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Glossary
I.  INTRODUCTION

BlueCross BlueShield of Tennessee, Inc. is an independent licensee of the BlueCross BlueShield Association consisting of some 60 BlueCross and/or BlueShield Plans throughout the United States.

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

Understanding the increasing role that consumers play in choosing their health plans, BlueCross BlueShield of Tennessee launched its Blue of Tennessee Consumer Information Centers in 2014. One center is located in Nashville, and the second is a mobile center which travels throughout the state of Tennessee serving communities where there is a greater need for information about health insurance. Both centers are staffed with highly trained insurance advisors including bilingual advisors.

The centers are designed to make it easier for consumers, especially those who may be currently uninsured, to learn about health plan options, benefits and wellness. They provide face-to-face, in person support and education on many health and wellness topics, including health plan options and how to access health plan benefits.

Additionally, both centers offer support and guidance to existing BlueCross BlueShield of Tennessee Members on a number of topics, including:

- Finding network Providers
- Using BlueAccess, the secure area on the company website
- Replacement ID cards
- Address Changes
- Appeals/Grievance Issues
- Claims & Explanation of Benefits (EOBs)
- HRA/HAS Educations
- Premium Payments

For more information on BlueCross BlueShield of Tennessee and its Blue of Tennessee Consumer Information Centers, visit the company’s website, www.bcbst.com.
The following pages contain comprehensive information regarding operating policies and procedures established by BlueCross BlueShield of Tennessee and are incorporated by reference into the Participation Agreements.

This Manual is designed to provide information and guidelines for Facilities, Practitioners and other Providers who participate in one or more of the BlueCross BlueShield of Tennessee commercial Provider Networks listed below:

- Blue Network E<sup>SM</sup> - Essential
- Blue Network M<sup>SM</sup>
- Blue Network P<sup>SM</sup> - Preferred
- Blue Network S<sup>SM</sup> - Select
- CoverTN – (See Section XXV)

A. BlueCross BlueShield of Tennessee Statement of Purpose

- **BUSINESS**
  Our Business is financing affordable health care coverage.

- **PURPOSE**
  Our Purpose is *Peace of Mind*.

- **LONG-TERM CORPORATE GOALS**
  Our Long-Term Corporate Goals are:
  - Affordability
  - Sustainability
  - Outreach

**Code of Conduct**

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

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

We encourage suppliers and third parties with which we do business to adopt and follow a Code of Conduct particular to their own organization that reflects a commitment to prevent,
detect and correct any occurrences of unethical behavior. In addition, we embrace fraud prevention and awareness as essential tools in preserving affordable quality health care and actively work with our business partners and law enforcement agencies to combat health care fraud.

Included in our Code of Conduct are two sections entitled “Conflicts of Interest” and “Dealing with Customers, Suppliers, and Third Parties”. The primary focus of these sections is to help ensure business decisions are based on the merit of the business factors involved and not on the offering or acceptance of favors. Additionally, any activity that conflicts or is otherwise incompatible with our professional responsibilities should be avoided. You may review the Code of Conduct in its entirety online at: http://bluecare.bcbst.com/forms/VSHPCodeofConduct.pdf.

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

B. Descriptions of Networks

The following grid is intended to serve as a general guide in defining basic characteristics of BlueCross BlueShield of Tennessee networks. For more detailed, plan-specific information, please contact your BlueCross BlueShield of Tennessee Provider Relations Consultant.

<table>
<thead>
<tr>
<th>Network</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Network E&lt;sup&gt;ESM&lt;/sup&gt; Essential</td>
<td>To further support affordable coverage, we built a new high-value Provider network for the Health Insurance Marketplace. Blue Network E is only available in four service regions, which include Tennessee’s major cities: Chattanooga, Knoxville, Memphis, and Nashville.</td>
</tr>
<tr>
<td>Blue Network M&lt;sup&gt;ESM&lt;/sup&gt;</td>
<td>The Blue Network M Provider Network was created to be used with the clinical management services provided to self-funded employers by our partner, MissionPoint Health Partners (MPHP). MPHP is an Accountable Care Organization (ACO) affiliated with St. Thomas Health in Nashville. Blue Network M is only available to self-funded accounts in the Middle Tennessee market.</td>
</tr>
<tr>
<td>Blue Network P&lt;sup&gt;PSM&lt;/sup&gt; Preferred</td>
<td>The Blue Network P Provider Network offers a wide variety of credentialed Practitioners, hospitals and other health care Providers as well as all participating pharmacies. This Network is available for Plans purchased on (Multi-State Plans Only) and off the Health Insurance Marketplace.</td>
</tr>
<tr>
<td>Blue Network S&lt;sup&gt;SSM&lt;/sup&gt; Select</td>
<td>Like Blue Network P, the Blue Network S Provider Network is based on a variety of credentialed Practitioners, hospitals and other health care Providers as well as all participating pharmacies; It is available for Plans purchased on and off the Health Insurance Marketplace and focuses more on affordability. This is achieved, in most Tennessee markets, with a narrower Network of Providers than Blue Network P.</td>
</tr>
<tr>
<td>Nationwide</td>
<td>Benefits vary, to obtain benefit information, see Section III in this manual, How to Identify a BlueCross BlueShield of Tennessee Member.</td>
</tr>
</tbody>
</table>
C. Individual Product and Plan Options

BlueCross BlueShield of Tennessee offers a variety of health benefits plans to meet the needs of individuals who are not covered under an employer-sponsored health care plan.

The summary below is intended to assist you in identifying BlueCross BlueShield of Tennessee individual products and their supporting networks. Although Members' ID cards reflect network/copay information, Providers are encouraged to call the customer service telephone number on the Member ID card to verify benefits, deductible/copay amounts, and prior authorization requirements.

BCBST sample ID card – (benefits vary according to product and plan options)

![ID Card Image]

**Short Term Coverage – Group number 82125**

The Affordable Care Act has no impact on Short Term Coverage. Short Term Personal Health Coverage is available for periods of one, two or three months. This PPO product is supported by Blue Network P. There is no medical underwriting for this product; however, pre-existing conditions are not covered.

- 4 deductible options - $250, $500, $1,000, $2,500
- 80% coinsurance
- Pharmacy included in base benefit, subject to deductible and coinsurance
- No coverage for maternity
- No coverage for preventive services
- No coverage for pre-existing conditions
- No coverage for behavioral health

**Marketplace Plans – Group number 127600**

The first open enrollment period for Marketplace plans began on 10/1/13, and members enrolled in these plans beginning 1/1/14. In order to apply for, and receive financial assistance from Advance Premium Tax Credits or Cost Sharing Reductions, individuals must purchase through the Marketplace.

All options on the Marketplace are offered statewide on Blue Network S. In the four regions including the metropolitan areas; Chattanooga, Knoxville, Memphis, and Nashville, all options are available on Blue Network E. Additionally, a handful of options are available on Blue Network P.

These plans are Affordable Care Act (ACA) compliant.
- Out-of-Pocket maximums cannot be greater than $6,850 in 2016
- Pre-existing conditions cannot be excluded

Rev 03/16
All plans cover the Essential Health Benefits package required by the law. These include:
- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Treatment and services for mental illness and substance use disorders
- Prescription medications
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

All plans must meet one of the required metallic levels, bronze, silver, gold or platinum. A wide range of plan designs are available:
- Deductibles range from $0 - $6,350
- Out of Pocket Maximums range from $1,500 - $6,000
- Plans with office copays as low as $10 are available, with many plans covering office visits at deductible/coinsurance

**Marketplace Plans sample ID cards**

**Blue Network E - Essential**

**Blue Network P - Preferred**

**Blue Network S - Select**

**Off-Marketplace Plans – Group number 129800**

Open enrollment periods for Off-Marketplace plans matches that of the Marketplace, with the first open enrollment period having begun on 10/1/13, and members enrolled in these plans beginning 1/1/14. By choosing to enroll directly in one of these off-Marketplace plans, the consumers are not receiving any subsidies.

All options in these plans are offered statewide on Network P or S. Beginning in 2016, in the four regions including the metropolitan areas; Chattanooga, Knoxville, Memphis, and Nashville, all options are available in Blue Network E.

These plans are Affordable Care Act (ACA) compliant.
- Out of Pocket maximums cannot be greater than $6,850 in 2016
- Pre-existing conditions cannot be excluded

Rev 03/16
All plans cover the Essential Health Benefits package required by the law. These include:

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

All plans must meet one of the required metallic levels, bronze, silver, gold or platinum. A wide range of plan designs are available:

- Deductibles range from $0 - $6,350
- Out of Pocket Maximums range from $1,500 - $6,850
- Plans with office copays as low as $10 are available, with many plans covering office visits at deductible/coinsurance

**Off-Marketplace Plans sample ID cards**

<table>
<thead>
<tr>
<th>Blue Network E - Essential</th>
<th>Blue Network P - Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1" alt="Blue Network E ID Card" /></td>
<td><img src="image2" alt="Blue Network P ID Card" /></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Blue Network S - Select</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image3" alt="Blue Network S ID Card" /></td>
</tr>
</tbody>
</table>

**D. Health Insurance Portability and Accountability Act of 1996**

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

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

Rev 03/16
1. Health Information Privacy Policies and Procedures

BlueCross BlueShield of Tennessee Privacy Policies and Procedures implement its obligations to protect the privacy of individually identifiable health information that is created, received or maintained by BlueCross BlueShield of Tennessee. A major component of protecting health information is to adhere to the necessary data safeguards set forth in the Information Security’s policies and procedures.

BlueCross BlueShield of Tennessee must promptly change these policies and procedures as necessary to comply with changes in federal and state law. Any changes in the policies and procedures will generate a revision to the Notice of Privacy Practices, which must be distributed within sixty (60) days of the effective date of change. The revised Notice will be available to anyone upon request on the effective date of the change.

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

BlueCross BlueShield of Tennessee’s Privacy Office will review and update the protected health information use and disclosure assessment every two (2) years.

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

BlueCross BlueShield of Tennessee’s Privacy Policies can be seen in their entirety on the company website at http://www.bcbst.com/about/legal/hipaa/HIPAA_privacy/policies.shtml. Any questions concerning these policies and procedures should be directed to the BlueCross BlueShield of Tennessee Privacy Office by calling 1-888-455-3824.

2. Protected Health Information-allowable disclosures under HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule establishes national standards to protect individual’s medical records and other personal health information and applies to 1) health plans, 2) health care clearinghouses, and 3) those health care Providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. The Rule also gives rights to patients over their health information, including rights to examine and obtain a copy of their health records, and to request corrections.

Members have the right to access their health information and to know how it is being protected. As such, BlueCross requests Providers maintain a notice of privacy practices and encourages them to publish such notices prominently on their websites.

Federal regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) may require some changes in the way BlueCross BlueShield of Tennessee operates, however, it will not prevent us from exchanging the information we need for treatment, payment, and health care operations (TPO).
BlueCross will continue to conduct business as usual in most circumstances. HIPAA regulations allow the disclosure and contractually, BlueCross BlueShield of Tennessee Providers (subject to all applicable privacy and confidentiality requirements) are obligated to make medical records of BlueCross BlueShield of Tennessee Members available to each Physician and/or Health Care Professional treating BlueCross Members and to BlueCross BlueShield of Tennessee, its agents, or representatives at no charge.

Privacy Regulations should not impact patient treatment and quality of care; it is vital for the benefit of our Members and your patients that quality of care is not negatively impacted due to misconceptions about allowable exchanges of information for TPO. Examples of TPO, include, but are not limited to:

**Treatment** - rendering medical services, coordinating medical care for an individual, or even referring a patient for health care.

**Payment** - the money paid to a covered entity for services rendered whether it is a health plan collecting premiums, a health plan fulfilling its responsibility for coverage, or a health plan paying a Provider for services rendered to a patient.

**Health care operations** - conducting quality assessment and improvement activities, underwriting, premium rating, auditing functions, business planning and development, and business management and general administrative activities.

For complete TPO definitions and a listing of examples, please review the federal regulations at [http://www.hhs.gov/ocr/hipaa/finalreg.html](http://www.hhs.gov/ocr/hipaa/finalreg.html).

If you have any questions or concerns regarding privacy matters, you may call the BlueCross BlueShield of Tennessee Privacy Office at 1-888-455-3824 or e-mail us at privacy_office@bcbst.com.

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**E. General Information**

1. **Fraud and Abuse Hotline**
   A special telephone hotline is available to report possible fraudulent activities involving the delivery or financing of health care. Anyone, whether or not they are a BlueCross BlueShield of Tennessee participating Provider or Member, can report suspected health care fraud by: calling BlueCross BlueShield of Tennessee Fraud and Abuse Hotline at 423-535-7900 or e-mailing us at [http://www.bcbst.com/fraud/report.shtml](http://www.bcbst.com/fraud/report.shtml).

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

   The financial responsibility for the provision of the requested language assistance is that of the entity that provides the service. It is not permissible to charge BlueCross BlueShield of Tennessee Members, including a BlueCare or TennCare Select Member, for these services. Full text of Title VI of the Civil Rights Act of 1964 can be found online at [http://www.justice.gov/crt/about/cor/13166.php](http://www.justice.gov/crt/about/cor/13166.php).

   Providers can use the "I Speak" Language Identification Flash Card to identify the primary language of BlueCross BlueShield of Tennessee Members, including BlueCare and
TennCareSelect Members. The flash card, published by the Department of Commerce Bureau of Census, containing 38 languages can be found online at http://www.usdoj.gov/crt/Pubs/IsspeakCards.pdf.

Additionally, the National Health Law Program and Access Project 2003 is an organization that assists Providers having patients with language issues by providing a Language Services Action Kit. The kit can be purchased by e-mailing lepactionkit@accessproject.org.

The Department of Health and Human Services can also recommend resources for use when LEP services are needed or Providers can locate interpreters specializing in meeting needs of LEP clients by calling one of the following numbers listed below:

- Language Line 1-800-874-9426
- Hablamos Juntos Line 205-824-2360
- AVAZA Language Service 1-866-452-6582
- Hablamos Juntos Line 1-205-824-2360

Providers may also consider:
- Training bilingual staff;
- Utilizing telephone and video services;
- Using qualified translators and interpreters; and
- Using qualified bilingual volunteers.

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

3. Provider Communications
BlueCross BlueShield of Tennessee produces the BlueAlert newsletter on a monthly basis to communicate important policy and benefit-related news to health care Providers. Also included are helpful tips and reminders on how to file claims and conduct other business more efficiently with BlueCross BlueShield of Tennessee. The newsletters are mailed to all BlueCross BlueShield of Tennessee participating Providers.

Providers are also encouraged to visit the company website, www.bcbst.com to verify Member eligibility, benefit coverages and check claims status in a secure area.

4. Pre-existing Condition
The definition of pre-existing condition differs between Group and Individual Health Coverage. Additionally, standard waiting periods vary by health plan. Some older Individual policies also have benefit exclusion riders that apply to specific conditions and continue past the pre-existing waiting period.

Key differences between Group and Individual pre-existing clauses are:

Group Health Coverage – Employer-funded or sponsored
A pre-existing condition is defined as:
- any physical or mental condition that began prior to the enrollment date\(^1\) of the Member's coverage;
- any physical or mental condition, which was present during a variable look back period immediately before the Member's enrollment date, for which medical advice, diagnosis, care or treatment was recommended or should reasonably have been received; and is
- **treatment** driven.

\(^1\)Could be the effective date of contract, but can be the hire date, if a policy waiting period exists.
Individual Health Coverage – Coverage not sponsored by an employer. Some older Individual products are medically underwritten.

A pre-existing condition is defined as any physical or mental condition that was present during the 12-month period before Coverage became effective under this Policy, for which: (1) medical advice, diagnosis, care or treatment was recommended or received; or (2) symptoms existed and a reasonably prudent person would have sought medical advice, diagnosis, care or treatment from a Provider of health care services; and is symptom driven.

**Examples of Pre-existing Lack of Information Codes:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>W57</td>
<td>Information has been requested from another Provider to complete pre-existing review. <strong>No action is required.</strong></td>
</tr>
<tr>
<td>W74**</td>
<td>Medical information is needed to complete a pre-existing review. <strong>Correspondence will follow.</strong></td>
</tr>
<tr>
<td>Z57*</td>
<td>We are investigating to determine if this condition is pre-existing. If found to be pre-existing we may seek a refund.</td>
</tr>
</tbody>
</table>

*If condition under review is later determined to be pre-existing, the payment may be recovered resulting in Member liability.

**Once a decision is made regarding the condition in question, claims previously denied will be re-processed. Responding promptly and completing all requested information helps ensure claims are handled expeditiously.

**Examples of Pre-existing Denial Codes:**

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>XP1</td>
<td>This service is denied as a pre-existing condition because symptoms existed prior to this Member’s effective date.</td>
</tr>
<tr>
<td>XP2</td>
<td>This service is denied as a pre-existing condition because treatment was recommended prior to this Member’s enrollment date.</td>
</tr>
<tr>
<td>XP3</td>
<td>This service is denied as a pre-existing condition because treatment was received prior to this Member’s enrollment date.</td>
</tr>
<tr>
<td>XP4</td>
<td>This service is denied as a pre-existing condition because treatment was recommended prior to this Member’s effective date.</td>
</tr>
<tr>
<td>XP5</td>
<td>This service is denied as a pre-existing condition because treatment was received prior to this Member’s effective date.</td>
</tr>
<tr>
<td>PX</td>
<td>Charges for a pre-existing condition are not eligible for benefits.</td>
</tr>
</tbody>
</table>
## II. BLUECROSS BLUESHIELD OF TENNESSEE QUICK REFERENCE TELEPHONE GUIDE

<table>
<thead>
<tr>
<th>Contact</th>
<th>Location/Description</th>
<th>Telephone Number</th>
<th>Address/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BlueCross BlueShield of Tennessee</strong></td>
<td>Provider Service Line</td>
<td>1-800-924-7141</td>
<td>General inquiries - voice response line – speak when prompted. Available Mon.-Thurs. 8 a.m. to 6 p.m. (ET), and Friday, 9 a.m. to 6 p.m. (ET) Or write to: BlueCross BlueShield of TN Claims Service Center 1 Cameron Hill Cr, Ste 0002 Chattanooga, TN 37402-0002</td>
</tr>
<tr>
<td><strong>eBusiness Solutions</strong></td>
<td>Technical Support</td>
<td>423-535-5717 Option 2</td>
<td>BlueCross BlueShield of TN eBusiness Solutions 1 Cameron Hill Circle Chattanooga, TN 37402</td>
</tr>
<tr>
<td><strong>Provider Relations</strong></td>
<td>Chattanooga Office</td>
<td>423-535-6307</td>
<td>BlueCross BlueShield of TN ATTN: Provider Relations 1 Cameron Hill Circle Chattanooga, TN 37402</td>
</tr>
<tr>
<td></td>
<td>Johnson City /Knoxville</td>
<td>1-800-924-7141</td>
<td>BlueCross BlueShield of TN ATTN: Provider Relations 801 Sunset Drive, Bldg C Johnson City, TN 37604</td>
</tr>
<tr>
<td></td>
<td>Nashville/Memphis/Jackson</td>
<td>855-646-9258</td>
<td>BlueCross BlueShield of TN ATTN: Provider Relations 6305 Kingston Pike Knoxville, TN 37919</td>
</tr>
<tr>
<td><strong>Fraud &amp; Abuse Hotline</strong></td>
<td>Phone</td>
<td>1-888-343-4221</td>
<td>To report suspected fraudulent activity</td>
</tr>
<tr>
<td>Contact</td>
<td>Location/Description</td>
<td>Telephone Number</td>
<td>Address/Description</td>
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<tr>
<td><strong>Credentialing</strong></td>
<td></td>
<td>1-800-357-0395</td>
<td>BlueCross BlueShield of TN Credentialing Dept. 1 Cameron Hill Cr, Ste 0007 Chattanooga, TN 37402-0007</td>
</tr>
<tr>
<td><strong>Paper Claims Submission</strong></td>
<td>Blue Networks E, M, P, &amp; S BlueCross65SM Federal Employee Program (FEP)</td>
<td></td>
<td>Submit paper claims to: BlueCross BlueShield of TN Claims Service Center 1 Cameron Hill Cr, Ste 0002 Chattanooga, TN 37402-0002</td>
</tr>
<tr>
<td><strong>BlueCard® Benefits &amp; Eligibility</strong></td>
<td>Phone</td>
<td>1-800-676-2583</td>
<td>Available Monday through Friday, 8 a.m. to 6 p.m. (ET)</td>
</tr>
<tr>
<td></td>
<td>Phone</td>
<td>1-800-705-0391</td>
<td></td>
</tr>
<tr>
<td><strong>BlueAdvantage (Medicare Advantage product)</strong></td>
<td>Phone</td>
<td>1-800-841-7434</td>
<td>Available Monday through Friday, 8 a.m. to 6 p.m. (ET)</td>
</tr>
<tr>
<td><strong>Provider Audit Inquiries</strong></td>
<td></td>
<td></td>
<td>BlueCross BlueShield of TN Provider Audit Department 1 Cameron Hill Cr, Ste 0018 Chattanooga, TN 37402-0018</td>
</tr>
<tr>
<td><strong>Utilization Management (UM)</strong></td>
<td>Phone</td>
<td>1-800-924-7141</td>
<td>Selected services require prior authorization. (See Sec. VIII. for a listing of those services.) Prior authorization is required for all inpatient admissions and may be obtained Monday through Thursday, 8 a.m. to 6 p.m. (ET), Friday, 9 a.m. to 6 p.m. (ET). (See Sec. VIII for information on emergency and after-hours admissions.)</td>
</tr>
<tr>
<td></td>
<td>Fax</td>
<td>1-866-558-0789</td>
<td></td>
</tr>
<tr>
<td><strong>UM Appeals Reconsideration</strong></td>
<td>Phone</td>
<td>1-800-924-7141</td>
<td>BlueCross BlueShield of TN Clinical Review Supervisor 1 Cameron Hills Cr, Ste 0017 Chattanooga, TN 37402-0017</td>
</tr>
<tr>
<td><strong>Standard Appeal and Retro Authorization Request</strong></td>
<td>Written Only</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax</td>
<td>423-591-9451</td>
<td></td>
</tr>
<tr>
<td>Contact</td>
<td>Location/Description</td>
<td>Telephone Number</td>
<td>Address/Description</td>
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</tr>
<tr>
<td><strong>Case Management/ Disease Management/ Transplant Case Management</strong></td>
<td>Phone</td>
<td>1-800-225-8698</td>
<td>To arrange coordination of care for Members with complicated needs, e.g., chronic illnesses and/or catastrophic illnesses or injuries. Available Mon.-Thurs. 8 a.m. to 6 p.m. (ET), and Friday, 9 a.m. to 6 p.m. (ET)</td>
</tr>
<tr>
<td></td>
<td>Fax</td>
<td>1-888-328-0394</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phone</td>
<td>1-888-207-2421</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax</td>
<td>423-535-5260</td>
<td></td>
</tr>
<tr>
<td><strong>Pharmacy Program</strong></td>
<td>Phone</td>
<td>1-800-924-7141</td>
<td>To submit comments or suggestions regarding BCBST formulary, appeal a denial of a prior authorization, or quantity limitation request.</td>
</tr>
<tr>
<td>BlueCross BlueShield of Tennessee</td>
<td>Fax</td>
<td>1-888-343-4232</td>
<td></td>
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<tr>
<td><strong>ExpressScripts (ESI)</strong></td>
<td>Phone</td>
<td>1-877-916-2271</td>
<td>Prior authorization medication requests (for criteria visit the Pharmacy page on the company website, <a href="http://www.bcbst.com">www.bcbst.com</a>); or Requests to override pre-established quantities for drugs listed on the Quantity Limitation List</td>
</tr>
<tr>
<td></td>
<td>Fax</td>
<td>1-800-837-0959</td>
<td></td>
</tr>
<tr>
<td><strong>ESI Pharmacy Help Desk</strong></td>
<td>Phone</td>
<td>1-800-922-1557</td>
<td>Claims processing and technical assistance</td>
</tr>
<tr>
<td><strong>Enrollment</strong></td>
<td></td>
<td>1-800-314-8457</td>
<td>Pharmacy network contract inquiries</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>To request information or order specialty pharmacy drugs</td>
</tr>
<tr>
<td><strong>Specialty Pharmacy Vendors</strong></td>
<td>Phone</td>
<td>1-855-405-6923</td>
<td></td>
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<tr>
<td>AcariaHealth</td>
<td>Fax</td>
<td>1-866-892-3223</td>
<td></td>
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<tr>
<td><strong>Accredo Health Group</strong></td>
<td>Phone</td>
<td>1-888-239-0725</td>
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<tr>
<td></td>
<td>Fax</td>
<td>1-866-387-1003</td>
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<tr>
<td><strong>Acro Health Group</strong></td>
<td>Phone</td>
<td>1-800-906-7798</td>
<td></td>
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<tr>
<td></td>
<td>Fax</td>
<td>1-844-612-9057</td>
<td></td>
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<tr>
<td><strong>Amerita, Inc.</strong></td>
<td>Phone</td>
<td>1-855-778-2229</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax</td>
<td>1-877-801-1540</td>
<td></td>
</tr>
<tr>
<td><strong>Avella of Deer Valley, Inc.</strong></td>
<td>Phone</td>
<td>1-877-792-7684</td>
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<tr>
<td></td>
<td>Fax</td>
<td>1-866-792-7684</td>
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<tr>
<td><strong>Axium Healthcare Group</strong></td>
<td>Phone</td>
<td>1-888-315-3395</td>
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<tr>
<td></td>
<td>Fax</td>
<td>1-888-315-3270</td>
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<tr>
<td><strong>Barnes Healthcare Services</strong></td>
<td>Phone</td>
<td>1-352-333-2525</td>
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<tr>
<td></td>
<td>Fax</td>
<td>1-888-276-7948</td>
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<tr>
<td>Benevere Pharmacy</td>
<td>Phone</td>
<td>1-844-842-7722</td>
<td></td>
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<tr>
<td></td>
<td>Fax</td>
<td>1-844-588-5560</td>
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</tr>
<tr>
<td>BioPlus Specialty Pharmacy</td>
<td>Phone</td>
<td>1-888-292-0744</td>
<td></td>
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<tr>
<td></td>
<td>Fax</td>
<td>1-800-269-5493</td>
<td></td>
</tr>
<tr>
<td>BriovaRX</td>
<td>Phone</td>
<td>1-866-791-8679</td>
<td></td>
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<tr>
<td></td>
<td>Fax</td>
<td>1-888-791-7666</td>
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</tr>
<tr>
<td>Caremark Specialty Pharmacy</td>
<td>Phone</td>
<td>1-800-237-2767</td>
<td></td>
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<tr>
<td></td>
<td>Fax</td>
<td>1-800-323-2445</td>
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<td>Eiris Health Services</td>
<td>Phone</td>
<td>1-855-394-2930</td>
<td></td>
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<tr>
<td></td>
<td>Fax</td>
<td>1-901-367-4814</td>
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<tr>
<td>EntrustRX</td>
<td>Phone</td>
<td>1-855-273-3924</td>
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<tr>
<td></td>
<td>Fax</td>
<td>1-855-273-3925</td>
<td></td>
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<tr>
<td>HPC Specialty Pharmacy</td>
<td>Phone</td>
<td>1-800-757-9192</td>
<td></td>
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<tr>
<td></td>
<td>Fax</td>
<td>1-855-813-0583</td>
<td></td>
</tr>
<tr>
<td>Long’s Drugs</td>
<td>Phone</td>
<td>1-866-437-6717</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax</td>
<td>1-866-550-7421</td>
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<tr>
<td>NPS Pharmacy</td>
<td>Phone</td>
<td>1-866-406-9266</td>
<td></td>
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<tr>
<td></td>
<td>Fax</td>
<td>1-866-420-4686</td>
<td></td>
</tr>
<tr>
<td>Onco 360</td>
<td>Phone</td>
<td>1-877-662-6633</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax</td>
<td>1-877-662-6355</td>
<td></td>
</tr>
<tr>
<td>PANTHERx Specialty Pharmacy</td>
<td>Phone</td>
<td>1-855-726-8479</td>
<td></td>
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<tr>
<td></td>
<td>Fax</td>
<td>1-855-246-3986</td>
<td></td>
</tr>
<tr>
<td>Restore Rx, Inc.</td>
<td>Phone</td>
<td>1-877-388-0507</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax</td>
<td>1-901-388-0407</td>
<td></td>
</tr>
<tr>
<td>Transcript Pharmacy, Inc.</td>
<td>Phone</td>
<td>1-866-420-4041</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Fax</td>
<td>1-844-407-4040</td>
<td></td>
</tr>
</tbody>
</table>

We encourage you to logon to BlueAccess®, the secure area on the company website, [www.bcbst.com](http://www.bcbst.com) to access real time information. On this site you can:

- Check medical, behavioral health and dental claims status (excludes prescription drug claims);
- View your remittance advice;
- Submit prior authorization requests and receive online approvals when specific criteria are met;
- Verify benefits, including eligibility and coverage details; and much, much more….
III. HOW TO IDENTIFY A BLUECROSS BLUESHIELD MEMBER

A. Identifying a Member’s ID Card

Each BlueCross BlueShield of Tennessee (BCBST) Member is issued an ID card. The ID card contains much of the information you will need to submit claims and coordinate your patient’s care.

BCBST provides standard ID cards to support its commercial health care benefit plans. Some Members have access to more than one BCBST Network, which will be indicated on the Member’s ID card. In the event that a Provider treats a Member who has access to more than one Network in which the Provider participates, BCBST will reimburse the Provider in accordance with the terms of the Network listed first on the Member’s ID card.

Note: In the event that a Member’s ID card lists more than one Network, reimbursement will be paid in accordance with Section VI. Billing and Reimbursement in this Manual.

While BCBST ID cards differ depending on the Member’s health care benefit plan, there are some standard elements common to most BCBST ID cards.

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

If a Member presents without his or her ID card, Providers should verify health care benefits or eligibility by:

* calling Provider Service at 1-800-924-7141; or
* logging on to BlueAccess, the secure area on the company website, www.bcbst.com

The sample ID cards shown below are representative of some Member ID cards in use.
Some Member health care benefit plans may have customized ID cards* which differ slightly from those shown above. The BlueCross BlueShield of Tennessee logo should appear on all BlueCross BlueShield of Tennessee ID cards, however, some national accounts may have the BlueCross BlueShield logo without the specific Plan designation, i.e., “of Tennessee”.

*The Federal Employees Program (FEP) ID card is a nationally recognized identification card that will aid in admissions to hospitals without having to verify benefits with the Member's employer. Members and Providers may call FEP Customer Service at 1-800-572-1003 or 423-535-5707 for claims filing procedures, requests for additional claim forms and/or benefit information.

All ID cards for federal employees are issued by FEP Operations Center in Washington, DC. Providers may submit claims to the following claims address for Members carrying a BlueCross BlueShield FEP ID card, regardless of the state in which the Member resides.

