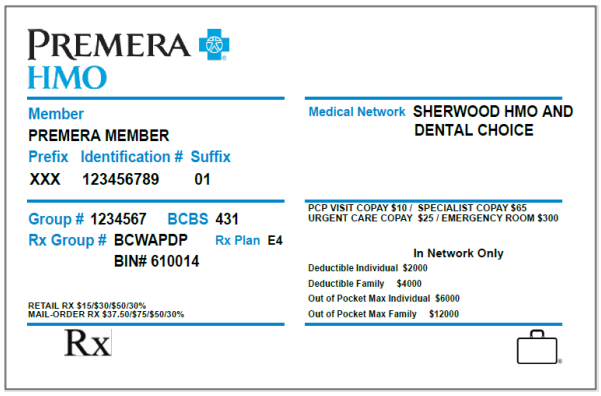
Premera Blue Cross HMO ID cards serve as a member's health plan identification and ensure that a member is covered. Providers can check a member's eligibility, benefits, and get a copy of their ID card through **Availity**. The HMO ID card has unique HMO plan features listed. The plan name can be identified by the Premera Blue Cross HMO logo and the network name Sherwood HMO on the front of the ID card.

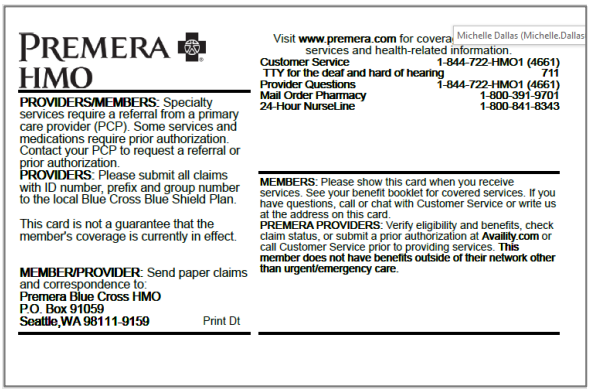
Large group ID card





Small group ID card with pediatric dental





HMO ID card features:

- Customer information
- Group number
- Medical network
- Prefixes for HMO are QZY, Z3T, Z3W, TZH
- Copay, emergency room, Rx
- Rx group # and BIN #
- Suitcase symbol for nationwide coverage
- Plan deductible
- Out-of-pocket maximum
- Contact information and web tools
- Billing information

Note: Premera Blue Cross HMO doesn't currently offer a standalone dental plan. Premera does offer dental plans through Premera Blue Cross. Please see **dental care** for more information.

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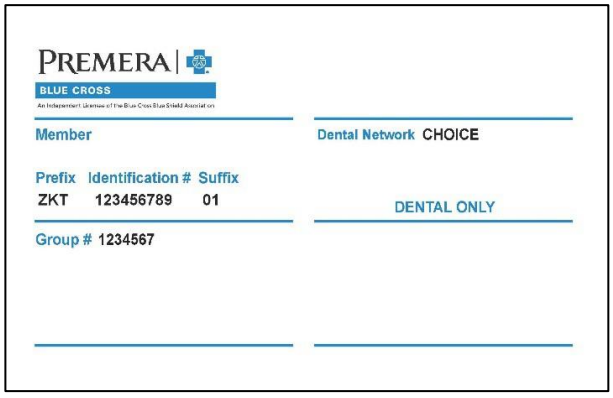
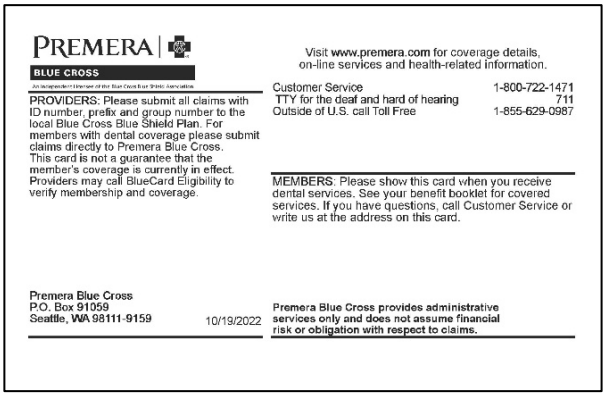
Dental care

HMO plans cover certain medical services that are provided by a dental provider, which are listed as covered under the medical plan, but dental services are offered separately from Premera Blue Cross HMO.

Employers offering the HMO medical plan can select a Premera Blue Cross-branded dental plan. If the employer selects a dental plan, their employees will have dental coverage through Premera Blue Cross. If an employer doesn't select a Premera Blue Cross dental plan, then the member will not have dental coverage through Premera Blue Cross.

The following is an example of a member dental ID card:





Program benefits

The HMO Plus Team: HMO customer service experts

The HMO Plus Team has the skills and autonomy to guide both members and providers through their entire journey while resolving any issues along the way. This team is focused specifically on Premera Blue Cross HMO and will be able to collaborate directly with providers and respond quickly when an issue arises. Providers can call provider customer service for HMO: **844-PBC- HMO1** (844-722-4661) or email **hmoplusprovidersupport@premera.com** for support.

The team will assist members and providers with the following:

- Manage inbound and outbound calls.
- Answer chats and emails.
- Partner with case management and pharmacy teams.
- Communicate proactively.
- Support referral processes.*
- Decrease claims rework.

*The team will review out-of-network referral requests and communicate to the referring provider that an in-network provider is available. In addition, the HMO Plus Team will do outreach to provide support if a member receives a referral from an out-of-network provider.

Matchmaker™ for Behavioral Health

Behavioral health is a key part of whole person care. Premera Blue Cross HMO has a navigation service to help members find the care they need, and to assist providers when finding care for their patients. With one phone call to our HMO Plus Team number (**844-PBC-HMO1** or 844-722-4661), members will be connected with a mental health provider that meets their needs and is accepting new patients.

Urgent and emergency care

Premera Blue Cross HMO is an in-network offering only. However, when an urgent situation arises, an HMO member can utilize urgent care and emergency care anywhere in the United States. Emergency care information is explained as the following:

- "Examination and treatment as required to stabilize a patient to the extent the examination and treatment are within the capability of the staff and facilities available at a hospital."
- "Stabilize means to provide medical, mental health, or substance use disorder treatment necessary to ensure that, within reasonable medical probability, no material deterioration of an emergency condition is likely to occur during or to result from the transfer of the patient from a facility; and for a pregnant member in active labor, to perform the delivery."

Urgent care comes to the member with DispatchHealth

Members can avoid wait times for urgent care with DispatchHealth, a provider group contracted with Premera Blue Cross HMO.

- At the cost of their urgent care copay, members can request DispatchHealth to come to their home or work.
- They provide on-demand, qualified, acute care to keep patients out of the hospital seven days per week, 8 a.m. to 10 p.m. Pacific Time.
- A provider, case manager, or patient can request care on behalf of the member via phone at (855) 354-8961 or our website.
- Once on the scene, the care team can provide 60 to 70 percent of care available in the ER.
- **DispatchHealth** collaborates with the patient's primary care provider for close follow-up if needed.

Enhanced digital experience

To give HMO members more control over the management of their healthcare, Premera Blue Cross HMO provides digital tools that assist members with the following:

- Selecting a PCP
- Tracking referrals and authorizations
- Finding in-network providers

Pharmacy services

Pharmacy services include dedicated support from the HMO Plus Team and proactive outreach that provides the right care at the right time. Premera Blue Cross HMO pharmacists provide clinical assessment, outreach, and clinical consultations with the member and provider.

Here are some examples of questions they can assist with:

- Reviewing medications, providing information, or answering drug questions
- Discussing medication side effects, interactions, and possible alternatives
- Reviewing benefit information and identifying savings opportunities
- Helping support medication management addressing barriers to optimal use

HMO members have access to the National 2.0 network through Express Scripts (ESI), providing many options for patients to fulfill their medication needs. Most Premera Blue Cross HMO plans* include mail-order service and a 90-day supply for maintenance medications. This benefit is designed to support both medication adherence and be a cost-saving strategy for members while conveniently delivering medications to their home.

*Note: School Employees Benefits Board (SEBB) is not included in plan year 2024.

Find more information here: **premera.com/wa/provider/pharmacy/understanding-your-benefits/about-pharmacy**

Formulary

The pharmacy drug list included with the HMO health plan is either Essentials or Metallic. Both lists cover prescription drugs for patients' medical needs, offer quality medicine at a reasonable cost, and at least one option in each drug class.

HMO Essentials formulary (E4-HMO)		HMO Metallic formulary (M4)	
Tier 1	Preferred generics	Tier 1	Preferred generics
Tier 2	Preferred brand	Tier 2	Preferred brand
Tier 3	Preferred specialty	Tier 3	Non-preferred
Tier 4	Non-preferred	Tier 4	Specialty drugs
Rx Formulary E4 Drug List		RX Formulary M4 Drug List	

Note: Some drugs may also be excluded from coverage.

All drugs are reviewed and placed into a formulary tier by the Premera Pharmacy & Therapeutics (P&T) Committee based on clinical efficacy, safety, alternatives, and cost effectiveness. The Premera P&T Committee is an independent set of experts composed of leading physicians, pharmacists, health economists, a bioethicist, and a member representative.

Case management

At Premera Blue Cross HMO, we are passionate about helping our members and their families by listening and meeting them where they are. Our approach is simple: we work to improve quality outcomes and experience, and help reduce costs for the members, employer, and healthcare system. We use the integrated (medical, behavioral health, social determinants of health) case management model to assess the whole person and provide individualized assistance and support. Our case managers serve as the member's single point of contact and focus on removing barriers to improved self-management skills and health outcomes.

Our case managers work directly with facility discharge planners to address barriers to a safe and timely discharge plan, with outpatient providers to schedule a post discharge follow-up appointment, and with the member/designee post discharge focused on readmission prevention. Our case managers also work with outpatient providers to assist members between primary care appointments, to address barriers to following the provider's treatment plan and ensure care is coordinated between providers.

Digital health management (powered by Wellframe)

Our digital health management service meets members in the modality and cadence they prefer. The service offers digital text and chat functionality between a member and their Premera Blue Cross HMO case manager. It also provides:

- Digital programs curated for a digital user with case management support
- Care transition management
- Behavioral health coordination
- Condition management
- Lifestyle management

To refer a member to the Premera Blue Cross HMO case and digital health management service:

- Email: case.management@premera.com
- Contact a case manager: 888-742-1479

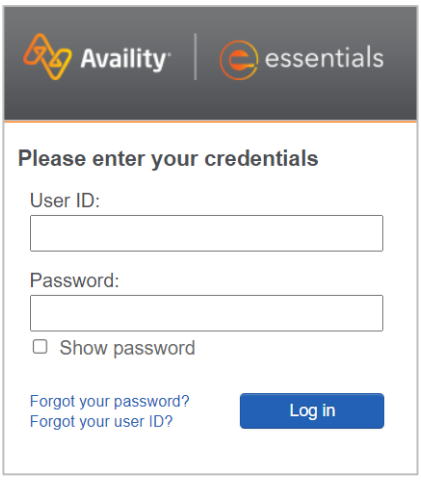
Provide the following brief information:

- Referent name
- Referent phone number
- Member name
- Member Premera ID number
- Member date of birth
- Member phone number
- Reason for referral

Availity

Online provider tools

Availity is a single-source platform for the Premera Blue Cross HMO health plan for checking member eligibility and benefits; claims status and submission, submitting referral and prior authorizations, and more.



Availity essentials is a free platform. **Sign in to Availity** or **register and get training.** View our **Availity provider FAQ** for more details.

Availity offers the quickest way to obtain secure, personalized, easy-to-use information. Providers can:

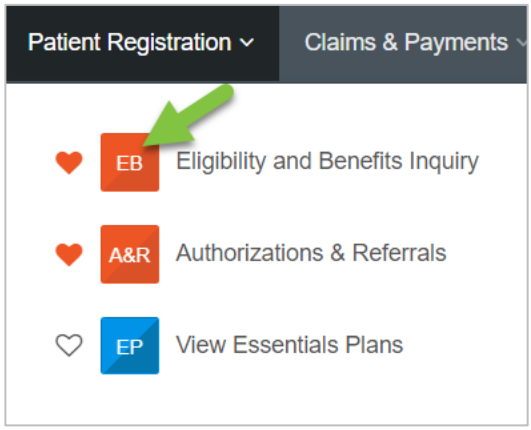
- Verify member eligibility and benefits (including plan effective dates).
- Verify information about deductibles, copays, and coinsurance.
- Verify benefit limit accumulators.
- Download a copy of a member's ID card.
- Check the status of a claim.
- Submit a professional or facility claim (free service through the Premera Blue Cross HMO Payer).
- Submit and check the status of a prior authorization and referral.
- View check and explanation of payment (EOP) information.
- Register for electronic funds transfer (EFT) for enrollment or cancellation using Premera Blue Cross HMO and affiliates as a health plan payer.

Availity: Eligibility and benefits

Member eligibility and coverage

Providers can verify members' eligibility and benefits (including plan effective dates), basic demographic information, deductible, and benefit limit accumulators with Availity.

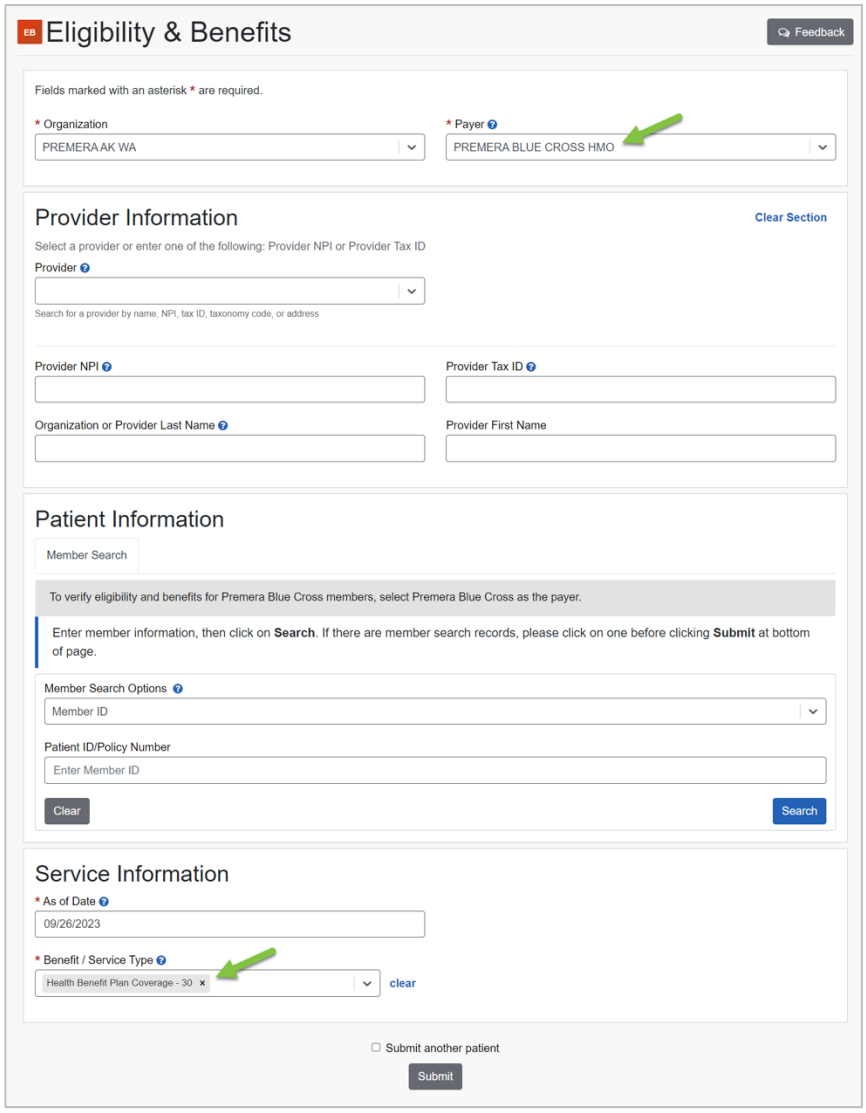
Sign in to Availity. In the Availity menu bar, click Patient Registration > Eligibility and Benefits Inquiry. Select Premera Blue Cross HMO as a payer and complete the required fields to submit a request.



Availity: Eligibility and benefits payer and summary

Select the Premera Blue Cross HMO payer from the drop-down menu and complete the rest of the required fields.

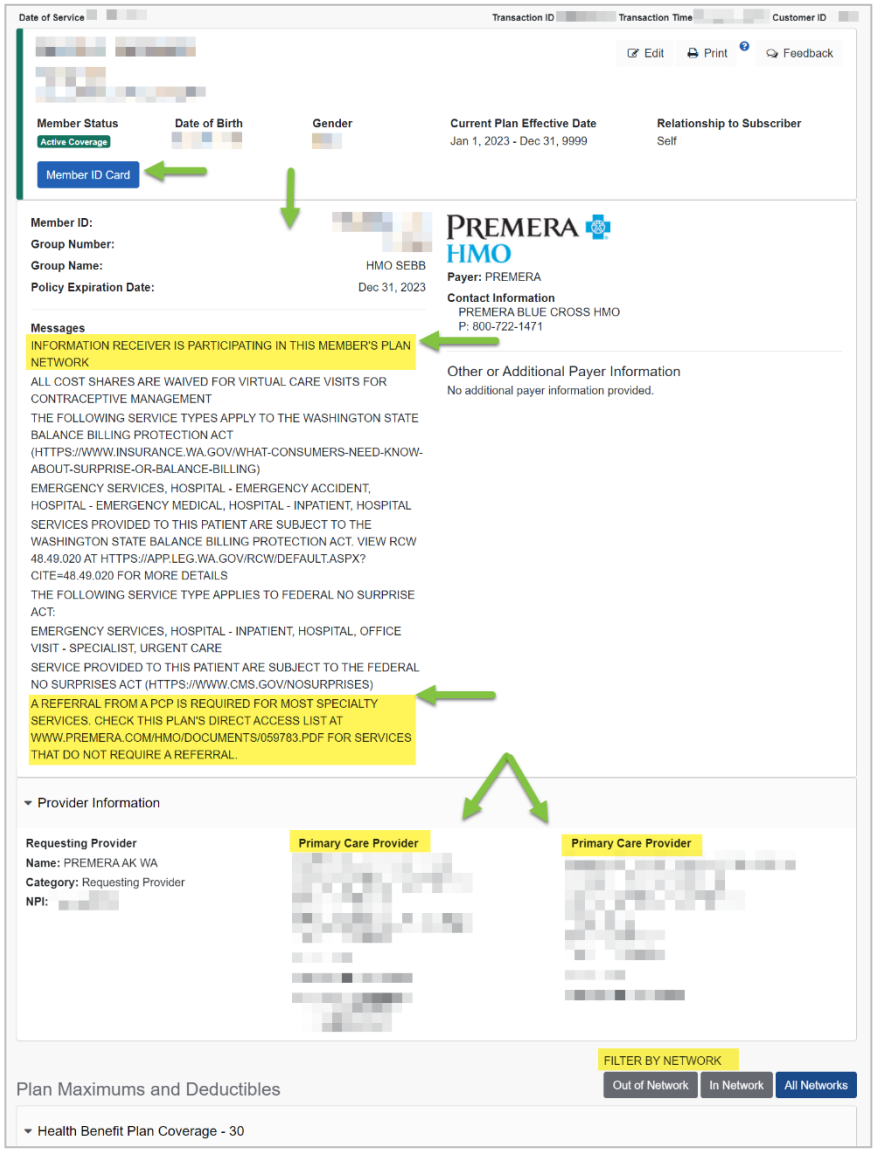
Note: Select the specific Benefit/Service Type needed from the drop-down menu to display the appropriate benefits needed.



The eligibility and benefit summary page has a section at the top that includes valuable information about the member's plan, policy expiration date, and copy of the member's ID card.

The Messages section includes important information about the member's plan like the required PCP referral requirements, a link to the Direct Access list, and whether the provider is in the member's network.

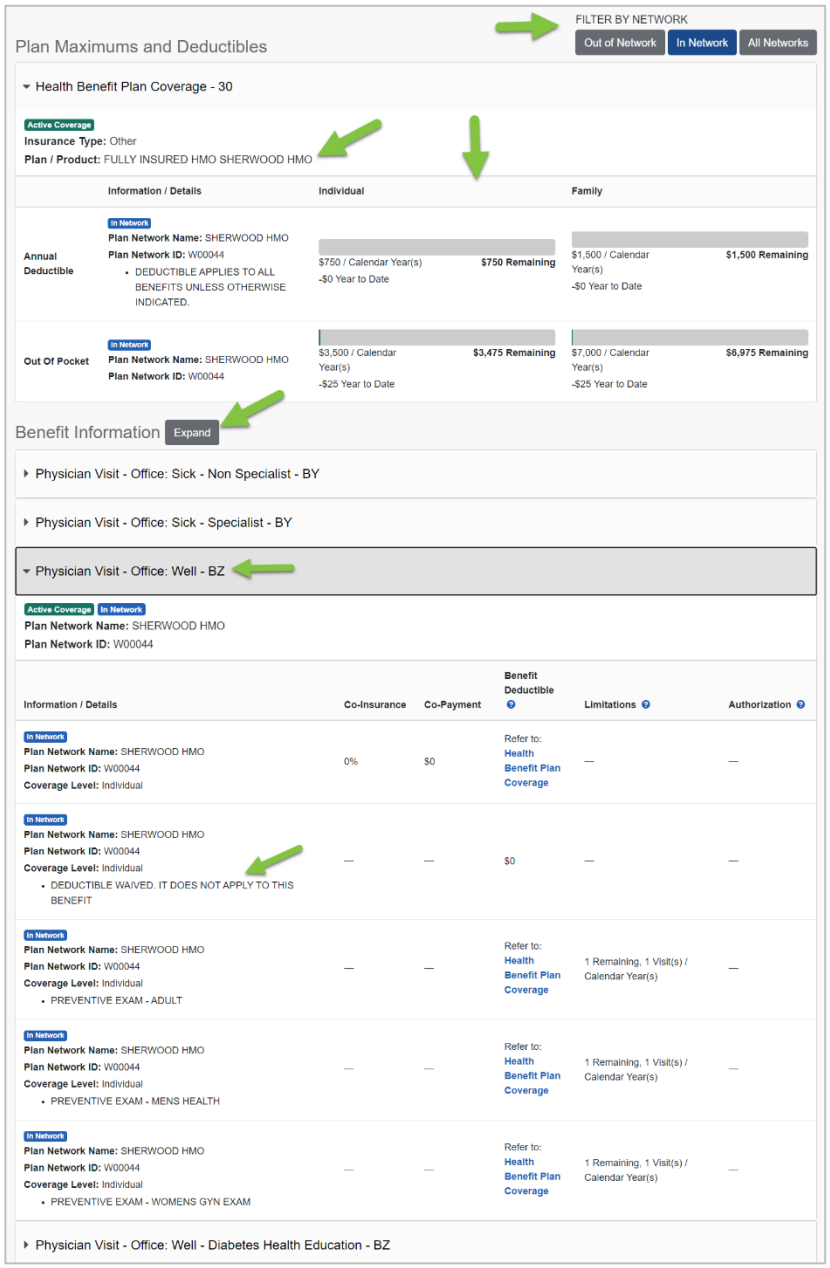
The Provider Information section displays detailed information about the member's PCP and provider group information.



The Plan Maximums and Deductibles section displays information about the member's plan network. It also provides details about the member's deductible and out-of-pocket costs.

The Benefit Information segment provides specific benefit details under each section and the member's cost shares and limits if they apply.

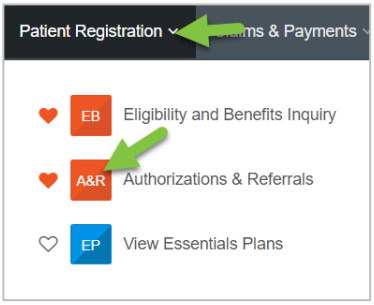
Note: Deductible applies to all benefits unless otherwise indicated under the specific benefit/service type.



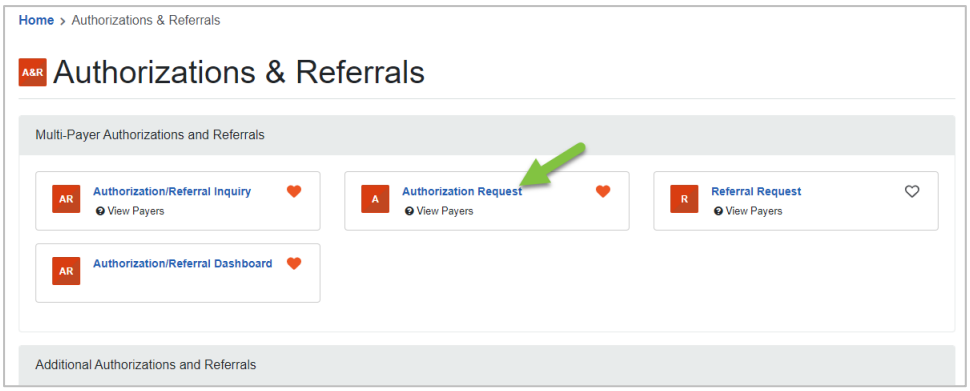
Availity: Prior authorization

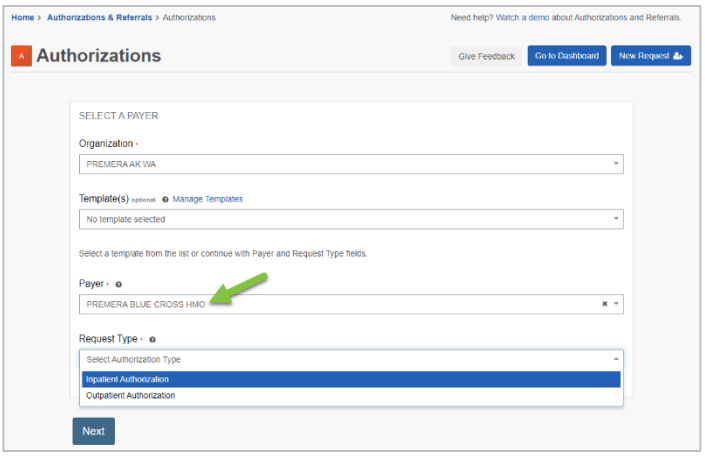
Sign in to Availity to access the prior authorization tool for Premera Blue Cross HMO. The Availity prior authorization tools considers a member's eligibility and coordination of benefits. The status of these requests can be checked through the Authorization/Referral inquiry tool or dashboard. If the request is denied, a letter will be mailed to the provider and member.

Sign in to Availity. In the Availity menu bar, click Patient Registration | Authorizations & Referrals. On the Authorizations and Referrals page, click Authorization Request. Select Premera Blue Cross HMO as a payer and complete the steps to complete a request.



Prior authorizations request and payer





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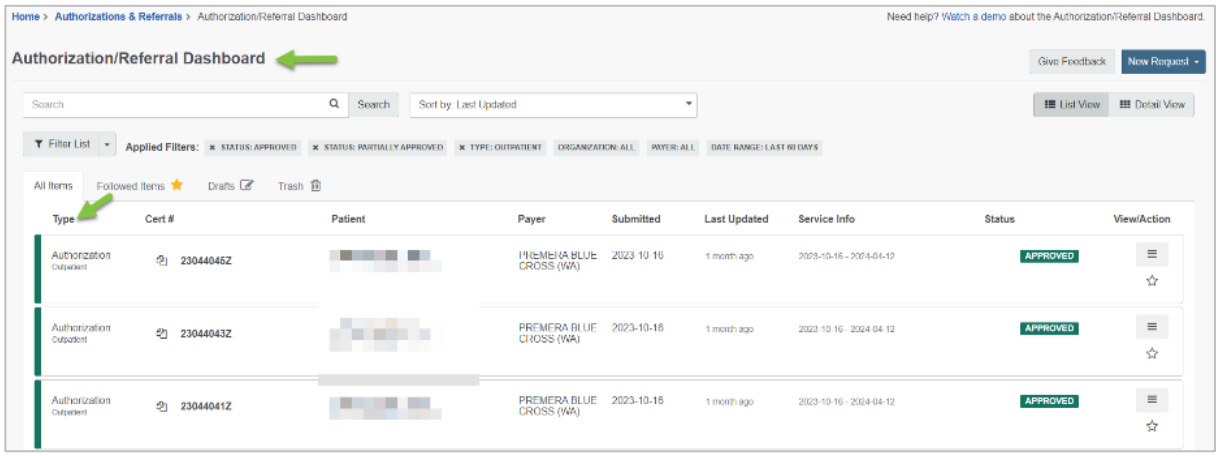
Prior authorizations dashboard

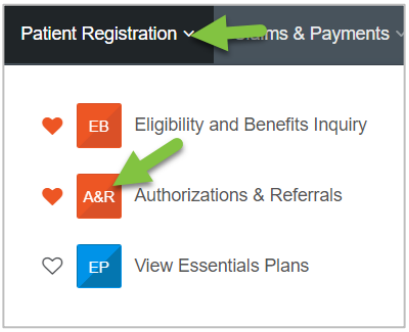


Availity: Referrals

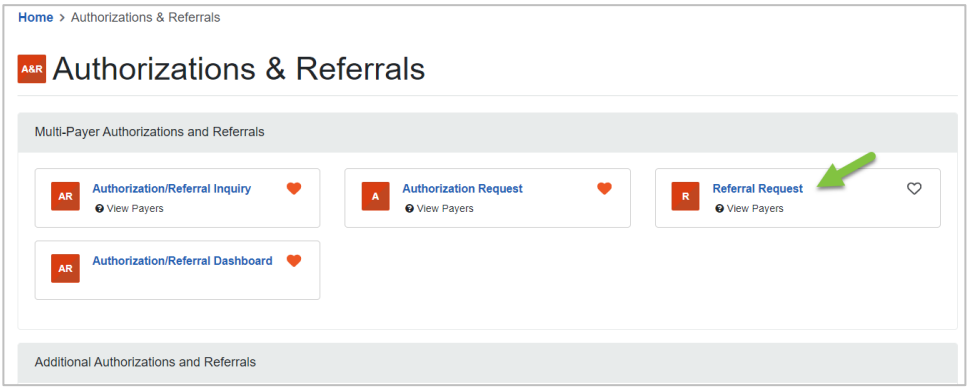
A Premera Blue Cross HMO member is required to have a referral from their PCP for most specialty services. The referral tool is available in Availity. There are certain services that are Direct Access and do not require a referral. Direct Access Services.

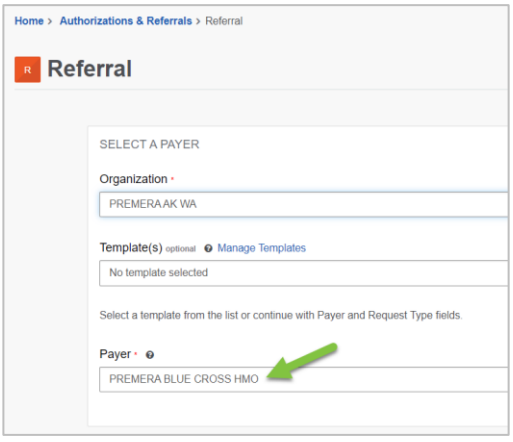
Sign in to Availity. In the Availity menu bar, click Patient Registration > Authorizations & Referrals. On the Authorizations & Referrals page, click Referral Request. Select Premera Blue Cross HMO as a payer and complete the steps to complete a request.