Mail claims to:
BlueCross BlueShield of Tennessee, Inc.
FEP Claims Department
1 Cameron Hill Circle, Ste 0002
Chattanooga, TN  37402-0002

B. Determining Eligibility

Providers may obtain eligibility or Member health care benefits information by

- calling Provider Service at 1-800-924-7141; or
- logging on to BlueAccess, the secure area on the company website, www.bcbst.com.

Note: Verification of BlueCross BlueShield of Tennessee health coverage is not a guarantee of benefits or coverage (does not guarantee benefits will be paid for the Provider’s services). The Member’s health care benefit plan may have terminated, self-insured or administrative services only (ASO) group may not pay for services, or benefits may be limited by the terms of the Member’s contract or by pre-existing conditions. The Provider’s services and course of treatment must also be deemed Medically Necessary and Medically Appropriate. BlueCross BlueShield of Tennessee reserves the right to determine whether, in its judgment, a service is Medically Necessary and Medically Appropriate for purposes of benefit determination. The fact that a Practitioner has prescribed, performed, ordered, recommended or approved a service does not in itself make it Medically Necessary and Medically Appropriate.
**BlueAccess**

With BlueAccess, Providers can view information as it appears right now in BlueCross BlueShield of Tennessee’s records. This information is located in a secure area on the company website at www.bcbst.com. To access the secured area main menu, first-time users need to register by initiating the following steps:

- Assign a user ID and password;
- Select a token question and complete the personal profile; and
- Assign “permissions” giving you access to all patient data. (*Note: This process replaces use of Digital Certificates to obtain secured information.*)

Each Provider number or National Provider Identifier (NPI) number has a “shared secret”. If a Provider does not know his/her shared secret, he/she can select “Request Shared Secret” from the secured main menu; follow the prompts and he/she will receive the requested information via mail within a few days. Once this information is received, the Provider can go to the secured area main menu on the company website; select “Update Permissions” and click on “Add Providers.” Enter the requested information and he/she can access patient data on any Member covered under BlueCross BlueShield of Tennessee commercial lines of business.

If the Provider office staff handles thirty (30) or more different Providers, they can request a single reference number, which will conveniently give access to all patients associated with those provider numbers or NPIs. Please call eBusiness Solutions at 423-535-5717 for assistance with a reference ID.

BlueAccess offers the following Member-specific information:

- Eligibility;
- Health care benefits;
- Other insurance;
- Dental coverage (if applicable);
- Participating Provider; and
- Status of previously submitted:
  - Claims;
  - Prior authorizations; and
  - Referrals

Providers can now submit Inpatient Procedures, Outpatient Procedures, and 23-hour Observation prior authorization requests and receive online approval by selecting the option to apply MCG guidelines criteria and answer a few clinical questions. If the authorization meets specific criteria they will receive online approval and a reference number. Requests will be recorded in the BlueCross BlueShield of Tennessee computer system real time as it is received.

This service* is available 24-hours-a-day, 7-days-a-week for all registered BlueCross BlueShield of Tennessee commercial Providers. Those who have not yet tried BlueAccess can now register online by visiting the company website, www.bcbst.com and then clicking on the “Providers” tab on the right side of the page. Once on the Providers page, click on the tab to enter the Provider Secure Area and then follow the simple registration instructions. Within two (2) business days of registering, Providers will receive a “Shared Secret” for use in gaining access to the BlueAccess secure area for Providers.

Additionally, Providers can securely communicate with BlueCross BlueShield of Tennessee via Message Center on BlueAccess. All correspondence will be answered in the order it was received. For more information on BlueAccess or authorization access, please call BlueCross BlueShield of Tennessee eBusiness Solutions at 423-535-5717, option 2.

*At this time, excludes Home Infusion Therapy, Durable Medical Equipment and Outpatient Rehabilitation services.
Retroactive Member Termination Recoveries

If BlueCross BlueShield of Tennessee verifies eligibility of an individual who is subsequently determined to have been ineligible at the time services were rendered, BlueCross BlueShield of Tennessee shall recover payments made to BlueCross BlueShield of Tennessee Providers for services rendered to that Member no more than ninety (90) days prior to the date that BlueCross BlueShield of Tennessee was notified the individual Member was ineligible. Such recovery will be based upon actual claim payment date. If the Member Benefit Agreement contains a lesser retroactive Member termination clause (e.g. seven (7) days), such clause shall apply.

C. Member Fees

Members agree to pay certain cost-sharing fees for a Covered Service, depending upon the health care benefit plan under which he or she is enrolled. These cost-sharing fees are described below:

- **Co-insurance** - a pre-determined percentage of amount allowed;

- **Copayment** - a specified dollar amount that a Member pays each time he or she visits a Provider’s office. A Provider can collect a copayment from the Member at the time of the office visit.

- **Deductible** - the amount of money the Member is required to pay in a given time period before BlueCross BlueShield of Tennessee starts to pay benefits. The deductible is usually a set amount or percentage determined by the Member’s health care benefit plan.
IV. GROUP HEALTH CARE BENEFITS

Commercial Products
BlueCross and BlueShield of Tennessee, Inc. offers a variety of products with network configurations to meet our Member needs for coordination of care and greater affordability. We have a variety of products for individuals, small and large groups on a fully insured and self-funded basis. These products may or may not have out-of-network benefits and may include broad or narrow network of participating Providers.

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

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

Member health care benefits may be verified by calling Provider Services at 1-800-924-7141, the BlueCross BlueShield of Tennessee Customer Service number listed on the Member’s ID card or accessing e-Health Services® on the company website, www.bcbst.com. (See Section III. How to Identify a BlueCross BlueShield of Tennessee Member in this Manual for access information.)

The Member’s health care benefit plan will pay the Maximum Allowable Charge for Medically Necessary and Medically Appropriate services and supplies provided in accordance with the reimbursement schedules. Charges in excess of the reimbursement rates are not eligible for reimbursement or payment.

To be eligible for reimbursement or payment, all services or supplies must be provided in accordance with BlueCross BlueShield of Tennessee Medical Policies and Procedures. (See Sec. X. Care Management in this Manual for specifics.)

Obtaining services not in accordance with BlueCross BlueShield of Tennessee Medical Policies and Procedures may result in the denial of payment or a reduction in reimbursement for otherwise eligible Covered Services.

A. Eligible Providers of Service

1. **Practitioners** - All services must be rendered by a Practitioner type listed in the BlueCross BlueShield of Tennessee Referral Directory of Network Providers, or as otherwise required by Tennessee law. The services provided by a Practitioner must be within his or her specialty or scope of practice.

2. **Network Provider** - A Provider who has contracted with BlueCross BlueShield of Tennessee to provide Covered Services.

3. **Out-of-Network Provider** - Any Provider who is an eligible Provider type but who does not hold a contract with the Member’s health care benefits plan to provide Covered Services.

4. **Other Providers of Service** - An individual or facility, other than a Practitioner, duly licensed to provide Covered Services.

5. **Assistant-at-Surgery** - Benefits will be provided for surgery performed by a Practitioner (see Section VI. for Assistant-at-Surgery specifics) who actively assists the operating surgical procedure, provided no intern, resident or other staff Practitioner is available.
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BlueCross BlueShield of Tennessee Provider Administration Manual

B. Additional Services

BluePerks

Providers can help their patients save money on a number of non-covered services by informing them about the BluePerks Discount Program. BluePerks is a value-added program available to BlueCross Members located throughout the country. Members can receive discounts on a wide variety of products and services to help Members and their families live a healthy balanced lifestyle. Services are offered through partnerships with discount service Providers.

The BluePerks Discount program is not a covered benefit or service like Practitioner office visits or inpatient hospital stays. BlueCross does not reimburse Members or pay Practitioners for any portion of the costs associated with services accessed through the BluePerks Discount Program. Members are responsible for the entire cost of all services they receive through the BluePerks Discount Program and the terms and conditions of the Member’s health plan do not apply to these services. Website offers subject to change as Providers revise promotions. Services discounted with BluePerks include, but are not limited to:

- Acupuncture
- Cosmetic Dentistry
- Cosmetic Services
- Diet & Supplement Supplies
- Fitness Memberships
- Health Magazine Subscriptions
- Healthy Events & Activities
- Hearing Aids
- Lasik Corrective Vision Surgery
- Massage Therapy
- Mind/Body Relaxation Therapy
- Spa Services
- Vision Care Products
- Vitamins
- Weight Loss Programs
- Yoga & Tai Chi Instructions

Members can take advantage of the BluePerks Discount Program by logging on to the company website, www.bcbst.com, clicking on the "My Health and Wellness" tab and selecting “BluePerks”. There is no paperwork, prior authorizations, reimbursements or claims to file.

Note: Members of Tennessee Rural Health plans (TRH, Farm Bureau, First Farmers, Merchants Bank, the Federal Employee Program (FEP), BlueCare or TennCare Select are not eligible for the BluePerks Discount Program.

Health Reimbursement Arrangement (HRA)

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

- BlueCross BlueShield of Tennessee Members with HRAs are identified by the “[HRA Plan]” reflected on their ID cards.

- HRA information is reflected in BlueAccessSM, BlueCross BlueShield of Tennessee’s secure area on its website, www.bcbst.com under the “Medical Plan Info” section.
Administration –
- For Members with an HRA, when the medical claim is submitted for processing, the HRA benefits will automatically process at the same time.
- With BlueCross BlueShield of Tennessee’s integrated HRA, the HRA payment is reimbursed directly to the Provider on the same remit but on a separate line item as the medical reimbursement.
- Because the HRA reimbursement is sent directly to the Provider, it may be administratively easier to collect from the Member a portion of the expected Member liability at the time of service. This will reduce the likelihood of an overpayment after the claim has been processed.
- As with medical claims, the HRA is processed on a first-in/first-out basis.

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<th>Account Balance</th>
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<tr>
<td>HRA Balance</td>
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<tr>
<td>Remaining balance</td>
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<tr>
<td>Total paid this year</td>
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<tr>
<td>Employer annual pledge</td>
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<tr>
<td>Prior Year Carryover</td>
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C. General Exclusions from Coverage

Non-Covered Services include, but are not limited to:
- Services or supplies not listed as a Covered Service under the Member’s health care benefits plan;
- Services or supplies that are determined to not be Medically Necessary and Medically Appropriate or have not been authorized by the Member’s health care benefits plan;
- Services or supplies that are Investigational in nature including, but not limited to: 1) drugs; 2) biologicals; 3) medications; 4) devices; and 5) treatments;
- Services or supplies provided by a Provider that is not accredited or licensed or are outside the scope of his/her/its license;
- Illness or injury resulting from war that occurred before the Member’s coverage began and that is covered by (1) veteran’s benefit or (2) other coverage for which the Member is legally entitled;
- Self-treatment or training;
- Staff consultations required by hospital or other facility rules;
- Services rendered free of charge, except when rendered by a non-governmental, charitable research hospital that bills patients for services rendered but does not enforce collection from an individual patient;
- Services or supplies for the treatment of work-related illness or injury, regardless of the presence or absence of Workers’ Compensation coverage. This exclusion does not apply to injuries or illnesses of an employee who is (1) a sole-proprietor of the Group, unless required by law to carry Workers’ Compensation insurance; (2) a partner of the Group, unless required by law to carry Workers’ Compensation insurance; or (3) a corporate officer of the Group, provided the officer filed an election not to accept Workers’ Compensation with the appropriate government department;
- Personal, physical fitness, recreational or convenience items and services, even if ordered by a licensed Practitioner, including but not limited to: weight loss programs and equipment; physical fitness/exercise programs and equipment; devices and computers to assist in communication or speech, (e.g., Dynabox); air conditioners, humidifiers, air filters and heaters; saunas, swimming pools and whirlpools; water purifiers; tanning beds; televisions; barber and beauty services;

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Non-Covered Services include, but are not limited to (cont’d):

- Services or supplies received before the effective date of the Member’s coverage;
- Services or supplies related to a hospital confinement, received before the Member’s effective date of coverage;
- Services or supplies received after the Member’s coverage ceases for any reason. This is true even though the expenses relate to a condition that began while the Member was Covered. The only exception to this is described under Extended Benefits under the Member’s health care benefits plan;
- Services or supplies received in a dental or medical department maintained by or on behalf of the Member’s employer, mutual benefit association, labor union or similar group;
- Charges for telephone consultations, e-mail or web-based consultations, or charges for failure to keep a scheduled appointment;
- Services or charges to complete a claim form or to provide medical records or other administrative functions. BlueCross BlueShield of Tennessee does not charge the Member or his/her legal representative for statutorily required copying charges;
- Court ordered examinations and treatment, unless Medically Necessary and Medically Appropriate;
- Room, board and general nursing care rendered on the date of discharge, unless admission and discharge occur on the same day;
- Charges in excess of the Maximum Allowable Charge for Covered Services;
- Any service stated in the Member’s health care benefits plan as a non-Covered Service or limitation;
- Charges for services performed by the Member or his/her spouse, or the Member’s/Member’s spouse’s parent, sister, brother or child;
- Any charges for handling fees that includes shipping and handling (S & H) and state sales tax;
- Safety items, or items to affect performance primarily in sports-related activities;
- Services or supplies, including Bariatric surgery, for weight loss or to treat obesity, even if the Member has other health conditions that might be helped by weight loss or reduction of obesity. This exclusion applies whether the Member is of normal weight, overweight, obese or morbidly obese;
- Services or supplies related to treatment of complications (except complications of pregnancy) that are a direct or closely related result of a Member’s refusal to accept treatment, medicines, or a course of treatment that a Provider has recommended or has been determined to be Medically Necessary, including leaving an inpatient medical facility against the advice of the treating Practitioner;
- Services considered Cosmetic, except when Medically Appropriate per Medical Policy. This exclusion also applies to surgeries to improve appearance following a prior surgical procedure, even if that prior procedure was a Covered Service. Services that could be considered cosmetic include, but are not limited to: (1) breast augmentation, (2) sclerotherapy injections, laser or other treatment of spider veins and varicose veins, (3) rhinoplasty, (4) panniculectomy/abdominoplasty, (5) Botulinum toxin;
- Services that are always considered cosmetic, including, but not limited to: (1) removal of tattoos; (2) facelifts; (3) body contouring, or body modeling; (4) injections to smooth wrinkles; (5) piercing ears or other body parts; (6) rhytidectomy or rhytidoplasty (Surgery for the removal or elimination of wrinkles); (7) thighplasty; (8) brachioplasty; (9) keloid removal; (10) dermabrasion; (11) chemical peels; (12) lpectomy; (13) laser resurfacing;
- Blepharoplasty and browplasty;
- Charges relating to surrogate pregnancy when the surrogate mother is not a Covered Member under the Member’s health benefit plan;
- Sperm preservation;
- Services or supplies for Orthognathic surgery, a discipline to specifically treat malocclusion. Orthognathic surgery is not surgery to treat cleft palate, or TMJ/TMD;
- Services or supplies for maintenance care;
Non-Covered Services include, but are not limited to (cont’d):

- Private duty nursing;
- Unless Covered by a supplemental Prescription Drug Rider, services or supplies to treat sexual dysfunction, regardless of cause, including but not limited to erectile dysfunction, delayed ejaculation, anorgasmia and decreased libido;
- Charges for injuries due to chewing or biting or received in the course of other dental procedures;
- Removal of impacted teeth, including wisdom teeth;
- Services or supplies related to complications of cosmetic procedures, complications of Bariatric surgery, re-operation of Bariatric surgery or body remodeling after weight loss;
- Cranial orthosis, including helmet or headband, for the treatment of non-synostotic plagiocephaly;
- Chelation therapy, except for (1) control of ventricular arrhythmias or heart block associated with digitalis toxicity, (2) emergency treatment of hypercalcemia, (3) extreme conditions of metal toxicity, including thalassemia with hemosiderosis, (4) Wilson’s disease (hepatolenticular degeneration), (5) lead poisoning;
- Vagus nerve stimulation for the treatment of depression;
- Balloon sinuplasty for treatment of chronic sinusitis;
- Treatment for benign gynecomastia;
- Treatment for hyperhidrosis;
- Intradiscal annuloplasty to treat discogenic back pain. This procedure provides controlled delivery of heat to the intervertebral disc through an electrode or coil;
- Methadone not received at a Pharmacy;
- Unless Covered by a supplemental Prescription Drug Rider: (1) human growth hormones and (2) nicotine replacement therapy and aids to smoking cessation including, but not limited to patches; and
- Prescription Drugs that are illegal under federal law such as marijuana.
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V. MEMBER POLICY

A. Introduction

BlueCross BlueShield of Tennessee, Inc. is dedicated to the prevention and treatment of diseases by promoting access to quality medical services to its Members. Members and participating Providers share a partnership for quality health care. Members have the right to receive covered medical services and have certain responsibilities to aid in receiving them.

B. Member Access-to-Care

To ensure quality and continuity of care for BlueCross BlueShield of Tennessee Members after regular clinic hours, Practitioners will provide 24-hour-a-day, 7-days-a-week service. Practitioners must be able to respond to Member calls or calls from an Emergency Department or Hospital concerning their BlueCross BlueShield of Tennessee patients within the time limits described in the BlueCross BlueShield of Tennessee Member Access and Availability Standards for routine or urgent care.

Arrangements for 24-hour access to equally qualified Practitioners participating in the same BlueCross BlueShield of Tennessee network as the Member’s Practitioner are the responsibility of all contracted Practitioners who participate in BlueCross BlueShield of Tennessee networks.

Standards for telephone access after regular clinic hours:

1. A telephone number or pager answered by covering Practitioner;
2. A non-automated, “live” answering service that directs Members’ calls to an “on-call” covering Practitioner; or
3. An automated answering machine that directs the Member to the Practitioner or appropriate covering Practitioner.

Standards for responding to Member telephone calls after regular hours:

1. The Member, or Member’s representative, must be able to speak directly with an appropriate Practitioner;
2. It is acceptable for the answering service to take a message and have the Practitioner return the call to the Member;
3. At a minimum, the live answering service should request the following from the Member:
   - Reason for call
   - Name
   - Telephone number
   - Name of Practitioner
4. Practitioners providing on-call coverage after regular office hours must respond directly to Members or Members’ representative within the following time frames:
   - If Urgent, within 30 minutes of receipt of the message from the answering service/machine; or
   - If routine, within 90 minutes of receipt of the message from the answering service machine.

A survey of compliance with BlueCross BlueShield of Tennessee’s call coverage policy is performed during office site visits. Noncompliance is addressed through the company’s Medical Corrective Action Plan (See Section XII.). BlueCross BlueShield of Tennessee uses these guidelines when credentialing and recredentialing its Practitioners.

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Specific ambulatory encounters that BlueCross BlueShield of Tennessee will monitor are:

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<tr>
<th>Appointment Type</th>
<th>Definition</th>
<th>Standard</th>
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<tr>
<td>Routine Adult Physical Examination</td>
<td>Routine exam of a patient who has no acute symptoms which includes Medically Necessary and Medically Appropriate health screenings and immunizations, if a covered benefit.</td>
<td>Annually – within 1 year of last scheduled physical after coverage becomes effective, or if last physical is greater than one year, within 3 months</td>
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<tr>
<td>Children Preventive</td>
<td>Counseling, coordination, and treatment of an anticipatory nature to include guidance and risk reduction interventions. (E.g., vaccinations, immunizations) according to the American Academy of Pediatrics periodicity schedule.</td>
<td>According to the American Academy of Pediatrics periodicity schedule</td>
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<tr>
<td>Prenatal Care</td>
<td>Counseling, diagnosis, treatment and coordination of care for pregnancy for all Members to prevent complications, and to decrease the incidence of maternal and prenatal mortality.</td>
<td>≤ 6 weeks&lt;br&gt;≤ 15 weeks</td>
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<tr>
<td>Urgent Care for Adult and Child</td>
<td>1. Urgent Examination: Medically Necessary and Appropriate services and supplies to diagnose and treat acute symptoms of sufficient severity that cannot wait until the next available appointment. These services may be provided by facility-based Providers.&lt;br&gt;2. Urgent Specialty: Coordination of care which is diagnostic or confirmatory in nature and needed when an expert opinion is required to determine appropriate care for a patient with an acute condition which is moderate to severe in complexity. If not treated, this condition could lead to harmful outcomes and emergency care.</td>
<td>≤ 48 hours</td>
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<td>Emergency Care</td>
<td>Medically Necessary services that are required to evaluate, treat, and stabilize a patient’s emergency condition. An emergency is defined as a sudden and unexpected medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect to result in: serious impairment of bodily functions; serious dysfunction of any bodily organ or part; or placing the prudent layperson’s health in serious jeopardy. These services may be provided by facility-based providers. It is understood that in those instances where a Physician makes emergency care determinations, the Physician shall use the skill and judgment of a reasonable Physician in making such determinations.</td>
<td>Immediate</td>
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<td>Specialty Care for both Adult and Child</td>
<td>Coordination of care, which is diagnostic or confirmatory in nature and needed when an expert is required to perform or determine appropriate follow-up care for a patient. (E.g., cardiology, orthopedics, urology, neurology)</td>
<td>As Practitioner deems appropriate for condition or follow-up</td>
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<th>Wait Times</th>
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<td>1. Office Wait Time (including lab and X-ray)……………</td>
<td>≤ 45 minutes</td>
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<td></td>
<td>2. Member Telephone Call (during office hours):&lt;br&gt;• Urgent………………………………………………………</td>
<td>≤ 15 minutes&lt;br&gt;≤ 24 hours&lt;br&gt;≤ 30 minutes&lt;br&gt;≤ 90 minutes</td>
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<td>3. Member Telephone Call (after office hours):&lt;br&gt;• Urgent………………………………………………………</td>
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C. Member Rights and Responsibilities

BlueCross BlueShield of Tennessee educates its Members on their rights and responsibilities. As a participating network Provider, you should know what our Members are being told to expect from you and what you have the right to expect from those Members. To comply with regulatory and accrediting requirements, BlueCross BlueShield of Tennessee periodically reminds Members of their rights and responsibilities. These reminders are intended to make it easier for Members to access quality medical care and to attain services.

Member Rights

Members have the right to:

- Be treated with respect and dignity, and need for privacy.
- Receive information about policies and services of their Plan network, including structure, operation, quality improvement activities, Practitioners and Providers, and Member rights and responsibilities.
- Participate with Practitioners in the decision-making regarding their health care.
- Voice complaints or appeals about the organization or the care it provides.
- A candid discussion of appropriate Medically Necessary treatment options for their condition regardless of cost or benefit coverage.
- Make recommendations regarding the organization’s Member rights and responsibilities.

Member Responsibilities

Members are expected to:

- Provide, to the extent possible, all information that the organization and its Practitioners and Providers need in order to provide care.
- Follow plans and instructions for care that they have agreed to with their Practitioners.
- Understand their health problems and participate in developing mutually agreed upon treatment goals, to the degree possible.

D. Member Grievance Process

BlueCross BlueShield of Tennessee has incorporated formal mechanisms to address Member concerns and complaints or grievances. Concerns raised by Members and Providers will be utilized to continuously improve product lines, processes and services. All employees are alert for and responsive to inquiries, complaints and concerns and address such issues promptly and professionally. All other written concerns or complaints are considered grievances and will be processed through BlueCross BlueShield of Tennessee’s usual grievance procedure described in Sec. VIII and Sec. XIII In this Manual.

Member concerns, complaints, and resolutions, if applicable, are documented and maintained by BlueCross BlueShield of Tennessee in accordance with its corporate policies. If a Member has an inquiry, concern or complaint regarding any aspect of services received, the Member may contact the designated Customer Service Representative of BlueCross BlueShield of Tennessee to discuss the matter. If a Member feels that the Customer Service Representative has not resolved a problem, it is his/her right to submit a written grievance or suggestion for improvement to the Grievance Committee.
E. Financial Responsibility for the Cost of Services

If a BlueCross BlueShield of Tennessee Network Provider renders a service which is Investigational or does not meet Medically Necessary and Appropriate criteria, the Provider must obtain a written statement from the Member, prior to the service(s) being rendered, acknowledging that the Member understands he/she may be responsible for the cost of the specific service(s) and any related services. Providers may also utilize this form in the event a Member requests non-emergency, cosmetic or elective services that are specifically excluded under the Member’s health benefits plan. It is essential the signed statement be kept on file, as it may be necessary to provide a copy of the signed statement to BlueCross BlueShield of Tennessee verifying the Member’s agreement to the financial responsibility.

To help assist in this process, BlueCross BlueShield of Tennessee developed the Acknowledgement of Financial Responsibility for the Cost of Services form for Provider use. This form meets the contractual obligations of BlueCross BlueShield of Tennessee Provider Agreements. Providers are strongly encouraged to use this form. Providers using their own form should insure their form includes the following:

1. The name of the specific service/procedure the Provider will perform;
2. The reason why the Provider believes that BlueCross BlueShield of Tennessee will not provide benefits for the service/procedure; i.e., BlueCross BlueShield of Tennessee considers the service/procedure to be Investigational, Cosmetic or not Medically Necessary and Appropriate;
3. The approximate cost of the service/procedure and associated costs;
4. A statement acknowledging the Member understands that BlueCross BlueShield of Tennessee will not provide benefits for the service/procedure;
5. A statement acknowledging the Member has been advised why BlueCross BlueShield of Tennessee will not cover the service/procedure and that he/she understands and agrees that he/she will be responsible for all the costs and any associated costs;
6. A statement indicating the form is only valid for one (1) service/procedure; and
7. A specific expiration date.

Note: Some out-of-state plans have different coverage provisions. Please make sure that the out-of-state plan does not cover the service in question prior to the Member signing the waiver agreement. The Acknowledgement of Financial Responsibility for the Cost of Services form can only be used in the event the Member does not have coverage for the service in question as determined by verification of the Member’s coverage.

A sample copy of the Acknowledgement of Financial Responsibility for the Cost of Services form follows:
BlueCross BlueShield of Tennessee
Acknowledgement of Financial Responsibility
for the Cost of Services
(For use with Blue Networks E, M, S, and P)

To: ________________;

Re: (Identification of Prescribed Service)

I have been informed that my health care benefits insurer or administrator, BlueCross BlueShield of Tennessee, may determine that the above referenced service(s) may be an Investigational Service, Cosmetic, may not be a Covered Service or may not be Medically Necessary or Medically Appropriate as those terms are defined in my Member health care benefits plan from BlueCross BlueShield of Tennessee. Therefore, the service would be excluded from coverage by my health care benefits plan. My provider has also informed me about alternative treatments, if any, that may be covered by BlueCross BlueShield of Tennessee.

I understand that my provider may request that BlueCross BlueShield of Tennessee reconsider that determination by presenting evidence that the referenced service(s) is not an Investigational Service, is a Covered Service or the service is considered to be Medically Necessary or Medically Appropriate. I also understand that I have the right to request reconsideration of that determination, as described in the Member grievance section of my health care benefits plan, either before or after receiving the service(s).

I have been informed that the potential costs of the referenced service(s) will be approximately $_____________. I understand that, if I elect to receive the service(s) and BlueCross BlueShield of Tennessee determines that the service(s) is an Investigational Service, is not a Covered Service or the service is not considered to be Medically Necessary or Medically Appropriate, I will be responsible to pay for all costs associated with the service(s), including, but not limited to, practitioner costs, facility costs, ancillary charges and any other related expenses. I acknowledge that BlueCross BlueShield of Tennessee may not pay for the service(s).

In the event of multiple procedures, this form is valid only for one (1) unit of the prescribed service(s), unless specifically provided for otherwise.

This form will expire and will no longer be valid six (6) months from the date of execution.

Signature of Patient or Responsible Person

___________________________________

Date: ______________________________

Rev 12/14
F. Member/Practitioner Relationship Termination

Whether the termination of the Practitioner and Member relationship is initiated by the Practitioner or by BlueCross BlueShield of Tennessee's termination of the Practitioner, it is the responsibility of the Practitioner to notify the Member prior to the effective date of the termination.
VI. BILLING AND REIMBURSEMENT

A. How to File a Claim

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

<table>
<thead>
<tr>
<th>Institutional Claims</th>
<th>Professional Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>CMS-1450</td>
<td>CMS-1500</td>
</tr>
<tr>
<td>UB-04</td>
<td>HCFA-1500</td>
</tr>
<tr>
<td>ANSI-837I</td>
<td>ANSI-837P</td>
</tr>
<tr>
<td>Hospital or Facility claims</td>
<td>Medical or Practitioner claims</td>
</tr>
</tbody>
</table>

BlueCross BlueShield of Tennessee (“BCBST”) is prepared to accept claims electronically in the ANSI 837 format or in paper; the required method is electronically. An acceptable alternative for the Centers for Medicare and Medicaid Services (CMS) CMS-1500 or CMS-1450 claims is the Optical Character Recognition (OCR) scannable format. Electronic and OCR scannable claims promote effective processing and timely payment. Where neither of the above methods is practical, paper claims will be accepted.

Professional charges should be submitted on the CMS-1500/ANSI-837 Professional Transaction and Institutional charges on the CMS-1450/ANSI-837 Institutional Transaction. Complete claims data should be filed for all services regardless of whether those services are covered. All services for the same patient, same date of service, same place of service, and same Provider must be billed on a single claim submission.

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

BCBST commercial timely filing period is 180 days from the date of service or, for facilities, within 180 days from the date of discharge.

If the Provider has documented evidence the Member did not provide BCBST insurance information, the timely filing provision shall begin with receipt of insurance information, subject to the limitations of the Member’s benefit agreement.

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

Proof of timely filing for a returned paper claim is the black and white copy of the claim with error codes listed at the top of the claim that was returned to the Provider. Providers should always maintain a copy of the returned claim in case there is a question about timely filing. BCBST will maintain in archives for future reference an image of the original claim submitted. BCBST generates the following proof of timely filing report for electronically submitted claims:

- 277CA Health Care Claim Acknowledgement Report or CARES Report

The new electronic claims 277CA Health Care Claim Acknowledgement Report supplies Providers with one comprehensive report of all claims received electronically. This report should be maintained by the Provider for proof of timely filing. Providers submitting claims electronically either directly or through a billing service/clearinghouse will automatically receive claims receipt reports in their electronic mailbox. To learn more about retrieving your electronic reports, call eBusiness Solutions at 423-535-5717, Monday through Thursday, 8 a.m. to 6 p.m. (ET) and Friday, 9 a.m. to 6 p.m. (ET). Note: Submission dates of claims filed electronically that are not accepted by BCBST due to transmission errors are not accepted as proof of timely filing.
1. Filing Electronic Claims (Required Method)

BCBST implemented an electronic claims processing system in 2003 to be in compliance with federal Health Insurance Portability and Accountability Act of 1996-Administrative Simplification (HIPAA-AS) requirements. This system is used for processing of American National Standards Institute (ANSI) 837 claims and other ANSI transactions, and to verify HIPAA compliancy of those transactions. BCBST business edits have been modified to recognize the required ANSI formats. These edits apply to both electronic and scannable paper claims.

a. Provider Number/National Provider Identifier (NPI) Number for Electronic Claims:
Claims submitted electronically must include the Provider’s appropriate individual BCBST Provider number and/or NPI in the required data elements as specified in the Implementation Guide. This guide is available online via the Washington Publishing Company website at http://www.wpc-edi.com/. Additional companion documents needed for BCBST electronic claims submission can be accessed at http://www.bcbst.com/providers/ecomm/technical-information.shtml.