Referral tool in Availity

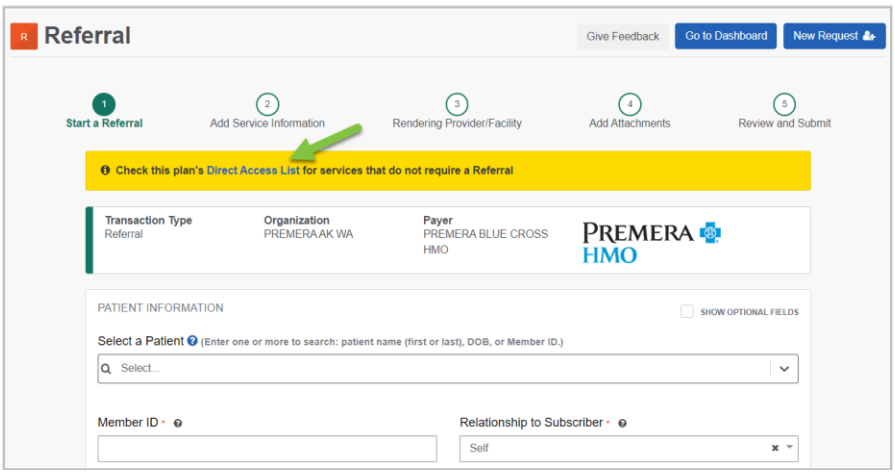


Referral request and payer

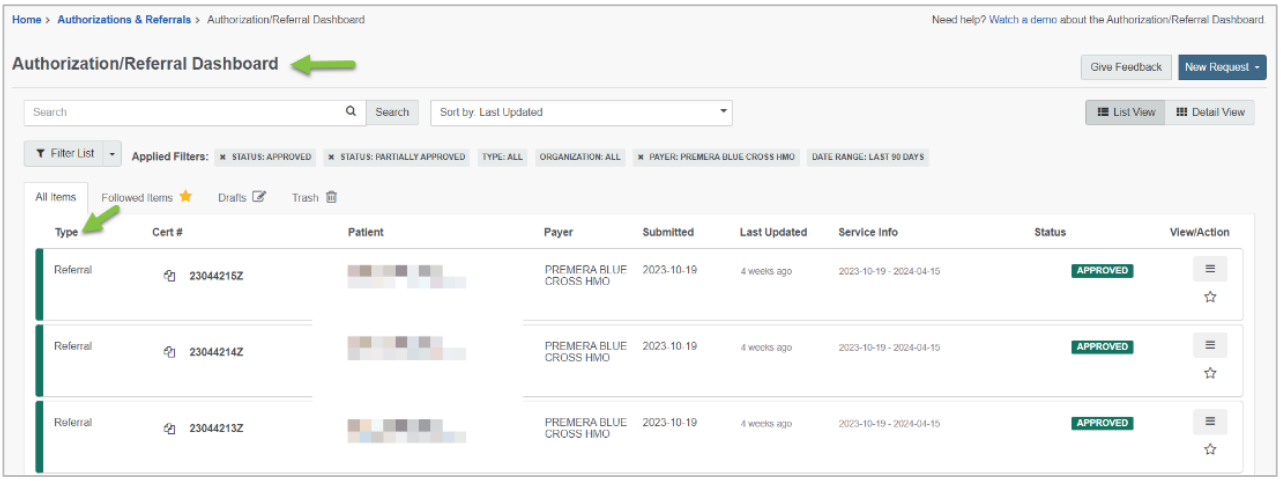




Referral Direct Access list and network status

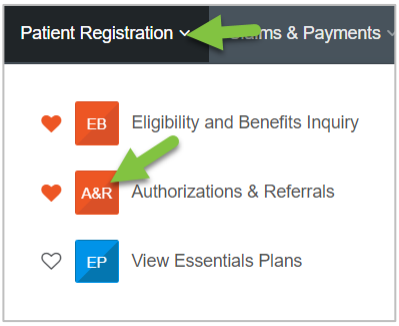


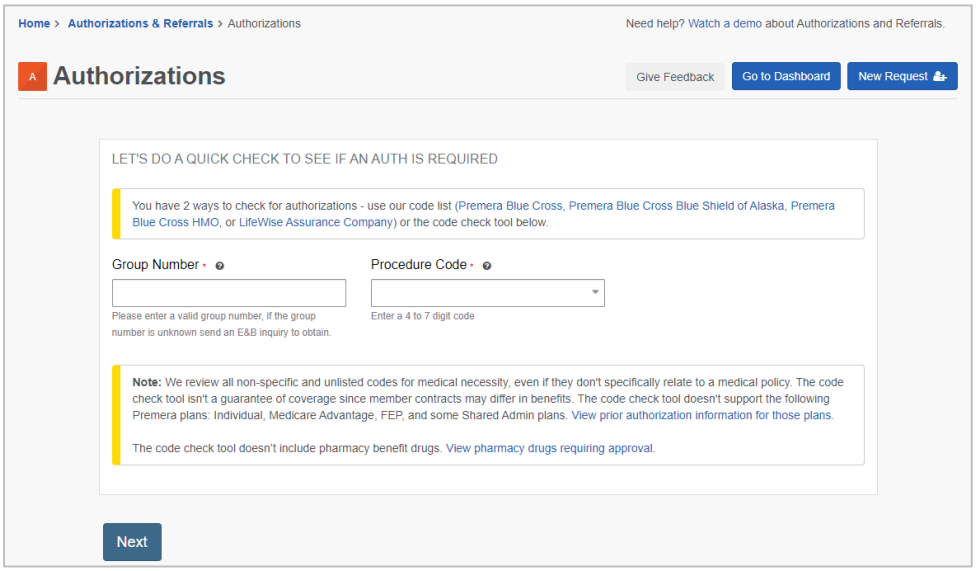
Referral dashboard

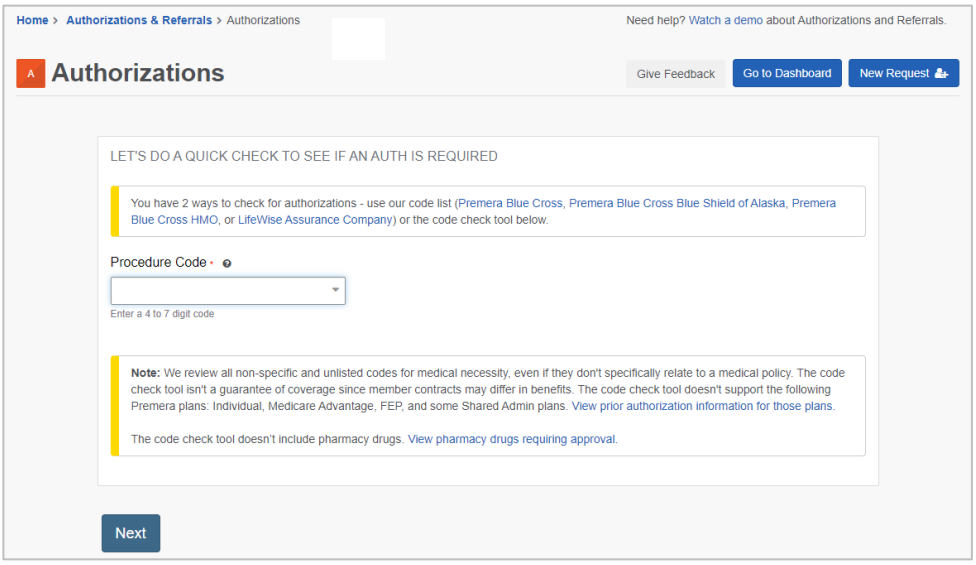


Availity: Code check tool

The code check tool is available to validate if a code requires prior authorization and can be accessed by signing in to Availity. Go to Payer Spaces and look for the Premera Blue Cross HMO logo and click on the code check tool link under the Resources tab. Or find the tool in Authorization & Referrals through Additional Authorizations and Referrals.





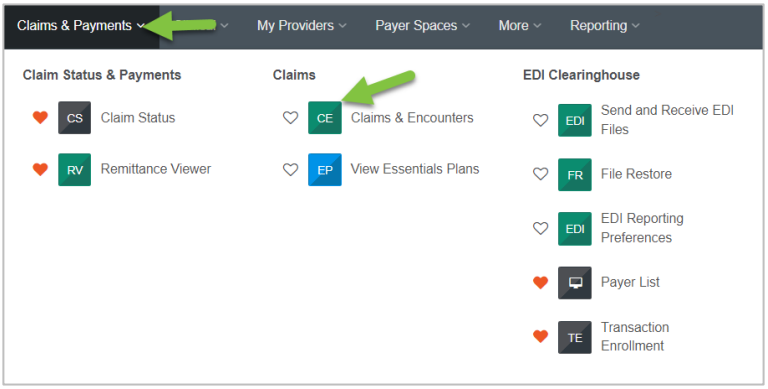


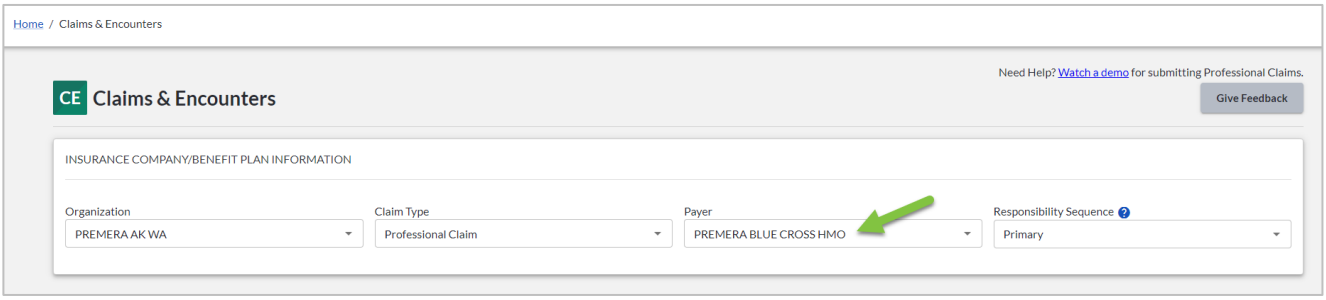
Availity: Claims submission

Claim submission and payments

Claims can be submitted daily, weekly, or monthly. The earlier claims are submitted, the earlier they will be processed. Ideally, claims should be submitted within 60 calendar days of the covered services, but no later than 365 calendar days from the date of submission. Claims can also be submitted to Premera Blue Cross HMO through Availity Essentials for free.

Sign in to Availity. In the Availity menu bar, click Claims & Payments > Claims to submit a professional and facility. Select Premera Blue Cross HMO as a payer.





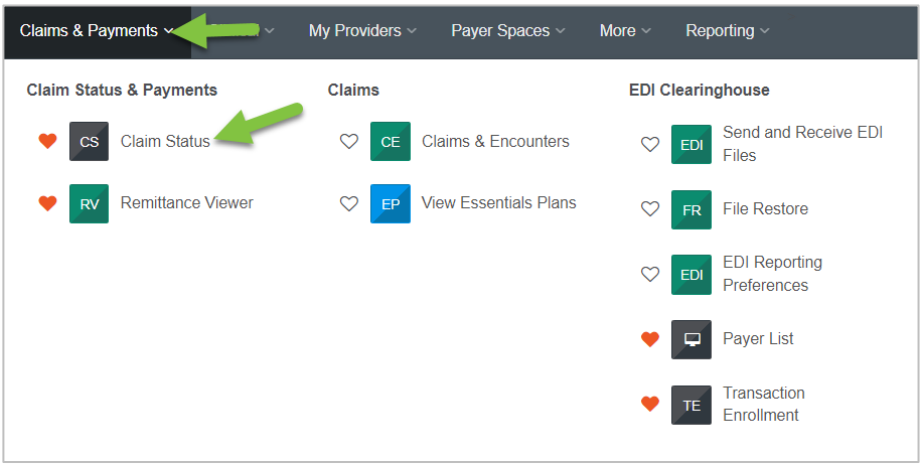
Availity: Claims status

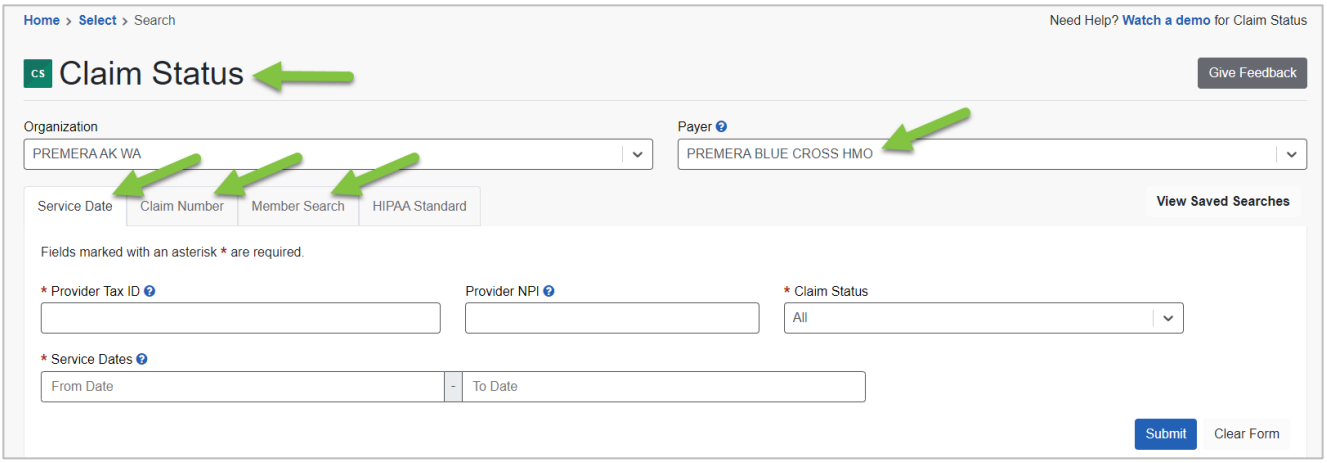
To obtain the status of a claim:

- **Online:** The best method to check the status of a claim is to visit the Availity secure provider portal. Information is available 24 hours per day, seven days per week.
- **Customer Service:** If there is no Internet access, contact HMO Customer Service by calling 844-722-4661 or by calling the phone number on the back of the member's ID card.
- **Interactive voice response (IVR):** Available 24 hours per day, seven days per week. IVR provides claims information.

Sign in to Availity. In the Availity menu bar, click Claims & Payments | Claim Status to search for a claim by date of service, member ID, or claim number. Select Premera Blue Cross HMO as a payer.

Claims status, payer, and search features

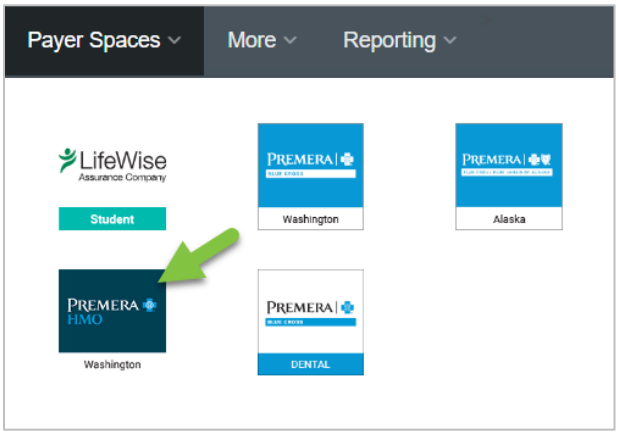




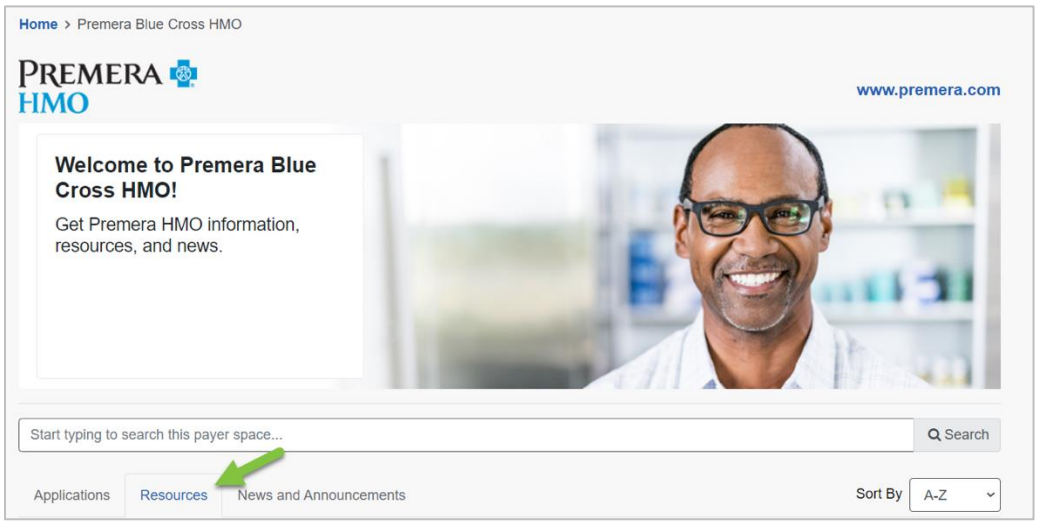
Availity: Provider online PCP Roster tool

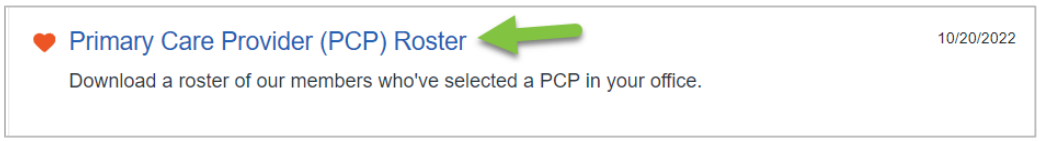
The PCP Roster tool lets a provider see a list of patients who selected the provider as their PCP or who were assigned to the provider by Premera Blue Cross HMO. A provider can search by TIN, provider, or clinic. The provider can download the roster to see all the information they need to know about their patient(s).