Note: BCBST follows the CMS guidelines for filing the National Provider Identifier (NPI) Number.

Electronic Enrollment and Support
Enrollment of new Providers, changes to existing Provider or billing information (address, tax ID, Provider number, NPI, name), or any changes of software vendor should be communicated to eBusiness Provider Solutions via the Provider Electronic Profile form. The Provider Electronic Profile form can be downloaded from the company website, www.bcbst.com or obtained upon request. (See contact numbers listed below.)

Mail Provider Electronic Profile forms to:
BlueCross BlueShield of Tennessee
Provider Network Services
1 Cameron Hill Circle, Ste 0007
Chattanooga, TN  37402-0007

Technical Support
call:  423-535-5717
e-mail:  eBusiness_Service@bcbst.com

Enrollment
call:  1-800-924-7141
fax:  423-535-7523
e-mail:  eBusiness_SysConfig@bcbst.com

b. Electronic Data Interchange (EDI)
HIPAA standards require Covered Entities to transmit electronic data between trading partners via a standard format (ANSI X12). EDI allows entities within the health care system to exchange this data quickly and securely. Currently, BCBST uses the ANSI 837 version, 5010 format.

American National Standards Institute has accredited a group called “X12” that defines EDI standards for many American industries, including health care insurance. Most electronic standards mandated or proposed under HIPAA are X12 standards.

c. Secure File Gateway (SFG)
The Secure File Gateway allows trading partners to submit electronic claims and download electronic reports using multiple secure managed file transfer protocols. The SFG provides the ability to transmit files to BCBST using HTTPS, SFTP, and FTP/SSL connections. The below grid reflects a short description of each protocol:
### Protocol Description

<table>
<thead>
<tr>
<th>Protocol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>HTTPS Website, <a href="https://mftweb.bcbst.com/myfilegateway">https://mftweb.bcbst.com/myfilegateway</a></td>
<td>The BCBST secure website allows individuals to login with their secure credentials and submit electronic claims or download electronic reports.</td>
</tr>
<tr>
<td>SFTP (server mftsftp.bcbst.com)</td>
<td>The BCBST SFTP server allows trading partners to automate their processes to submit electronic claims or download electronic reports.</td>
</tr>
<tr>
<td>FTP/SSL (server mftsftp.bcbst.com)</td>
<td>The BCBST FTP/SSL server is an additional option to allow trading partners to automate their processes to submit electronic claims or download electronic reports.</td>
</tr>
</tbody>
</table>

**d. ANSI 837 (Version 5010)**

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


*Coordination of Benefits (COB) is part of the ANSI 837, which provides the ability to transmit primary and secondary carrier information. The primary payer can report the primary payment to the secondary payer. For detailed specifics on the ANSI 837 format, Providers should reference the appropriate guidelines found in the National Electronic Data Interchange Transaction Set Implementation Guide. This guide is available online via the Washington Publishing Company website at [http://www.wpc-edi.com/](http://www.wpc-edi.com/). Additional companion documents needed for BCBST electronic claims submission can be accessed at [http://www.bcbst.com/providers/ecomm/technical-information.shtml](http://www.bcbst.com/providers/ecomm/technical-information.shtml).

**2. Filing Paper Claims**

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

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

- CMS-1500 Practitioner’s Manual
- CMS-1450 Hospital Manual
- Tennessee Uniform Procedure Coding Manual
- ICD Code Manual

Also refer to the Data Elements required for submitting CMS-1500 claims included later in this section. In order to assure precise control and timely and accurate payment of claims and to reduce the potential of fraud, BCBST will not accept claims faxed, photocopied or altered; claims which do not meet exception criteria listed below will be returned to the Provider:

- **Faxed and Photocopied Claims:** All faxed and photocopied claims must be approved by BCBST management or faxed at the request of BCBST.

- **Altered Claims:** All altered claims are returned to the Provider with an attachment stating BCBST does not accept claims that have been altered.

*Altered claims are claims with whiteout or which BCBST Operations determines are suspicious.*
3. Tips for Completing CMS-1500 and CMS-1450 Claim Forms

Listed below are some tips that will help ensure claims are processed rapidly and accurately.

a. General tips whether submitting OCR or paper:
   - Use red standard claim form;
   - Type all letters in upper case (capital letters);
   - Align all print in appropriate blocks;
   - Use a black typewriter ribbon (if typed) or block letters (if handwritten) to reflect a clear impression;
   - Enter insured’s ID number including the three-letter alpha prefix, exactly as shown on ID card;
   - Review each claim to ensure all required fields have been provided;
   - Send only original claims and supporting documentation;
   - Securely staple any attachments or receipts;
   - Do not use Correction Tape or Whiteout when submitting paper claims;

b. Billing Requirements for Faxed Paperwork (PWK) Attachments

When paper documentation is necessary to support an electronically submitted claim, you can utilize the PWK06 (paperwork) segment (Loop 2300) to indicate that documentation will be sent to BCBST separately from the electronic claim. The actual supporting documentation would be faxed accompanied with a PWK Fax Cover Sheet. BCBST will match the documentation to your electronic claim using the information supplied from the PWK06 segment and PWK Fax Cover Sheet and utilize that documentation during claims processing and payment. To ensure BCBST matches the documents to an electronic claim for processing; the documentation and fax sheet should be submitted no later than the day of claims submission.

BCBST will only match on the first iteration of PWK06 (ACN) from the ANSI 837 data. Ensure your first iteration at claim or line level matches the PWK06 (ACN)

<table>
<thead>
<tr>
<th>ANSI 837 Loop</th>
<th>Field Description</th>
<th>837P/I Segment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2300</td>
<td>Attachment Report Type Code</td>
<td>PWK01</td>
</tr>
<tr>
<td></td>
<td>Use the values indicated in the IG to identify the type of attachment.</td>
<td></td>
</tr>
<tr>
<td>2300</td>
<td>Attachment Transmission Code</td>
<td>PWK02</td>
</tr>
<tr>
<td></td>
<td>Use the values indicated in the IG to identify how the attachment will be sent. BCBST accepts supporting documentation by fax only, the value of FX (By Fax) in this data element is the only value accepted.</td>
<td></td>
</tr>
<tr>
<td>2300</td>
<td>Identification Code Qualifier</td>
<td>PWK05</td>
</tr>
<tr>
<td></td>
<td>Use code value of AC (Attachment Control Number). This data element is required if PWK02 = FX.</td>
<td></td>
</tr>
<tr>
<td>2300</td>
<td>PWK06 Attachment Control Number</td>
<td>PWK06</td>
</tr>
<tr>
<td></td>
<td>This is a value assigned by the provider to uniquely identify the attachment. This number must also be included on the &quot;Attachment Fax Sheet&quot;.</td>
<td></td>
</tr>
</tbody>
</table>

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

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

Note: The PWK Fax Cover Sheet can be found on the company website at http://www.bcbst.com/docs/providers/PWK-Coversheet.pdf. Complete the form and fax with documentation to (423) 591-9481.
4. CMS-1500 Health Insurance Claim Form

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

The 1500 Health Insurance Claim Form is the basic paper claim for use by Practitioners and suppliers, and in some cases, for ambulance services. The National Uniform Claim Committee released a revised CMS-1500 (02/12) claim form replacing the CMS-1500 (08/05) version. Effective 4/1/14, **only** use the CMS-1500 (02/12) version.

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

- Professional Outpatient Services;
- Emergency Room Practitioner Fees-must be filed with Location Code 23 (Emergency Room, Hospital); and
- Clinic Visits (professional fees)

**Note:** BCBST follows CMS guidelines for filing the National Provider Identifier (NPI) Number.

A sample copy of the CMS-1500 (02/12) claim forms and block descriptions follow:
HEALTH INSURANCE CLAIM FORM
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

1. MEDICARE MEDICAID TRICARE CHAMPVA
   Group Plan (GEM) FFEA OTHER
   (Medicare) (Medicaid) (TriCare) (Champa) (Group) (FFE) (Other)

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

3. PATIENT’S BIRTH DATE YY MM DD

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

5. PATIENT’S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED

7. INSURED’S ADDRESS (No., Street)

8. RESERVED FOR NUCC USE

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

10. IS PATIENT’S CONDITION RELATED TO:

11. INSURED’S POLICY GROUP OR FECA NUMBER

   a. OTHER INSURED’S POLICY OR GROUP NUMBER
   b. RESERVED FOR NUCC USE

12. CLAIM CODES (Designated by NUCC)

13. INSURED’S OR AUTHORIZED PERSON’S SIGNATURE (If payment of medical benefits is not to be paid directly to your provider or supplier for services described below)

14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP)

15. OTHER DATE QUAL

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

17. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YYYY

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY

   a. CODE

22. RESUBMISSION CODE

23. PREVIOUS AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE MM DD YYYY

25. B. PLACE OF SERVICE

26. C. PROFESSION

27. D. PROCEDURES, SERVICES, OR SUPPLIES

28. E. DIAGNOSIS

29. F. MODIFIER

30. ICD-9 CODE

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS

32. SERVICE FACILITY LOCATION INFORMATION

33. BILLING PROVIDER INFO & PH #

NUCC Instruction Manual available at: www.nucc.org PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

VI-6
<table>
<thead>
<tr>
<th>Block</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Type of Plan</td>
</tr>
<tr>
<td>1a</td>
<td>Insured’s ID Number (include three-letter alpha prefix)</td>
</tr>
<tr>
<td>2</td>
<td>Patient’s Name</td>
</tr>
<tr>
<td>3</td>
<td>Patient’s Date of Birth</td>
</tr>
<tr>
<td>4</td>
<td>Insured’s Name</td>
</tr>
<tr>
<td>5</td>
<td>Patient’s Address and Telephone Number</td>
</tr>
<tr>
<td>6</td>
<td>Patient’s Relationship to Insured</td>
</tr>
<tr>
<td>7</td>
<td>Insured’s Address</td>
</tr>
<tr>
<td>8</td>
<td>Reserved for NUCC Use</td>
</tr>
<tr>
<td>9</td>
<td>Other Insured’s Name</td>
</tr>
<tr>
<td>9a</td>
<td>Other Insured’s Policy or Group Number</td>
</tr>
<tr>
<td>9b</td>
<td>Reserved for NUCC Use</td>
</tr>
<tr>
<td>9c</td>
<td>Reserved for NUCC Use</td>
</tr>
<tr>
<td>10abc</td>
<td>Is Patient’s Condition Related To</td>
</tr>
<tr>
<td>10d</td>
<td>Claim Codes</td>
</tr>
<tr>
<td>11</td>
<td>Insured’s Policy Group or FECA Number</td>
</tr>
<tr>
<td>11a</td>
<td>Insured’s Date of Birth</td>
</tr>
<tr>
<td>11b</td>
<td>Other Claim ID</td>
</tr>
<tr>
<td>11c</td>
<td>Insurance Plan Name or Program Name</td>
</tr>
<tr>
<td>11d</td>
<td>Is There Another Health Benefit Plan</td>
</tr>
<tr>
<td>12</td>
<td>Patient’s or Authorized Person’s Signature (Information Release/Government Assignment)</td>
</tr>
<tr>
<td>13</td>
<td>Insured’s or Authorized Person’s Signature (Payment Authorization)</td>
</tr>
<tr>
<td>14</td>
<td>Date of Current Illness, Injury, or Pregnancy (LMP)</td>
</tr>
<tr>
<td>15</td>
<td>Other Date</td>
</tr>
<tr>
<td>16</td>
<td>Dates Patient Unable to Work in Current Occupation</td>
</tr>
<tr>
<td>17</td>
<td>Name of Referring Provider or Other Source</td>
</tr>
<tr>
<td>17a</td>
<td>ID Number of Referring Provider or Other Source</td>
</tr>
<tr>
<td>17b</td>
<td>NPI (National Provider Identifier) of Referring Provider</td>
</tr>
<tr>
<td>18</td>
<td>Hospitalization Dates Related to Current Services</td>
</tr>
<tr>
<td>19</td>
<td>Additional Claim Information</td>
</tr>
<tr>
<td>20</td>
<td>Outside Lab?</td>
</tr>
<tr>
<td>21A-L</td>
<td>Diagnosis or Nature of Illness or Injury; ICD Ind</td>
</tr>
<tr>
<td>22</td>
<td>Resubmission Code/Original Reference Number (Identifies Corrected Bill)</td>
</tr>
<tr>
<td>23</td>
<td>Prior Authorization Number (If Applicable)</td>
</tr>
<tr>
<td>24A</td>
<td>Dates of Service</td>
</tr>
<tr>
<td>24B</td>
<td>Place of Service</td>
</tr>
<tr>
<td>24C</td>
<td>EMG (if emergency indicator required, enter “Y” for yes; leave blank if No)</td>
</tr>
<tr>
<td>24D</td>
<td>CPT® or HCPCS code, modifiers</td>
</tr>
<tr>
<td>24E</td>
<td>Diagnosis Pointer</td>
</tr>
<tr>
<td>24F</td>
<td>Charges</td>
</tr>
<tr>
<td>24G</td>
<td>Days or Units</td>
</tr>
<tr>
<td>24H</td>
<td>EPSDT/Family Plan (TENnderCARE)</td>
</tr>
<tr>
<td>24I</td>
<td>ID Qualifier</td>
</tr>
<tr>
<td>24J</td>
<td>Rendering Provider ID Number</td>
</tr>
<tr>
<td>25</td>
<td>Federal Tax ID Number or SSN</td>
</tr>
<tr>
<td>26</td>
<td>Patient’s Account Number</td>
</tr>
<tr>
<td>27</td>
<td>Accept Assignment</td>
</tr>
<tr>
<td>28</td>
<td>Total Charge</td>
</tr>
<tr>
<td>29</td>
<td>Amount Paid</td>
</tr>
<tr>
<td>30</td>
<td>Reserved for NUCC Use</td>
</tr>
<tr>
<td>31</td>
<td>Signature of Physician or Supplier</td>
</tr>
<tr>
<td>32</td>
<td>Service Facility Location Information (address where service provided)</td>
</tr>
<tr>
<td>32a</td>
<td>NPI (National Provider Identifier) of Service Facility</td>
</tr>
<tr>
<td>32b</td>
<td>Non-NPI ID Number (unique identifier of the facility)</td>
</tr>
<tr>
<td>33</td>
<td>Billing Provider Info and Telephone Number</td>
</tr>
<tr>
<td>33a</td>
<td>NPI (National Provider Identifier) of Billing Provider in Block 33</td>
</tr>
<tr>
<td>33b</td>
<td>Non-NPI Number (unique identifier number of professional)</td>
</tr>
</tbody>
</table>
b. Data Elements Required for Submitting CMS-1500 Claims

To avoid delays in receiving payments and to avoid unnecessary claim denials, all required information must be provided. The following lists data required when filing a CMS-1500 Claim Form. Note: (+) indicates if format or data is not valid, the claim will be rejected and returned to the Provider for correction and resubmission.

- +Insured’s I.D. number (include three-letter alpha prefix) Block 1A
- +Patient’s Name Block 2
- +Patient’s Date of Birth Block 3
- Insured’s Name Block 4
- Patient’s Address Block 5
- +Patient’s Relationship to Insured Block 6
- Another Health Plan Block 11d
- +Patient’s or Authorized Person’s Signature Block 12
- Insured’s or Authorized Person’s Signature Block 13
- +Date of Accident Block 14
- Name of Referring Practitioner Block 17
- ID Number of Referring Provider Block 17a
- NPI (National Provider Identifier) of Referring Provider Block 17b
- +Diagnosis Block 21A-L
- +Dates of Service Block 24a
- +Place of Service Block 24b
- +Procedure Codes/Modifiers Block 24d
- +Diagnosis Pointer Block 24e
- +Charges Block 24f
- +Days/Units Block 24g
- +Federal Tax ID Number Block 25
- Patient’s Account Number Block 26
- +Total Charges Block 28
- Signature of Physician/Supplier Block 31
- +Billing Provider Info and Telephone Number Block 33
- +NPI (National Provider Identifier) of Billing Provider Block 33a
5. Completing CMS-1500 Claim Form

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

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

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

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

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

The following general instructions are intended to be a guide only for completing the CMS-1500 claim form. Providers should refer to the most current federal, state, or other payer instructions for specific requirements applicable to the 1500 Claim Form. The 1500 Health Insurance Claim Form Reference Instruction Manual for 02/12 Version can be found on the National Uniform Claim Committee (NUCC) website, www.nucc.org.

a. General Instructions

The form designated CMS-1500 is approved by CMS, TRICARE/CHAMPUS on Medical Services, and BCBST.

A summary of suggestions and requirements needed to complete the CMS-1500 claim form follows:

- Only one line item of service per claim line (Block #24) can be reported. If more than 6 lines per claim are needed, additional claim forms will be required.
- “Super bills,” statements, computer printout pages, or other sheets listing dates, service, and/or charges cannot be attached to the CMS-1500 claim form.
- The form is aligned to a standard typing format of 10 pitch (PICA) or standard computer-generated print of 10 characters per inch. Vertical spacing is 6 lines per inch.
- The form is designated for double spacing with the exception of Blocks #31, 32 and 33, which may be single-spaced.
- Use standard fonts: do not intermix font styles on the same claim form.
- Do not use italics and script on the form.
- In completing all claim information COLOR OF INK should be as follows:
  1. Computer generated color of black
- Use upper case (CAPITAL) letters for all alpha characters.
- Do not use dollar signs ($), decimals (.), or commas (,) in any dollar amount blocks.
- Enter information on the same horizontal plane.
- Enter all information within the boundaries of the designated block.
Extraneous data (handwritten or stamped) may not be printed on the form except to mark as “Corrected Bill”.

- Pin feed edges should be evenly removed prior to submission.

1. Form Alignment

The CMS-1500 is designed for printing or typing 6 lines per inch vertically and 10 characters per inch horizontally. On the title line of the form above Block #1 and Block #1A are 6 boxes labeled “PICA”. These boxes should be considered Line 1, Columns 1, 2 and 3, and Line 1, Columns 77,78 and 79. Form alignment can be verified by printing “X’s” in these boxes.

2. Entering All Dates

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

Unless otherwise indicated, all date information should be shown in the following format:

For Blocks 3, 9B, and 11A

MMblankDDblankCCYY
MM=month (01-12)
1 blank space
DD=day (01-31)
1 blank space
CC=century (20, 21)
YY=year (00-99)

The blank space should fall on the vertical lines provided on the form.
Do NOT exclude leading zeros in the date fields.
(Correct: January 1, 2012 = 01 01 12; Incorrect: 1112).

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

For Block 24A

MMDDCCYY
MM=month (01-12)
DD=day (01-31)
CC=century (20, 21)
YY=year (00-99)

b. Physical Claim Form Specifications

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

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

**BLOCK 1 - TYPE COVERAGE**

1. **MEDICARE** |
   □ (Medicare #)

1. **MEDICAID** |
   □ (Medicaid #)

1. **TRICARE** |
   □ (Military)

1. **CHAMPVA** |
   □ (Sponsor's (SSN))

1. **GROUP** |
   □ (VA File #)

1. **HEALTH PLAN** |
   □ (SSN or ID)

1. **FECA** |
   □ (SSN)

1. **OTHER** |
   □ (ID)

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

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

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

Description: Enter the insured's identification number (including the 3-letter alpha prefix) as shown on the Member's ID card. Correctly and completely record the number in your file, including all alphabetic (alpha) and numeric characters.

**BLOCK 2 - PATIENT'S NAME**

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

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

Example: Tim L. O'Neal, Jr. = ONEAL TIM L
BLOCK 3 - PATIENT'S BIRTH DATE AND SEX

<table>
<thead>
<tr>
<th>3. PATIENT'S BIRTH DATE</th>
<th>SEX</th>
</tr>
</thead>
<tbody>
<tr>
<td>MM : DD : YY</td>
<td></td>
</tr>
<tr>
<td>01 : 03 : 2015</td>
<td>M</td>
</tr>
<tr>
<td></td>
<td>F</td>
</tr>
</tbody>
</table>

Description
Enter the patient’s date of birth and sex. Enter the patient’s birth date in numerical format, using two (2) digits for the month, two (2) digits for the day and four (4) digits for the year for a total of eight (8) digits. Check the box that indicates the sex of the patient. Enter 8 positions (MMDDCCYY) indicating the date on which the patient was born.

Examples:
January 3, 2015 = 01032015

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

BLOCK 4 - INSURED'S NAME

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

Description:
For patients with coverage through private insurance (BCBST, etc.) or Medicaid, FEP, TRICARE/CHAMPUS, etc., the patient's name may be different from the "insured". As the payor also needs the insured's name, place the full name of the "insured", "subscriber," or "contract holder" in this block (see Block 2). If the subscriber's name on the identification card is the same as the patient's name, you may use the word SAME or SELF.

ALL CAPITAL LETTERS. No special characters, no titles and no imbedded spaces except to separate last and first names, and middle initial. (Must be filed as Last Name first, then First Name followed by Middle Initial, if applicable.)

BLOCK 5 - PATIENT'S ADDRESS (multiple fields)

5. PATIENT'S ADDRESS (No., Street)
123 MAIN STREET

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ANYTOWN</td>
<td>TN</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ZIP CODE</th>
<th>TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>30400</td>
<td>(423) 535 5600</td>
</tr>
</tbody>
</table>

Description:
Enter patient's permanent mailing address and telephone number:
Line 7 = street address, including apt #
Line 9 = city and state
Line 11 = ZIP code and telephone #

Special character "-" (dash) may be used, No imbedded spaces except to separate street number/name, and to separate city/state.

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**BLOCK 6 - PATIENT'S RELATIONSHIP TO INSURED**

<table>
<thead>
<tr>
<th>6. PATIENT RELATIONSHIP TO INSURED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self ☐</td>
</tr>
</tbody>
</table>

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

**BLOCK 7 - INSURED'S ADDRESS (multiple fields)**

<table>
<thead>
<tr>
<th>7. INSURED'S ADDRESS (No., Street)</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAME</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CITY</th>
<th>STATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>ZIP CODE</td>
<td>TELEPHONE (Include Area Code)</td>
</tr>
<tr>
<td>( )</td>
<td></td>
</tr>
</tbody>
</table>

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

ALL CAPITAL LETTERS. No special characters, except "-" (dash) may be used. No imbedded blanks except to separate street number/name, and city/state.

**BLOCK 8 – RESERVED FOR NUCC Use (02/12)**

<table>
<thead>
<tr>
<th>8. RESERVED FOR NUCC USE</th>
</tr>
</thead>
</table>

**BLOCK 9 - OTHER INSURED’S NAME**

Description: Enter the name of the insured individual who is enrolled in any other policy if the name is different from that shown in Block 2. Enter the word “SAME” if the name is the same for Block 2. If no other policy benefits are assigned, leave this block blank. The name of the insured individual is entered in the order of the last name, first name and middle initial. If the “insured” under the additional coverage is the same as the person listed in Block 4, enter “SAME”.

ALL CAPITAL LETTERS. No imbedded spaces except to separate last and first names, and middle initial.
BLOCKS 9a-9d - COORDINATION OF BENEFITS

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

a. OTHER INSURED’S POLICY OR GROUP NUMBER

b. RESERVED FOR NUCC USE

c. RESERVED FOR NUCC USE

d. INSURANCE PLAN NAME OR PROGRAM NAME

Coordination of benefits is a very important cost containment feature for payers. Providing complete and accurate information about a patient’s health care coverage will help your office receive prompt and accurate claim payments.

Blocks 9a-9d pertain to the coverage not shown in Block 1a. For the company receiving the original claim (the company whose identification data is included in Block 1a), this information pertains to the “other” coverage.

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

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

Description: Enter the policy or group of the other insurance coverage for the patient. If the patient does not have other coverage, leave this block blank.

Payer organizations may use different wording to signify the policy or group number (e.g. “insured’s identification number,” “contract number” or “certificate number”).

(Do not repeat the same number listed in block 1a.)

BLOCK 9b - RESERVED FOR NUCC USE

BLOCK 9C - RESERVED FOR NUCC USE

BLOCK 9d - INSURANCE PLAN NAME OR PROGRAM NAME

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

Note: Medicare carriers require you to attach an additional page to the claim form providing the complete mailing address for the company/organization listed in Block 9d. Enter “ATTACHMENT” in Block 10d to indicate this required page is provided.
BLOCK 10 – IS PATIENT’S CONDITION RELATED TO

10. IS PATIENT’S CONDITION RELATED TO:
   a. EMPLOYMENT? (CURRENT OR PREVIOUS)
      YES □  NO □
   b. AUTO ACCIDENT?  PLACE (State)
      YES □  NO □
   c. OTHER ACCIDENT?
      YES □  NO □

Description: Indicate whether the patient’s condition is related to his or her employment and is applicable to one (1) or more of the services described in Block 24. If the patient’s condition is related to employment, put an “X” in the “YES” box and indicate whether it is related to the patient’s “current” or “previous employment by circling the appropriate term. If the injury or illness is related to an automobile accident, place an “X” in the “YES” box. Enter the date of the accident in Block 14 in eight (8)-digit format. If the patient’s condition is related to an “other accident”, place an “X” in the “YES” box. Enter the date of the accident in Block 14.

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

BLOCK 10d – CLAIM CODES (DESIGNATED BY NUCC)

10d. CLAIM CODES (Designated by NUCC)

BLOCK 11 - INSURED’S POLICY GROUP OR FECA NUMBER

11. INSURED’S POLICY GROUP OR FECA NUMBER
   G12345

   a. INSURED’S DATE OF BIRTH
      MM : DD : YY  SEX
      01 : 03 : 2015  M □  F □
   b. OTHER CLAIM ID (Designated by NUCC)
   c. INSURANCE PLAN NAME OR PROGRAM NAME
      RETIRED
   d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
      YES □  NO □  If yes, complete items 9, 9a. and 9d

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

Description: Enter the 8-digit date of birth of the insured (if insured is not the patient) and the sex of the insured. Place an “X” in the appropriate box to indicate the insured’s sex.

(See previous example under BLOCK 11 - INSURED’S POLICY GROUP OR FECA NUMBER)
BLOCK 11b — OTHER CLAIM ID (DESIGNATED BY NUCC)

BLOCK 11c — INSURANCE PLAN NAME OR PROGRAM NAME

Description: Enter complete name of the insurance plan or program that provides health care benefits for the person listed in Block 4.

ALL CAPITAL LETTERS.

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

BLOCK 11d — IS THERE ANOTHER HEALTH BENEFIT PLAN?

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

BLOCK 12 — PATIENT’S OR AUTHORIZED PERSON’S SIGNATURE (INFORMATION RELEASE/GOVERNMENT ASSIGNMENT)

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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

SIGNED ______________________________________________________ DATE

Description: This block contains the signature of the patient or the patient’s representative and the date in eight (8)-digit format. The signature authorizes the release of medical information necessary to process the claim and the payment of benefits to the physician or supplier if the physician/supplier accepts assignment. In lieu of a signature on the claim, enter “SOF” in this block if there is a “signature on file” agreement with the Provider.

ALL CAPITAL LETTERS,
Print “SOF” if release/assignment is being kept in patient’s file

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

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

SIGNED ______________________________________________________

Description: For non-governmental programs, an assignment of benefits separate from the information release (Block 12) is required if benefits are to be sent to the Provider. The patient must sign in this block if payment to the Provider is desired, or, the patient/insured’s signature on a separate document must be maintained in the patient’s file (enter “ON FILE”). Some Provider Agreements (PPOs, HMOs, etc.) specifically address how payments are to be handled, in which case, leave this block blank. However, it is still advisable to obtain an assignment of benefits from
the patient or patient’s representative if payment is to go to your office. Do not make any notation in this space if payment is to go to the patient. Signature on file will also be accepted here.

ALL CAPITAL LETTERS,
Print “ON FILE” if signature is kept in the patient’s file.

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

| 14. DATE OF CURRENT ILLNESS, INJURY, OR PREGNANCY (LMP) |
|-------------|-------------|-------------|
| MM          | DD          | YY          |
| 01          | 01          | 2015        |

Description: Enter the date of the current illness (first symptom), injury (accident) or pregnancy (last menstrual period or LMP) in eight (8)-digit formats. This information is necessary to determine the effective date of TennCare secondary payer coverage. If an accident date is provided, complete Block 10b or 10c. For chiropractic services, enter the date of the initiation of the course of treatment and the eight (8)-digit X-ray date in Item 19.

Example: January 1, 2015 = 01012015

**BLOCK 15 — OTHER DATE**

<table>
<thead>
<tr>
<th>15. OTHER DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>QUAL</td>
</tr>
</tbody>
</table>

**BLOCK 16 — DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION**

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

Description: This block identifies the dates that the patient was employed but unable to work in his or her current occupation and may indicate employment-related insurance coverage. The eight (8)-digit format must be used in this block. Completion of this field is important for worker’s compensation cases. An entry in this block may indicate employment-related insurance coverage.

**BLOCK 17 — NAME OF REFERRING PROVIDER OR OTHER SOURCE**

**BLOCK 17a — OTHER ID NUMBER**

**BLOCK 17b – NPI NUMBER**

<table>
<thead>
<tr>
<th>17. NAME OF REFERRING PROVIDER OR OTHER SOURCE</th>
<th>17a.</th>
<th>1B</th>
<th>ABC1234567890</th>
</tr>
</thead>
<tbody>
<tr>
<td>RALPH SMITH MD</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Description: The name of the referring Provider, ordering Provider, or other source who referred or ordered the service(s) or supply(s) on the claim. Do not use periods or commas.
within the name. A hyphen can be used for hyphenated names.
The Other ID number of the referring Provider, ordering Provider, or other source is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a. The non-NPI ID number of the referring Provider, ordering Provider, or other source refers to the Payer assigned unique identifier of the professional. The NUCC defines the applicable qualifiers, which can be found on the National Uniform Claim Committee (NUCC) website, www.nucc.org.

Enter the NPI number of the referring Provider, ordering Provider, or other source in 17b.

**BLOCK 18 — HOSPITALIZATION DATES RELATED TO CURRENT SERVICES**

<table>
<thead>
<tr>
<th>FROM</th>
<th>TO</th>
</tr>
</thead>
<tbody>
<tr>
<td>02 15 2015</td>
<td>02 17 2015</td>
</tr>
</tbody>
</table>

**Description:** Enter the applicable month, day and year of the hospital admission and discharge using an eight (8)-digit date format. This block is to be completed when medical services are rendered as a result of, or subsequent to, a related hospitalization. If services were rendered in a facility other than the patient’s home or a physician’s office, provide the name and address of that facility in Block 32.