Sign in to Availity. In the Availity menu bar, click Payer Spaces and then click on the Premera Blue Cross HMO logo. Click on the Resources tab and scroll down to the Primary Care Provider (PCP) Roster link to access the tool.



Provider online PCP Roster tool





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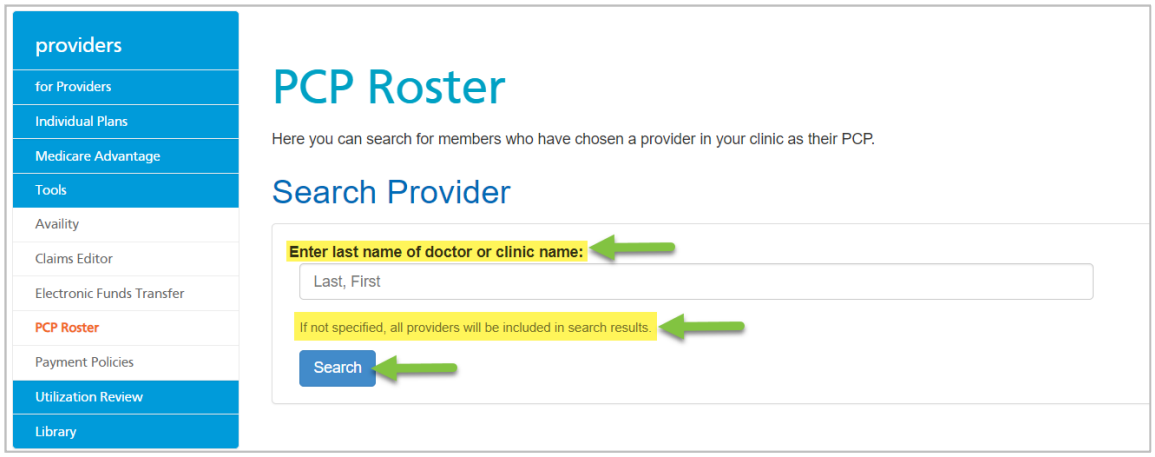
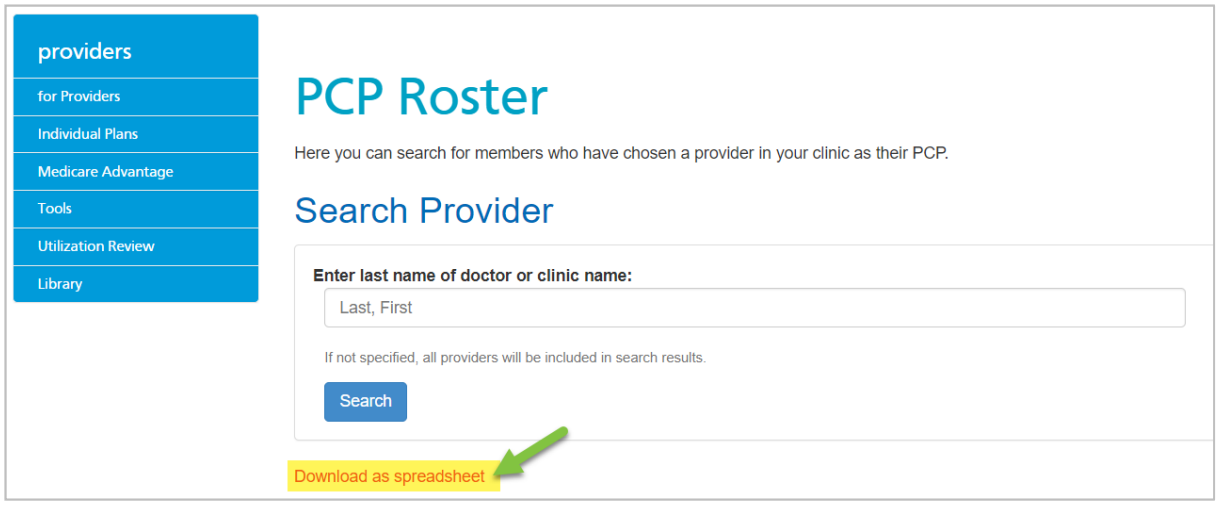
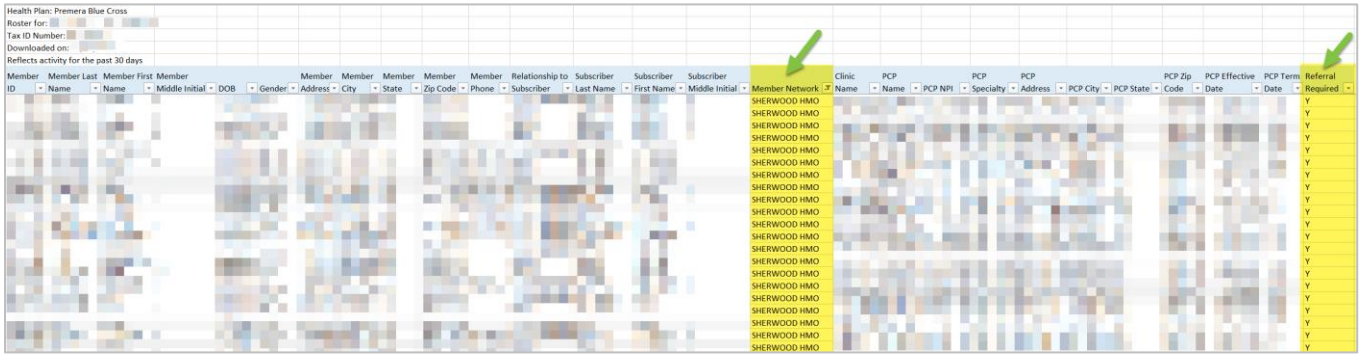




Provider online PCP Roster tool display

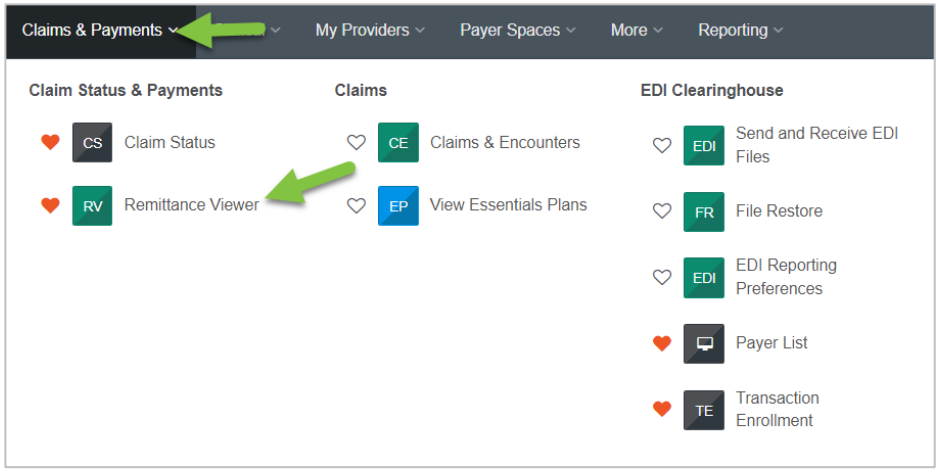


Availity: Remittance and Explanation of Payments (EOP)

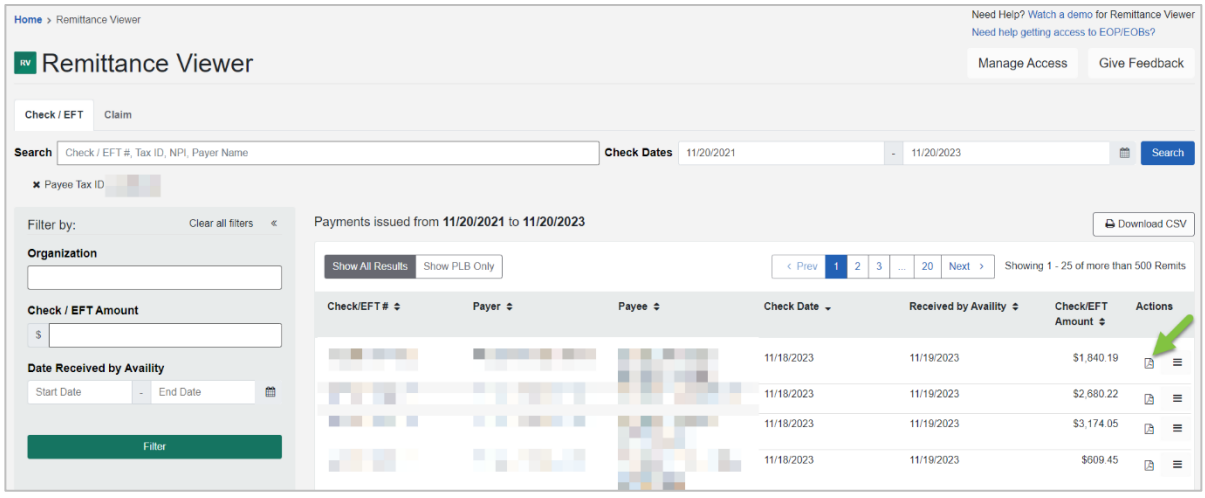
Premera Blue Cross HMO submits checks and EOPs to Availity. To see submitted information, a check needs to be validated for Premera business and be dated within the last 30 days. Only then can the check information and EOPs be made visible.

EOPs can be accessed through Remittance Viewer, which uses multiple data search points including claim number, check/EFT number, tax ID, NPI, member ID, patient control number, and payer name. **View how to find EOPs**.

Note: If searching by check/EFT number, use a payment reference number if registered for electronic funds transfer. Otherwise, search using the check number.



Check information, EOPs, and get help



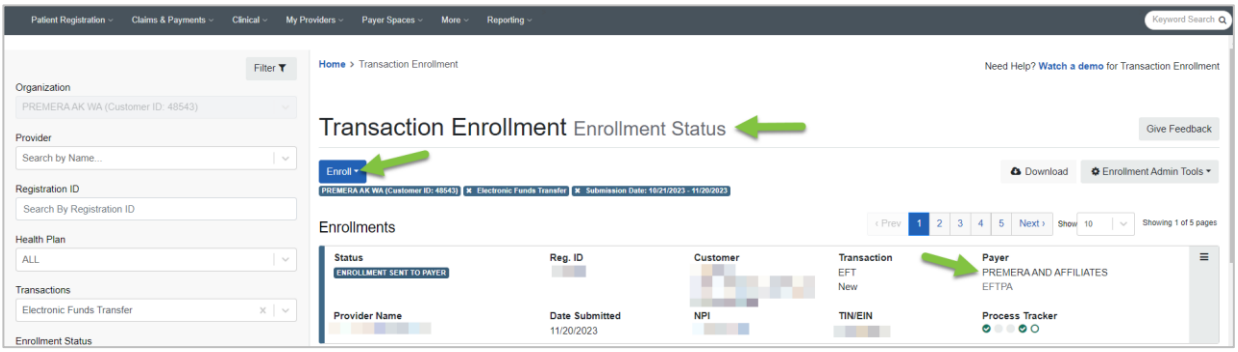
Availity: Electronic funds transfer for enrollment or cancellation

If a provider is already enrolled in Electronic Funds Transfer (EFT) with Premera Blue Cross plans, no action is needed to re-enroll through Availity. Premera Blue Cross HMO still processes Availity transactions for EFT requests. However, if you're a new provider, you must enroll for EFT using Availity's Transaction Enrollment tool.

Note: Use Premera and Affiliates as a Health Plan payer.

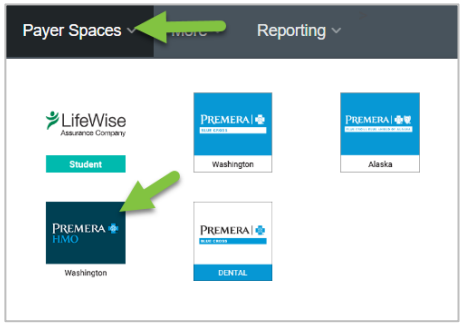
Watch this how-to demo or view an EFT enrollment help topic.

Sign in to Availity or register and get training. View our Availity provider FAQ for more details.

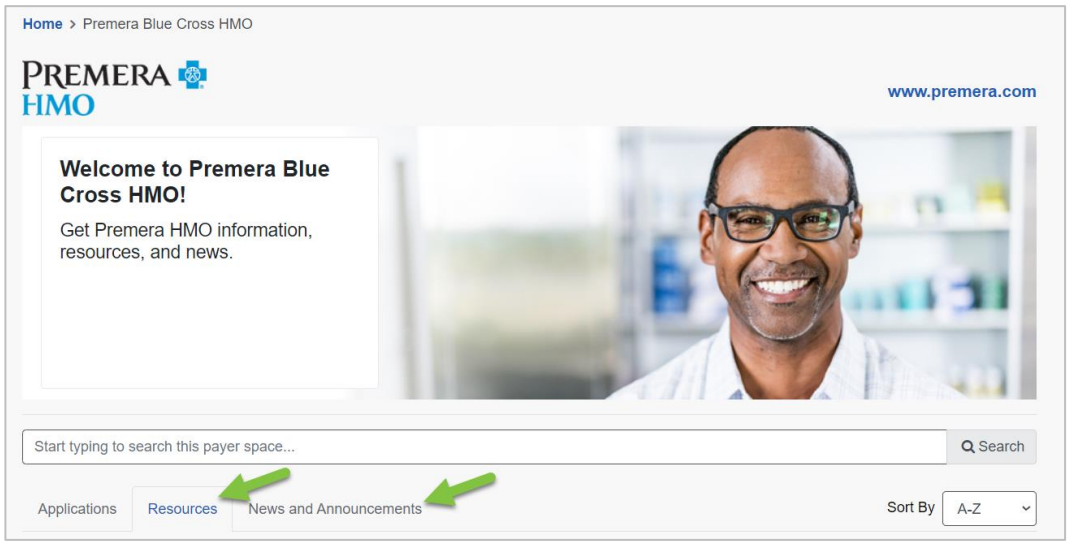


Availity: Resources

In the Availity menu bar, click Payer Spaces and then click on the Premera Blue Cross HMO logo. Click on the Resources or News and Announcements tabs to access information specific to Premera Blue Cross HMO. [Sign in to Availity](#).



Availity: Provider online

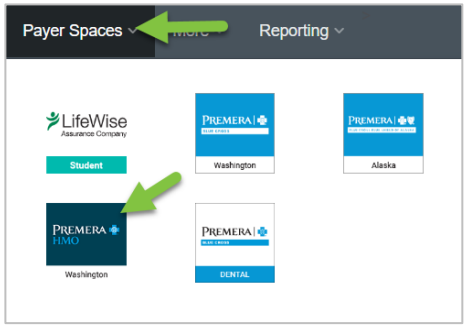


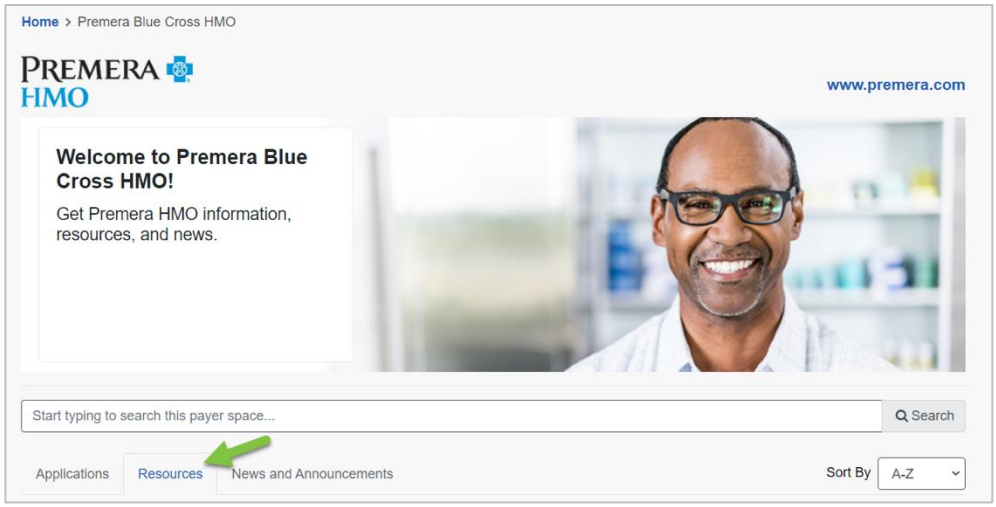
Availity: Premera Blue Cross HMO forms

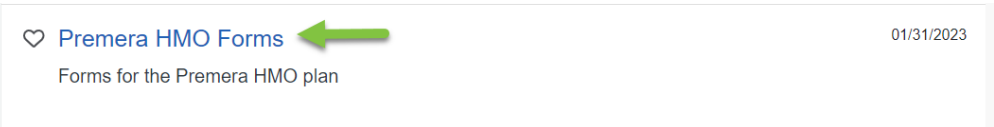
There are a variety of forms available:

- Appeals
- Claims and billing
- Care management, prior authorizations, and referrals
- Credentialing and provider updates

Providers can access Premera Blue Cross HMO forms through the Availity Premera Blue Cross HMO Payer Space under Resources.







Reconsideration/Quality/Medical management forms

Appeals

Provider appeals: Providers have the right to appeal certain actions of Premera Blue Cross HMO. Our provider complaints and appeals process ensures we address a complaint or an appeal in a fair and timely manner. Our process meets or exceeds the requirements set by the Office of the Insurance Commissioner.

Providers can submit a complaint about one of our actions (verbally or in writing) to one of our employees. Providers have 365 calendar days to submit a complaint following the action that prompted the complaint. Complaints received beyond the 365-day timeframe will not be reviewed and the appeals rights pertaining to the issue will be exhausted. If Premera Blue Cross HMO receives the complaint before the 365-day deadline, it can be reviewed, and a decision issued within 30 calendar days via letter or revised Explanation of Payment. **Claim submission and payments**

Appeals: Provider forms

Member appeals: Members have the right to voice and/or submit their complaints when they have a problem or concern about claims, quality of care or service, network physicians and other providers, or other issues relating to their coverage. If a provider's office receives a request for information or records in connection with a patient's appeal, please expedite the request. **Member eligibility and coverage**

Benefit level exceptions

The HMO plan does not have out-of-network benefits. Members will see their selected PCP for their care or for referrals to in-network specialists.

If there are no in-network specialists who meet a member's specific needs, their PCP can submit a referral to request an out-of-network provider with clinical documentation.

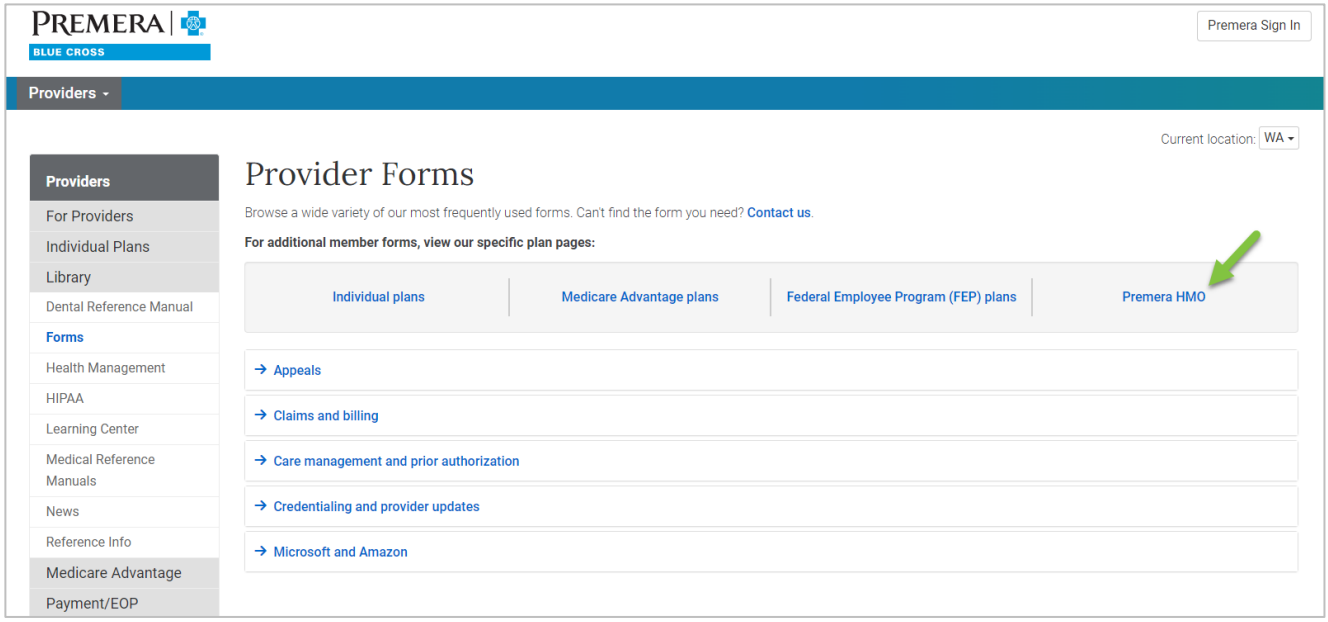
If a member needs direct access care (that doesn't require a referral and/or preauthorization), or medically necessary services from an out-of-network provider, the provider can submit a benefit level exception (BLE) request to have the services covered as in network.

Medical management forms

There are a variety of forms available:

- Appeals
- Claims and billing
- Care management and prior authorizations
- Credentialing and provider updates

Forms: [Provider forms]



HMO medical and payment policies

Providers can access the Premera Blue Cross HMO medical and payment policies through the Availity Premera Blue Cross HMO Payer Space under Resources.

Medical policies: [premera.com/wa/provider/reference/medical-policies]

Payment policies: [premera.com/wa/provider/reference/payment-policies]

Quality and HEDIS measures

The Healthcare Effectiveness Data and Information Set (HEDIS) is a set of nationally recognized performance measures developed and maintained by the National Committee for Quality Assurance (NCQA). HEDIS is used by more than 90 percent of U.S. health plans to measure quality of care, access to care, and satisfaction with care.

HEDIS measures:

- This measurement tool is used by more than 90 percent of health payers to assess and collect data their provider network performance.
- The tracked data is measured year to year for health plans to assess the valuable information on their patient populations served and reviewed the actual care received, not just what was ordered.
- HEDIS measures effectiveness of care, access/availability of care, utilization, risk adjustment utilization, and use of electronic clinical data systems.

Quality measures

Our Quality Program benefits Premera Blue Cross HMO members and providers with health awareness education, disease management, health risk management, and more. Premera Blue Cross HMO collaborates with providers and members to monitor and improve the cases they provide.

The Premera Quality Program measures the quality of healthcare, identifies areas for improvement, and drives efforts to improve the experience and health outcomes for our members by focusing on providing the right care, to the right individual, at the right time, and in the right place. Our Quality Program empowers members and providers in a comprehensive and meaningful way.

Premera Blue Cross HMO creates and administers member engagement initiatives that encourage active participation in their healthcare. Premera Blue Cross HMO partners with our providers and the healthcare delivery system to support members' empowerment. This is accomplished by delivering patient-specific information on opportunities for care, clinical best practices, and members' feedback to providers. Learn more about Quality Programs at **premera.com/wa/provider/patient-programs/quality-programs**.

Quality and risk adjustment Provider Clinical Consulting

Provider Clinical Consultants (PCC) work directly with providers to support best practice implementation for improved outcomes that focus on keeping Premera Blue Cross HMO members healthy. Providers can connect with their PCC by emailing **ProviderClinicalConsulting@premera.com**.

- Gain access to the online provider platform, One View Population Health (OVPH), to help manage members due for care across a suite of quality metrics or due for chronic condition management. This includes data on quality, pharmacy, and coding gaps; admits, can upload medical records to close care gaps and invalidate conditions to close coding gaps.
- Submit supplemental quality EMR extracts and supplemental diagnosis files to close care and coding gaps via data elements not submitted on claims.
- Assess current performance and partner with Premera Blue Cross HMO to identify opportunities to improve on specific metrics.
- Consult on learnings gleaned from quality metric and condition-specific training tools (including four web trainings), which are available on the **quality and coding tools page.**
- Obtain monthly reporting, updates about Premera Blue Cross HMO member engagement initiatives, and other notifications to support your provision of high-quality care.

Eligibility, benefits, and claims

Member eligibility and coverage

The benefits of each plan vary widely by contract. Providers can verify a member's eligibility and benefits in the provider website, interactive voice response, and limitations and exclusions.

However, actual payment is subject to the subscriber's contract and eligibility at the time of service.

Provider website

Our secure provider website through Availity offers the quickest way to obtain secure, personalized, easy-to-use information. With Availity, a member's eligibility and benefits (including plan effective dates), basic demographic information, deductible, benefit limit accumulators, and member ID card can be verified.

Interactive voice response

Our interactive voice response (IVR) provides self-service, specific information, and is available 24 hours per day, seven days per week. Customer service numbers offer an IVR option. Callers enter the member's ID number, date of birth, and the provider's tax ID number to obtain eligibility, general benefit information, and claims information. Information available on the IVR system varies by plan:

- Key in or say the member's identification number. Enter the member's date of birth as month (two digits), day (two digits), and year (four digits). Do not use slashes or hyphens. Example: 03011972 represents March 1, 1972.
- Once familiar with the script, there no longer is a need to listen to the complete prompt before entering a selection.
- When requesting eligibility verification for more than one member at the same time, if there are errors for subscriber or birth date, note them, and wait until all the inquiries are completed before connecting to a customer service representative.
- If there is a delay of more than five seconds when responding to each prompt, the system will repeat the prompt. If the caller does not respond in another five seconds, the caller will be routed to a customer service representative (during normal customer service hours).
- If there is an error while keying in the member ID number, press the * key and the system will provide a prompt to re-enter it.

Contact IVR for HMO at **844-722-4661** (844-PBC-HMO1).

Limitations and exclusions

Benefit plans typically have exclusions and limitations—services and supplies that plans do not cover.

Benefits are not provided for services, treatment, surgery, drugs, or supplies for any of the following:

- Conditions arising from acts of war or service in the military
- Cosmetic or reconstructive services, except as specifically provided
- Experimental or investigative services
- Orthognathic surgery
- Services determined by us to be not medically necessary
- Services more than specified benefit maximums
- Services payable by other types of insurance coverage
- Services received when the member is not covered by the program
- Sterilization reversal
- Treatment for work-related conditions for which benefits are provided by Workers' Compensation or similar coverage

Note: Plan limitations and exclusions vary widely by contract and are subject to change. This is not a complete explanation of covered services, exclusions, limitations, reductions, or the terms under which the program may be continued in force. This manual is not a contract. For full coverage provisions, including a description of waiting periods, limitations, and exclusions, please contact HMO Customer Service at 844-PBC-HMO1 or 844-722-4661.

Benefit-level exceptions

When a service or specialist is not available within the Sherwood HMO network, a member may be referred outside the network for medically necessary care. Examples of medically necessary care may include treatment for rare conditions or unique services. Care or services provided by an out-of-network provider may be covered as an in-network service if authorization is requested and approved prior to services being rendered. Members may at times be financially responsible for out-of-network services.

Out-of-network services may be covered at an in-network benefit level if they are determined to be medically necessary. Examples include medically necessary specialist care, network capacity, distance from a member, or unique services. A benefit-level exception is subject to a review process prior to approval or denial. See the **Integrated Health Management section** for information about prospective review.

Emergency care

Members should call 911 or seek care immediately if they have a medical emergency condition. Our plans cover emergency care 24 hours per day in the United States.

A medical emergency condition is defined as the sudden, acute onset of a symptom or symptoms that requires immediate medical attention. A healthcare provider must decide that without immediate medical attention, the individual will suffer serious harm to bodily functions, dysfunction of an organ or body part, or jeopardize the person's health. A healthcare provider is someone who has an average knowledge of health and medicine.

Medical emergency examples include severe pain, suspected heart attacks, and fractures. Examples of non-emergencies include minor cuts and scrapes. In a medical emergency, members can utilize emergency care at an urgent care or emergency room anywhere in the United States.

The hospital's emergency department must perform a medical screening examination for any individual seeking evaluation for treatment for a medical condition. For presenting conditions that are not a medical emergency, the emergency department must have the authorization of the member's treating physician or other provider to treat past the point of screening and stabilization. In such cases, Premera Blue Cross HMO expects the treating physician or other provider to respond within 30 minutes of being called, or Premera will assume there is authorization to treat, and the emergency department will treat the member.

If a member is treated in the emergency department, the member's physician or other provider needs to provide any necessary follow-up care (such as suture removal).

Member appeals

Members have the right to voice and/or submit their complaints and/or appeals when they have a problem or a concern about claims, quality of care or service, network physicians, and other providers, or other issues relating to their coverage. If the provider's office receives a request for information or records in connection with a member's appeal, please expedite the request.

Level 1 appeal

Premera Blue Cross HMO evaluates all the information and decides. The member is sent a written notice of the decision, including a reason, within 30 calendar days of the date the appeal was received.

Providers submitting a Level 1 request on the member's behalf must provide a signed appeals authorization form from the member. Level 1 requests will not be accepted from the providers on the member's behalf without this authorization. If the member is not satisfied with the outcome from the first review, they may request an independent review (IRO).

Independent review

If a member is not satisfied with a Level 1 they may request an independent review. The written request must be received in writing from the member within 120 days of the date the member received notice of the Level 1. Providers submitting a request for independent review on the member's behalf must provide a signed appeals authorization form from the member. The provider's request will not be considered for independent review without the signed authorization.

An independent review organization (IRO) conducts independent reviews. An IRO is an organization of medical and contract experts not associated with Premera Blue Cross HMO that is qualified to review appeals. Premera Blue Cross HMO submits the member's file to the IRO, and for fully insured groups, pays the costs of the review. The IRO gives the member its decision in writing, and Premera Blue Cross HMO promptly implements the IRO's determination.

Expedited appeal

Expedited appeals are warranted when following the routine appeals process might jeopardize the life or health of the member. The request must come from the provider and include a clinical reason for expediting the request.

Level 1 expedited appeal

All information is evaluated, and a decision is made. Premera Blue Cross HMO will notify the provider and member of our decision, and the reasons for it, within 72 hours after the appeal is received. If a member is not satisfied with the Level 1 decision, they may request an independent review.