**BLOCK 19 — ADDITIONAL CLAIM INFORMATION (DESIGNATED BY NUCC)**

**BLOCK 20 — OUTSIDE LAB? $CHARGES**

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>$ CHARGES</th>
</tr>
</thead>
</table>

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

**BLOCK 21 — DIAGNOSIS OR NATURE OF ILLNESS OR INJURY**

A.                    B.                    C.                    D.                    
E.                    F.                    G.                    H.                    
I.                    J.                    K.                    L.                    

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BLOCK 22 — RESUBMISSION CODE/ORIGINAL REFERENCE NUMBER

<table>
<thead>
<tr>
<th>22. RESUBMISSION CODE</th>
<th>ORIGINAL REF. NO.</th>
</tr>
</thead>
</table>

**Description:** This block is to be used when submitting a corrected claim. “Resubmission” means the code and original reference (claim) number assigned by the destination payer or receiver to indicate a previously submitted claim or encounter.

- A Resubmission Code should be filed in the first portion of Block 22. The valid values for this field are “7” Replacement of prior claim and “8” Void/Cancel of prior claim. These codes should be left-justified in the box so that they will be processed correctly.
- The original claim number issued to the claim being corrected should be filed in the Original Ref. No. portion of Block 22.
- This block is not intended for use for original claim submissions.
- Failure to include the proper “Resubmission Code” and “Original Ref. No.” may result in a claim rejection or denial.

BLOCK 23 — PRIOR AUTHORIZATION NUMBER

<table>
<thead>
<tr>
<th>23. PRIOR AUTHORIZATION NUMBER</th>
</tr>
</thead>
<tbody>
<tr>
<td>009876</td>
</tr>
</tbody>
</table>

**Description:** The “Prior Authorization Number” is the payer assigned number authorizing the services(s) for plans that require them.

**NOTE** - For Air Ambulance services submitted on the CMS1500 claim form the Pick-up Location Zip Code should be submitted in Block 23. Multiple Zip Codes should not be submitted in this block. If the points of pick-up are located in different Zip Codes a separate claim form should be submitted for each trip. The correct ZIP Code is five numeric digits; if a nine-digit ZIP Code is submitted the last four digits are ignored. **If Pick-up Location Zip Code is missing, invalid, or submitted in an incorrect format the claim will be returned unprocessed.**

BLOCK 24A. – 24J. – SUPPLEMENTAL INFORMATION

The following lists qualifier codes and description of supplemental information that can be entered in the shaded lines of Block 24:

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

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

The following qualifiers are to be used when reporting NDC units:

- F2 International Unit
- ME Milligram
- ML Milliliter
- GR Gram
- UN Unit

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

The following qualifiers are to be used when reporting these services:

- **ZZ** Narrative description of unspecified code
- **N4** National Drug Codes (NDC)

**Example:** N450242006101 ME1.25 ZZAvastin

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

The following examples define how to enter different types of supplemental information in Block 24. These examples demonstrate how the data are to be entered into the fields and are not meant to provide direction on how to code for certain services:

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

<table>
<thead>
<tr>
<th>ZZ</th>
<th>Date(s) of Service</th>
<th>Place of Service</th>
<th>EMG</th>
<th>Procedures, Services, or Supplies</th>
<th>Diagnosis Pointer</th>
<th>Charges</th>
<th>G.</th>
<th>H.</th>
<th>I.</th>
<th>J. Rendering Provider ID</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ZZ</td>
<td>03/06/15 to 03/10/15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>00770</td>
<td>P2</td>
<td>134</td>
<td>875.00</td>
<td>6 N</td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>ZZ</th>
<th>Date(s) of Service</th>
<th>Place of Service</th>
<th>EMG</th>
<th>Procedures, Services, or Supplies</th>
<th>Diagnosis Pointer</th>
<th>Charges</th>
<th>G.</th>
<th>H.</th>
<th>I.</th>
<th>J. Rendering Provider ID</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ZZ</td>
<td>03/06/15 to 03/10/15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>00770</td>
<td>P2</td>
<td>134</td>
<td>875.00</td>
<td>6 N</td>
<td></td>
</tr>
</tbody>
</table>

**Example 3:** Unspecified Code

<table>
<thead>
<tr>
<th>ZZ</th>
<th>Date(s) of Service</th>
<th>Place of Service</th>
<th>EMG</th>
<th>Procedures, Services, or Supplies</th>
<th>Diagnosis Pointer</th>
<th>Charges</th>
<th>G.</th>
<th>H.</th>
<th>I.</th>
<th>J. Rendering Provider ID</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ZZ</td>
<td>03/06/15 to 03/10/15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>E1399</td>
<td>12</td>
<td>165.00</td>
<td>1 N</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Example 4:** NDC Code

<table>
<thead>
<tr>
<th>ZZ</th>
<th>Date(s) of Service</th>
<th>Place of Service</th>
<th>EMG</th>
<th>Procedures, Services, or Supplies</th>
<th>Diagnosis Pointer</th>
<th>Charges</th>
<th>G.</th>
<th>H.</th>
<th>I.</th>
<th>J. Rendering Provider ID</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>ZZ</td>
<td>03/06/15 to 03/10/15</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>J1583</td>
<td>13</td>
<td>500.00</td>
<td>20 N</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>24A. Date(s) of Service From MM DD YY To MM DD YY</th>
<th>B. Place of Service</th>
<th>C. EMG</th>
<th>D. Procedures, Services, or Supplies (Explain Unusual Circumstances) CPT/HCPCS</th>
<th>Modifier</th>
<th>E. Diagnosis Pointer</th>
</tr>
</thead>
<tbody>
<tr>
<td>03 06 2015 03 10 2015</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>F. $CHARGES</th>
<th>G. DAYS OR UNITS</th>
<th>H. EPSDT Family Plan</th>
<th>I. ID QUAL</th>
<th>J. Rendering Provider Id. #</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td>NPI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td>NPI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td>NPI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
<td>NPI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td>NPI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
<td>NPI</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

BLOCK 24A — DATE(S) OF SERVICE

Description: This block indicates the beginning and ending dates of service for the entire period reflected by the procedure code, using six (6) digit formats, excluding all punctuation. Do not use slashes between dates. If the date or month is a single-digit, precede it with a zero (0). Make sure the dates shown are no earlier than the date of the current illness shown in Block 14. If the same service is furnished on different dates, each date should be listed on the claim. For services performed on a single day, the “from” and “to” dates are the same.

Up to 6 services (line items) may be reported on any one document. If more than 6 services (line items) need to be reported, additional forms must be completed.

The six (6) service lines in BLOCK 24 have been divided horizontally to accommodate submission of both the NPI and another/proprietary identifier during the NPI transition and to accommodate the submission of supplemental information to support the billed service.

The top area of the six service lines is shaded and is the location for reporting supplemental information. It is not intended to allow the billing of 12 lines of service. Supplemental information can only be entered with a corresponding, completed line and is to be placed in the shaded section of 24A through 24G.

Example: March 6, 2015 = 03062015

BLOCK 24B — PLACE OF SERVICE

Description: Enter the appropriate two (2) digit Place of Service Code for each item used or service performed. If services were provided in the emergency department, use code 23. If services were provided in an urgent care center, use code 22. If services were rendered in a hospital, clinic, laboratory or other facility, show the name and the address of the facility in Block 32.
BLOCK 24C — EMG (This field was originally titled “Type of Service”. “Type of Service” is no longer used and has been eliminated)

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

BLOCK 24D — PROCEDURES, SERVICES, OR SUPPLIES

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

Modifiers: A modifier is a 2-digit combination of numeric, alpha and/or numeric that may be added to a procedure code. Modifiers may be used to indicate that:

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

BLOCK 24E — DIAGNOSIS POINTER

Description: Indicate reference numbers linking the ICD codes listed in Block 21 (alpha A – L) to the dates of service and CPT® codes listed in Blocks 24A and 24D. This information is used to document that the patient’s diagnosis warranted the Physician’s services. Do not enter 01, 02, 03, or 04. When multiple services are performed, the primary reference letter (A-L) for each service should be listed first, other applicable services should follow. (ICD diagnosis codes must be entered in Block 21 only. Do not enter them in 24E.) Numeric entries in Block 24E are no longer valid for this block. Minimum of 3 alpha characters required.

Enter each applicable diagnosis at the line item level. If the service is for three (3) diagnosis codes, it should be keyed as ABC. Do not enter a span such as A-C.

NOTE: Per NUCC guidelines, submit diagnosis pointer ONLY. Failure to follow instructions will result in claim being returned unprocessed.
BLOCK 24F — CHARGES

Description: Enter the amount charged by the Practitioner for each of the services or procedures listed on the claim. If multiple occurrences of the same procedure are being billed on the same line, indicate the inclusive dates of service in Block 24A. List the separate charge for each service in this block and the number of units or days in Block 24G. Do not bill a flat fee for multiple dates of service on one line. Always print 2 digits in cents columns.

BLOCK 24G — DAYS OR UNITS

Description: This block shows the number of days or units of procedures, services or supplies listed in Block 24D. This block is most commonly used to report multiple visits, units of supplies, minutes of anesthesia and oxygen volume. The number “1” must be entered if only one service is performed. For some services (e.g., hospital visits, tests, treatments, doses of an injectable drug, etc.), indicate the actual quantity provided. When the number of days is reported, it is compared with the inclusive dates of service listed in Block 24A. Days usually are reported when the patient has been hospitalized. When billing radiology services, do not provide the number of X-ray views. However, when the same radiology procedure is performed more than once on the same day, the number of times should be shown in this block. Anesthesia claims must be reported in minutes. (Refer to Anesthesia Specifics for billing procedures). Numeric characters only.

BLOCK 24H — EPSDT

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

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

Description: If the Provider does not have an NPI number, enter the appropriate qualifier and identifying number in the shaded area. (See the National Uniform Claim Committee (NUCC) website, www.nucc.org for this information.)

The rendering Provider is the person or company (laboratory or other facility) who rendered or supervised the care. In the case where substitute Provider (Locum Tenens) was used, enter that Provider’s information here. Report the identification number in Blocks 24I and 24J only when different from data recorded in Blocks 33a and 33b.

BLOCK 24J —RENDERING PROVIDER ID # (This field was originally titled “COB”)

Description: The individual rendering the service is reported in 24J. The original fields for 24J and 24K have been combined and re-numbered as 24J. Enter the non-NPI number in the shaded area of the field. Enter the NPI number in the unshaded area of the field.
The rendering Provider is the person or company (laboratory or other facility) who rendered the care. In the case where a substitute Provider (locum tenens) or delegated was used, enter that Provider’s information here. Report the identification number in Blocks 24I and 24J only when different from data recorded in Blocks 33a and 33b. If a Nurse Practitioner, Physician’s Assistant, CRNA, etc. is billing a service that does not require supervision, the actual rendering professional’s ID number can be filed as the rendering Provider in Block 24J with a Group Name and NPI submitted as the Billing Provider in Blocks 33-33a.

**Note:** When Block 24J, line item rendering Provider is used:
- it should be an individual, never a group identity
- it must be the individual who performed the service(s)
- it must be an identity that BCBST recognizes as a valid Provider of health care services
- multiple rendering Providers may NOT be submitted on the same claim
- Block 24J and 33a do NOT have to match

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

<table>
<thead>
<tr>
<th>25.</th>
<th>FEDERAL TAX I.D. NUMBER</th>
<th>SSN</th>
<th>EIN</th>
</tr>
</thead>
<tbody>
<tr>
<td>612123456</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Description: Enter the Federal Tax I.D. Number or Social Security Number of the Provider identified in Block 33. Designate whether number listed is SSN or EIN by placing an "X" in the appropriate box.

**BLOCK 26 — PATIENT'S ACCOUNT NUMBER**

<table>
<thead>
<tr>
<th>26.</th>
<th>PATIENT’S ACCOUNT NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>M123456</td>
<td></td>
</tr>
</tbody>
</table>

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

**BLOCK 27 — ACCEPT ASSIGNMENT?**

<table>
<thead>
<tr>
<th>27.</th>
<th>ACCEPT ASSIGNMENT?</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES □ NO □</td>
<td></td>
</tr>
</tbody>
</table>

Description: Place an "X" in the box indicating whether you are accepting assignment.
**BLOCK 28 — TOTAL CHARGE**

<table>
<thead>
<tr>
<th>28. TOTAL CHARGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 1150.00</td>
</tr>
</tbody>
</table>

Description: Enter the total of all charges for services listed in Block 24. The total amount should be the sum of the individual amounts shown in Block 24F. DO NOT use dollar signs ($) or decimals (.) since both are reflected on the printed document.

Always print 2 positions in the cents field.

**BLOCK 29 — AMOUNT PAID**

<table>
<thead>
<tr>
<th>29. AMOUNT PAID</th>
</tr>
</thead>
<tbody>
<tr>
<td>$ 50.00</td>
</tr>
</tbody>
</table>

Description: Enter the amount that has been paid on the charges listed in Block 24.

**BLOCK 30 — RESERVED FOR NUCC USE**

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

<table>
<thead>
<tr>
<th>31. SIGNATURE OF PRACTITIONER OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS</th>
</tr>
</thead>
<tbody>
<tr>
<td>(I certify that the statements on the reverse apply to this bill and are made a part thereof.)</td>
</tr>
</tbody>
</table>

**BLOCK 32 — SERVICE FACILITY LOCATION INFORMATION**

<table>
<thead>
<tr>
<th>32. SERVICE FACILITY LOCATION INFORMATION</th>
</tr>
</thead>
<tbody>
<tr>
<td>GENERAL HOSPITAL</td>
</tr>
<tr>
<td>123 EAST STREET</td>
</tr>
<tr>
<td>THIS TOWN, TN 37000</td>
</tr>
</tbody>
</table>

a. NPI                                      

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

Rev 06/15
BLOCK 32a — NPI #

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

BLOCK 32b — OTHER ID #

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

BLOCK 33 — BILLING PROVIDER INFOR & PH #

<table>
<thead>
<tr>
<th>33. BILLING PROVIDER INFO &amp; PH # ( )</th>
</tr>
</thead>
<tbody>
<tr>
<td>RALPH S SMITH MD</td>
</tr>
<tr>
<td>124 EAST STREET</td>
</tr>
<tr>
<td>THIS TOWN, TN 37000</td>
</tr>
</tbody>
</table>

a. NPI  

Description: Enter the Provider’s or supplier’s billing name, address, zip code, and phone number. The phone number is to be entered in the area to the right of the field title.

BLOCK 33a — NPI #

Description: Enter the NPI number of the billing Provider.

Note: When Block 33, billing Provider is used:

- submit the Individual NPI for Billing Provider in Block 33a only when the Provider is an individual, unincorporated entity;
- submit the supervising Physician as the Billing Provider only when billing delegated services or locum tenens;
- Otherwise, the Group NPI should always be filed as the Billing Provider.

BLOCK 33b — OTHER ID #

Description: Enter the two-digit qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen, or other separator between the qualifier and number.
c. CMS-1500 Specific

- Multi-page Claims:
  - List diagnosis code(s) for all conditions related to the patient’s illness on each page.
  - Place the total amount only on the last page of the claim. The total on the last page should reflect the sum of the line items for all pages.
  - Use the words “Continued on next page” or “Page X of X” in Block 28 on each page (except on the last page, which reflects the total charge in Block 28).
  - Staple each page of the multi-page claim together. (This will help us identify multi-page claims.)
  - Staple only the pages of the individual claim together as one. Do not staple several multi-page claims together as one.

- Donor/Recipient information when filing transplant claims:
  - Block 8 should contain the patient information of the person that received the service. “In this case it will be the Donor”.
  - Block 58 should contain the Subscriber, the Recipient “if different from the Subscriber” and the Donor (the Donor should only be listed if there is other insurance coverage for the donor charges making the Recipient’s plan “BCBST” Secondary).
  - Block 59 on the Subscriber/Recipient lines should contain the patient Relationship code “39”. 39=”Organ Donor”.

The National Uniform Claim Committee (NUCC) maintains the 1500 form. Visit the NUCC “1500 Health Insurance Claim Form Reference Instruction Manual” at http://www.nucc.org for additional information. From the top of the website, select “1500 Claim Form,” then “1500 Instructions.”

**Note:** Beginning January 1, 2014, the National Drug Code (NDC) was required on all CMS-1500 claims for Provider-administered medications for all BCBST Members, including commercial Members. This requirement for Provider-administered medications applies to all lines of business.

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

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

1. **Physician**
   Practitioners should use their individual Provider number assigned by BCBST. Some Practitioners may have multiple Provider numbers. Practitioners should use the appropriate Provider number based on a unique tax, pay to, or physical location.

   - **Block 31** Signature of Practitioner or Supplier including degrees and credentials
   - **Block 33** Provider’s or supplier’s billing name, zip code, and phone number. The phone number is to be entered in the area to the right of the field title.
     - 33a NPI # of the billing Provider. **This number should represent the Practitioner’s signature in Block 31 unless billing via Delegated Services Policy.**
     - 33b Two-digit qualifier identifying the non-NPI number followed by the ID number.
2. **Health Care Professional**
   All contract-eligible Health Care Professionals should follow the Practitioner previously noted guidelines.

3. **Medical Service Provider**
   Durable Medical Equipment (DME) suppliers, Home Infusion Therapy services, and laboratories should bill on the CMS-1500/ANSI-837P for all BCBST commercial business using the following billing requirements:

   **Specific Billing Requirements:**
   
   Block 31  Signature of Supplier (or an authorized representative of the same) including degrees or credentials.
   Block 33  Provider’s or supplier’s billing name, zip code, and phone number. The phone number is to be entered in the area to the right of the field title.
   33a  NPI # of the billing Provider.
   33b  Two-digit qualifier identifying the non-NPI number followed by the ID number.

   **Note:** Home Health Agencies and Hospice Providers should bill charges on the CMS-1450/ANSI-837I.

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

6. **Staff Supervision Requirements for Delegated Services**

   This policy defines BCBST requirements for supervision by eligible Physicians and Chiropractors of their associates and assistants. Supervision by itself does not create eligibility for the services of associates and assistants. Such Practitioners must be supervised as specified in the categories below for a service to be eligible for reimbursement. The policy also describes requirements for billing delegated services. To the extent that state or federal law or regulation exceeds these internal requirements, these laws or regulations will control.

   Licensed Medical Doctor (MD), Doctor of Osteopathy (DO), Doctor of Chiropractic (DC), Doctor of Podiatric Medicine (DPM), Licensed Professional Counselor (LPC), Licensed Clinical Social Worker (LCSW), and Licensed Pharmacist are examples of autonomous Providers. Their services do not require the supervision of another profession. These Practitioners should bill their services under their own Provider number, NPI, or the Provider number, NPI of their facility. (Refer to clarification of term “autonomous” under **Clarification of terms used within this policy**.)

   a. **Provider Categories/Billing and Supervision Requirements**
      
      1. **Licensed Providers Requiring Supervision by Retrospective Review**
         
         Supervision by Retrospective Review is defined as supervision that does not take place during the time that a service is performed, but after the service has been rendered. This form of supervision may take place several days or even weeks after a service was rendered and may merely involve a review of an individual’s medical record (e.g., complaints, signs, symptoms, diagnostics and subsequent treatment[s]). The supervising Practitioner is typically not within the place of service (e.g., facility, office) during the time that a delegated service is performed.

         Licensed Providers requiring supervision by Retrospective Review include Certified Nurse Midwife, Certified Registered Nurse Anesthetist, Licensed Resident Physician, Nurse Practitioner, and Physician Assistant.
Supervising Physicians or Chiropractors are required to perform a review of the services they delegate to this category of Practitioner. Practitioners in this category are required to bill under the billing number of their supervising Practitioner except when rendering services independently, and are eligible to bill directly under their own BCBST Provider billing number. The actual Provider of service must also be listed on the billing form. This does not apply to licensed residents when performing services that are a part of their residency program.

**Supervising Physicians and Chiropractors must:**
- Annually review and document the licensure or certification of any office staff or employee to whom they delegate medical services.
- Review the patient records and certify by signed notation that evaluations and treatment plans are appropriate, as prescribed by law.
- Only delegate services that are within the scope of the delegated Practitioner's license.

**Specific Billing Requirements:**
- Block 31 Practitioner rendering the service
- Block 33 Provider’s or supplier’s billing name, zip code, and phone number. The phone number is to be entered in the area to the right of the field title.
  - 33a NPI # of the billing Provider.
  - 33b Two-digit qualifier identifying the non-NPI number followed by the ID number.

2. **Licensed Physicians Requiring Minimal Supervision**
Minimal Supervision requires that the supervising/treating Physician evaluate the patient at some reasonable time prior to receiving a delegated service, that a specific written order for the service be issued prior to the service being performed, and that a notation be made of the results obtained from the delegated service. The supervising/treating Practitioner may or may not be within the place of service (i.e., facility, office) during the time that a delegated service is rendered.

However, Senate Bill No.1144 and House Bill No. 964 allows for direct patient access to licensed physical therapists without an oral or written referral from a licensed doctor of medicine, chiropractic, dentistry, podiatry or osteopathy under the conditions set forth in T.C.A. Section 63-13-303.

Licensed Physicians requiring Minimal Supervision include Certified Athletic Trainer, Certified Audiologist, Certified Occupational Therapist, Chiropractic Radiology Technician, Licensed Physical Therapist, Licensed Practical Nurse, Licensed Psychological Examiner, Medical Laboratory Technologist, Orthopedic Physician Assistant, Radiologic Technician, Registered Dietitian/Registered Nutritionist, Registered Nurse, Registered Respiratory Therapist, Speech and Language Pathologist. Some Practitioners within these health care fields may be eligible for a BCBST Provider ID number.

Supervising Physicians, Chiropractors, or Psychologists are required to supervise the provision of delegated services for this category of Providers. If the actual Provider of the service needs the direction or supervision of a Chiropractor, Physician or Psychologist to legally perform a service and is ineligible to bill under their own number, then the Chiropractor, Physician or Psychologist will be allowed to bill those services under their name, Provider number and/or NPI. The actual Provider of service must also be listed on the billing form (i.e., in Block number 31 of the CMS-1500 claim form).
Supervising Physicians, Chiropractors and Psychologists must:
- Annually review and document the licensure or certification of any office staff or employees to whom they delegate medical services;
- Only delegate services that are within the scope of the Practitioner’s certification or license as determined by law. Such services should not require the exercise of independent professional judgment;
- Include the following documentation: 1) an evaluation of the patient prior to delegating or ordering any services, 2) a specific order for the service to be delegated, and 3) notation of the results obtained from the service ordered.
- Use treatment protocols from nationally recognized professional sources and have them available on-site for review by BCBST.

Specific Billing Requirements:
Block 31 Practitioner rendering the service
Block 33 Provider’s or supplier’s billing name, zip code, and phone number. The phone number is to be entered in the area to the right of the field title.
  33a NPI # of the billing Provider.
  33b Two-digit qualifier identifying the non-NPI number followed by the ID number.

3. Certified Providers Requiring Direct and Close Supervision
Direct and Close Supervision requires that the supervising Physician have, at a minimum, face-to-face contact with the patient immediately before and after a service is received. Material participation by the supervising Practitioner must include evaluation of the patient immediately prior to the service, a detailed written order, and a final evaluation of the patient and the service performed prior to the patient leaving the facility. The supervising Practitioner must be within the place of service (e.g., facility, office) and readily available during the time that a delegated service is rendered. (Note: See Extenuating Circumstances.) Being available via telephone does not constitute direct and close supervision.

Certified Providers requiring Direct and Close Supervision include Certified Chiropractic Therapy Assistant, Certified Medical Assistant, Certified Nursing Assistant, Certified Occupational Therapy Assistant, Certified Podiatric Assistant, Licensed Physical Therapy Assistant, and Medical Laboratory Technician. These health care Practitioners are not eligible for a BCBST Provider ID number.

Supervising Physicians, Chiropractors and Therapists must:
- Annually review and document certification of any office staff or employees to whom they delegate medical services.
- Only delegate services in which the supervising Practitioner materially participates. “Materially participate” means the supervising Practitioner must evaluate the patient immediately prior to the service, prepare a detailed written order, and perform a final evaluation of the patient and the service performed prior to the patient leaving the facility. The final evaluation should ensure that the service was delivered appropriately and was clinically effective. The supervising Practitioner must be on-site and available at all times. Documentation in the patient medical record must reflect that these steps occurred.
- Follow required treatment protocols from nationally recognized sources. Protocols must be kept on-site and be made available for review by BCBST.
- Only delegate services that do not require clinical judgment or could not be construed as a service requiring the expertise of Practitioners in categories 1&2.
Extenuating Circumstances
Under extenuating circumstances (e.g., network inadequacy in rural areas) a licensed/ certified therapy assistant may render services through a home health Provider in the home health setting under the general supervision of a licensed therapist. Under these conditions, a licensed therapist must evaluate the patient, develop a treatment plan, and implement the plan. General supervision requires initial direction and periodic re-evaluation by the registered therapists; however, the supervisor does not have to be physically present or on the premises.

Specific Billing Requirements:
Block 31. Physician rendering the service
Block 33. Provider’s or supplier’s billing name, zip code, and phone number. The phone number is to be entered in the area to the right of the field title.
33a. NPI # of the billing Provider.
33b. Two-digit qualifier identifying the non-NPI number followed by the ID number.

4. Clarification of terms used within this policy:
   a. **Autonomous Providers** – Providers who by their state license are qualified to diagnose and initiate treatment independently. For example, a Doctor of Chiropractic (DC) is licensed to diagnose and initiate chiropractic treatment without an order to treat from another profession. A DC is an autonomous Provider and as such, does not require supervision or orders from another profession.

   b. **Supervision by retrospective review** – Supervision that does not take place during the time that a service is performed, but after the service has been rendered. This form of supervision may take place several days or even weeks after a service was rendered and may merely involve a review of an individual’s medical record (i.e., complaints, signs, symptoms, diagnostics and subsequent treatment[s]). The supervising Practitioner is typically not within the place of service (i.e., facility, office) during the time that a delegated service is performed.

   c. **Minimal supervision** – Requires that the supervising/treating Practitioner evaluate the patient at some reasonable time prior to receiving a delegated service, that a specific written order for the service be issued prior to the service being performed, and that a notation be made of the results obtained from the delegated service. The supervising/treating Practitioner may or may not be within the place of service (i.e., facility, office) during the time that a delegated service is rendered.

   d. **Direct and close supervision** – Requires that the supervising Practitioner has, at a minimum, face-to-face contact with the patient immediately before and after a service is received. Material participation by the supervising Practitioner must include evaluation of the patient immediately prior to the service, a detailed written order, and a final evaluation of the patient and the service performed prior to the patient leaving the facility. The supervising Practitioner must be within the place of service (i.e., facility, office) and readily available during the time that a delegated service is rendered. (Note: Extenuating circumstances above.) Being available via telephone does not constitute direct and close supervision.
7. Locum Tenens Policy

A “locum tenens” is a temporary Practitioner who fills in for a Practitioner on a short-term basis. A Practitioner who is to be a permanent member of a practice or who performs services for over sixty (60) days does not meet the definitions of a “locum tenens” and must initiate contracting and credentialing with BCBST. Any Practitioner that has been denied credentials by BCBST and has not successfully appealed that denial cannot serve as a locum tenens and treat BCBST Members as an in-network Provider or bill under an in-network Provider’s ID number.

The substitute Practitioner generally does not have a practice of his/her own and moves from area to area as needed. The regular practitioner generally pays the substitute practitioner or an agency a fixed amount per diem, giving the substitute practitioner the status of independent contractor rather than an employee.

A BCBST Participating Practitioner may submit a claim for a Member’s Covered Services (including emergency visits and related services) of a “locum tenens” Practitioner who is not an employee and whose services for Members of the regular Practitioner are not restricted to the regular Practitioner’s office, if:

- The Member has arranged or seeks to receive services from the regular Practitioner;
- The regular Practitioner is unavailable to provide the visit services due to leave of absence for illness, vacation, pregnancy, continuing medical education, etc.;
- The regular Practitioner has left a group practice and the group has engaged a “locum tenens” Practitioner as a temporary replacement until a permanent replacement Practitioner is obtained. In this case, group must select a member of the group as an oversight Practitioner.
- The regular Practitioner, or group practice acting on his behalf, sends a letter to the appropriate BCBST Provider Network mailbox, PNS_GM@bcbst.com stating the reason for “locum tenens”. The letter should state the date the services will begin and the estimated end date;
- The regular Practitioner, or group practice acting on his behalf, has ascertained that the “locum tenens” is qualified by training and experience to temporarily maintain the regular Practitioners’ practice;
- The regular Practitioner pays the “locum tenens” for his/her services on a per diem or similar fee-for-time basis; Compensation paid by a group to the “locum tenens” Practitioner is considered paid by the regular Practitioner for purposes of this policy.
- The services are not provided over a continuous period of longer than sixty (60) days. The regular Practitioner, or group practice acting on his behalf, must keep on file a record of each service provided by the substitute Practitioner and make the records available to BCBST upon request;
- Professional claims should be submitted with BCBST Participating Practitioner’s name, individual Provider number, and/or NPI in Block 33 and “locum tenens” name in Block 31 as the servicing Provider. In case of regular Practitioner who has left group practice, claims should be submitted with BCBST Participating Oversight Practitioner name, individual Provider number, and/or NPI in Block 33 and “locum tenens” name in Block 31 as the servicing Provider.

8. CMS-1450 Facility Claim Form

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

The UB-04 contains a number of improvements and enhancements that include better alignment with the electronic HIPAA ASC X 12N 837-Institutional Transaction Standard. The UB-04 paper billing form accommodates the reporting of the National Provider Identifier Number (NPI). The NPI is a single Provider identifier, replacing the different Provider
identifiers health care systems previously used for each health plan with which you do business. The NPI Identifier, which implements a requirement of Health Insurance Portability and Accountability Act of 1996 (HIPAA), must be used by all HIPAA covered entities, which are health plans, health care clearinghouses, and health care Providers.

**Note:** BCBST follows CMS guidelines for filing the National Provider Identifier (NPI) Number.

A sample copy and field description of the UB-04 claim form follows:
**a. CMS-1450 (UB-04) Form Locators and Field Description:**

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Provider Name, Address, Telephone Number***</td>
</tr>
<tr>
<td>2</td>
<td>Pay-to Name, Address, City, State, and ID</td>
</tr>
<tr>
<td>3</td>
<td>3a&gt;Patient Control Number*** 3b&gt;Medical Record Number***</td>
</tr>
<tr>
<td>4</td>
<td>Type of Bill***</td>
</tr>
<tr>
<td>5</td>
<td>Federal Tax Number***</td>
</tr>
<tr>
<td>6</td>
<td>Statement Covers Period***</td>
</tr>
<tr>
<td>7</td>
<td>Unlabeled Field</td>
</tr>
<tr>
<td>8</td>
<td>8a&gt;Patient Name-ID 8b&gt;Patient Name***</td>
</tr>
<tr>
<td>9</td>
<td>9a&gt;Patient Address-Street 9b&gt;Patient Address-Other 9b&gt;Patient Address-City 9c&gt;Patient Address-State 9d&gt;Patient Address-Zip 9e&gt;Patient Address-Country Code***</td>
</tr>
<tr>
<td>10</td>
<td>Patient Birthdate***</td>
</tr>
<tr>
<td>11</td>
<td>Patient Sex***</td>
</tr>
<tr>
<td>12</td>
<td>Admission Date*** (Inpatient)</td>
</tr>
<tr>
<td>13</td>
<td>Admission Hour*** (except for Bill Type 02X)</td>
</tr>
<tr>
<td>14</td>
<td>Type of Admission/Visit***</td>
</tr>
<tr>
<td>15</td>
<td>Source of Admission***</td>
</tr>
<tr>
<td>16</td>
<td>Discharge Hour*** (final inpatient claim only)</td>
</tr>
<tr>
<td>17</td>
<td>Patient Discharge Status***</td>
</tr>
<tr>
<td>18</td>
<td>Condition Codes</td>
</tr>
<tr>
<td>19</td>
<td>Condition Codes</td>
</tr>
<tr>
<td>20</td>
<td>Condition Codes</td>
</tr>
<tr>
<td>21</td>
<td>Condition Codes</td>
</tr>
<tr>
<td>22</td>
<td>Condition Codes</td>
</tr>
<tr>
<td>23</td>
<td>Condition Codes</td>
</tr>
<tr>
<td>24-28</td>
<td>Condition Codes</td>
</tr>
<tr>
<td>29</td>
<td>Accident State</td>
</tr>
<tr>
<td>30</td>
<td>Unlabeled Field</td>
</tr>
<tr>
<td>31</td>
<td>a-b Occurrence Code/Date</td>
</tr>
<tr>
<td>32-34</td>
<td>a-b Occurrence Codes and Dates</td>
</tr>
<tr>
<td>35</td>
<td>a-b Occurrence Span Code/From//Through</td>
</tr>
<tr>
<td>36</td>
<td>a-b Occurrence Span Code/From/Through</td>
</tr>
<tr>
<td>37</td>
<td>a-b Unlabeled Fields</td>
</tr>
<tr>
<td>38</td>
<td>1-5 Responsible Party Name/Address</td>
</tr>
<tr>
<td>39</td>
<td>a-d Value Code-Code</td>
</tr>
<tr>
<td></td>
<td>a-d Value Code-Amount</td>
</tr>
<tr>
<td>40</td>
<td>a-d Value Code-Code</td>
</tr>
<tr>
<td></td>
<td>a-d Value Code–Amount</td>
</tr>
<tr>
<td>41</td>
<td>a-d Value Code-Code</td>
</tr>
<tr>
<td></td>
<td>a-d lines Value Code-Amount</td>
</tr>
<tr>
<td>42</td>
<td>Revenue Code***</td>
</tr>
<tr>
<td>43</td>
<td>1-22 Revenue Code Description***</td>
</tr>
<tr>
<td>43-44</td>
<td>Line 23 Page_of_Creation_Date</td>
</tr>
<tr>
<td>44</td>
<td>HCPCS/Rates/HIPPS/Rate Codes***</td>
</tr>
<tr>
<td>45</td>
<td>1-22 Service Date</td>
</tr>
<tr>
<td>46</td>
<td>Line 23 Creation Date</td>
</tr>
<tr>
<td>47</td>
<td>Units of Service***</td>
</tr>
<tr>
<td>48</td>
<td>Total Charges***</td>
</tr>
<tr>
<td>49</td>
<td>Non-Covered Charges</td>
</tr>
<tr>
<td>50</td>
<td>Unlabeled Field</td>
</tr>
<tr>
<td>51</td>
<td>Payer Identification***</td>
</tr>
<tr>
<td></td>
<td>Health Plan ID</td>
</tr>
</tbody>
</table>
### CMS-1450 (UB-04) Form Locators and Field Description (cont'd):

<table>
<thead>
<tr>
<th>Form Locator</th>
<th>Field Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>52</td>
<td>Release of Information Certification Indicator</td>
</tr>
<tr>
<td>53</td>
<td>Assignment of Benefits Certification Indicator</td>
</tr>
<tr>
<td>54</td>
<td>Prior Payments -- Payer</td>
</tr>
<tr>
<td>55</td>
<td>Estimated Amount Due</td>
</tr>
<tr>
<td>56</td>
<td>NPI</td>
</tr>
<tr>
<td>57</td>
<td>Other Provider ID-Primary/Secondary***</td>
</tr>
<tr>
<td>58</td>
<td>Insured's Name***</td>
</tr>
<tr>
<td>59</td>
<td>Patient's Relationship to Insured</td>
</tr>
<tr>
<td>60</td>
<td>Certificate/Social Security Number/Health Insurance</td>
</tr>
<tr>
<td></td>
<td>Claim/Identification Number***</td>
</tr>
<tr>
<td>61</td>
<td>Insured Group Name</td>
</tr>
<tr>
<td>62</td>
<td>Insurance Group Number</td>
</tr>
<tr>
<td>63</td>
<td>Primary/Secondary/Third</td>
</tr>
<tr>
<td>64</td>
<td>Document Control Number</td>
</tr>
<tr>
<td>65</td>
<td>Employer Name</td>
</tr>
<tr>
<td>66</td>
<td>DX Version Qualifier</td>
</tr>
<tr>
<td>67</td>
<td>Principal Diagnosis Code***</td>
</tr>
<tr>
<td>68</td>
<td>A-Q Other Diagnosis Codes</td>
</tr>
<tr>
<td>69</td>
<td>Admitting Diagnosis Code*** (Inpatient)</td>
</tr>
<tr>
<td>70</td>
<td>Patient’s Reason for Visit Code</td>
</tr>
<tr>
<td>71</td>
<td>PPS Code*** (if in Provider contract with payor)</td>
</tr>
<tr>
<td>72</td>
<td>A-C External Cause of Injury Code</td>
</tr>
<tr>
<td>73</td>
<td>Unlabeled</td>
</tr>
<tr>
<td>74</td>
<td>ICD Code/Date*** (if surgical procedure performed)</td>
</tr>
<tr>
<td>75</td>
<td>a-e Other Procedure Code/Date</td>
</tr>
<tr>
<td>76</td>
<td>1- Attending –NPI/QUAL/ID</td>
</tr>
<tr>
<td>77</td>
<td>2-Attending-Last/First</td>
</tr>
<tr>
<td>78</td>
<td>1-Operating-NPI/QUAL/ID</td>
</tr>
<tr>
<td>79</td>
<td>2-Operating-Last/First</td>
</tr>
<tr>
<td>80</td>
<td>1-Other ID-QUAL/NPI/ID</td>
</tr>
<tr>
<td>81</td>
<td>2-Other ID-Last/First</td>
</tr>
<tr>
<td></td>
<td>1-4 Remarks</td>
</tr>
<tr>
<td></td>
<td>a-d Code-Code-QUAL/CODE/VALUE</td>
</tr>
</tbody>
</table>

** Required Fields by Pre Adjudication Edits
*** Required Fields by BCBST Electronic Billing
b. Revenue Code (FL42)
Complete this field with the revenue code related to the services that are being billed to BCBS. For specific instructions regarding each revenue code, refer to the billing guidelines defined below:

- **Billing Guidelines (Form Locator 42) Field Definitions**
  Each field contains specific billing information critical to understanding how to file a claim with BCBS. By following these guidelines the facility will maximize reimbursement.

- **Revenue Code** – The Revenue Code is the initial indicator to the claims administration system as to what type of services were performed. Revenue Codes for inpatient and outpatient services are included in the billing guidelines.

- **Category** – The Category defines a general description of the type of service provided under the Revenue Code. Some Revenue Codes fall into several Categories such as Revenue Code 110. Revenue Code 110 is generally used to file services under Medical, Surgical, Orthopedic, Trauma, Trauma Medical and Trauma Surgical, among others. The participating Provider Contract outlines which Revenue Codes can be filed under each Category.

- **Reimbursement Rule** - The Reimbursement Rule explains what type of reimbursement the facility should expect if billed properly. It is extremely important to have the facility’s contract on hand when reviewing how a claim should be reimbursed. BCBS claims administration system in some cases will default to another Category in the event that there is no specifically contracted rate for a service. In addition, some services are ineligible as “Not Medically Necessary,” or there is no negotiated fee.

- **Principal Diagnosis** - The Principal Diagnosis determines the Category for reimbursement. The Principal Diagnosis should always be billed in Form Locator 67 on the CMS-1450 claim form. This field indicates to our system the primary reason for the services rendered to the patient.

- **Principal Procedure Code** – The Principal Procedure Code is an ICD Procedure Code. This code will help determine the Category of service. The facility should bill the correct Principal Procedure Code in Form Locator 74 of the CMS-1450.

- **CPT®/HCPCS Required** – CPT® Codes should always be billed on the CMS-1450 in Form Locator 44. This field indicates when a Revenue Code must be filed with a CPT®/HCPCS Code. If a required CPT®/HCPCS Code is missing, the claim may be denied and returned to the facility for proper coding.

**Note:** Billing outpatient procedures using CPT®/HCPCS Codes on the CMS-1450 is a new requirement for BCBS. However, Medicare already requires this information.

c. HCPCS Codes/Rates (FL44)
Complete this field with the CPT®/HCPCS Code related to the service being provided. To determine which CPT®/HCPCS Codes are to be filed with a related Revenue Code, refer to the FL44 – BCBST CPT®/HCPCS Code Requirement.

**Note:** For the related contract, BCBS accepts only valid CPT®/HCPCS Codes that can be billed in a hospital acute care setting. Prior to payment, unlisted procedures must be filed hard copy with the supporting medical record.
Billable Guidelines (Form Locator 44) Field Definitions
Each field contains specific billing information critical to understanding how to file a claim with BCBST. By following these guidelines, the facility will maximize reimbursement. These guidelines only apply to Revenue Codes stated in the Billable Guidelines (Form Locator 42) as requiring a CPT®/HCPCS Code.

- **CPT®** – The CPT® Field lists the CPT®/HCPCS Code or Range of Codes eligible to be filed in Form Locator 44 of the CMS-1450.
  
  - Codes ranging from 10000-69999 are generally surgical codes and require individual negotiated rates for outpatient services. Please refer to the correct Network Attachment for reimbursement schedules.
  
  - Codes ranging from 70000-79999 are generally radiology codes. Please refer to the Provider Network Attachment for any Procedure Codes that have individual negotiated rates.
  
  - Codes ranging from 80000-89999 are generally laboratory or pathology codes. Please refer to your Provider Network Attachment for any Procedure Codes that have individual negotiated rates.

- **MOD** – The Modifier (MOD) Field states any code that must be filed with a modifier in addition to a CPT®/HCPCS Code.

- **Required Revenue Code(s)** - The Required Revenue Code(s) Field is provided so the facility will know exactly what Revenue Codes are eligible to bill BCBST for each CPT®/HCPCS Code. Without the correct Revenue Code and CPT®/HCPCS Codes, BCBST will not accept the claim for consideration of benefits. Incorrectly filed claims may be returned to the Provider for correction.

- **Billing Instructions** – The Billing Instruction Field explains the requirements to bill the selected CPT®/HCPCS Code. This field also provides an insight as to how BCBST adjudicates the claim.

d. **Service Units (FL46)**
In general, report the quantitative measure of service, by revenue category, to or for the patient; such as, the number of accommodation days, visits, miles, pints of blood, units or treatments. Units for related CPT®/HCPCS Codes are to be based on the number of times the service or procedure was performed, as defined by the CPT®/HCPCS Code. Visit codes are not to be reported as units.

e. **Principal Diagnosis Code (FL67)**
Depending on your contract, the Principal Diagnosis Code may be required for proper adjudication of an inpatient claim. For specific instructions, see Billing Guidelines (Form Locator 42). If applicable, report the full ICD Code that describes the principal diagnosis.

f. **Principal Procedure Code and Date (FL74)**
Depending on your contract, the Principal Procedure Code may be required for proper adjudication of an inpatient claim. For specific instructions refer to Billing Guidelines (Form Locator 42). If applicable, report the ICD Code for the principal procedure performed during the period covered by the bill and the date that the principal procedure was performed.

g. **Attending Physician (FL76)**
Report the name and UPIN Number of the licensed Physician who is expected to certify the Medical Necessity of the services rendered and who is primarily responsible for the patient’s care. (If UPIN is NOT available, enter “OTH000” in this field.

Rev 12/15
h. **CMS-1450 Specific**

- All date information should be shown in the following format (except Form Locator 10 – Birth Date):
  - MMDDYY
  - MM=month (01-12)
  - DD=day (01-31)
  - YY=year (00-99)

  - Example: January 1, 2004 = 010404

  - Form Locator 10 must be a continuous 8-digit number (Correct: January 1, 2004 = 01042004)

- Do not exclude leading zeros in the date fields;

- Multi-page Claims:
  - All diagnosis code(s) listed on first page must be listed on each page.
  - Place the total amount and 0001 Total Revenue Code only on the last page of the claim. The 0001 Total Revenue Code line on the last page of the claim should reflect the sum of the line items for all pages.
  - Use the words “Continued on next page” or “Page X of X” on line 23 on each page (except on the last page, which reflects the total charge on the 0001 Total Revenue Code line).
  - Staple only the pages of the individual claim together as one. Do not staple several multi-page claims together as one.

- Donor/Recipient information when filing transplant claims:
  - Block 2 should contain the name of patient that received the service. “In this case it will be the Donor”.
  - Block 19 should be marked “Donor” and contain the “Recipient’s” name.

BCBST updated the OCR scanning processes for CMS-1500 and CMS-1450 paper claims. Following the 2012 Official UB-04 Data Specifications Manual guidelines, this update did not require any changes related to the CMS-1500 claim form, however the following changes will be required when submitting CMS-1450 paper claims:

- **Form Locator 12 - Admit Date:** Admit date should only be populated for inpatient, home health, and hospice claims. A rejection will occur for any other claim type.

- **Form Locator 13 - Admit Hour:** Admit hour should only be populated for inpatient claims, excluding type of bill 021x. A rejection will occur for any other claim type.

- **Form Locator 15 - Admission Source:** Admission source should be populated for ALL institutional claims except those with a TOB 014X. Any UB-04 (or its successor) claim form submitted without an Admission Source will be rejected and returned for correction.

- **Form Locator 69 - Admitting Diagnosis Code:** Admitting diagnosis code is only required for inpatient claims. A rejection will occur for any other claim type.

- **Form Locator 74 - Principal Procedure Code:** Principal procedure code should only be submitted for inpatient claims. A rejection will occur for any other claim type.

- **Form Locator 74a-e - Other Procedure Code:** Other procedure codes should only be submitted for inpatient claims. A rejection will occur for any other claim type.

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

<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. NDC Qualifier</td>
<td>N4</td>
</tr>
<tr>
<td>2. NDC Number</td>
<td>Eleven digit number</td>
</tr>
<tr>
<td>3. NDC Quantity Qualifier</td>
<td>F2 - International Unit</td>
</tr>
<tr>
<td></td>
<td>GR – Gram</td>
</tr>
<tr>
<td></td>
<td>ME - Milligram</td>
</tr>
<tr>
<td></td>
<td>ML - Milliliter</td>
</tr>
<tr>
<td></td>
<td>UN - Unit</td>
</tr>
<tr>
<td>4. NDC Quantity</td>
<td>Numeric value</td>
</tr>
<tr>
<td>5. NDC Unit Price</td>
<td>(ANSI-837 only)</td>
</tr>
</tbody>
</table>

As a reminder, to help ensure compliance with National Uniform Billing Committee (NUBC) guidelines, claims submitted with a discharge status 20, 40, 41, or 42 must also include an Occurrence Code 55 and date of death.

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

9. Instructions for Returned Claims and Processed Claims needing Correction

Note: Corrected bills must be submitted within two years of the end of the year the claim was originally submitted. For example, if a claim was filed on 2/15/15, any corrected bill must be submitted by 12/31/17.

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

Providers should correct the error(s) and resubmit the claim as a new claim on a **new** claim form. **DO NOT WRITE OR STAMP “CORRECTED CLAIM” ON THE NEW CLAIM.** Correcting the error(s) and resubmitting on a **new** claim form will help ensure quicker turnaround.

Incomplete electronic claims are reflected on the Provider’s 277CA Health Care Information Status Notification Report. Providers should correct the error and resubmit the claim electronically.

**Note:** Since incomplete returned claims have not been processed (Providers have not received a Remittance Advice for these claims), the claim will not be denied “duplicate” when resubmitted. Images of all rejected and accepted claims will be maintained in BCBST’s archives for future reference.

b. Corrected Bills
Claims that have been **processed** (Providers receive a Remittance Advice that includes the claim) and were paid incorrectly because of an error or omission on the claim may be filed as a “**Corrected Bill**”. A true corrected bill includes additional/changed dates of service, codes, units, and/or charges that were not filed on the original claim.
**Note:** Claims returned or rejected should not be submitted as corrected claims. Only claims that have completed adjudication should be submitted as corrected bills. When sending a Corrected/Replacement Claim you must re-send the claim in its entirety including the corrections.

Also, when a Corrected Bill is filed, BCBST will recover any payment previously made under the original claim submission from the Provider’s remittance advice (a refund request letter will not be sent). Any applicable new payment will be based on the services submitted on the Corrected Bill claim.

1. **Corrected Electronic Claims (Required Method)**

   If a claim is rejected, it requires correction and resubmission electronically. **Corrected Bills** for facility and professional claims can be filed electronically in the ANSI-837, version 5010 format. The following guidelines are based on National Implementation Guides found at [http://www.wpc-edi.com](http://www.wpc-edi.com) and BCBST Companion Documents found at [http://www.bcbst.com/providers/ecomm/technical-information.shtml](http://www.bcbst.com/providers/ecomm/technical-information.shtml) when filing these claims.

2. **ANSI-837P - (Professional) and ANSI-837I - (Institutional)**

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

   - In the 2300 Loop, the CLM segment (claim information), CLM05-3 (claim frequency type code) must indicate the third digit of the Type of Bill being sent. The third digit of the Type of Bill is the frequency and can indicate if the bill is an Adjustment, a Replacement or a Voided claim as follows:
     - “7” – REPLACEMENT (Replacement of Prior Claim)
     - “8” – VOID (Void/Cancel of Prior Claim)

   - In the 2300 Loop, the REF segment (claim information), must include the original claim number issued to the claim being corrected. The original claim number can be found on your electronic remittance advice.
     - REF01 must contain ‘F8’
     - REF02 must contain the original BCBST claim number

   **Example:** REF*F8*1234567890~

   - In the 2300 Loop, the NTE segment (free-form ‘Claim Note’), must include the explanation for the Corrected/Replacement Claim.
     - NTE01 must contain ‘ADD’
     - NTE02 must contain the free-form note indicating the reason for the corrected replacement claim.

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

For Technical Support assistance, contact eBusiness Technical Support at 423-535-5717 or via e-mail at EcommTechSupport@bcbst.com. Technical support is available Monday through Thursday, 8 a.m. to 6 p.m. (ET), and Friday, 9 a.m. to 6 p.m. (ET).
3. Method for Filing Corrected Paper Claims

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

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

- **Submit a new claim form with the correct data.**
  - Attach correspondence behind the claim form indicating what information was originally submitted and what was changed on the new claim form. Example: “Procedure code in Block 24D of first line item was submitted as 99201; corrected to 99202 on new claim.”
  - Write (using pen with black ink) or type qualifier “7” (Replacement of prior claim), or “8” (Void/Cancel of prior claim) in Block 22 on the CMS-1500 claim form. Our Optical Character Recognition (OCR) equipment will not recognize red ink. Do not use a thick marker or crayon that may cover other form fields.
  - On the CMS-1450 (UB-04) claim form, if the third digit in the Type of Bill field (form locator 4) ends in a “7” or “8”, the claim is considered a corrected bill.

<table>
<thead>
<tr>
<th>If third digit in type of bill is:</th>
<th>it indicates:</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>Replacement of prior claim</td>
</tr>
<tr>
<td>8</td>
<td>Void/cancel of prior claim</td>
</tr>
</tbody>
</table>

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

- **Alternate Method for Filing Corrected Paper Claims**
  - Draw a thin line through the original information and clearly list the new information above, below or beside the original information.
  - Keep within the boundaries of the form field when adding the correct information. Do not use a thick marker or crayon that may cover other form fields.
  - Do not use correction tape or fluid (White Out) – the original information MUST be visible.
  - Write (using pen with black ink) or type qualifier “7” (Replacement of prior claim), or “8” (Void/Cancel of prior claim) in Block 22 on the CMS-1500 claim form.
  - Use the appropriate Type of Bill on the CMS-1450 claim form to identify the claim as a corrected bill. (See code definitions above.)
  - If filing a corrected claim as a new claim submission, the claim number originally used by BCBST to process the claim should be included in the Original Ref. No. field – FL64. This item number is not intended for use for original claim submissions. Failure to include the proper indicator and original claim number may result in a claim denial.
10. Coordination of Benefits

BCBST Provider Contracts include the provision for Coordination of Benefits (COB), which applies when a Member has coverage under more than one group contract or health care benefits plan. Claims should be submitted to the primary carrier prior to submission to BCBST. Upon claim submission to BCBST, please provide a copy of the Remittance Advice from the primary carrier.

11. Maintenance of Benefits

Maintenance of Benefits (MOB) is a form of Coordination of Benefits (COB). When BCBST’s health care coverage is secondary to another plan, Maintenance of Benefits ensures that the combined payments of the two health care plans do not exceed what BCBST would have paid if it had been the only coverage. MOB is often referred to as “preservation” COB, because it preserves the secondary plan’s deductibles, copayments and coinsurance amounts.

If the primary insurance carrier’s payment amount is the same or more than what BCBST would have paid, BCBST will not make any additional payment. If the primary insurance carrier’s payment is less than what BCBST would have paid, BCBST will only pay the difference in what it would have paid and what the primary insurance carrier did pay. Even if BCBST does not make payment, and a BCBST participating Provider rendered the services, the Member is not liable for any amount over the Provider’s negotiated reimbursement amount, which is the maximum allowable charge. The Provider cannot bill the Member for any amount over the maximum allowable charge.

Note: *If the Member is a Medicare beneficiary, routine waiver of deductible and copayments by the charge-based Providers, Practitioners or suppliers is unlawful because it results in (1) false claims, (2) violations of the anti-kickback statute, and (3) excessive utilization of items and services paid for by Medicare.*

12. Right of Reimbursement and Recovery (Subrogation)

The Right of Reimbursement and Recovery (Subrogation) is a provision in the Member’s health care benefits plan that permits BCBST to pay the Provider when a third party causes the Member’s condition. BCBST handles subrogation cases on a “pay and pursue” basis. If a Provider becomes aware that the services rendered result from the actions of a third party, he/she should contact us at the following address and telephone number:

BlueCross BlueShield of Tennessee
Subrogation Department
1 Cameron Hill Circle, Ste 0008
Chattanooga, TN  37402-0008
423-535-5847

If there is a payment from a third party carrier that results in an overpayment, it is the responsibility of the Provider to reimburse BCBST the overpaid amount. If a Provider receives more than he/she should have when benefits are provided by an auto insurance or a homeowner’s plan, the Provider will be expected to repay any overpayment to the appropriate insurer. The Provider will not pursue any third party recoveries, nor accept any payments from other parties after payment by BCBST. This does not apply to copayments, deductible or coinsurance amounts.
13. Balance Billing

Providers agree to accept reimbursement made in accordance with the terms of their Provider Contract with BCBST, plus any applicable Member copayment/deductible, and coinsurance amounts as the maximum amount payable to the Provider for Covered Services rendered to Members.

Providers may not seek payment from a BCBST Member when:

- The Provider failed to comply with BCBST medical management policies and procedures or provided a service which does not meet BCBST standards for medical necessity or does not comply with BCBST medical policy;
- The Provider failed to submit or resubmit claims for payment within the time periods required by BCBST (timely filing guidelines); or
- Services rendered are considered Investigational by BCBST and are therefore non-reimbursable, unless prior to rendering such services to the Member, Provider has entered into a procedure-specific written agreement with the Member, which advised Member of his/her payment responsibilities.

Providers may bill the Member for:

- Non-Covered Services*;
- Any applicable Deductible/Copay Amounts; and
- Any applicable Co-Insurance Amounts.

When seeking payment from a BCBST Member, please refer to the Patient Owes column on your Provider Remittance Advice. This column includes the Non-covered total, Deductible/Copay total and Coinsurance total. It may also reflect the Other Insurance total, which is the amount paid by the patient’s other insurance carrier.

Before billing the Member, check both the Deductible/Copay and the Other Insurance columns to make sure that any applicable copayment or other insurance payments haven’t already been received.

*When billing Members for non-covered services due to benefit limitations, i.e. dollar limits or service limits, network Providers may bill the Member the difference between the limit amount and the allowed amount. The difference between the billed amount and the allowed amount is considered a Provider write-off.

Example: Dollar Limit

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

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

Example: Service Limit

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

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

Note: BCBST Members shall be held harmless for any contractual difference between billed charges and BCBST and Member payment obligations unless noted above.
14. Provider Overpayment Recovery Policy/Process

If a Provider identifies that a payment made by BCBST results in an overpayment, it is the responsibility of the Provider to reimburse BCBST the overpaid amount. The Provider should return the overpayment with a copy of the Remittance Advice (RA) and a cover letter explaining why the payment is being refunded. A sample copy of the Commercial Remittance Advice can be found on the company website at http://www.bcbst.com/providers/Sample-Copies-of-Remittance-Advices.page.

Mail to: BlueCross BlueShield of Tennessee
Receipts Department
1 Cameron Hill Circle
Chattanooga, TN 37402

In the event that a Provider receives a BCBST overpayment notification, no action is required unless records conflict with the findings. BCBST will recover the overpayment through an offset to the remittance advice within 45 days from the date of the notification. Please do not send a check for the overpayment.

a. Overpayment Notifications

An overpayment notification is sent on all overpayments that are identified on claims submitted by Physicians, non-participating facilities and par facilities requiring notification.

Requests for reimbursement of overpayment shall be made no later than eighteen (18) months after the date that BCBST paid the claim submitted by the Provider, except in the case of Provider fraud, in which case no time limit shall apply. In addition, the limited period shall not apply to any federal governmental program, including the Federal Employee Program (FEP).

Notwithstanding anything to the contrary, BCBST’s review of relevant financial and/or medical records shall not be limited for the time period of eighteen (18) months nor shall BCBST be prohibited to pursue any other available remedy, either at law or in equity.

The following instructs Providers how to read BCBST’s Remittance Advice transactions when overpayment recovery activity is reflected:

b. Automatic Overpayment Recovery

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

**Exception:** If the overpayment was the result of 1) payment made to an incorrect Provider, 2) a duplicate payment, 3) a claim billed in error, or 4) payment made on an incorrect Member, the negative adjustment line will indicate the recovery and there will **not** be a second line entry.
- The second line entry has the corrected amounts listed in the “Covered Charges”, “Provider Contract Adjustment” and “Patient Owes” columns. Please use the corrected amount in these columns to adjust the Member’s account accordingly.

- The explanation code reflected in the “Note” column indicates the reason for the adjustment.

- On the last page of the Remittance Advice, (bottom of page), the columns are totaled, including any negative adjustments listed on the remit. In the “Amount Paid” column, the amount listed should equal the amount of payments and adjustments listed in the “Remittance Advice Detail”.

**Note:** The “Amount Paid” column will not always equal the amount of the check when BCBST recovery amounts are carried from one Remittance Advice to the next.

It is important that Providers post all negative adjustments to a “payables” account when posting from the remit. By posting to a “payables” account, the Provider’s records will show funds owed to BCBST. This account can then be adjusted when the moneys are actually recovered by BCBST.

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

  **Note:** If there is a negative amount in the “Amount Paid” column, no check will be issued. However, the Remittance Advice detail should be used to post all Member accounts listed on the remit.

  - When a credit balance is created, a “Remittance Adjustment” and “Adjustment Details” section will be added to the remit. These sections list any negative balances that have been carried over from any previous remits. These sections also indicate how much of the negative balance was applied to the current remit payment. Any remaining negative balance will continue to be recorded in this section until the negative balance is satisfied.

  - The “Adjustment Details” section reflects the overpayments deducted from the current remit and those carried forward for deduction from a future remit. The dollar value of overpayments deducted from the current remit will be reflected in the “Currently Applied” field. The dollar amount still owed BCBST to be recovered from future remits will be reflected in the “Balance Outstanding” field.

  - The “Activity Date” under the Adjustment Details” section is critical to posting Member accounts. The “Activity Date” communicates the remit date of the original adjustment transaction. In order for the Provider to identify Member-specific details required to post accounts due to overpayment recoveries carried forward from previous remits, the remit with a date matching the date listed in the “Activity Date” field must be retrieved. (It is important to retain copies of all BCBST remits for future reference.) To obtain the Member-specific claim
payment details, refer to the claim number listed under the "Adjustment Details" section on previous remits.

c. **Manual Overpayment Recovery**

BCBST utilizes a manual recovery transaction to recover overpayment dollars from the Provider’s check and Remittance Advice when normal activities are not successful in resolving an overpayment situation.

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

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

These manual overpayment recoveries will appear on the last page of the Provider’s remittance advice with a narrative description of "Manual Reduction". Instructions on the remittance advice state “Manual Recovery Detail Sent Separately”. These claim details are mailed to the Provider’s office in advance of the BCBST check and Remittance Advice.

An overpayment claim detail fax hotline telephone number is listed on the Provider’s remit beside the “Manual Reduction Transaction” narrative. Provider’s office staff can call this hotline telephone number to request claim details supporting the manual reduction. The additional information will assist Providers when posting their BCBST Member accounts.

15. **Electronic Funds Transfer**

Beginning January 1, 2015, BCBST began executing the July 2013 electronic claims filing requirement pursuant to the BCBST Minimum Practitioner Network Participation Criteria, which requires all network Providers to enroll in the Electronic Funds Transfer (EFT) process. EFT is a free service that sends payments directly to the Provider’s financial institution and increases the speed at which they receive payment.

Key advantages to receiving payments electronically are:

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

BCBST accepts electronic funds transfer (EFT) enrollment through CAQH Solutions, who offers a universal enrollment tool for providers that provides a single point of entry for adopting EFT and ERA. The CAQH process facilitates compliance with the 2014 EFT/ERA Administrative Simplification mandate under the Affordable Care Act, eliminates administrative redundancies and creates significant time and cost savings. Enrollment information is available on the CAQH Solutions website at [https://solutions.caqh.org](https://solutions.caqh.org).

To view/print a copy of your remittance advices, ensure you have access to BlueAccess, BCBST’s secure area on its websites, [www.bcbst.com](http://www.bcbst.com) and [http://bluecare.bcbst.com](http://bluecare.bcbst.com). To register, just click on the “Register Now” link located in the BlueAccess section on the website and follow the simple instructions to obtain a user ID and password.