Member rights

Our members have the right to:

- Easily get information about the organization, and its services, practitioners, and providers.
- Easily get information about their rights and responsibilities.
- Be treated with respect. We will act with respect to our members' dignity and their right to privacy.
- Work with their healthcare provider to decide on treatments they need.
- Talk honestly about the treatments that are right for their conditions, regardless of cost or benefit coverage.
- Make complaints or appeals about us or the care or service we provide.
- Recommend changes to our member rights and responsibilities policy.
- Choose their healthcare providers.
- Keep things members tell us about their health plan claims and other related information private.
- Have their healthcare and healthcare coverage information protected.
- Review and get copies of their personal information on file.
- Receive screening and stabilization emergency services when and where they need them. Members do not need prior authorization, regardless of cost or benefits coverage. This applies if severe pain, injury, or sudden illness convinces a member that their health is at great risk.
- Continue to get care from their specialty provider for up to 90 days or until they complete their care. This applies if the member is getting treatment for a chronic or disabling condition. It applies if they are in their second or third trimester of pregnancy. It applies when members involuntarily change their healthcare plan. It applies if the member’s provider leaves the network for any reason other than cause.

Member responsibilities

Our members have the responsibility to:

- Give as much information as they can so that Premera Blue Cross HMO and its providers can provide care.
- Follow the agreed upon care plans and instructions from their providers.
- Try to understand their health problems.
- Work as much as possible with their healthcare providers to develop treatment goals they can agree on.
- Try to keep healthy habits, such as exercising, not smoking, and eating a healthy diet.
- Disclose relevant information. The member must try to communicate clearly what they want and need.
- Avoid knowingly spreading disease.
- Understand their healthcare provider's obligation to provide care equally and efficiently to other patients and the community.
- Learn about their health plan coverage and options, including all covered benefits, limitations and exclusions, and rules about the use of information.
- Understand how to appeal coverage decisions.
- Show respect for other patients, health workers, and health plan employees.
- Make a good-faith effort to meet financial obligations.
- Follow the administrative and operational procedures of their health plan and healthcare providers.
- Report wrongdoing and fraud.

ID cards

Members should present their ID cards at each time of service. Depending on the plan, members are responsible for any applicable copayment (copay), coinsurance, or deductible. Members are also responsible for the costs of non-covered services beyond their program's maximum benefit.

Copayments

The copay is a predetermined amount a member pays for a specific service (for example, $20 for an office visit). Typically, copayments are fixed amounts for office visits, prescriptions, or hospital services. Copays should be collected at the time of service from the member. If the member is admitted to the hospital from the emergency room, the emergency room copay may be waived. The member's copay is calculated into the Premera Blue Cross HMO payment.

Deductible

The deductible is a predetermined amount of eligible expense, designated by the subscriber's contract that the member must pay each year from their own pocket before the plan will make payment for eligible benefits.

Coinsurance

Coinsurance is the portion of covered healthcare costs for which a member is financially responsible, usually according to a fixed percentage of the allowed amounts for services rendered. Coinsurance often applies after first meeting a deductible requirement.

Copay, coinsurance, and deductible amounts vary by plan. Check the member's ID card or call HMO Customer Service at 844-722-4661 (844-PBC-HMO1) for the specific copay amount.

Non-covered services

Members are responsible for the payment of services not covered by their contracts. Non-covered services (services that are not medically necessary or a covered benefit) can vary based on the member's plan. To verify if a service is covered, use the online eligibility and benefits tool, or contact HMO Customer Service at 844-722-4661 (844-PBC-HMO1).

If a member decides to proceed with a non-covered service, before or following a determination by Premera Blue Cross HMO, the member should sign a consent form agreeing to financial responsibility before the service is provided. The consent form should clearly state the proposed service that will be rendered and the cost of the service. If the consent form is not obtained, services deemed not medically necessary would be the provider's financial responsibility.

Language translation line

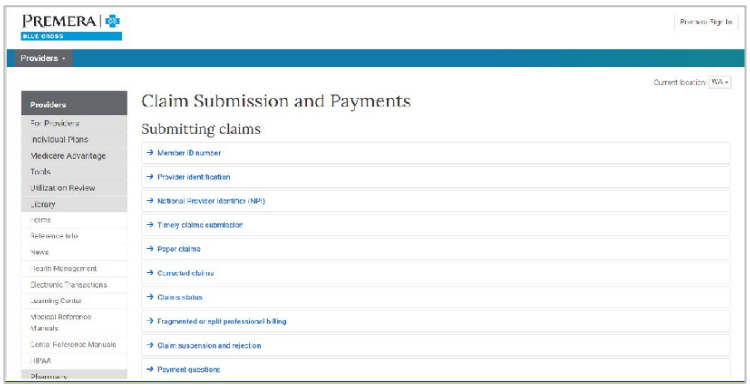
We offer a language translation line for 140 languages. For more information, please call HMO Customer Service at 844-722-4661 (844-PBC-HMO1), or the number listed on the back of the member's ID card.

Claims submission and payments

To submit a claim, visit **claim submission and payments.**

Billing and claims

Reimbursement processing will work the same way as Premera Blue Cross PPO network with claims paid on a fee-for-service basis with exceptions for any providers with alternative payment methodologies (such as Primary Care Capitation). Providers may be accountable through risk-bearing arrangements for the total cost of care of the member once membership thresholds and requirements are met. Telehealth member cost shares will be the same as an in-person visit. Gap-fill providers: Reimbursements will work the same as the Premera Blue Cross PPO network with claims paid on a fee-for-service basis. Telehealth member cost shares will be the same as an in-person visit.



Pharmacy benefit claims will be the responsibility of the dispensing pharmacy.

Member ID number

When submitting claims, transfer the member's identification (ID) number exactly as printed on the ID card. Remember to include the leading three-character prefix and enter it in the appropriate field on the claim form.

Provider identification

When completing the CMS-1500 form, note the following:

- Box 25– Enter the applicable tax ID number.
- Box 31– Enter the physician or provider's name that performed the service.
- Box 33– Enter the "contract name" of physician or provider who performed the service.

National Provider Identifier (NPI)

HIPAA's Administration Simplification provision requires a standard unique identifier for each covered healthcare provider (those that transmit healthcare information in an electronic form in connection with HIPAA-standard claim transactions). The NPI replaces all proprietary (payer-issued) provider identifiers—it doesn't replace your tax ID number (TIN) or Drug Enforcement Administration (DEA) number. TINs are still a required element for claims. Electronic claims without a TIN are rejected as incomplete. If you need more information about the NPI mandate, Medicare timelines, and/or the enumeration process, visit the CMS website.

Timely claims submission

Claims can be submitted daily, weekly, or monthly. The earlier claims are submitted, the earlier the claim will be processed. Ideally, please submit the claims within 60 calendar days of the covered services, but no later than 365 calendar days from the date of submission. For most plans, claims will be denied if received more than 12 months after the date of service with no member responsibility. Refer to the contract for further claims submission information.

Paper claims

If a claim cannot be submitted electronically, then a paper claim can be submitted on CMS-1500 or UB-04 forms. To speed claims processing, Premera Blue Cross HMO uses document imaging and optical character recognition (OCR) equipment to read the claim. Keep the following in mind to ensure the OCR reads your paper claims correctly:

- Use only red CMS-1500 forms (no photocopied forms).
- Type forms in black ink (handwritten forms cannot be read by OCR equipment).
- Don't fold, staple, or tape the claim.
- Be sure information lines up correctly within the respective fields (data that overlaps another field/box cannot be read accurately).
- Don't write or stamp extra information on the form.
- Avoid white correction fluid.
- Avoid highlighting information.

Corrected claims

Submitting a corrected claim may be necessary when the original claim was submitted with incomplete information (such as procedure code, date of service, diagnosis code). The preferred process for submitting corrected claims is to use the 837 transaction (for both professional and facility claims) using claim frequency code 7.

Submitting a corrected claim on paper

Remember to do the following when submitting a corrected claim on paper:

- Submit as a replacement claim, clearly marking the claim as a corrected claim; failure to indicate that a claim is a corrected claim may result in a denial as a duplicate claim.
- Bill all original lines—not including all the original lines will cause the claim to be rejected.
- Attach a completed "Corrected Claim - Standard Cover Sheet."
- In box 22 on the CMS-1500 Claim form, enter the appropriate bill frequency code, left justified in the left-hand side of the field. Use the following codes:
  - 7– Replacement of prior claim
  - 8– Void/cancel of prior claim
- In the "Original. Ref. Co" segment of box 22 enter the original claim number.
  - Obtain Corrected Claim - Standard Cover Sheets at onehealthport.com in the administration simplification claims processing section, or under Forms on the provider website.
  - Submitting a corrected claim via an 837 Transaction.

Remember the following when submitting a corrected claim electronically:

- Use the HIPAA 837 standard claims transaction including the following information:
  - Frequency code of "7" in look 2300, CLM05-3 segment to indicate a corrected/replacement of a previously processed claim. Use "8" to void a claim billed in error.
  - The initial claim number (in loop 2300, REF01 must contain "F8" and REF02 must contain the claim number)
  - A free form notes with an explanation for the corrected/replacement claim, in loop 2300 claim note as:
    - For professional and dental claims: Segment NTE01 must contain "ADD" and segment NET02 must contain the note, for example: NTE*ADD*CORRECTED PROCEDURE CODE (or whatever data element was corrected/changed on the claim)
    - For facility/institutional claims: Segment NTE01 must contain "UPI" and segment NTE02 must contain the note, for example: NTE*UPI*CORRECTED LAB CHARGES (or whatever data element was corrected/changed on the claim)

For additional instructions on electronic corrected, replacement or voided claims, visit the online section **electronic transactions and claim payer ID**, for additional information.

Claims status

The status of a claim can be obtained through the following:

1. **Online:** The best method to check the status of a claim is to visit the Premera website through Availity. Information is available 24 hours per day, seven days per week.
2. **HMO Customer Service:** Contact HMO Customer Service at **844-PBC-HMO1** or 844-722- 4661 or by calling the phone number on the back of a member's ID card.
3. **Interactive voice response (IVR):** Available 24 hours per day, seven days per week. IVR provides claims information.

Fragmented or split professional billing

A fragmented or split professional billing is defined as professional services rendered by the same provider for the same date of service and submitted on multiple professional claim forms. All services rendered by the same provider for the same patient for the same date of service must be submitted on one claim form. Claim edits in place will identify those services previously billed and bundle all services into a single claim and apply additional edits if applicable.

When a Medicare patient received services that Medicare specifically requires to be submitted on separate claim forms, the one claim requirement will not apply.

Claims suspension and rejection

Be sure to submit a paper CMS-1500 claim form or electronic 837P claim form that is complete and accurately filled out. Here are common reasons why claims might be suspended or rejected:

- **Information doesn't match:** Physician/provider information doesn't exactly match what is in the payment system.
- **Rebilling:** Records are missing when rebilling with a different diagnosis or other change. The claim rejects if records are not attached that support the change.
- **Anesthesia:** The hours/minutes for anesthesia claims are not included. Anesthesia time is billed in units to represent minutes and additional base units for the code.
- **Home IV drugs:** NDC number and quantity is missing.
- **Advanced registered nurse practitioner:** Supervising physician's name is missing for non-credentialed and/or not contracted ARNP.
- **Physician's assistant:** Supervising physician's name is missing for PA (**Note:** A PA does not need to bill with a supervising physician if they are a surgical assistant and has completed the paperwork to be set up independently in our payment systems).
- **Codes:** The person submitting the claim used invalid CPT/HCPCS, modifiers, or diagnosis codes.
- **Date of current illness:** The onset date was missing from box 14 in the CMS-1500 claim form.
- **Incorrect member number:** Provider billed with an incorrect member number (social security number, incomplete member number, transposed digits in member number).

Payment questions

Contact HMO Customer Service with questions regarding claims processing or send a copy of the voucher highlighting the claim in question and the inquiry reason. If the original claim was processed incorrectly, there is no need to rebill. The claim will be reprocessed and reflected on the payment voucher. HMO Customer Service can be reached at 844-PBC-HMO1 or 844-722-4661, or by calling the phone number on the back of the member's ID card. Before discussing member claim information, the customer service representative must verify the identity of the caller.

CMS 1500 form completion

For clinics, hospital-based physicians, or other qualified healthcare providers, use a CMS-1500 (02-12) form for claims for professional services and supplies related to the following:

- Anesthesia
- Office visits
- Day surgery/professional
- Emergency physician services
- Mental health
- Obstetrics
- Occupational therapy
- Pathology/interpretation
- Physical therapy
- Radiology/interpretation
- Speech therapy

This includes claims for outpatient services and services performed by a hospital-based physician or other qualified healthcare provider.

Patient account numbers assigned by your office

Offices can assign their own account numbers to patients. To make tracking patient reimbursement easier, Premera Blue Cross HMO can include these account numbers on the payment vouchers. The account number can be included in box 26 (Patient's Account Number) of the CMS-1500 form whether it is submitted electronically or on paper. Note that processing systems may have a limitation regarding the number of characters recognized.

Guidelines

The National Uniform Claim Committee (NUCC) has developed a 1500 Reference Instruction Manual detailing how to complete the claim form to help nationally standardize how the form is completed. Please refer to your electronic billing manual for specific formatting for electronic claims.

Electronic claims submission

Our electronic claims process electronically separates and routes only valid claims for processing. Invalid claims are reported back to the provider with rejection details. There is no charge to healthcare providers who submit electronic claims directly to us. If a claim is submitted electronically, an electronic remittance will be received for the following:

- Premera Blue Cross HMO

Advantages to submitting claims electronically:

- Faster claims payment turnaround
- Less time spent on claims preparation
- Validation to ensure that they are HIPAA compliant
- Detailed claim acceptance and rejection reporting

Remittance is available online please notify Premera Blue Cross HMO how claims will be submitted. Each office can post this remittance manually or electronically (if the software has electronic posting capability).

Getting started

To assist in moving from paper to electronic claims, follow these steps:

1. For offices interested in purchasing a new computer system, ask Premera Blue Cross HMO for a list of vendors that submit claims in the HIPAA standard ANSI 837 format.
2. For offices that already have a computer system, notify the software vendor of the interest in converting to electronic claims. Special software is needed to send insurance claims electronically.
3. Call EDI at 800-435-2715 for information. They will send the following documents:
   - EDI Enrollment Information
   - Secure Transport (ST) User Guide
   - Testing process information
4. The software vendor can help set up the computer to accommodate Premera Blue Cross HMO billing requirements.
5. Plan to submit test claims. Continue to submit paper claims until the office is told to stop. Premera Blue Cross HMO reviews test claims for accuracy but doesn't process them for payment.
6. An EDI representative will review the test claims with the provider or their vendor. A notification will be sent in writing or by telephone when the test phase is successfully completed. When this notification has occurred, change the indicator on the claims from (T)est to (P)roduction and begin submitting live electronic claims. At that time, please discontinue submitting paper claims.

Submitting secondary claims electronically

Electronic claims can be sent when Premera Blue Cross HMO is the secondary insurance payer. If a bill is sent for a claim using the ANSI 837 electronic format, then the Coordination of Benefits (COB) information must be included from the primary coverage payer in the claim. COB information is allowed when the primary coverage is with a commercial payer; this excludes Medicare and FEP. If the provider's office is unsure how to submit secondary claims electronically, contact the practice management system vendor or contact an EDI representative at 800-435-2715.

Coordination of Benefits

Coordination of Benefits (COB) is a provision included in both member and physician and provider contracts. When two or more health plans cover a member, COB protects against double or over- payment. When Premera Blue Cross HMO processes a claim, Premera Blue Cross HMO coordinates the benefits if the member has other primary coverage from another carrier, our health plan, service plan, or government third-party payer. Premera Blue Cross HMO coordinates the benefits of the members plan with those of other plans to make certain that the total payments from all plans aren't more than the total allowable expenses. Premera Blue Cross HMO abides by the following COB standards to determine which insurance plan pays first (primary carrier) and which pays second (secondary carrier). Briefly, these rules are as follows:

1. A member is primary on the plan in which they are the subscriber versus the plan in which they are a dependent. When a member is the subscriber on more than one plan, when both plans have a COB provision, the plan with the earliest start date pays first (primary).
2. When a dependent is double covered under married parents' health plans, the primary plan is the coverage of the parent with the birthday earlier in the year, regardless of their actual age. This standard is called the ""Birthday Rule."
3. When dependent children are double covered by divorced parents, coverage depends on any court decrees. If the court decrees financial responsibility for the child's healthcare to one parent, that parent's health plan always pays first. If there are no court decrees, the plan of the parent with custody is primary.

Some group contracts are not subject to state regulations may have unique COB rules that could change the order of liability.