For more information regarding the EFT Program Process, or for assistance with BlueAccess, please call eBusiness Service at 423-535-5717, Option 2, Monday through Thursday, 8 a.m. to 6 p.m., Friday 9 a.m. to 6 p.m. (ET), or e-mail [eBusiness_Service@bcbst.com](mailto:eBusiness_Service@bcbst.com).
EnrollHub™ is the new name for the CAQH EFT and ERA enrollment tool.
Phone: 1-844-815-9763 available Monday through Thursday 7 a.m. to 9 p.m. (ET)
Friday 7 a.m. to 7 p.m. (ET)
Email: eftenrollhub@caqh.org
Website: http://www.caqh.org/eft_enrollment.php

CAQH ProView™ is now the provider data collection tool formerly the Universal Provider Datasource®.
Phone: 1-844-259-5347 available Monday through Thursday 7 a.m. to 9 p.m. (ET)
Friday 7 a.m. to 7 p.m. (ET)
Email: proview@caqh.org
Website: https://proview.caqh.org

Note: Vendor and BCBST shall be bound by the National Automated Clearing House Association rules relating to corporate trade payment entries (the "Rules") in the administration of these ACH Credits.


BCBST commercial timely filing period is 180 days from the date of service or, for facilities, within 180 days from the date of discharge. Exception, for claims filed by out-of-network Providers, all claims must be submitted no later than December 31 of the calendar year following the year during which the service or supply is received. For example, if a Member receives Covered Services on May 8, 2015 a claim for reimbursement must be submitted no later than December 31, 2016. Claims for long hospital stays or other long-term care should be submitted every 30 days.

The BlueCross BlueShield Plan serving the area where the services are received or where the Member resides processes most FEP Member claims. All Plans are responsible for processing claims within their FEP service area. A claim for services obtained outside the Plan’s service area can only be processed by that Plan if the claim is for outpatient services for a Member residing in the Plan’s service area. However, to take advantage of Participating Provider arrangements when possible, claims should be processed by the Plan that serves the area where the services were rendered. Claims not meeting those criteria should be forwarded (by the Plan) to the Plan where the services were rendered. Claims for Covered Services provided to FEP Members are submitted by Providers in the same manner as other local BCBST contracts.

B. General Billing Information

Unless otherwise indicated, the information in this section is common for both Professional and Institutional Services. (See also Professional or Institutional sections for more specific guidelines.) All billing and reimbursement guidelines included in this section also apply to Blue Network E, BCBST’s limited regional Provider network offered on the Marketplace. These billing guidelines, however, may not apply to our Medicare lines of business. Please refer to Section XXIV. MedAdvantage, in this Manual where specific guidelines may apply.

1. Medical Clinical Code Sets and Maintenance

Unless specified otherwise in this Manual, medical/clinical codes including modifiers should be reported in accordance with the governing coding organization. The following update schedules reflect the additional, revision, or deletion of codes only and do not relate to reimbursement updates. See Acute Care Fee Schedules section for Reimbursement Update information.
a. **Current Dental Terminology (CDT)**—These codes should be reported in accordance with the American Dental Association guidelines (e.g., CDT manual).

**Addition/Deletion/Revision CDT Codes**

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

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<th>Effective Date of Change by the American Dental Association</th>
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BCBST will implement updates to CDT codes according to the following schedule:

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

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

b. **Current Procedural Terminology (CPT®)**—These codes should be reported in accordance with the American Medical Association guidelines including the *CPT® Manual, CPT® Coding Changes, CPT® Assistant, CPT® Clinical Examples, CPT® Companion* and other coding resources authorized by the American Medical Association.

**Addition/Deletion/Revision CPT® Codes**

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

CPT® codes are updated and maintained by the American Medical Association. Currently, CPT® codes are subject to updates effective January 1 and July 1 of each year. CPT® updates include the addition, revision and/or deletion of codes.

**BCBST will implement updates to CPT® codes according to the following schedule:**

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In the event the American Medical Association modifies the schedule for coding updates, the BCBST schedule will be modified accordingly. CPT® codes billed prior to the effective date of the code will be rejected or returned by BCBST as an invalid code for the date of service.
Due to the short American Medical Association publication schedule, it is not possible for BCBST to notify Providers of changes to CPT® codes. The Provider is responsible for ensuring codes billed are valid for the date of service. CPT® codes and CPT® coding resources can be obtained from the American Medical Association. CPT® code updates may also be located on the American Medical Association website at www.ama-assn.org.

c. HealthCare Common Procedural Coding System (HCPCS) – These codes should be reported in accordance with the Department of Health and Human Services guidelines including, but not limited to, the HCPCS Manual, Federal Register, Centers for Medicare & Medicaid Program Memorandums and Transmittals, Medicare Part B Bulletins, Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for Jurisdiction C guidelines (e.g., the DMEPOS Supplier Manual and Revisions, DME MAC Jurisdiction C Fee Schedule, Pricing, Data Analysis and Coding Contractor (PDAC**) Product Classification Lists and Pricing, Data Analysis and Coding Contractor (PDAC**) Coding Bulletins.

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

HCPCS codes are updated and maintained by the Department of Health and Human Services. Currently, HCPCS codes are subject to updates effective January 1, April 1, July 1, and October 1 of each year. HCPCS updates include addition, deletion, and/or revision of codes.

BCBST will implement updates to HCPCS codes according to the following schedule:

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

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

Due to the short Department of Health and Human Services’ publication schedule, it is not possible for BCBST to notify Providers of changes to HCPCS codes. The Provider is responsible for ensuring codes billed are valid for the date of service. HCPCS codes, HCPCS code updates, and HCPCS coding resources include, but are not limited to the following:

- Federal Register
- Center for Medicare and Medicaid Program Memorandums and Transmittals
- Medicare Part B Educational Materials
Durable Medical Equipment Medicare Administrative Contractor (DME MAC*) for Jurisdiction C guidelines including, but are not limited to the following:

- DMEPOS Supplier Manual and Revisions
- DME MAC Jurisdiction C Fee Schedules
- Pricing, Data Analysis and Coding Contractor (PDAC**) Product Classification Lists
- Pricing, Data Analysis and Coding Contractor (PDAC**) Advisory Articles

*This document is located on the CGS Administrators, LLC website at http://www.cgsmedicare.com.

**This document is located on the Noridian Administrative Services, LLC (NAS) website at http://www.dmepdac.com.

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

**Note:** Effective 10/1/15, ICD codes should be filed in accordance with CMS guidance issued in MLN Matters Article SE1408 found at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1408.pdf.

**Addition/Deletion ICD Codes**

**ICD-9** includes:

- Volume 1 and 2 ICD codes are used to report diseases, injuries, impairments, their manifestations, and causes of injury, disease, impairment, or other health problems
- Volume 3 ICD codes are used to report prevention, diagnosis, treatment, and management

**ICD-10** includes:

- ICD-CM codes are used to report diseases, injuries, impairments, their manifestations, and causes of injury, disease, impairment, or other health problems
- ICD-PCS codes are used to report prevention, diagnosis, treatment, and management

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

**BCBST will implement updates to ICD codes according to the following schedule:**

| Effective Date of Change by the Department of Health and Human Services | Effective Date of Change by BCBST (Date of Discharge) |
|---|---|---|---|
| April 1 | April 1 | April 1 | April 1 |
| October 1 | October 1 | October 1 | October 1 |

In the event the Department of Health and Human Services modifies the schedule for coding updates, the BCBST schedule will be modified accordingly. ICD codes billed prior to the effective date of the code will be rejected or returned by BCBST as an invalid code for the date of service.
Due to the short Department of Health and Human Services' publication schedule, it is not possible for BCBST to notify Providers of changes to ICD codes. The Provider is responsible for ensuring codes billed are valid for the date of service. ICD codes can be obtained from the Department of Health and Human Services.

BCBST has made available online an educational tool to assist Providers in utilizing ICD codes appropriately. The tool can be accessed from the Provider page on the company website, www.bcbst.com.

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

Unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) procedures/services should only be used when a more specific CPT® or HCPCS code is not available or appropriate. The maximum allowable for eligible procedures/services reported using an unlisted, miscellaneous, non-specific CDT, CPT® or HCPCS code will be based on “Individual Consideration”.

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

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

For radiopharmaceuticals and contrast materials:
- The name of the radiopharmaceutical and or contrast material, NDC, dosage and quantity; Or
- The manufacturer’s invoice listing the name of the patient, name of the specific diagnostic radiopharmaceutical or contrast material, dosage and number of units. If multiple patients are listed on the manufacturer’s/supplier’s invoice, the diagnostic radiopharmaceutical imaging agent or contrast material, dosage and number of units for the patient being billed should be clearly indicated.

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

3. Special Report

A service that is rarely provided, unusual, variable, or new, may require a special report in determining medical appropriateness of the service. Pertinent information should include an adequate definition or description of the nature, extent, and need for procedure; and time, effort, and equipment necessary to provide service.

- Complexity of symptoms;
- Final diagnosis;
- Pertinent physical findings (such as size, locations, and number of lesion[s], if appropriate);
- Diagnostic and therapeutic procedures (including major and supplementary surgical procedures, if appropriate);
- Concurrent problems;
- Follow-up care.
Providers should send an appropriate "Special Report" documenting the service or procedure designated by the "Unlisted Procedure" code. Undocumented "Unlisted Procedure" code claims will be denied or developed when appropriate. Unlisted services or procedures must be submitted on a paper copy claim.

For services billed with an unlisted, miscellaneous, non-specific, or not otherwise classified code, refer to the Unlisted Service or Procedure Guidelines.

4. Code Edits

Code edits are performed during the initial claim processing phase, when feasible, and are based on nationally recognized code bundling guidelines including:

- National Correct Coding Initiative (NCCI)
- American Medical Association (AMA) coding guidelines
- Centers for Medicare & Medicaid (CMS) guidelines
- Guidelines published by medical societies/associations such as the American Academy of Orthopedic Surgeons (AAOS) and American College of Obstetricians and Gynecologists (ACOG)
- Clinical rationale/expertise

BCBST code edit rules are also based on reimbursement policies such as, but not limited to, the following:

- Bundled Services regardless of the Location of Service
- Bundled Services when the Location of Service is the Practitioner's Office
- Durable Medical Equipment (Purchase and Rentals)
- Home Pulse Oximetry
- Screening Test for Visual Acuity
- Visual Function Screening
- Quarterly Reimbursement Changes

BCBST code edit rules will be applied during the claim payment process, when feasible; however, some edits can only be applied when all associated claims are processed. In those cases, the edit will be applied during the retrospective audit process when all associated claims are available for review. BCBST’s Provider Audit Department will continue to periodically conduct on-site reviews.

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

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

Code editing can occur on multiple levels depending on the combination of codes reported. For example, when multiple codes are billed for one date of service, two codes could bundle into one code. That one code could then bundle into another code.

Providers can access the code bundling rules for code pairs via the company website at [http://www.bcbst.com/providers/code_bundling/](http://www.bcbst.com/providers/code_bundling/).

Code pairs reported on the BCBST website will be updated on a quarterly basis effective for dates of service January 1, April 1, July 1, and October 1. The updated rules will be posted on the company website at least 30 days prior to the effective date.

BCBST reserves the right to request supplemental information (e.g., anesthesia record, operative report, specific medical records) to determine appropriate application of its code bundling rules.
5. Modifiers

Modifiers should be reported in accordance with the governing coding organization.

Modifiers are two-digit indicators (alpha or numeric) that, when appended to a procedure code, indicate that a service or procedure has been altered by some specific circumstance, but not changed in its definition or code.

a. Modifier 22 – Unusual Procedural Services

Description
Modifier 22 should be utilized to identify when services provided are greater than what is usually required for the listed procedure. The increment of work represented by affixing Modifier 22 should not be frequently encountered when performing the base procedure, nor should it be reportable with another code.

Guidelines
Documentation should exist that reflects justification of unusual and extraordinary complex work levels far more extensive than is usually necessary for the listed procedure. Documentation should clearly describe the difficult and complex nature of the procedure and support the difficulty of the case. It would be expected that several complicating factors prove an extremely hard case.

Examples/language which may indicate services may be greater than what would ordinarily be required are:

- Difficulty obtaining desired outcomes- due to anomalies, extenuating circumstances, etc.;
- Increased risk due to extenuating circumstances/conditions of patient;
- Extended time to accomplish end results (must be significant and demonstrate why);
- Excessive blood loss/hemorrhage (must note amount of (estimated) blood loss);
- Trauma extensive enough to complicate procedures- ensure that the complication is not billed with additional procedure codes;
- Pathologies, tumors, anomalies, or malformations that directly interfere with the base procedure, but not reported with other procedures;
- Extensive adhesions must be more than routine lysis performed to achieve end results and well documented with time involved, etc. and not separately reported;
- Complications, medical emergencies can warrant reporting with Modifier 22 when resulting in more work by physician than what would normally be required; or
- Clearly more extensive service, based on qualifying factors and/or judgment of reviewer.

Documentation supporting the unusual procedural service such as descriptive statements identifying the unusual circumstances, operative report, pathology report, progress notes, and/or office notes must be submitted by the Provider in order to determine if the service is eligible for additional reimbursement. Services billed with CPT® modifier 22 without the required supplemental documentation will not be considered for additional reimbursement.

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

This policy applies to unusual procedural services billed with CPT® modifier 22 on a Professional claim form.

Specially designation of Provider type would not automatically qualify service for Modifier 22 eligibility.
b. **Modifier 25**

**Description**  
Significant, separately identifiable evaluation and management service by the same Physician on the same day of the procedure or other service. Under certain circumstances, the Physician may need to indicate that a significant and separately identifiable evaluation and management (E&M) service was performed beyond the usual pre-procedure, intra-procedure, and post-procedure physician work; or beyond the normal components of another E&M service (e.g., preventive medicine service, anticoagulation management service, osteopathic manipulative treatment, chiropractic manipulative treatment, ophthalmological evaluation service) requiring significant additional work. The E&M service may or may not require a different diagnosis.

**Guidelines**  
Modifier 25 will only be recognized as valid to bypass edits when:

- There is documentation of a significant, separately identifiable E&M service which must contain the required number of key elements (history, examination, & medical decision making) for the E&M service reported;
- The E&M service is provided beyond usual preoperative, intraoperative, or postoperative care associated with a procedure performed on the same day;
- A symptom or procedure presents that prompts the E/M service (may not require a separate diagnosis);
- An initial hospital visit, an initial inpatient consultation, and a hospital discharge service is billed for the same date of service as an inpatient dialysis service;
- Critical care codes are billed within a global surgical period; or
- A Medically Necessary visit is performed on the same day as routine foot care.

Modifier 25 will not be recognized for (including but not limited to the following):

- E&M service that resulted in decision for surgery
- Ventilation management in addition to E&M service
- Use on surgical codes
- Use on same day of minor procedure
- Use within global surgical period (pre- or postoperative care)

Use of Modifier 25 merely to bypass a bundling edit is inappropriate and will result in recoupment of erroneous reimbursement. Documentation for the evaluation and management service must be able to stand alone.

c. **Modifier 57**

**Description**  
Decision for surgery

Under certain circumstances, an evaluation and management (E&M) service that resulted in the decision to perform the surgery may be identified by adding the Modifier 57 to the appropriate E&M service code. When the Modifier 57 is used appropriately, the E&M service should be separately reimbursed.

**Guidelines**  
Guidelines related to the appropriate reporting of the Modifier 57 include, but are not limited to the following:

- Use of Modifier 57 may not be valid when the E&M service is associated with a minor surgical procedure. Because the decision to perform a minor procedure is typically
done immediately before the service, it is considered a routine preoperative service and therefore not separately reimbursable.

- Modifier 57 may be recognized as valid when used appropriately and there is documentation that the E&M service resulted in the initial decision to perform the service.
- Modifier 57 will not be recognized when the decision to perform the surgery was made in advance of the E&M visit.
- Modifier 57 is not appropriate when reported with non E&M codes.
- Modifier 57 is not appropriate to report with the E&M service when performed for the preoperative evaluation.
- Use of Modifier 57 merely to bypass a bundling edit is inappropriate and will result in recoupment of erroneous reimbursement.

d. Modifier 59 and Other Specific Modifiers for Distinct Procedural Services

As consistent with the initiatives of the Office of Inspector General (OIG), BCBST reserves the right to evaluate, audit and/or recoup any and all payments resulting from erroneous reporting of the Modifier 59. (OIG Workplan, FY 2005)

As of 1/1/2015, modifiers XE, XS, XP and XU will be included in the scope of the review.

Description
Distinct procedural service: Under certain circumstances, the Physician may need to indicate that a procedure or service was distinct or independent from other services performed on the same day. Modifier 59 is used to identify procedure(s)/service(s) that are not normally reported together, but are appropriate under the circumstances. This may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, separate lesion, or separate injury not ordinarily encountered or performed on the same day by the same Physician.

59 – Distinct Procedural Service

XE Separate Encounter - A Service That Is Distinct Because It Occurred During A Separate Encounter

XS Separate Structure - A Service That Is Distinct Because It Was Performed On A Separate Organ/Structure

XP Separate Practitioner - A Service That Is Distinct Because It Was Performed By A Different Practitioner

XU Unusual Non-Overlapping Service - The Use Of A Service That Is Distinct Because It Does Not Overlap Usual Components Of The Main Service

Guidelines
Modifier 59, XE, XS, SP and XU will only be recognized as valid to bypass edits when:

- Combination of procedure codes represent procedures that would not normally be performed at the same time (e.g. procedure on head and procedure on feet; craniotomy and setting of compound fracture);
- Different session or patient encounter is documented in patient’s medical record;
- Surgical procedures performed are not through the same incisional site (Note: doesn’t matter if instrumentation changes if incision or presentation is the same);
- Surgical knee procedures involving multiple compartments of the same knee; or
- Another modifier is not more appropriate (e.g., Modifier 51).

Use of Modifier 59, XE, XS, SP and XU merely to bypass a bundling edit is inappropriate and will result in non-payment or recoupment of erroneous reimbursement.
Modifier 59, XE, XS, SP and XU should never be appended to an Evaluation & Management service, as this is inappropriate coding convention.

Refer to the resources/tools section on the BCBST website, www.bcbst.com for the National Correct Coding Initiative Superscript Designations – NCCI Indicators.

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

Procedures on neonates and infants up to a present body weight of 4 kg may involve significantly increased complexity and physician work. According to the Current Procedural Terminology, CPT® Manual, this modifier may only be appended to procedures/services listed in the 20005 through 69990 code series.

According to presentations made by representatives of the American Pediatric Surgical Association (APSA), there are many definite exclusions of CPT® codes within the Surgical series of CPT® codes.

The APSA consistent with CPT® guidelines, note the following exclusions, whereas Modifier 63 should not be appended to any CPT® codes listed in the Evaluation and Management Services, Anesthesia, Radiology, Pathology/Laboratory, or Medicine sections and any of the codes listed in the Summary of Codes Exempt from Modifier 63. These codes will be in an Appendix and have instructions listed below the code “(Do not report modifier 63 in conjunction with…)”.

If the documentation supports additional reimbursement for the indication of procedure performed on an infant less than 4 kg representing physician work and complexity over and above the services included in the standard base code, then reimbursement for eligible services will be based on the lesser of total covered charges or up to 130 percent (130%) of the contracted rate for that procedure. Documentation should include the procedure code, weight of the neonate or infant, time required to perform the procedure, anesthesia flow sheet/record, and any unusual condition/outcome for that particular procedure (complexity). Services billed with Modifier 63 without the required supplemental documentation will not be considered for additional reimbursement.

This policy applies to those appropriate CPT® codes with a Modifier 63 billed on a CMS-1500/ANSI-837P for all BCBST business.


BCBST makes every effort to structure its commercial Provider network contracts and specific billing guidelines to meet the reporting requirements imposed by federal and state agencies. However, due to contract terms in our commercial networks and other business requirements, it sometimes becomes necessary that we require a facility bill in a manner that does not conform to these reporting requirements.

Additionally, BCBST provides services to a diverse Member population whose benefits may or may not be provided by federal and state agencies and the billing guidelines required for these services may not always be conducive to the requirements of federal and state agencies.

In circumstances where BCBST’s billing requirements are not consistent with federal and state agency reporting, Providers are still required to remain in compliance with all reporting requirements mandated by those agencies. The Provider’s medical records, census documents and financial reporting should never change as a result of BCBST’s billing requirements. BCBST recognizes this may cause a discrepancy between the Provider’s reporting records and the actual billing documents; however the billing to BCBST is a contractual requirement for claim payment only and should never impact regulated reporting requirements.
The most common example of a non-standard billing requirement is billing for observation services when BCBST has only authorized outpatient observation services and the admitting physician has written an inpatient admission order. In this case, in order to receive payment for observation services, the Provider is required to bill BCBST as follows:

- Change the Type of Bill from inpatient to outpatient (13x)
- Convert the Room and Board revenue code to Observation (76x)

In this example the Provider should make no changes to its medical records, continue to report the days as inpatient on their census reports and reflect charges under the Room & Board revenue codes on their financial system. This will keep the Provider in compliance with Medicare reporting but will allow payment under contractual terms of their BCBST Provider Contract.

7. Ambulance Services

Claims filed to BCBST for ambulance services are to be filed with the appropriate origin and destination modifiers as outlined by national standards.

**NOTE:** For Air Ambulance services submitted on the CMS1500 claim form the Pick-up Location Zip Code should be submitted in Block 23. Multiple Zip Codes should not be submitted in this block. If the points of pick-up are located in different Zip Codes a separate claim form should be submitted for each trip. The correct ZIP Code is five numeric digits; if a nine-digit ZIP Code is submitted the last four digits are ignored. If Pick-up Location Zip Code is missing, invalid, or submitted in an incorrect format the claim will be returned unprocessed.

8. Network M<sup>SM</sup> – Effective January 1, 2014

Network M was created to be used with the clinical management services and shared savings arrangement provided to self-funded employers by our partner, MissionPoint Health Partners (MPHP). MPHP has negotiated the rates with participating Providers and holds the contracts with those Providers. The rates and pricing methodologies contracted by MPHP may be different from those used by BCBST.

Some Members have access to more than one BCBST Network, which will be indicated on the Member’s ID card. In the event that a Provider treats a Member who has access to more than one Network in which the Provider participates, BCBST will reimburse the Provider in accordance with the terms of the Network listed first on the Member’s ID card.

9. Qualitative Drug Screen Testing

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

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

For more information and a list of the G-codes, please refer to the CMS documentation “Clinical Laboratory Fee Schedule (CLFS)” located on its website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2016-CLFS-Codes-Final-Determinations.pdf.
10. Reimbursement Policy for Serious Reportable Adverse Events (Never Events)

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

According to the National Quality Forum (NQF), Serious Reportable Adverse Events, (commonly referred to as "never events") are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility. Therefore, in an effort to reduce or eliminate the occurrence of "never events", BCBST will not provide reimbursement or allow hospitals to retain reimbursement for any care directly related to the never event. BCBST has adopted the list of serious adverse events in accordance with CMS as well as any additional events assigned by the BlueCross and BlueShield Association (BCBSA). The list of Serious Reportable Adverse Events can be located at CMS website, www.cms.gov.

BCBST will require all participating Providers to report Serious Adverse Events by populating Present on Admission (POA) indicators on all acute care inpatient hospital claims. Otherwise, BCBST will follow CMS guidelines for the billing of Never Events. In the instance that the "Never Event" has not been reported, BCBST will use any means available to determine if any charges filed with BCBST meet the criteria, as outlined by the NQF and adopted by CMS, as a Serious Reportable Adverse Event. In the circumstance that a payment has been made for a Serious Reportable Adverse Event, BCBST reserves the right to re-coup the reimbursement as necessary. BCBST will require all participating acute care hospitals to hold Members harmless for any services related to Never Events in any clinical setting.

11. Final Reimbursement

Presence of a fee on the Maximum Allowable Fee Schedule is not a guarantee the procedure, service or item will be eligible for reimbursement. Final reimbursement determinations are based on several factors, including but not limited to, Member eligibility on the date of service, Medical Appropriateness, code edits, applicable Member co-payments, coinsurance, deductibles, benefit plan exclusions/limitations, authorization/referral requirements and BCBST Medical Policy/coverage decisions.

When considering final reimbursement for services, procedures and items, BCBST considers several factors including:

- Member eligibility on the date of service
- Medical Necessity and Medical Appropriateness
- Code edits
- Applicable Member copayments, coinsurance and deductible
- Member’s health care benefits plan exclusions/limitations
- Authorization/Referral requirements
- BCBST Medical Policy

12. Policy for Quarterly Reimbursement Changes

This policy will be applicable when referenced in the Provider Agreement or BCBST Reimbursement Policy. Reimbursement changes* applicable to this policy will be made according to the following schedule:

<table>
<thead>
<tr>
<th>Date Reimbursement Data is Published by Source</th>
<th>Date Change Will Be Applied by BlueCross Blue Shield of Tennessee</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 1 to March 31</td>
<td>July 1</td>
</tr>
<tr>
<td>April 1 to June 30</td>
<td>October 1</td>
</tr>
<tr>
<td>July 1 to September 30</td>
<td>January 1</td>
</tr>
<tr>
<td>October 1 to December 31</td>
<td>April 1</td>
</tr>
</tbody>
</table>

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

Note:

1) This Quarterly Reimbursement Change Policy will not apply to Providers contracted for the Resourced Based Relative Value Scale (RBRVS) Reimbursement Methodology Amendment on or after July 23, 2011. The reimbursement changes applicable to this amendment will be updated per policy RBRVS Reimbursement Methodology Amendment Updates.

2) The Banded RBRVS Reimbursement Methodology Amendment for Providers contracted on or after November 1, 2014, will be updated per guidelines in Provider’s Contract as indicated below:

- For those procedure codes that fall into bands with a fee source of 2013 CMS RBRVS, the established fee will be calculated based on the Relative Value Units (RVUs), conversion factors and Geographic Practice Cost Indices (GPCIs) in effect as of October 31, 2013. No updates will be made to these fee components, except with regard to any new procedure code added after October 31, 2013.

- Other fee components, which are listed in the Guidelines for RBRVS Reimbursement Methodology in this Manual, may be updated to ensure that reimbursement is consistent with current usage of the code. Updates to these components may result in increases or decreases to the established fee at the individual code level.

C. Professional Claim Billing and Reimbursement Guidelines

1. Lesser Of Calculation

The line item level lesser of methodology is utilized for professional services and is indicated on the Physician’s contract in effect on the date the services are rendered.

2. Guidelines for Resource Based Relative Value Scale (RBRVS) Reimbursement Methodology

This policy only applies when specifically referenced in the Provider’s Agreement.

RBRVS is a reimbursement methodology, which values services according to the relative costs required to provide them.
RBRVS reimbursement methodology applies to most surgery, radiology, non-clinical laboratory, evaluation and management services, and diagnostic/therapeutic procedures.

RBRVS reimbursement methodology does not apply to anesthesia administration, clinical laboratory, immune globulins, vaccines, toxoids, injectable drugs, radiopharmaceuticals, medical supplies, durable medical equipment, orthotics, prosthetics, visions products (e.g. frames, lens, contact lens), or hearing products (e.g., hearing aids).

RBRVS is comprised of the following components used to determine the base maximum allowable for a service:

- **Relative Value Units (RVUs)**

  RVUs are expressed in numeric units that represent the units of measure of cost for Physician services. Services that are more complex, more time consuming will have higher unit values than services that are less complex, less time consuming.

  There are three (3) types of RVUs including:

  - **Physician Work RVUs** – reflects the cost of the Physician’s time and skill related to each service provided.

  - **Practice Expense RVUs** (facility and non-facility) – represents the Physician’s direct and indirect costs related to each service provided.

    Direct expenses include non-physician labor, medical equipment and medical supplies.

    Indirect expenses include the cost of general office supplies, rent, utilities and other office overhead that cannot be directly tied to a specific procedure.

    When a procedure is performed in a facility setting, the expenses related to non-physician labor, medical equipment, and medical supplies are incurred and billed by the facility. As a result, the physician’s cost related to a procedure performed in a facility is less than the Physician’s cost related to a procedure performed in a non-facility.

    The facility practice expense RVUs apply when the location of service is inpatient hospital (place of service 21), on-campus outpatient hospital (place of service 22), off-campus outpatient hospital (place of service 19), emergency room-hospital (place of service 23), ambulatory surgery center (place of service 24), or skilled nursing facility (place of service 31).

    The non-facility practice RVUs apply to all other locations of service.

  - **Malpractice RVUs** – the relative value units assigned to the malpractice insurance component for a procedure.

    The source for the physician work, practice expense (facility and non-facility) and malpractice RVUs is the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals published by Medicare. These documents can be located at [www.cms.gov](http://www.cms.gov).

    **Note:** Updates to the RVUs are made in accordance with the BCBST Policy for Quarterly Reimbursement Changes with some exceptions as previously stated in the Policy for Quarterly Reimbursement Changes.

- **Geographic Practice Cost Indices (GPCIs)**

  GPCIs are used to adjust the relative value units to reflect cost differences among geographic areas.

Rev 12/15
There are three types of GPCIs including:

- Physician Work GPCI
- Practice Expense GPCI
- Malpractice GPCI

The source for GPCIs is the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals published by Medicare. These documents can be found on CMS website, www.cms.gov.

BCBST uses the GPCIs assigned to Tennessee regardless of the geographic location in which the services are provided.

**Note:** Updates to the GPCIs are made in accordance with the BCBST Policy for Quarterly Reimbursement Changes with some exceptions as previously stated in the Policy for Quarterly Reimbursement Changes.

**Conversion Factor**

The conversion factor represents the dollar value of each relative value unit.

When the conversion factor is multiplied by the geographically adjusted relative value units it will yield the maximum allowable for the specific service.

Network conversion factors are determined by the Provider Contract.

The following are formulas used to calculate the base professional maximum allowable for procedures applicable under RBRVS reimbursement methodology:

**Non-facility Professional Maximum Allowable**

\[\text{Non-facility Professional Maximum Allowable} = ((\text{Physician Work RVU} \times \text{Physician Work GPCI}) + (\text{Non-Facility Practice Expense RVU} \times \text{Practice Expense GPCI}) + (\text{Malpractice RVU} \times \text{Malpractice GPCI})) \times \text{Conversion Factor}\]

**Facility Professional Maximum Allowable**

\[\text{Facility Professional Maximum Allowable} = ((\text{Physician Work RVU} \times \text{Physician Work GPCI}) + (\text{Facility Practice Expense RVU} \times \text{Practice Expense GPCI}) + (\text{Malpractice RVU} \times \text{Malpractice GPCI})) \times \text{Conversion Factor}\]

**Note:** The sum of the Physician Work, Practice Expense, and Malpractice components of the RBRVS formula will be rounded to the nearest thousandth (i.e., to the 3rd decimal place, x.xxx) before the conversion factor is applied.