Billing information

Primary submission: Show all insurance information on the claim, and then submit the claim to the primary plan first.

Secondary submission: When submitting secondary claims, submit the primary processing information with the submission of the secondary claim.

How payments are made

When applicable, payment will be suspended until Premera Blue Cross HMO determines which carrier is primary and which is secondary. A questionnaire may be sent to the member regarding possible duplicate coverage. Members need to promptly complete and return this questionnaire to process claims in a timely manner. When Premera Blue Cross HMO is the primary carrier, benefits will be calculated and paid routinely.

It is important to file a claim with all insurance companies to which the member subscribes. To ensure prompt and accurate payment when Premera Blue Cross HMO is the secondary carrier, please send the secondary claims with the primary processing information as soon as it is received.

If the EOB is not received and Premera Blue Cross HMO is unable to obtain the primary payment information by phone, the claim will be denied with a request for a copy of the primary EOB before processing can be completed. If there are questions about COB, contact customer service by calling the phone number on the back of the member's ID card.

Third-party liability and subrogation

Subrogation permits the plan to recover payments when the negligence or wrongdoing of another causes a member personal illness or injury. A subrogation provision is included in both member and physician/provider contracts. In third-party cases, this provision permits the plan to recover the medical bill costs on behalf of the member.

Injury accident claims

The member's benefit program contains special provisions for benefits when an injury or condition is:

- Caused by another party (such as slip and fall, medical malpractice, or similar)
- Covered under the provisions of motor vehicle medical policy, personal injury protection (PIP), medical payments (Medpay)
- Uninsured (UIM) and/or underinsured (UM) motorist or other similar coverage (such as homeowners, commercial medical premises)
- Covered by Workers' Compensation

An onset date should be recorded on all accident-related claims. The claim(s) will suspend, and a processor will review to determine whether to send an Incident Questionnaire (IQ) to the member. The IQ is available in the Provider Library under Forms. The provider can print and assist the member in completing the form, but it's important to review the instructions included with the form because the patient must complete the form and then sign it. If the member does not return the IQ within the specified timeframe, all related claim(s) will be denied. Once the IQ is returned, all claims are reviewed and processed based on the information supplied. The member or provider can submit the completed IQ using one of the following methods:

- Fax it to 425-918-5878
- Mail it to: Subrogation Department
  MS 227
  PO Box 327
  Seattle, WA 98111-327

The member may contact customer service (the number is on the back of the ID card) to update IQ information over the phone. If all pertinent information is obtained, the claim(s) will then be processed according to the member's contract benefits. If we need additional information for subrogation determine to pay or deny, the IQ will either be sent back to the member requesting the information, or subrogation will make two calls within five days of receiving the IQ. If the member does not return the call, claims will be denied until information is received. If the member returns the call and the information is obtained, claims will be processed.

The member will be sent an IQ if the claim(s) is potentially accident related. When the member completes and returns the IQ form to Calypso Subrogation department, a representative will screen the document to determine if another party is responsible for processing claims prior to the health carrier stepping in. This review is necessary to determine whether the claim(s) should be covered by a first-party carrier (like PIP, Med Pay or similar coverage—homeowners or a commercial medical premise policy).

Benefits are not available through Premera Blue Cross HMO until the first-party carrier has exhausted, denied, or stopped paying due to its policy limits. Once a payment ledger is received from the first-party carrier(s) showing where they paid out their limits (with dates of services, provider names, total charges, total paid, and other relevant fields), claims will be processed accordingly and under the terms of our subscriber's contract. If the IQ states that there is no first-party coverage(s) available, but there is a third-party that is responsible for the incident, all related claims will be processed based on the member's contract with Premera Blue Cross HMO until all parties are ready to negotiate a settlement for reimbursement.

Workers' Compensation

Workers' Compensation will pay when the member's employer is liable to pay medical bills resulting from illness or injury arising out of, or in, the scope of employment. All our contracts exclude coverage for care covered under the Workers' Compensation Act.

Claims submitted that indicate Workers' Compensation illness or injuries are investigated. We send the member a questionnaire requesting information to determine if benefits are available. If a response is not received within the specified period, the claim(s) is denied pending further information. If the information received indicates an on-the-job illness or injury, both the member and physician/provider will receive a denial that states the Premera Blue Cross HMO contract excludes work-related conditions. If Workers' Compensation denies payment of such claims, Premera Blue Cross HMO will pay according to the subscriber's contract benefits after receiving a copy of a valid denial.

Reimbursement

The resource-based relative value scale (RBRVS) that was developed by the CMS is used for contracts to calculate its fee-for-service fee schedule. RBRVS is a method of reimbursement that determines allowable fee amounts based on established unit values as set norms for various medical and surgical procedures, and further based on weights assigned to each procedure code. These weights are then multiplied by the dollar conversion factor Premera Blue Cross HMO publishes. The conversion factor represents the dollar value of each relative value unit (RVU). When the conversion factor is multiplied by the total RVUs, it will yield the reimbursement rate for the specific service (or code).

There are three separate components that affect the value of each medical service or procedure:

- **Physician work:** The work value reflects the cost of the physician's time and skill for each service.
- **Practice expense:** The physician's direct (non-physician labor, medical equipment, medical supplies) and indirect (general office supplies, rent, utilities, office overhead) costs related to each service.
- **Malpractice insurance:** The cost of malpractice insurance.

RVUs are assigned to each of these components. CMS also uses RVUs to allocate dollar values to each CPT or HCPCS code. For more information about RBRVS methodology, visit the CMS website.

For services not listed in the RBRVS published annually in the Federal Register, we use Optum's Essential RBRVS (previously known as Ingenix Essential RBRVS and St. Anthony's Complete RBRVS).

Claims adjudication system

We use an automated processing system to adjudicate claims. When processing claims, the system:

- Checks for eligibility of the member listed on the claim.
- Checks for completeness of the claim.
- Confirms the accuracy of the information.
- Compares the services provided on the claim to the benefits in the subscriber’s contract.
- Applies industry standard claim edits and applicable payment policy criteria.
- Concludes the payment amount.

Actual payment is subject to our fee schedule and payment policies; to a member’s eligibility, coverage, and benefit limits at the time of service; and to claims adjudication edits common to the industry.

Claims editors’ payment policies

The claims editor is regularly updated (at least quarterly) to keep pace with changes in medical technology, as well as CPT codes, HCPCS codes, and ICD-10-CM/PCS Diagnosis and Procedure code changes, standards, and complexities. These claim editors evaluate billing information and coding accuracy on submitted claims and assists in achieving consistent, accurate, and timely processing of physician and provider payments.

Payment policies

The Payment Integrity Oversight Committee reviews proposals for new payment policies and updates existing policies. Physicians and providers may submit a proposal to modify a payment policy. To do so, please submit the proposal in writing to the assigned Provider Network Executive (PNE) or Provider Network Associate (PNA).

Details on payment policies

Premera Blue Cross HMO follows industry standard coding recommendations and guidelines from sources such as the CMS, CPT, and AMA, and other professional organizations and medical societies and colleges. National Correct Coding Initiative (NCCI) editing is followed when applicable. Any exceptions are documented as payment policies. It is only after a member's eligibility or coverage is determined that payment policies and edits are applied. Payment policy:

- Applies to professional and facility claims
- Does not determine the reimbursement dollar amount for any service (reimbursement is specific to the provider applicable fee schedule)
- Is distinct from our medical policy, which sets forth whether a procedure is medically necessary/appropriate, investigational, or experimental and whether treatment is appropriate for the condition treated

The payment policy can be found on premera.com in the library, under **Reference information**. Always refer to the online branded versions of our payment policies for the most current and accurate information.

Overpayments

Calypso, our affiliate, processes refunds and overpayment requests. When Calypso identifies an overpayment, they mail an overpayment notification letter with a request for the overpaid amount.

Sometimes an office returns a check to Premera Blue Cross HMO that represents multiple claims because a *portion* (see Threshold below) of the payment may be incorrect. In these cases, please don't return the check to us. Instead, deposit the check, circle the claim in question on the Explanation of Payment (EOP) and include a brief explanation as to why there was an overpayment. After these steps are completed, choose one of the following options to resolve the overpayment:

- Mail the overpayment amount to the Premera Blue Cross HMO finance department (address on check) along with a completed Refund Request form, or
- Mail a completed Overpayment Notification form (found in our online library under Forms) and mark the box requesting a voucher deduction to recover the overpayment on future claim payments.

Calypso will apply the refund to the claim as soon as they receive the refund. If a written refund request is required before mailing the overpayment, contact Calypso directly at 800-364-2991. Premera Blue Cross HMO does not request refunds for overpayments less than $50, but the provider's office may submit these voluntarily. BlueCard will request refunds regardless of the dollar amount. Refund total overpayment amounts within 60 days of initial notice to avoid having outstanding refund amounts offset against future payments.

Prompt pay standards

Washington contracted providers: Claims are processed as soon they are received. Premera Blue Cross HMO also applies the following prompt pay standards set by Washington's Office of the Insurance Commission to claims adjudication process to:

- Pay or deny 95% of a provider's monthly clean claims within 30 days of receipt; and
- Pay or deny 95% of a provider's monthly volume of all claims within 60 days of receipt

If the above standards are met, the regulation does not require interest for those individual claims paid outside of the 95% threshold.

Clean claim definition

A clean claim is one that has no defect or impropriety, including any lack of any required substantiating documentation, or circumstances requiring special treatment that prevents timely payments from being made on the claim. This includes any missing required substantiating documentation or circumstances requiring special treatment.

Clean claim exclusions

Claims may also be delayed during processing if:

- They are suspended due to the group or individual's non-payment of premium or dues.
- They have Coordination of Benefits when we are the secondary carrier on the claim.
- They require completion and mailing of an Incident Questionnaire for accident investigation or a Workers' Compensation injury (claims in subrogation).

Applying interest

Washington contracted providers: If Premera Blue Cross HMO fails to satisfy either of the above standards, interest will be paid on each claim that took longer than 60 days to process at a 12% annual rate (unclean days are not applied toward the 60-day calculation).

Interest vouchers

Prompt pay interest is currently calculated monthly for the previous month's paid claims. Payments are issued under a separate voucher and mailed to the address on the original claim. Included with the interest voucher is a summary report detailing the claims for which interest payments have been applied during that period.

Interest threshold

There is a minimum threshold of $25 for monthly interest payments on delayed clean claims. An interest check is issued only for months in which the accumulated interest is equal to or greater than the minimum threshold of $25. Interest less than $25 will continue to accrue until it reaches that threshold or until December of each year. To help the provider's office complete year-end accounting, each December Premera Blue Cross HMO will issue a check for the accrued interest we owe you, even if the amount is below the threshold.

Claims from non-credentialed contracted providers

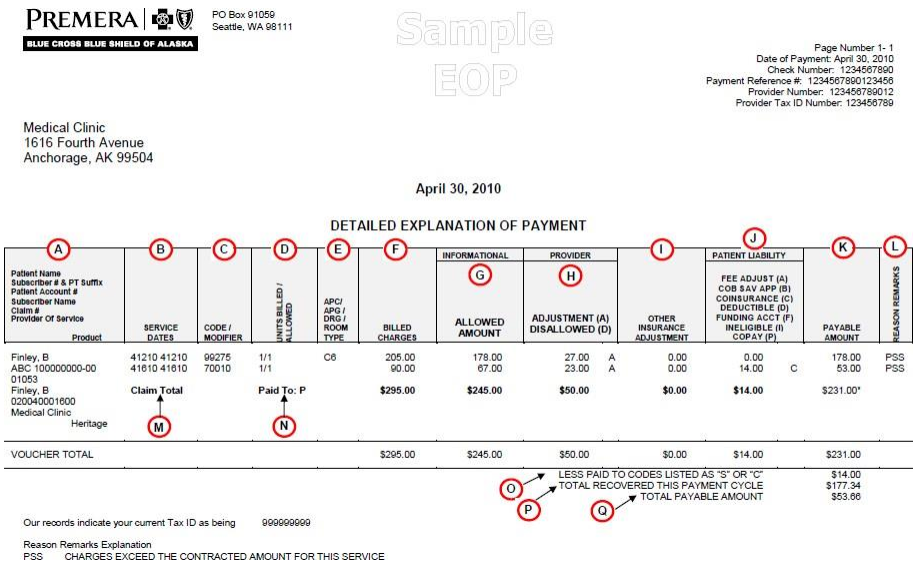
If your organization is contracted with Premera Blue Cross HMO, most practitioners must be credentialed, except for hospital-based practitioners. Learn more about which practitioners need to be credentialed by viewing our credentialing matrix, located in our credentialing manual, available by request from Credentialing.Updates@premera.com.

Practitioners who aren't credentialed may have their claims returned until they submit a complete credentialing application. Lack of credentialing can be grounds for termination from the Premera Blue Cross HMO network.

You can learn more about credentialing by visiting the provider section of our website.

Explanation of Payment

Physicians and other healthcare providers receive an Explanation of Payment (EOP), which describes the determination of the payment for services. See the pages below for an explanation and sample of the EOP fields and a description of codes and messages.



PREMERA BLUE CROSS BLUE SHIELD OF ALASKA
PO Box 91059
Seattle, WA 98111

Sample EOP

Page Number 1- 1
Date of Payment: April 30, 2010
Check Number: 1234567890
Payment Reference #: 123456789012345 6
Provider Number: 123456789012
Provider Tax ID Number: 123456789

Medical Clinic
1616 Fourth Avenue
Anchorage, AK 99504

April 30, 2010

DETAILED EXPLANATION OF PAYMENT

A	B	C	D	E	F	INFORMATIONAL G	PROVIDER H		I	J PATIENT LIABILITY	K	L
Patient Name Subscriber # & PT Suffix Patient Account # Subscriber Name Claim # Provider Or Service Product	SERVICE DATES	CODE / MODIFIER	UNITS BILLED / ALLOWED	APC / APG / DRG / ROOM TYPE	BILLED CHARGES	ALLOWED AMOUNT	ADJUSTMENT (A) DISALLOWED (D)		OTHER INSURANCE ADJUSTMENT	FEE ADJUST (A) COB $AV APP (B) COINSURANCE (C) DEDUCTIBLE (D) FUNDING ACCT (F) INELIGIBLE (I) COPAY (P)	PAYABLE AMOUNT	REASON REMARKS
Finley, B	41210 41210	99275	1/1	C6	205.00	178.00	27.00	A	0.00	0.00	178.00	PSS
ABC 100000000-00 01053	41610 41610	70010	1/1		90.00	67.00	23.00	A	0.00	14.00 C	53.00	PSS
Finley, B	Claim Total		Paid To: P		$295.00	$245.00	$50.00		$0.00	$14.00	$231.00*	
020040001600 Medical Clinic Heritage	M		N									
VOUCHER TOTAL					$295.00	$245.00	$50.00		$0.00	$14.00	$231.00	

O LESS PAID TO CODES LISTED AS "S" OR "C" $14.00
P TOTAL RECOVERED THIS PAYMENT CYCLE $177.34
Q TOTAL PAYABLE AMOUNT $53.66

Our records indicate your current Tax ID as being 999999999

Reason Remarks Explanation
PSS CHARGES EXCEED THE CONTRACTED AMOUNT FOR THIS SERVICE

EOP Form descriptions

	Field name	Description
A	Patient name	Patient/member name
	Subscriber number and patient suffix	Subscriber's number and patient suffix number (including plan prefix) assigned by plan as shown on the member's identification card
	Patient account number	Number assigned by the clinic for patient. If no account number is assigned, the words “no patient account #” are noted.
	Subscriber name	Name of the subscriber
	Claim number	Number assigned to the claim when received by plan
	Provider of service	Provider who rendered the service. Professional example: General clinic is the provider of service.
B	Service dates	The dates of service (to and from—also referred to as beginning and ending dates) at a line-item level
C	Code/Modifier	The code/modifier shown in box 24D of the CMS-1500
D	Units billed/Allowed and paid to	Units shown in box 24G of the CMS-1500 form. “Paid to” refers to the payee code (where the check was sent/issued) and is listed only in the claim total or subtotal line (for example, G = provider group).
E	APG/DRG/Room type	Applicable to facility claims only - reflects the APG code, DRG code, or room type that may relate to the reimbursement amounts. Field not populated for CMS-1500 claims.
F	Billed charges	Charges billed by physician/provider at a line-item level
G	Allowed amount	Amount allowed for service at a line-item level
H	Provider adjustment	“Provider write-off” amount
I	Other insurance	Amount paid by other carrier(s)
J	Patient liability	Total patient liability: Amount owed by patient. Patient liability is deductible and copay/coinsurance and ineligible amounts rolled up.
		• FEE ADJUST (A) = Member responsibility per subscriber contract • COB SAV APP (B) = Amount applied from member's COB saving account • COINSURANCE (C) = A predetermined amount designated by the subscriber's plan. Applies after the patient meets their deductible • DEDUCTIBLE (D) = A predetermined amount designated by the subscriber's plan, must be satisfied by member before benefits apply • INELIGIBLE (I) = Services that the member does not have a benefit predetermined by the plan • COPAY (P) = Amount member is responsible to pay at time of service (for example, $20 office visit copay)

	Field name	Description
K	Payable amount	Amount payable by plan
L	Reason remark	Adjudication explanation code(s) at a line-item level and claim level (if applicable)
M	Claim total	Printed at the end of each claim, the line items are summed, and an asterisk indicates the claim total line
N	Paid to	Indicates the claim payment recipient
O	Fewer “paid to” codes listed as “S” or “C”	The sum of the claim total “payable amounts,” which have a “PD TO” code of S or C
P	Total recovered this payment cycle	The sum of any amount withheld and applied to a prior refund or recovery
Q	Total payable amount	Indicates the amount of the check

EOP codes and messages

The most commonly occurring codes and messages are listed below. A comprehensive list is posted in the Library under Reference info.

EOP code	Printed message
202	A required waiting period must pass before we can provide benefits for this service.
318	We forwarded this claim to the member's home plan for processing.
401	Our medical staff reviewed this claim and determined that this admission doesn't meet the criteria for medical necessity.
402	Our medical staff reviewed this claim and determined that this continued stay doesn't meet the criteria for medical necessity.
403	Our medical staff reviewed this claim and determined that this service isn't covered by the plan.
406	Payment of this claim depended on our review of information from the provider. We haven't received the information.
453	We can't process this claim until the incident questionnaire we sent the member is fully completed, signed, and returned.
466	This is a claim adjustment of a previously processed claim.
473	Need information from the member's other insurance carrier to process claim. Send us other carrier's explanation of benefits.
474	The provider needs to submit itemized charges to us.
480	We can't process this claim until the questionnaire we recently sent the member is completed and returned to us.
487	To pay this claim, we needed to review information from the provider. We haven't received the information.

EOP code	Printed message
497	This is a duplicate of a previously denied claim.
498	This claim was paid previously to the provider or applied to the member's deductible.
500	This member wasn't eligible for services on the date of service.
550	This member wasn't eligible for services on the date of service.
551	The maximum limit has been met for this benefit.
575	This procedure is considered cosmetic. The plan doesn't cover cosmetic services.
578	The plan doesn't cover this service.
581	This service is considered a standard exclusion.
741	The charges for this service have been combined into the primary procedure based on the provider's contract.
763	These charges are included in the main anesthesia service.
800	We can't process this claim because we haven't received the necessary information we requested from your provider.
801	We can't process this claim because we haven't received your response to our request for information.
840	This claim is a duplicate of a previously submitted claim for this member.
844	Provider: send us the member's medical records for this claim. We can process the claim after we receive that information.
845	Provider: please send us your office notes for this claim. We can process the claim after we receive that information.
846	Provider: please send us your operative notes for this claim. We can process the claim after we receive that information.
847	Provider: please send us the member's lab results for this claim. We can process the claim after we receive that information.
848	Provider: please send us the radiology reports for this claim. We can process the claim after we receive that information.
876	Provider: send us the NDC #, quantity, and date span for this claim. We can process the claim after we receive that information.
877	Provider: send us medical records relating to prescription drug charges. We'll process the claim after we receive that information.

Statement of Overpayment Recoveries

A Statement of Overpayment Recoveries (SORA) is included with an Explanation of Payment (EOP) when we've processed an overpayment recovery activity within a payment cycle. The SORA is generated when one of the following occurs during a payment cycle:

- An amount is deducted from your check.
- An overpayment was recorded during the payment cycle.
- There is a balance due to us at the end of the payment cycle.
- Money was posted to your account during the payment cycle.
- When there is any other activity on the account during the payment cycle (in other words: voluntary money sent from the provider).

Provider appeals

Physicians and providers have the right to appeal certain actions of ours. Our provider complaints and appeals process ensure we address a complaint or an appeal in a fair and timely manner. Our process meets or exceeds the requirements set by the Office of the Insurance Commissioner.

The provider appeals process does not apply to FEP, BlueCard Home Claims, Medicare Supplement plans, or Medicare Advantage plans.

Complaints

A provider's office can submit a complaint about one of our actions (verbally or in writing) to one of our employees. The office has 365 calendar days to submit a complaint following the action that prompted the complaint. Complaints received beyond the 365-day timeframe will not be reviewed and the appeals rights pertaining to the issue will be exhausted.

If Premera Blue Cross HMO receives the complaint before the 365-day deadline, we review and issue a decision within 30 calendar days via letter or revised Explanation of Payment.

You can make a complaint verbally to customer service or in writing to Customer Service Correspondence. You can reach HMO Customer Service by calling 844-PBC-HMO1 or 844-722- 4661. The plan mailing addresses are available on our website under **Contact us**.

Level 1 appeal

A level 1 appeal is used to dispute one of our actions.

The level 1 appeal must be submitted within 365 days following the action that prompted the dispute. Only appeals received within this period will be accepted for review. Appeals rights will be exhausted if not received within the required timeframe.

Modifications we make to your contract or to our policy or procedures are not subject to the appeal process unless we made it in violation of your contract or the law.

A level 1 appeal is used for both billing and non-billing issues. A billing issue is classified as a provider appeal because the issue directly impacts your write-off or payment amount. A non- billing issue is classified as a member appeal because the financial liability is that of the member, not the provider (please refer to chapter six). Here are examples:

Billing examples	Non-billing examples
Multiple modifier reimbursement	Service not a benefit of subscriber's contract
Bundling or inclusive procedures	Investigational or experimental procedure

A level 1 appeal must be submitted with complete supporting documentation that includes all the following:
1. A detailed description of the disputed issue
2. Your position on the disputed issue
3. All evidence offered by you in support of your position including medical records
4. A description of the resolution you are requesting

Incomplete appeal submissions are returned to the sender with a letter requesting information for review. The time does not start until we receive a complete appeal. Once the submission is complete and if the issue is billing related, we review the request and issue a decision within 30 days, along with your right to submit a level 2 appeal if you are not satisfied with the outcome.

Only a member can request a level 1 or level 2 appeal for a non-billing issue unless the member has completed a release to allow the provider to function as their representative.

Level 2 appeal

Level 2 appeals must be submitted in writing within 30 calendar days of the level 1 appeal decision and can only pertain to a billing issue. If the level 2 appeal is timely and complete, the appeal will be reviewed. We notify you in writing if the Level II appeal is not timely and your appeal rights will be exhausted. Once we accept your level 2 appeal, we will respond within 15 days in writing or a revised Explanation of Payment.

Mediation

Please request mediation in writing within 30 days after receiving the level 2 appeals decision on a billing dispute. We notify you in writing if the request for mediation is not timely. If the request for mediation is timely, both parties must agree upon a mediator. The mediator consults with the parties, determines a process, and schedules the mediation. If we cannot resolve the matter through non-binding mediation, either one of us may institute an action in any superior court of competent jurisdiction. The mediator's fees are shared equally between the parties. All other related costs incurred by the parties shall be the responsibility of whoever incurred the cost.

Submitting an appeal

To submit a level 1, level 2, or mediation appeal (see above to submit a complaint), send complete documentation to:
Physician and Provider Appeals
PO Box 91102
Seattle, WA 98111-9202

Ancillary

The ancillary team has overall responsibility for provider and cross-regional contracts. **Ancillary**.
These responsibilities include:

- Contracting
- Fee schedule reviews
- Issue resolution
- Education

To contact our ancillary team, email **hmoplusprovidersupport@premera.com**.

Provider specialties

Ancillary provider specialties include:

Alternative care:

- Massage therapy
- Naturopathy
- Nutrition and diet
- Acupuncture
- Chiropractic care

Home-based services:

- Home health
- Home hospice
- Private duty nursing
- Home infusion
- Home medical equipment, including prosthetics and orthotics

Other specialties:

- Behavioral health
- Dental
- Physical therapy
- Occupational therapy
- Speech therapy
- Laboratories
- Mass immunizers
- Ambulance—air and ground
- Dialysis centers
- Skilled nursing facilities (SNF)
- Inpatient hospice

The following benefit quotes can't be obtained online. Please contact customer service at 877- 342-5258, option 2, or Customer Service for HMO at 844-PBC-HMO1 (844-722-4661) for:

- Home infusion services
- Ambulance (non-emergent)
- Dieticians/nutritionists
- Private duty nursing

Ancillary: Claims and billing

Claims submission

Our billing guidelines are described in the Claims and Payment section of the Provider Reference Manual. Please note the following additional information:

- Bill home health, hospice, dialysis, and SNF claims on a UB-04 claim form with appropriate revenue codes.
- Bill all other ancillary provider types with a CMS 1500 claim form.
- HCPC codes are required for suppliers of home medical equipment, prosthetics and orthotics, and home infusion. Include modifiers when applicable (such as NU for purchase, RR for rental).

Home health

Types of services

The types of services covered under the home health benefit can include skilled nursing, home health aide service, rehabilitative therapy, social services, respiratory therapy, and nutritional services. These agencies must be credentialed by us and bill services through the home health agency. Covered employees of a home health agency include:

- Registered nurse (RN)
- Licensed practical nurse (LPN)
- Certified nursing assistant (CNA)
- Physical therapist
- Occupational therapist
- Speech therapist
- Master's level social worker (MSW)
- Licensed respiratory therapist
- Registered dietician (RD)

When requesting coverage for visits, include the member's treatment plan and goals with the faxed request. Some services may require prior authorization.

Home infusion description requirements

For home infusion services, each member must have a written physician's plan of care, which includes the medication prescription and statement of medical necessity.

The medication prescription must include the:

- Drug
- Route
- Frequency
- Medication dosage

The statement of medical necessity renewal is required with each initial therapy request. Changes in therapy require renewal only if they are long-term drugs and/or therapies (such as IGG, prolastin).

Billing
Bill drugs using the appropriate HCPC code, including NDC number. Units of billed services must be equal to the dosage referenced in the HCPC code description.

Home medical equipment

Home medical equipment description
Home medical equipment is:
- Able to withstand repeated use
- Primarily and customarily used to serve medical purposes
- Not useful to a person in the absence of illness or injury
- Appropriate for use in the home

General coverage

Coverage of home medical equipment is subject to medical necessity. We do not cover equipment that:
- Cannot be expected to perform a therapeutic function in an individual case.
- Substantially exceeds the level required for the treatment of the illness or injury.

Rental and purchase

Please note the following guidelines:
- We may allow charges for renting home medical equipment when a member rents equipment for a brief period.
- If the rental exceeds the period allowed by the prescription, we require documentation of medical necessity.
- Reimbursement for rental items can't exceed the contracted purchase price.

Repairs and service

When necessary, we cover repair and servicing charges for patient-owned equipment due to normal use. Repair charges are not covered if they are greater than the cost of replacing the equipment. Refer to the replacement guidelines below.

All claims for home medical equipment repairs or servicing are subject to review by Premera Blue Cross HMO. If not covered by the manufacturer's warranty, Premera Blue Cross HMO covers the rental fee for necessary loaner equipment while member-owned equipment is being repaired or serviced.

Replacement

For replacement of home medical equipment, the referring physician must submit a new prescription, and the supplier must indicate the condition of the present equipment on the prescription. Claims for replacement are subject to our review.

Billing

Each supply provided should be itemized using appropriate HCPC codes and modifiers.

Prosthetics/Orthotics

The benefits for external prosthetic devices (including fitting expenses), except for intraocular lens, are provided when such devices are used to replace all or part of an absent body limb, or to replace all or part of the function of a permanently inoperative or malfunctioning body organ.

In general, foot orthotics (shoe inserts) and therapeutic shoes (orthopedic) are covered when prescribed for the condition of diabetes or for corrective purposes.

Ancillary hospice care

Description

Premera Blue Cross HMO contracts with providers who are licensed as outpatient hospice agencies. Outpatient hospice care is designed to be used by patients who meet all the following conditions:

- Have life threatening conditions
- Expected to live for no more than six months
- Desire and require palliative care

Requirements

Covered services for hospice care require that this care be:

- Part of a prescribed written plan
- Periodically reviewed
- Approved by a physician (MD or DO)

Because the patient's care may change, the plan should be reviewed every 60 days and revised as needed.

Respite care

Respite care is unique to hospice care. It is designed to relieve anyone who lives with and cares for a terminally ill person.

Total hours of covered service for respite care may vary. It is important to verify coverage for all available hospice services at the time you receive the referral.

Alternative care services

Chiropractic services

We contract directly with providers who are licensed to provide chiropractic services.

Coverage:

- Chiropractic manipulative treatment (CMT) services are covered when the care is medically necessary and the CMT is for a diagnosed neuromuscular condition that may be improved or resolved by standard chiropractic treatment.
- CMT services that are eligible for coverage are specifically limited to treatment by means of manual or instrument assisted manipulation. Services other than CMT (including diagnostic imaging) may be covered under the member's rehabilitation or other medical benefit and are subject to member eligibility, benefits, and copay or coinsurance requirements.
- Chiropractic wellness, preventive services, and maintenance therapy are not covered benefits. For more information about coverage and policy guidelines, the Premera Chiropractic Medical Policy and the Physical Medicine & Rehabilitation/Physical Therapy Medical Policy can be viewed online. The medical policy covers medical necessity and documentation requirements and lists procedures or techniques that we consider investigational. Chiropractic Position Papers that give additional information regarding medical necessity, documentation of care, use of Evaluation and Management CPT codes, delegation of duties, treatment plans for physical medicine and rehabilitation, and multiple copays are on our website.

Ancillary massage therapy

Premera Blue Cross HMO contracts directly with providers who are licensed to provide massage therapy services.

Coverage:

- Massage therapy is typically covered under the Physical Medicine and Rehabilitation benefit. Some self-funded groups may have a separate benefit for massage therapy services.
- Services may be considered medically necessary when performed to meet the functional needs of a patient who suffers from physical impairment, functional limitation, or disability due to disease, trauma, congenital anomalies, or prior therapeutic intervention. Maintenance programs are a member benefit exclusion and aren’t covered.
- Massage therapists are required to obtain and keep the member’s medical massage prescription on file. The prescription for medically necessary massage must come from a clinician who has prescribing authority. It needs to specify a diagnosis as well as the frequency and duration, or number, of medical massage visits.

New technologies or treatments

New technologies or treatments may not be covered. A pre-service review can be requested to confirm coverage and medical necessity. See the Integrated Health Management—Reviews section of our manual for more information.

Resource material

Additional training material, resources, and provider news are available on the Availity secure provider website.

- **Availity training:** Available through Help & Training | Get Trained located in the upper right-hand top of the page.
- **Resources:** Available on the Premera Blue Cross HMO Payer Space under the Resources tab.
  - Premera Learning Center
- **Premera** Provider news: Sign up for email notifications. Available on the Premera Blue Cross HMO Payer Space under the News and Announcements tab.

Premera Blue Cross HMO Resources for Providers—see the **Provider HMO website** for more information.

HMO contact information

Contact information for Premera Blue Cross HMO

HMO Customer Service number for providers: **844-PBC-HMO1** or 844-722-4661

HMO Customer Service email for providers: **hmoplusprovidersupport@premera.com**

Customer service number (non-HMO): **877-342-5258**, option 2

Care management: **888-742-1479**
Monday to Friday, 8:00 a.m. to 7:00 p.m. and Saturdays 9:00 a.m. to 1:00 p.m.

Carelon: **866-666-0776**

Pharmacy services number: **888-261-1756**