The following are examples only and may not reflect current percentages or rates

**Example 1**

Maximum Allowable = \[((1.27 \times 0.8994 \times 1.000) + (2.20 \times .900) + (.08 \times .612)) \times \text{Conversion Factor}\]

Maximum Allowable = 3.17119 \times \text{Conversion Factor}

Maximum Allowable = 3.171 \times \text{Conversion Factor}

In this example 3.17119 is rounded to 3.171 before the conversion factor is applied.

**Example 2**

Maximum Allowable = \[((1.19 \times 0.8994 \times 1.000) + (4.73 \times .900) + (.29 \times .612)) \times \text{Conversion Factor}\]

Maximum Allowable = 5.50476 \times \text{Conversion Factor}

Maximum Allowable = 5.505 \times \text{Conversion Factor}

In this example 5.50476 is rounded to 5.505 before the conversion factor is applied.
Example 3

Maximum Allowable = [(2.30 x 0.8994 x 1.000) + (.55 x .900) + (.21 x .612)] x Conversion Factor
Maximum Allowable = 2.69214 x Conversion Factor
Maximum Allowable = 2.692 x Conversion Factor

In this example 2.69214 is rounded to 2.692 before the conversion factor is applied.

The following are other major components that may have an impact on the base maximum allowable under RBRVS reimbursement methodology:

- Reimbursement Policy for Bilateral Procedures
- Reimbursement Policy for Bundled Services Regardless of the Location of Service
- Reimbursement Policy for Bundled Services When the Location of Service is the Practitioner’s Office
- Reimbursement Policy for Global Periods
- Reimbursement Policy for Multiple Procedures
- Reimbursement Policy for Preoperative Management Only, Surgical Care Only, and Postoperative Management Only
- Policy for Quarterly Reimbursement Changes

3. Anesthesia Billing and Reimbursement Guidelines

Note: Anesthesia services provided by an anesthesiologist or CRNA should be billed on a Professional claim form.

a. Administration of Anesthesia

Paper Claim Form - Block 24D (CPT®/HCPCS)

Administration of anesthesia must be billed using the most appropriate CPT® code 00100-01995 or 01999 in effect for the date of service.

The anesthesia administration code includes the following:

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

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

When multiple surgical procedures are performed during a single anesthetic administration, only the procedure with the highest Basic Value should be reported. Refer to the American Society of Anesthesiologist Relative Value Guide in effect for the date of service to determine the procedure with the highest Basic Value. This applies to vaginal deliveries and Cesarean Sections followed immediately by a hysterectomy.

Billing more than one anesthesia administration code for a single anesthetic administration may result in delay in reimbursement, rejection of charge(s) or return of claim.

When multiple surgical procedures are performed during a single anesthetic administration, only the procedure with the highest Basic Value should be reported. Refer to the American Society of Anesthesiologist Relative Value Guide in effect for the date of service to determine the procedure with the highest Basic Value. This applies to vaginal deliveries and Cesarean Sections followed immediately by a hysterectomy.

Billing more than one anesthesia administration code for a single anesthetic administration may result in delay in reimbursement, rejection of charge(s) or return of claim.
Paper Claim Form - Block 24D (First Modifier)
Anesthesia services must be billed using the most appropriate anesthesia modifier. Acceptable anesthesia modifiers are as follows:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AA</td>
<td>Anesthesia service performed personally by anesthesiologist</td>
</tr>
<tr>
<td>AD</td>
<td>Medical supervision by a physician: more than 4 concurrent procedures</td>
</tr>
<tr>
<td>QK</td>
<td>Medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individuals</td>
</tr>
<tr>
<td>QX</td>
<td>CRNA service: with medical direction by a physician</td>
</tr>
<tr>
<td>QY</td>
<td>Anesthesiologist medically directs one CRNA</td>
</tr>
<tr>
<td>QZ</td>
<td>CRNA service: without medical direction by a Practitioner</td>
</tr>
</tbody>
</table>

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

It is not appropriate to bill modifier 47 (Anesthesia by Surgeon) with CPT® codes 00100-01995 or 01999.

Paper Claim Form - Block 24D (Second Modifier)
A physical status modifier may be billed in the second modifier field. Acceptable physical status modifiers are as follows:

<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>A normal healthy patient</td>
</tr>
<tr>
<td>P2</td>
<td>A patient with mild systemic disease</td>
</tr>
<tr>
<td>P3</td>
<td>A patient with severe systemic disease</td>
</tr>
<tr>
<td>P4</td>
<td>A patient with severe systemic disease that is a constant threat to life</td>
</tr>
<tr>
<td>P5</td>
<td>A moribund patient who is not expected to survive without the operation</td>
</tr>
<tr>
<td>P6</td>
<td>A declared brain-dead patient whose organs are being removed for donor purposes</td>
</tr>
</tbody>
</table>

Paper Claim Form - Block 24G (Days or Units)
Anesthesia time begins when the anesthesiologist or CRNA begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ends when the anesthesiologist or CRNA is no longer in personal attendance, that is, when the patient may be safely placed under post-anesthesia supervision.

In cases where there is a break in anesthesia (e.g., due to technique used, delay of surgeon, relief, multiple start and stop times, etc.) time should be reported by summing up the blocks of time around a break in continuous anesthesia care.

Anesthesia time begins when the anesthesiologist or CRNA begins to prepare the patient for anesthesia care in the operating room or in an equivalent area, and ends when the anesthesiologist or CRNA is no longer in personal attendance, that is, when the patient may be safely placed under post-anesthesia supervision.

In cases where there is a break in anesthesia (e.g., due to technique used, delay of surgeon, relief, multiple start and stop times, etc.) time should be reported by summing up the blocks of time around a break in continuous anesthesia care.

Note: Anesthesia time must be reported in minutes. Anesthesia time must not be converted to units. Conversion to units will result in an incorrect payment.

If anesthesia time exceeds 0999 minutes, it is recommended a paper claim be submitted with the supplemental information such as the anesthesia flow sheet to ensure correct reimbursement.
b. Reimbursement Guidelines for Administration of Anesthesia

Maximum allowable for administration of anesthesia performed by an anesthesiologist or certified registered nurse anesthetist (CRNA) are based on the lesser of total covered charges or the following formula:

$$\text{Maximum Allowable} = (\text{Basic Value} + \text{Time Unit} + \text{Physical Status Unit Value}) \times \text{Conversion Factor} \times \text{Percentage}$$

1. Basic Values

Basic Values are based on the American Society of Anesthesiologist (ASA) Relative Value Guide in effect for the date of service.

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

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

2. Time

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

Anesthesia time in minutes will be converted to time units by BCBST as indicated below:

- Fractional time units will be rounded up to the next whole unit (i.e., 1.1 units will be rounded to 2 units, 1.4 units will be rounded to 2 units, 1.5 units will be rounded to 2 units, 1.6 units will be rounded to 2 units, 1.9 units will be rounded to 2 units). **Anesthesia time does not apply to Daily Hospital Management Services.**

3. Physical Status Unit Values

Additional base units for physical status will be allowed as follows:

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

4. Time Units, Conversion Factors and Percentages

Conversion Factors and Percentages are as follows:

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

Reimbursement for medical supervision of anesthesia services, e.g. anesthesia modifier AD, will be limited to three (3) Basic Values, one (1) unit of time, and 100% of the conversion factor for the anesthesiologist.

c. Qualifying Circumstances

Paper Claim Form - Block 24 D (CPT® /HCPCS)

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>99100</td>
<td>Anesthesia for patient of extreme age, under one year and over seventy</td>
</tr>
<tr>
<td>99116</td>
<td>Anesthesia complicated by utilization of total body hypothermia</td>
</tr>
<tr>
<td>99135</td>
<td>Anesthesia complicated by utilization of controlled hypotension</td>
</tr>
<tr>
<td>99140</td>
<td>Anesthesia complicated by emergency condition</td>
</tr>
</tbody>
</table>

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

Paper Claim Form - Block 24D Modifiers

Do not bill qualifying circumstances with an anesthesia modifier (e.g. AA, AD, QK, QX, QY, or QZ) or a physical status modifier (e.g. P1, P2, P3, P4, P5 or P6) as this may result in delay in reimbursement, rejection of charge(s) or return of claim.

Paper Claim Form - Block 24G (Days or Units)

Qualifying circumstances should be billed with one number of service.

Do not bill anesthesia minutes in this field.

d. Reimbursement Guidelines for Qualifying Circumstances for Anesthesia

Maximum allowable for qualifying circumstances for anesthesia performed by an Anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) are based on the lesser of total covered charges or the following formula:

Maximum Allowable = Unit Value x Conversion Factor

The following are the Unit Values for qualifying circumstances for anesthesia:

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

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

e. Unusual Forms of Monitoring

Paper Claim Form - Block 24 D (CPT® /HCPCS)

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

Paper Claim Form - Block 24D Modifiers

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

Paper Claim Form - Block 24G (Days or Units)

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

VI-66
f. Reimbursement Guidelines for Unusual Forms of Monitoring of Anesthesia
Maximum allowable for unusual forms of monitoring such as intra-arterial, central venous, Swan-Ganz, and transesophageal echocardiography (TEE) provided in conjunction with anesthesia administration will be based on the lesser of total covered charges or the Professional Maximum Allowable Fee Schedule.

g. Postoperative Pain Management-Placement of Epidural
If operative procedure was performed or ends under general anesthesia and epidural is placed for postoperative pain management purposes, placement of the epidural may be billed as follows:

**Paper Claim Form - Block 24D (CPT® /HCPCS)**
Postoperative pain management-placement of epidural should be billed using the most appropriate CPT® code. Refer to the CPT® book in effect for the date of service for the most appropriate CPT® code.

**Paper Claim Form - Block 24D Modifiers**
Do not bill postoperative pain management-placement of epidural with a (AA, AD, QK, QX, QY, or QZ) modifier or a physical status modifier (e.g. P1, P2, P3, P4, P5 or P6) as this may result in delay in reimbursement, rejection of charge(s) or return of claim.

**Paper Claim Form - Block 24G (Days or Units)**
Postoperative pain management-placement of epidural should be billed using the appropriate number(s) of service.

Do not bill anesthesia minutes in this field.

h. Reimbursement Guidelines for Postoperative Pain Management-Placement of Epidural
Maximum allowable for placement of epidural for postoperative pain management services performed by an Anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) are based on the lesser of total covered charges or the Professional Maximum Allowable Fee Schedule.

i. Postoperative Pain Management-Daily Hospital Management of Epidural (continuous) or subarachnoid (continuous) Drug Administration
Postoperative pain management-daily hospital management should only be billed for postoperative days. Postoperative pain management-daily hospital management should not be billed on the same day as the operative procedure.

Billing of postoperative pain management-daily hospital management billed on the same day as the operative procedure may result in delay in reimbursement, rejection of charge or return of claim.

Postoperative pain management-daily hospital management should be billed as follows:

**Paper Claim Form - Block 24D (CPT® /HCPCS)**
Postoperative pain management-daily hospital management should be billed using the most appropriate CPT® code. Refer to the CPT® book in effect for the date of service for the most appropriate CPT® code.

**Paper Claim Form - Block 24D Modifiers**
Do not bill postoperative pain management-daily hospital management with a (AA, AD, QK, QX, QY, or QZ) modifier or a physical status modifier (e.g. P1, P2, P3, P4, P5 or P6) as this may result in delay in reimbursement, rejection of charge(s) or return of claim.
Paper Claim Form - Block 24G (Days or Units)
Postoperative pain management—daily hospital management should be billed using one number of service for each day of postoperative management.

Do not bill anesthesia minutes in this field.

j. Reimbursement Guidelines for Postoperative Pain Management—Daily Hospital Management of Epidural (continuous) or Subarachnoid (continuous) Drug Administration
The maximum allowable for postoperative pain management daily management of epidural (continuous) or subarachnoid (continuous) drug administration performed by an Anesthesiologist or Certified Registered Nurse Anesthetist (CRNA) is based on the lesser of total covered charges or the following formula:

Maximum Allowable = Unit Value x Conversion Factor

The following is the Unit Value for postoperative pain management daily management of epidural (continuous) or subarachnoid (continuous) drug administration:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Unit Value</th>
<th>Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>01996</td>
<td>Daily Management of epidural or subarachnoid drug administration</td>
<td>3</td>
<td>Refer to contract</td>
</tr>
</tbody>
</table>

Reimbursement is limited to no more than three postoperative days of daily hospital management of epidural (continuous) or subarachnoid (continuous) drug administration.

4. Obstetric Anesthesia

Obstetric anesthesia for a planned vaginal delivery (01967) that ends in a C-Section delivery (01968) is to be billed on a single claim form using the date of delivery as the date of service. Add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code on a separate claim. Add-on codes submitted with no primary code or a different date of service result in rejection and non-payment of the add-on code.

Obstetric anesthesia services involving more than one Provider (e.g. two physicians or two CRNA's) for the same episode are to be submitted on a single claim with the date of delivery as the date of service.

5. Reimbursement Guidelines for Administration of Regional or General Anesthesia Provided by a Surgeon

Administration of regional or general anesthesia provided by a surgeon may be reported by appending Modifier 47 (Anesthesia by Surgeon) to the appropriate procedure code in accordance with CPT® guidelines.

Reimbursement for administration of regional or general anesthesia provided by a surgeon is included in the reimbursement for the surgical or other procedure and is not separately reimbursed.

Reimbursement for the surgical or other procedure is based on the lesser of total covered charges or the professional maximum allowable fee schedule.

Modifier 47 has no effect on the maximum allowable.
6. Reimbursement Policy for Moderate Conscious Sedation

Moderate (conscious) sedation provided by the same Physician performing the diagnostic or therapeutic service that the sedation supports.

Moderate (conscious) sedation provided by a Physician other than the health care professional performing the diagnostic or therapeutic service that the sedation supports.

Moderate Conscious Sedation codes are identified in the CPT® codebook with a special symbol for Moderate Conscious Sedation.

Reimbursement for Moderate (Conscious) Sedation will be paid in accordance to the CMS and Appendix G.

7. Reimbursement Guidelines for Bundled Services Regardless of the Location of Service

Under RBRVS methodology, Medicare considers reimbursement for certain codes bundled regardless of the location of service. Medicare considers these codes as an integral part of or incident to some other service even if billed alone. These codes are published by Medicare in the National Physician Fee Schedule Relative Value File and/or Program Memorandums/Transmittals with a Status Code “B”. These documents can be found online at www.cms.gov.

Unless specified otherwise in this policy, BCBST considers codes published by Medicare with a Status Code “B” as bundled regardless of the location of service. The maximum allowable for these codes is $0.00 even when billed alone.

Updates resulting from changes by Medicare for codes with a Status Code “B” will be made in accordance with the BCBST Policy for Quarterly Reimbursement Changes.

8. Reimbursement Guidelines for Bundled Services when the Location of Service is the Practitioner’s Office

Under RBRVS methodology, Medicare considers reimbursement for certain codes bundled when the location of service is the Practitioner’s office. Medicare considers these codes as an integral part of or incident to some other service even if billed alone. These codes are published by Medicare in the National Physician Fee Schedule Relative Value File and/or Program Memorandums/Transmittals with a Status Code “P”. These documents can be found online at www.cms.gov.

Unless specified otherwise in the policy, BCBST considers codes published by Medicare with a Status Code “P” as bundled when the location of service is the Practitioner’s office. The maximum allowable for these codes is $0.00 even when billed alone.

Updates resulting from changes by Medicare for codes with a Status Code “P” will be made in accordance with the BCBST Policy for Quarterly Reimbursement Changes.

This policy applies to services billed on a Professional claim form.

Exception:
When the location of service is the Practitioner’s office (place of service 11), HCPCS code V2520 is eligible for reimbursement.
9. Reimbursement Guidelines for Global Periods

The concept of the “Global Period” includes the routine preoperative history and physical including the hospital admission, the operative procedure, and all care related to the surgical procedure. The CMS established global periods for certain surgical procedures. These assigned periods can be 0 days, 10 days, or 90 days. Global periods are determined based on the guidelines published by Medicare in the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals. These documents can be found online at www.cms.gov.

If Medicare has not assigned a global period for certain procedures, BCBST reserves the right to assign a global period based on a similar service.

10. Assistant-at-Surgery

BCBST adopted CMS as the primary source for medical appropriateness for assistant-at-surgery services for Blue Networks E, M, P, and S.

CMS denotes whether a procedure is eligible for assistant-at-surgery services by assigning an indicator to each procedure code.

The following guidelines apply:

Assistant-at-Surgery Services Provided by a Physician

Assistant-at-surgery services provided by a Physician should be reported by appending the Level I HCPCS – CPT® modifier 80 (Assistant Surgeon), 81 (Minimum Assistant Surgeon) or 82 (Assistant Surgeon when qualified resident surgeon not available) to the procedure code.

The 80, 81 or 82 modifier should not be used to report assistant-at-surgery services provided by a Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist.

BCBST will reimburse eligible assistant-at-surgery services provided by a Physician based on the lesser of total covered charges or sixteen percent (16%) of the maximum allowable fee schedule amount for all BCBST networks.

Assistant-at-Surgery Services Provided by a Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist

Assistant-at-surgery services provided by a Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist should be reported by appending the Level II HCPCS modifier AS (Physician Assistant, Nurse Practitioner, or Clinical Nurse Specialist services for assistant-at-surgery).

Assistant-at-surgery services provided by a Nurse Practitioner or Clinical Nurse Specialist is considered ancillary support. Reimbursement for assistant-at-surgery services provided by a Nurse Practitioner or Clinical Nurse Specialist is included in the reimbursement to the licensed Practitioner for services provided in the Physician’s office or in the reimbursement to the facility for services provided in an inpatient or outpatient setting. The maximum allowable for assistant-at-surgery services provided by a Nurse Practitioner or Clinical Nurse Specialist will be $0.00. Participating and non-participating Providers will not be permitted to bill the Member for the difference between the charge and the BCBST maximum allowable for the AS modifier as the Nurse Practitioner or Clinical Nurse Specialist should be compensated directly by the supervising Physician or facility.

Eligible assistant-at-surgery services provided by a Physician Assistant credentialed as an assistant-at-surgery will be based on the lesser of total covered charges or 13.6% (i.e. 85% of 16%) of the maximum allowable fee schedule amount.

Note: Physician Assistants must bill assistant-at-surgery services using the unique Provider number and/or NPI assigned for this purpose. Some Physician Assistants may be contracted for both assistant-at-surgery and for other practitioner services. Assistant-at-surgery charges will only be reimbursed if filed with the appropriate taxonomy code.
11. Global, Professional and Technical Components for Radiology, Laboratory and Other Diagnostic Procedures

Per the BCBST Reimbursement Policy for Professional and Technical Components for Radiology, Laboratory, and Other Diagnostic Procedures, reimbursement will be limited to procedures where a 26-professional component or TC-technical component modifier is appropriate per the Medicare Physician Fee Schedule Data Base, Federal Register or National Physician Fee Schedule Relative Value File and/or Program Memorandums/Transmittals in effect for the date of service. These documents can be found online at www.cms.gov.

Reimbursement will be based on the lesser of total covered charges or the maximum allowable fee schedule allowance for the procedure.

Note:

- If the code is eligible to be billed with modifier TC per the BCBST’s Reimbursement Policy for Technical and Professional Components for Radiology, Laboratory, and Other Diagnostic Procedures, only the technical component for a radiology, laboratory, or other diagnostic procedure, the Provider should append modifier TC to the CPT® or HCPCS code.

- If the code is eligible to be billed with modifier 26 per the BCBST’s Reimbursement Policy for Technical and Professional Components for Radiology, Laboratory, and Other Diagnostic Procedures, only the professional component for a radiology, laboratory, or other diagnostic procedure, the Provider should append modifier 26 to the CPT® or HCPCS code.

- If both the technical and professional components for radiology, laboratory, or other diagnostic procedures are performed, it is appropriate to bill the service as a global procedure (i.e. without a 26 or TC modifier appended to the CPT® or HCPCS code).

12. Reimbursement Guidelines for Bilateral Procedures

This policy applies to bilateral procedures billed for the same patient on the same date of service by the same Provider on a Professional claim form for all BCBST commercial business.

The maximum allowable for eligible bilateral procedures billed for the same patient on the same date of service by the same Provider will be based on the bilateral procedure indicator published by Medicare in the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals. These documents can be found online at www.cms.gov.

Refer to Exhibit A for a summary of the percentages of the base allowable that will be applied for each bilateral procedure indicator.

Per HIPAA guidelines, bilateral procedures must be billed as a single line item using the most appropriate CPT® code with modifier 50. One (1) unit should be reported.

However, in certain situations, Modifier 50 should not be added to a procedure code. Some examples, but not limited to, are when:

- a bilateral procedure is performed on different areas of the right and left sides of the body (e.g. reduction of fracture, left and right arm);
- the procedure code description specifically includes the word “bilateral”; and/or
- the procedure code description specifically indicates the words “one or both”.

Therefore, sometimes it is appropriate to bill a bilateral procedure with:
BlueCross BlueShield of Tennessee Provider Administration Manual

- a single line with no modifier and 1 unit;
- a single line with modifier 50 and 1 unit; and/or
- two lines with modifier LT and 1 unit on one line and modifier RT and 1 unit on another line.

Exhibit A – Reimbursement Guidelines for All Bilateral Procedures

<table>
<thead>
<tr>
<th>MPFSRVF Indicator</th>
<th>Percentage</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>100%</td>
<td>150% payment adjustment for bilateral procedures does not apply. If procedure is reported with modifier -50 or with modifiers RT and LT, base the payment for the two sides on the lower of: (a) the total actual charge for both sides, or (b) 100% of the fee schedule amount for a single code.</td>
</tr>
<tr>
<td>1</td>
<td>150%</td>
<td>150% payment adjustment for bilateral procedures applies. If the code is billed with the bilateral modifier or is reported twice on the same day by any other means (e.g., with RT and LT modifiers, or with a 2 in the units field), base the payment for these codes when reported as bilateral procedures on the lower of: (a) the total actual charge for both sides or (b) 150% of the fee schedule amount for a single code.</td>
</tr>
<tr>
<td>2</td>
<td>100%</td>
<td>150% payment adjustment does not apply. RVUs are already based on the procedure being performed as a bilateral procedure. If the procedure is reported with modifier -50 or is reported twice on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for both sides on the lower of (a) the total actual charge by the Physician for both sides, or (b) 100% of the fee schedule for a single code.</td>
</tr>
<tr>
<td>3</td>
<td>200%</td>
<td>The usual payment adjustment for bilateral procedures does not apply. If the procedure is reported with modifier -50 or is reported for both sides on the same day by any other means (e.g., with RT and LT modifiers or with a 2 in the units field), base the payment for each side or organ or site of a paired organ on the lower of (a) the actual charge for each side or (b) 100% of the fee schedule amount for each side.</td>
</tr>
<tr>
<td>9</td>
<td>100%</td>
<td>Concept does not apply.</td>
</tr>
</tbody>
</table>

13. Reimbursement Guidelines for Multiple Procedures

This policy applies to multiple procedures billed for the same patient on the same date of service by the same Provider on a Professional claim form for all BCBST commercial business.

The maximum allowable for eligible multiple procedures billed for the same patient on the same date of service by the same Provider will be based on the multiple procedure indicator published by Medicare in the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals. These documents can be found online at www.cms.gov.

Codes published by Medicare National Physician Relative Value Fee Schedule with a multiple procedure indicator “3” will be administered by BCBST based on the guidelines for multiple procedure indicator “2”.

Updates resulting from changes to the multiple procedure indicators published by Medicare will be made in accordance with the BCBST Policy for Quarterly Reimbursement Changes.

Refer to Exhibit for a summary of percentages of the base allowable that will be applied for each multiple procedure indicator and procedure code rank.

The determination of the primary procedure when multiple procedures are billed for the same patient on the same date of service by the same Provider will be based on the procedure with the highest allowed amount according to the appropriate base fee schedule. All base allowables will be evaluated for each line billed. The procedure with the highest dollar amount according to the fee schedule will be considered as the primary procedure.
Exhibit A – Reimbursement Guidelines for All Multiple Procedures

<table>
<thead>
<tr>
<th>MPFSR</th>
<th>Procedure Rank</th>
<th>Percentage</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1st</td>
<td>100%</td>
<td>No payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure, base the payment on the lower of (a) the actual charge, or (b) the maximum allowable amount of the fee schedule for the procedure.</td>
</tr>
<tr>
<td>0</td>
<td>2nd +</td>
<td>100%</td>
<td>Standard payment adjustment rules for multiple procedures apply. If procedure is reported on the same day as another procedure with an indicator of 2, or 3, rank the procedures by the maximum allowable amount of the fee schedule and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the maximum allowable amount of the fee schedule reduced by the appropriate percentage, regardless of the amount billed.</td>
</tr>
<tr>
<td>2</td>
<td>1st</td>
<td>100%</td>
<td>If procedure is reported on the same day as another procedure with an indicator of 2, or 3, rank the procedures by the maximum allowable amount of the fee schedule and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the maximum allowable amount of the fee schedule reduced by the appropriate percentage, regardless of the amount billed.</td>
</tr>
<tr>
<td>2</td>
<td>2nd</td>
<td>50%</td>
<td>If procedure is reported on the same day as another procedure with an indicator of 2, or 3, rank the procedures by the maximum allowable amount of the fee schedule and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the maximum allowable amount of the fee schedule reduced by the appropriate percentage, regardless of the amount billed.</td>
</tr>
<tr>
<td>2</td>
<td>3rd</td>
<td>50%</td>
<td>If procedure is reported on the same day as another procedure with an indicator of 2, or 3, rank the procedures by the maximum allowable amount of the fee schedule and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the maximum allowable amount of the fee schedule reduced by the appropriate percentage, regardless of the amount billed.</td>
</tr>
<tr>
<td>2</td>
<td>4th</td>
<td>50%</td>
<td>If procedure is reported on the same day as another procedure with an indicator of 2, or 3, rank the procedures by the maximum allowable amount of the fee schedule and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the maximum allowable amount of the fee schedule reduced by the appropriate percentage, regardless of the amount billed.</td>
</tr>
<tr>
<td>2</td>
<td>5th</td>
<td>50%</td>
<td>If procedure is reported on the same day as another procedure with an indicator of 2, or 3, rank the procedures by the maximum allowable amount of the fee schedule and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the maximum allowable amount of the fee schedule reduced by the appropriate percentage, regardless of the amount billed.</td>
</tr>
<tr>
<td>2</td>
<td>6th +</td>
<td>IC</td>
<td>If procedure is reported on the same day as another procedure with an indicator of 2, or 3, rank the procedures by the maximum allowable amount of the fee schedule and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the maximum allowable amount of the fee schedule reduced by the appropriate percentage, regardless of the amount billed.</td>
</tr>
<tr>
<td>3</td>
<td>1st</td>
<td>100%</td>
<td>If procedure is reported on the same day as another procedure with an indicator of 2, or 3, rank the procedures by the maximum allowable amount of the fee schedule and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the maximum allowable amount of the fee schedule reduced by the appropriate percentage, regardless of the amount billed.</td>
</tr>
<tr>
<td>3</td>
<td>2nd</td>
<td>50%</td>
<td>If procedure is reported on the same day as another procedure with an indicator of 2, or 3, rank the procedures by the maximum allowable amount of the fee schedule and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the maximum allowable amount of the fee schedule reduced by the appropriate percentage, regardless of the amount billed.</td>
</tr>
<tr>
<td>3</td>
<td>3rd</td>
<td>50%</td>
<td>If procedure is reported on the same day as another procedure with an indicator of 2, or 3, rank the procedures by the maximum allowable amount of the fee schedule and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the maximum allowable amount of the fee schedule reduced by the appropriate percentage, regardless of the amount billed.</td>
</tr>
<tr>
<td>3</td>
<td>4th</td>
<td>50%</td>
<td>If procedure is reported on the same day as another procedure with an indicator of 2, or 3, rank the procedures by the maximum allowable amount of the fee schedule and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the maximum allowable amount of the fee schedule reduced by the appropriate percentage, regardless of the amount billed.</td>
</tr>
<tr>
<td>3</td>
<td>5th</td>
<td>50%</td>
<td>If procedure is reported on the same day as another procedure with an indicator of 2, or 3, rank the procedures by the maximum allowable amount of the fee schedule and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the maximum allowable amount of the fee schedule reduced by the appropriate percentage, regardless of the amount billed.</td>
</tr>
<tr>
<td>3</td>
<td>6th +</td>
<td>IC</td>
<td>If procedure is reported on the same day as another procedure with an indicator of 2, or 3, rank the procedures by the maximum allowable amount of the fee schedule and apply the appropriate reduction to this code (100%, 50%, 50%, 50%, 50% and by report). Base the payment on the lower of (a) the actual charge, or (b) the maximum allowable amount of the fee schedule reduced by the appropriate percentage, regardless of the amount billed.</td>
</tr>
</tbody>
</table>

14. Reimbursement Guidelines for Preoperative Management Only, Surgical Care Only, and Postoperative Management Only Services

This policy applies to the following services billed on a Professional claim form for all BCBST commercial business:

- Preoperative Management Only Services billed with CPT® modifier 56;
- Surgical Care Only Services billed with CPT® modifier 54; and
- Postoperative Management Only Services billed with CPT® modifier 55.

**Preoperative Management Only Services**
When one Physician performs the preoperative care and evaluation and another Practitioner performs the surgical procedure, the preoperative component should be reported with CPT® modifier 56 appended to the appropriate procedure code.

**Surgical Care Only Services**
When one Physician performs a surgical procedure and another Physician provides preoperative and/or postoperative management, the surgical services should be reported with CPT® modifier 54 appended to the appropriate procedure code.

**Postoperative Management Only Services**
When one Physician performs the postoperative management and another Physician performs the surgical procedure, the postoperative component should be reported with CPT® modifier 55 appended to the appropriate procedure code.
Eligible preoperative management only, surgical care only, and postoperative management only services will be reimbursed based on the lesser of total covered charges or a percentage of the base maximum allowable for the procedure code as published by Medicare in the National Physician Relative Value Fee Schedule and/or Program Memorandums/Transmittals. These documents can be found online at www.cms.gov.

Updates resulting from changes to the percentages published by Medicare will be made in accordance with the BCBST Policy for Quarterly Reimbursement Changes.

15. Reimbursement Guidelines for Procedures Performed by Two Surgeons

BCBST adopted Medicare as the primary source for medical appropriateness for procedures performed by two surgeons for Blue Networks E, M, P, and S. BCBST follows Medicare’s guidelines by assigning an indicator to each procedure code to denote whether the procedure is Medically Appropriate for co-surgery services.

Reimbursement for eligible procedures performed by two surgeons based on the lesser of total covered charges or 62.5% of the base maximum allowable fee schedule amount for the procedure for each surgeon (or a total of 125% of the base maximum allowable fee schedule amount for the procedure for both surgeons) when billed by the Provider in accordance with standard coding and billing guidelines.

Each co-surgeon from a different specialty performs a distinct portion of the complete procedure and reports the exact same surgical procedure code with the 62 modifier. Each surgeon must dictate his/her own operative report. BCBST uses the payment policy indicators on the Medicare Physician Fee Schedule Database (MPFSDB) to determine if co-surgeon services are reasonable and necessary for a specific HCPCS/CPT® code.

16. Reimbursement Guidelines for Screening Test for Visual Acuity

According to Current Procedural Terminology (CPT®), a “screening test of visual acuity must employ graduated visual acuity stimuli that allow a quantitative estimate of visual acuity (e.g. Snellen chart). Other identifiable services unrelated to this screening test provided at the same time may be reported separately (e.g. preventive medicine services). When acuity is measured as part of a general ophthalmological service or of an evaluation and management service of the eye, it is a diagnostic examination and not a screening test.”

The American Medical Association created code 99173 (Screening test of visual acuity, quantitative, bilateral) at the request of the American Academy of Ophthalmology in association with the American Academy of Pediatrics to enable pediatricians to bill for performing a visual screening test to ascertain whether future referral for visual care is needed. The code was also developed to electronically track visual screenings for pediatric patients to support proposed Utilization Review Accreditation Commission (URAC) and Healthcare Effectiveness Data and Information Set (HEDIS) efforts.

According to the American Academy of Pediatrics, a screening test of visual acuity is typically provided in conjunction with a preventive medicine service, which includes external inspection of eyes, tests for ocular muscle motility and eye muscle imbalance, and ophthalmoscopic examination. Since a screening test of visual acuity would not be provided as an independent/standalone service and the service involves minimal labor on part of the health care professional as does the external inspection of eyes, tests for ocular muscle motility and eye muscle imbalance, and ophthalmoscopic examination, reimbursement for code 99173 will be considered bundled with the service to which it is incident such as the preventive medicine service.

The maximum allowable for visual acuity will be $0.00 even when billed alone.
17. **Reimbursement Guidelines for Visual Function Screening**

According to Current Procedural Terminology (CPT®), code 99172 may be used to report visual function screening which includes automated or semi-automated bilateral quantitative determination of visual acuity, ocular alignment, color vision by pseudoisochromatic plates, and field of vision. Code 99172 may also include all or some screening of the determination(s) for contrast sensitivity vision under glare. This service must employ graduated visual acuity stimuli that allow a quantitative determination of visual acuity (e.g. Snellen chart).

Code 99172 is intended for use by Practitioners who provide occupational health services, usually involving the specialties of occupational medicine, internal medicine, family practice and emergency Practitioners.

Code 99172 was created to facilitate reporting of federally mandated visual function screening services for certain workers in an occupational field where optimal vision is crucial and safety standards for vision exist (e.g. firefighter, heavy equipment controller, nuclear power plant operators). Since a visual function screening would not be provided as an independent/stand alone service and the service involves minimal labor on part of the health care professional as does the external inspection of eyes, tests for ocular muscle motility and eye muscle imbalance, and ophthalmoscopic examination, reimbursement for code 99172 will be considered bundled with the service to which it is incident.

18. **OB/GYN Services**

Bill in accordance with CPT® and American College of Obstetricians and Gynecologist (ACOG) coding guidelines in effect for the date of service. Providers can write to the ACOG at 409 12th Street, SW, Washington, D.C., 20024-2188 to obtain a copy of ACOG’s CPT® Coding in Obstetrics & Gynecology guidebook.

19. **Reimbursement Guidelines for Independent Lab Services**

Reimbursement for Independent Lab services billed on a Professional claim form will be based on the lesser of total covered charges or at the contracted allowed amount of the published Current Medicare fee schedule for Tennessee, and the provisions, as outlined below for all BCBST commercial lines of business.

Services classified by Medicare as clinical laboratory services will be reimbursed by BCBST based on the published Current Clinical Lab, Non-Clinical Lab, and Pathology maximum allowable fee schedule. Updates for existing codes will be based on BCBST “Quarterly Reimbursement Changes” standard.

Services reimbursed by Medicare based on RBRVS methodology such as pathology and non-clinical laboratory, will be reimbursed by BCBST based on RVUs and GPCIs for Tennessee as published in the Federal Register-Department of Health and Human Services, Health Care Financing Administration (Final Rules). Updates for existing codes will be based on BCBST “Quarterly Reimbursement Changes” standard.

Fees for Independent Lab services not published by Medicare will be reimbursed based on a reasonable allowable as determined by BCBST. Methods used by BCBST include, but are not limited to the following:

- BCBST Reimbursement Policies and Procedures
- OPTUM (or it’s successors) RBRVS
- Based on fees for similar procedures in terms of time, skill, supplies, equipment, etc.

Updates to the Independent Lab Maximum Allowable Fee Schedule may result in increases and decreases in fees.
Independent Lab agrees to provide laboratory results to BCBST electronically, in accordance with the HL7 data format standards provided to Lab by BCBST, which may be updated from time to time. BCBST shall make updated standards available to Lab, either through providing Lab with a physical copy of updated standards or through publishing standards on www.bcbst.com, and shall use reasonable efforts to provide Lab with no less than ninety (90) days’ notice to eliminating a previously acceptable standard.

20. **Reimbursement Guidelines for Measurement Reporting Codes**

The purpose of measurement codes is to aid performance measurement by easing quality-of-care data collection. These codes generally describe either common components of Evaluation & Management services or test results that are part of a laboratory procedure. Each code is linked to a particular “performance measure set”.

BCBST considers measurement-reporting codes bundled to the service to which they are incident. The maximum allowable for measurement reporting codes is $0.00 even when billed alone with the exception of when the service is approved through an eligible BCBST initiative.

Examples of codes classified as measurement reporting codes:

- CPT® Category II codes (i.e., xxxxF codes)
- Other CPT® or HCPCS codes assigned a Status Code “M” (Measurement code, used for reporting purposes only) published on the Medicare Physician Fee Schedule Relative Value File

21. **Reimbursement Guidelines for STAT Services**

STAT services reported to denote procedures processed as done immediately, as soon as possible, and/or processed with priority.

Reimbursement by BCBST for STAT services will be considered bundled with the service to which it is incident (e.g. specific laboratory, pathology etc. codes) regardless of the location of service.

The maximum allowable fee schedule amount for STAT services is $0.00 even when billed alone with the exception of when the service is approved through an eligible BCBST initiative.

22. **Reimbursement Guidelines for Online Evaluation and Management (E&M) Services**

The American Medical Association established the CPT® codes 99444 and 98969 to report an online E&M service, per encounter, provided by a Physician (99444), or qualified non-Physician health care professional (98969), using the Internet or similar electronic communications network, in response to a patient’s request; established patient.

According to the American Medical Association, an online medical evaluation is a type of E&M service provided by a Physician or qualified health care professional, to a patient using Internet resources, in response to the patient’s online inquiry. Reportable services involve the Physician’s personal timely response to the patient’s inquiry and must involve permanent storage (electronic or hardcopy) of the encounter. This service should not be reported for patient contacts (e.g. Telephone calls) considered to be pre-service or post-service work for other E&M or non-E&M services. A reportable service would encompass the sum of communication (e.g. Related telephone calls, prescription provision, laboratory orders) pertaining to the online patient encounter or problem(s).

The maximum allowable fee schedule amount for online E&M services will be $0.00 even when billed alone with the exception of when the service is approved through an eligible BCBST initiative.

This policy applies to services billed on a Professional claim form for all BCBST commercial business.

Rev 06/15
23. **Guidelines for Evaluation and Management (E&M) New or Established Patient Determinations**

For the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by a Physician and reported by specific CPT® code(s).

A new patient is one who has not received any professional services (i.e., E&M or other face-to-face services) from the Physician, or another Physician of the same specialty who belongs to the same group practice, within the past three years.

An established patient is one who has received professional services (i.e., E&M or other face-to-face services) from the Physician or another Physician of the same specialty who belongs to the same group practice, within the past three years.

Audits will be performed to identify if a new patient E&M code is filed on a patient who has had a new patient E&M code filed by the Physician or another Physician of the same specialty who belongs to the same group within the past three (3) years. For occurrences identified, we will replace the new patient E&M code with an established patient E&M code as supported by CPT® to the most appropriate code.

CPT® codes and CPT® coding resources can be obtained from the American Medical Association. CPT® code updates may also be located on the American Medical Association website, [www.ama-assn.org](http://www.ama-assn.org).

24. **Billing Guidelines and Documentation Requirements for CPT® Code 99211**

The American Medical Association established the Evaluation and Management (E&M) CPT® code 99211 to report an office or other outpatient visit for the E&M of an established patient that may not require the presence of a Physician. Usually, the presenting problem(s) are minimal. Typically, five (5) minutes are spent performing or supervising these services.

According to the American Medical Association, medical record documentation is required to record pertinent facts, findings, and observations about an individual’s health history. The medical record facilitates the ability of the Physician and other health care professionals to evaluate and plan the patient’s immediate treatment and to monitor his/her health care over time.

There should be documentation in the medical record such as the patient/clinician face-to-face encounter exchanging significant and necessary information. There should be some type of limited physical assessment or patient review. The encounter must be for a problem stated by the patient and not involve solely the performance of tests or services ordered at prior encounters where E&M services were provided. There should be documentation in the medical record of the medical record of the encounter is required and documented.

Basic Guidelines for billing CPT® code 99211:

- The patient must be an established patient
- The patient/clinician encounter must be face-to-face
- Some degree of an evaluation and management service must be provided
- Pertinent documentation in the medical record of the encounter is required and documented
- Patient must state a present problem

This policy applies to services billed on a Professional claim form for all BCBST commercial business.

Rev 06/15
25. Genetic Counseling Services Billing Guidelines

Per Section 2713 of the Affordable Care Act (which is also 42 U.S.C. §300gg-13), BCBST will cover lactation training, with no cost-sharing requirement, women's preventive care and screening that is included in guidelines covered by HRSA. HRSA includes lactation training and support in its guidelines, which are found online at [http://www.hrsa.gov/womensguidelines/](http://www.hrsa.gov/womensguidelines/).

All Genetic Counseling services should be billed on a Professional claim form for any place of service (e.g. office, emergency room, outpatient or inpatient). When submitting ANSI-837 electronic claims, the Professional format must be used.

These guidelines apply to Genetic Counseling Specialty Contracted Providers only for services billed on a Professional claim form using the following HCPCS/CPT® codes:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Description</th>
<th>HCPCS/CPT® Code</th>
<th>Procedure Code</th>
<th>Billing Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetic Counseling Services</td>
<td>Genetic counseling, under physician supervision, each 15 minutes</td>
<td>S0265</td>
<td>required</td>
<td>1 unit 15 min.</td>
</tr>
<tr>
<td></td>
<td>Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family</td>
<td>96040</td>
<td>required</td>
<td>1 unit per 30 min.</td>
</tr>
<tr>
<td></td>
<td>Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient each 30 minutes</td>
<td>98961</td>
<td>required</td>
<td>1 unit per 30 min.</td>
</tr>
<tr>
<td></td>
<td>Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient each 30 minutes; 2-4 patients</td>
<td>98962</td>
<td>required</td>
<td>1 unit per 30 min.</td>
</tr>
<tr>
<td></td>
<td>Medical team conference with interdisciplinary team of health care professionals, face-to-face with patient and/or family, 30 minutes or more, participation by non-physician qualified health care professional</td>
<td>99366</td>
<td>required</td>
<td>1 unit per 30 min.</td>
</tr>
</tbody>
</table>

Genetic Counseling services not billed with the indicated HCPCS/CPT® codes will be rejected or denied.

To facilitate claims administration, a separate line item must be billed for each date of service and for each service previously indicated.

Allowable reimbursement will be per fee schedule indicated in Provider’s contract. Non-contracted Providers claims will be rejected or denied as non-contracted without Member liability.

Out-of-Network Provider’s claims will be rejected or denied as non-contracted as Member liability.

Code updates published by AMA/Medicare will be made in accordance with the BCBST Policy, “Quarterly Reimbursement Changes.”
26. Injections and Immunizations

a. Reimbursement Guidelines for Vaccines and Toxoids

BCBST shall reimburse Providers for eligible vaccines and toxoids based on a percentage of Average Wholesale Price (AWP), or Wholesale Acquisition Cost (WAC), if there is no published AWP, using one of the following methods:

**Method 1**

1. The AWP/WAC based on the National Drug Code (NDC) for the specific product billed.

**Method 2**

1. For a single-source product, the AWP/WAC equals the AWP/WAC of the single product.
2. For a multi-source product, the AWP/WAC is equal to the lesser of the median AWP/WAC of all of the generic forms of the product or the lowest brand name product AWP/WAC.

BCBST reserves the right to select the method used to calculate AWP/WAC and the source for AWP/WAC for vaccines and toxoids.

To determine eligibility and reimbursement for a vaccine or toxoid for items billed with a miscellaneous, unlisted, or not otherwise classified CPT® or HCPCS code. BCBST reserves the right to request the name of the product, National Drug Code (NDC), specific dosage administered and number of units, based on packaging.

Reimbursement for vaccines and toxoids will be 100% of AWP or a comparable percentage of WAC.

Reimbursement for the administration of vaccines and toxoids will be made when appropriately billed and submitted on the same claim form with the product administered.

b. Reimbursement and Billing Guidelines for Infusion Therapy, Immunosuppressive, Immune Globulin, Nebulizer, Chemotherapy and Other Injectable Drugs

**Reimbursement Guidelines**

The maximum allowable for eligible infusion therapy, immunosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs for professional and home infusion therapy Providers is based on a percentage of Average Sale Price (ASP) or Wholesale Acquisition Cost (WAC)/Average Wholesale Price (AWP) if there is no published ASP, or as indicated in the Provider Agreement and one of the below listed sources.

BCBST shall update maximum allowables for infusion therapy, immunosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs in accordance with the BCBST Policy for Quarterly Reimbursement Changes.

**Source A**

ASP as defined and published by the CMS for Medicare Part B - Tennessee.

**Source B**

The WAC/AWP based on the National Drug Code (NDC) for the specific drug billed per First Data/Medispan.

Maximum allowables for infusion therapy, immunosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs not published by Medicare Part B - Tennessee will be calculated based on a percentage of WAC/AWP according to one of the following methods:
Method 1

1. The WAC/AWP based on the National Drug Code (NDC) for the specific drug billed.

Method 2

1. For a single-source drug, the WAC/AWP equals the WAC/AWP of the single product.

2. For a multi-source drug, the WAC/AWP is equal to the lesser of the median WAC/AWP of all the generic forms of the drug or the lowest brand name product WAC/AWP.

BCBST reserves the right to select the method used to calculate ASP/WAC/AWP and the source for ASP/WAC/AWP for infusion therapy, immunosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs not published by Medicare Part B – Tennessee. Examples of sources for WAC/AWP include, but are not limited to First Data/Medispan, Redbook, and information provided by the drug manufacturer.

To determine eligibility and reimbursement for an injectable drug, BCBST reserves the right to request the name of the drug, National Drug Code (NDC), specific dosage administered and number of units, based on specific code description. For items billed with an unlisted, miscellaneous, not otherwise classified HCPCS code, specific dosage administered should be reported in appropriate form and number of units.

Refer to Provider Contract Agreements for network percentages and specific sources for facilities, professional Providers, and Home Infusion Therapy Providers.

Billing Guidelines

General

- When billing specific codes for drugs, the number of units billed should be based on the code description rather than the manufacturer’s packaging.
- Place of service should indicate where the medication is administered or instilled into external/implanted pump rather than where it is dispensed.
- Separate line items should not be billed for the HCPCS when the same therapeutic agent is administered on the same date of service. If different packages of the same therapeutic agent, with different national Drug Codes (NDCs), must be utilized to obtain the order dosage. Block 19 – Reserved For Local Use, section of the CMS-1500 or its equivalent should be utilized to report additional NDCs required.
- Saline and heparin, utilized for flushing and maintenance of infusion devices, are considered supplies included in professional services and home infusion therapy (HIT) per diems. These supplies are not eligible for separate reimbursement.
- Basic pre-packaged intravenous fluids utilized for IV hydration administered in the Practitioner’s office and fluids (e.g., partial-fills, 50 /100 / 250 ml bottles/bags) utilized to mix or facilitate administration of therapeutic agents in all places of service are considered supplies and are not eligible for separate reimbursement.
- Medications billed with unlisted, miscellaneous, non-specific and Not Otherwise Classified (NOC) codes should be billed with a unit of one (1) and require submission of drug name, National Drug Code (NDC), and dosage administered in appropriate form as ordered by Practitioner. Failure to submit this information may result in delay of reimbursement.

Compounds

- Only off-the-shelf medications packaged as manufactured from a pharmaceutical company should be coded utilizing specific HCPCS Level II codes with the exception of some inhalation mixtures having assigned specific codes.
- Refer to Compound Drugs in this Manual section for guidelines on medications compounded from bulk powder or altered from the manufacturers’ packaging.
Medication Wastage

- When necessary to discard a portion of a single dose vial (SDV), documentation of time, date, drug name, dosage administered, amount wasted and route of administration in the medical record is expected.
- Provider is responsible for using the most economical packaging of medication to achieve the required dosage with the least amount of medication wastage necessary.
- Wastage is not to be billed for medications available in multi-dose vials (MDV) and is not reimbursable.
- The NDC of the SDV requiring wastage should be submitted in Block 24 – Supplemental Information, section of the CMS-1500 or its electronic equivalent. Refer to Section VI. Billing and Reimbursement in this Manual for additional guidance.
- Instances of medication wastage from a SDV should be submitted on a single line item with the –JW modifier appended to the appropriate HCPCS Level II code. See General Guidelines section for reporting units of therapeutic agents with specific codes and for therapeutic agents billed with unlisted, miscellaneous, non-specific and Not Otherwise Classified (NOC) codes.
- The number of units billed for the SDV with specific HCPCS codes with the – JW modifier is inclusive of both the administered + discarded amounts.
- The number of units should be reported as one (1) for unlisted, miscellaneous, non-specific and Not Otherwise Classified (NOC) codes billed with the JW modifier appended. The “dosage administered” amount reported in Block 24 – Supplemental Information section of the CMS-1500 or its electronic equivalent should be inclusive of both the administered plus discarded amounts. The specific amounts administered and discarded should be reported in Block 19 - Reserved For Local Use section of the CMS-1500 or its electronic equivalent.

c. Preventive Vaccines Administered by a Pharmacist

Claim Form

Preventive vaccines administered by a Licensed Pharmacist and covered under the Member’s medical plan must be billed on a Professional claim form. Only those vaccines actually administered by the Pharmacist are to be billed. Vaccines administered in the pharmacy quick care clinic or by a subcontracted health care Provider (i.e. “flu clinics”) are not to be billed under these provisions.

Block 24b - Place of Service
The place of service (POS) should represent where the service is provided.

Block 24a - From and To Date(s) of Service
Enter the month, day and year for each vaccine and administration service provided.

Block 24d - Codes and Modifiers
Vaccines must be billed using the most appropriate CPT®/HCPCS code in effect for the date of service.

Block 24g – Days or Units
To report units for medications, the units must be billed in accordance with the CPT®/HCPCS definition in effect for the date of service and the Practitioner’s order.

General Billing Guidelines

- BCBST reserves the right to request the name of the drug, National Drug Code (NDC), dosage per the Practitioner’s order and quantity.
- Updates to the maximum allowable for existing codes will be made in accordance with the BCBST Reimbursement Policy for Immune Globulins, Vaccines and Toxoids.
Due to frequent changes in AWP, BCBST reserves the right to update the maximum allowable amount without prior notification.

Updates to the maximum allowable may result in increases and decreases in fees.

Refer to Section XIX. Pharmacy in this Manual for additional guidelines.

d. Specialty Pharmacy Medications

Claim Form
Specially pharmacy medications covered under the Member’s medical plan must be billed on a Professional claim form. Self-administered specialty pharmacy medications must be billed through the Member’s pharmacy benefits manager.

Block 24b - Place of Service
The place of service (POS) should represent where the service is provided.

Block 24a - From and To Date(s) of Service
Enter the month, day and year for each medication provided.

Block 24d - Codes and Modifiers
Medications must be billed using the most appropriate HCPCS code in effect for the date of service.

In the event there is not a specific HCPCS code for the medication, the most appropriate unlisted code (e.g., J3490, J7599, J9999) in effect for the date of service may be used.

Unlisted, miscellaneous, non-specific and Not Otherwise Classified (NOC) codes should only be used when a more specific CPT® or HCPCS code is not available or appropriate.

Medications billed with unlisted, miscellaneous, non-specific and Not Otherwise Classified (NOC) codes must be billed with the name of the drug, National Drug Code (NDC), dosage per the Practitioner’s order and quantity.

Block 24g – Days or Units
To report units for medications, the units must be billed in accordance with the HCPCS definition in effect for the date of service and the Practitioner’s order.

General Billing Guidelines

BCBST reserves the right to request the name of the drug, National Drug Code (NDC), dosage per the Practitioner’s order and quantity.

Updates to the maximum allowables for existing codes will be made in accordance with the BCBST Reimbursement Policy for Infusion Therapy, Immunosuppressive, Nebulizer, Chemotherapy and Other Injectable Drugs.

Due to frequent changes in ASP/WAC/AWP, BCBST reserves the right to update the maximum allowable amount without prior notification.

Updates to the maximum allowables may result in increases and decreases in fees.

Reimbursement for medications is limited to that amount actually prescribed and administered to the Member.

Provider is responsible for using the most economical packaging of medication to achieve the required dosage for the Member with the least amount of medication wastage.

Refer to Section XIX. Pharmacy in this Manual for self-administered specialty pharmacy medications as defined by BCBST covered under the Member’s medical benefits plan.
e. **Compound Drugs**

Eligible compound drugs must be billed with the most appropriate HCPCS Level II code for compound drugs and contain at least one legend drug with a valid National Drug Code (NDC) and billed on a Professional claim form.

BCBST maximum allowable is $0.00 for the following:

- Non-legend drugs
- Compounding and/or dispensing fees (May be considered for some lines of business – see following related Compound Services Policy)
- Diluents, solvents, or other ingredients utilized to mix, combine, or alter legend drug component(s)

The maximum allowable for compound drugs is determined from individual claim review and may vary by claim based on supplemental information provided with the claim or related claims. Supplemental information includes, but is not limited to:

- The name(s) of the drug component(s), NDC of legend drug component(s), and specific dosage of legend component(s) administered, instilled, inserted, or implanted.

The maximum allowable for eligible compound drugs for professional Providers is based on a percentage of Wholesale Acquisition Cost (WAC) or Average Wholesale Price (AWP) based on the Provider Agreement according to one of the following methods:

**Method 1**
1. The WAC/AWP based on the National Drug Code (NDC) for the specific drug billed.

**Method 2**
1. For a single-source drug, the WAC/AWP equals the WAC/AWP of the single product.
2. For a multi-source drug, the WAC/AWP is equal to the lesser of the median WAC/AWP of all of the generic forms of the drug or the lowest brand name product WAC/AWP.

BCBST reserves the right to select the method used to calculate WAC/AWP and the source for WAC/AWP. Examples of sources for WAC/AWP include, but are not limited to First Data/Medispan, Redbook, and information provided by the drug manufacturer.

f. **Compounding Services**

Eligible compounding services must be billed with the most appropriate HCPCS Level II code for consideration of reimbursement to Providers when eligible compound drugs are administered under the “incident to” provision and/or considered as eligible medical benefits. These services must be billed on a Professional claim form for BCBST commercial and MedAdvantage lines of business.

A reasonable compounding allowance will be reimbursed, if applicable, for each date of service compound drugs are administered, instilled, inserted, or implanted. In order to be considered for reimbursement, a separate line item must be included for these compounding services. This service must be billed with the appropriate HCPCS code for Pharmacy compounding and dispensing services.

### g. Reimbursement and Billing Guidelines for Radiopharmaceuticals and Contrast Materials

This policy applies to all eligible drugs filed on a Professional claim form for all BCBST business.
The maximum allowable for eligible radiopharmaceuticals and contrast materials is based on the lesser of total covered charges or a percentage of Average Sales Price (ASP) or Wholesale Acquisition Cost (WAC)/Average Wholesale Price (AWP) if there is no published ASP, or as indicated in the Provider Agreement and one of the following sources:

**Source A**

ASP as defined and published by the CMS on the "Medicare Part B Drugs Average Sales Price" file.

Updates to maximum allowables for radiopharmaceuticals and contrast materials published by CMS will be made in accordance with the BCBST Policy Quarterly Reimbursement Changes.

**Source B**

The WAC/AWP based on the National Drug Code (NDC) for the specific radiopharmaceutical or contrast material billed per First Data/Medispan.

Maximum allowables for radiopharmaceuticals and contrast materials not published by CMS will be calculated based on the lesser of total covered charges or a percentage of WAC/AWP according to one of the following methods:

**Method 1**

1. The WAC/AWP based on the National Drug Code (NDC) for the specific radiopharmaceutical or contrast material billed.

**Method 2**

1. For a single-source radiopharmaceutical or contrast material, the WAC/AWP equals the WAC/AWP of the single product.

2. For a multi-source radiopharmaceutical or contrast material, the WAC/AWP is equal to the lesser of the median WAC/AWP of all the generic forms of the radiopharmaceutical or contrast material or the lowest brand name product WAC/AWP.

BCBST reserves the right to select the method used to calculate WAC/AWP and the source for WAC/AWP for radiopharmaceuticals and contrast materials without an ASP published by CMS. Examples of sources for WAC/AWP include, but are not limited to First Data/Medispan, Redbook, and information provided by the radiopharmaceutical or contrast material manufacturer.

For codes where it is not feasible to establish a maximum allowable for a radiopharmaceutical or contrast material (e.g. when the radiopharmaceutical or contrast material does not have a NDC, when the dosage depends on the weight of the patient), the maximum allowable will be based on a reasonable allowable as determined by BCBST.

In order to determine a reasonable allowable, BCBST reserves the right to request one of the following:

- The name of the radiopharmaceutical or contrast material, NDC, dosage, and quantity;
- The manufacturer/supplier’s invoice. When a manufacturer / supplier’s invoice is requested, the name of the patient, name of the specific radiopharmaceutical or contrast material, dosage, and number of units must be provided. If multiple patients are listed on the manufacturer/supplier's invoice, the radiopharmaceutical or contrast material, dosage and number of units for the patient being billed should be clearly indicated.
Radiopharmaceuticals and contrast materials provided in a facility setting are not billable to or reimbursable by BCBST on a Professional claim form. Radiopharmaceuticals and contrast materials provided in a facility setting are considered facility services and must be billed by the facility.

- Reimbursement for medications is limited to that amount actually prescribed and administered to the Member.
- If the Radiopharmaceuticals and Contrast Materials are used in conjunction with a radiological procedure/service that is determined to be ineligible, the Radiopharmaceutical and Contrast Material will not be reimbursed.
- Provider is responsible for using the most economical packaging of medication to achieve the required dosage for the Member with the least amount of medication wastage.
- In order to be considered for reimbursement, Radiopharmaceuticals and Contrast Materials must be billed on the same claim as the related radiological procedure/service.
- Refer to Section XIX. Pharmacy in this Manual for self-administered specialty pharmacy medications as defined by BCBST covered under the Member’s medical benefits plan.

**h. Reimbursement Guidelines for Non-Injectable Medications when the Location of Service is the Practitioner’s Office**

Reimbursement by BCBST for prescription medications other than injectables when the location of service is the Practitioner’s office will not be allowed. Exceptions to this policy include, but are not limited to nebulized inhalation drugs and other prescription drugs addressed under Reimbursement Policy for Immune Globulins, Infusion Therapy, Immunosuppressive, Nebulizer, Chemotherapy and Other Injectable Drugs.

The maximum allowable fee schedule amount for non-injectable medications when the location of service is the Practitioner’s office is $0.00 unless otherwise specified in the Member’s medical benefit plan. This policy applies to services billed on a Professional claim form.

**i. Reimbursement Guidelines for Self-Administered Prescription Medications Dispensed and Submitted by a Licensed Pharmacist**

Whenever a Licensed Pharmacist submits a claim for reimbursement for self-administered medications to BCBST, the claim must either be submitted electronically or on a paper claim form through the appropriate Pharmacy Network. This will ensure that possible duplication of payment is avoided, that only costs for those prescription medications included on the appropriate contract formularies are reimbursed, that those medications requiring prior authorization are appropriately reviewed, and that all pertinent pharmacy discounts and copays apply. If a pharmacy claim is submitted paper to BCBST, that hardcopy will be routed to the appropriate pharmacy network for processing.

Self-administered prescription drugs submitted by a licensed pharmacist on a Professional or Institutional claim form will not be priced by BCBST as a medical benefit unless otherwise specified by the Member’s medical benefit plan.

**j. Reimbursement Guidelines Any Prescription Medications Dispensed by a Provider Other Than a Licensed Pharmacist when the Location of Service is Not the Practitioner’s Office**

Reimbursement by BCBST for any prescription medication dispensed by a Provider other
than a licensed pharmacist when the medication is not administered in the Practitioner’s office will not be allowed. This will ensure that only those professionals who are properly trained will administer these services at the contracted rates as stipulated in the Member’s prescription drug benefit plan.

The maximum allowable fee schedule amount for prescription medications dispensed by a Provider other than a licensed pharmacist when the medication is not administered in the practitioner’s office is $0.00.

This policy applies to prescription medications dispensed by a Provider other than a licensed pharmacist when the location of service is not 11 when billed on a Professional claim form for all BCBST business.

k. Reimbursement Guidelines for Medications Not Requiring a Prescription from a Licensed Pharmacist Regardless of the Location of Service

Reimbursement by BCBST for medications that do not require a prescription from a licensed physician regardless of the location of service will be considered non-covered.

The maximum allowable for medications that do not require a prescription from a licensed Physician as defined by this policy will be $0.00.

This policy applies to medications that do not require a prescription from a licensed Physician (e.g. over the counter drugs) regardless of the location of service billed on a Professional or Institutional claim form for all BCBST business.

27. Home Infusion Therapy (HIT)

Definitions:

Home Infusion Therapy is the continuous slow introduction of therapeutic agents—analgesics, chemotherapy, prostaglandins, tocolytics, hydration solutions, antibiotics, parenteral nutrition—into the body on an intermittent basis, to achieve practitioner defined beneficial outcomes for the condition being treated in the Member’s private residence.

- Therapeutic agents instilled into an implanted or ambulatory pump in the Practitioner’s office are not considered HIT.
- Medications delivered to the Practitioner’s office for infusion/instillation in the office setting are not billable or reimbursable as HIT.
- Infusion therapy provided in a location other than a Member’s private residence is not billable or reimbursable as HIT.
- Field-based nursing services for drug infusions, PICC insertion, Midline insertion or accessing implanted pumps are considered home health agency/private duty nursing services and are not billable by the home infusion therapy Provider.

Per Diems are a payment for each day maintenance is performed or a therapeutic agent is actually infused or instilled into the body, in the Member’s private residence, as prescribed by the Practitioner.

- A single per diem is reimbursable on the day therapeutic agent(s) is/are instilled into an implanted infusion device in the Member’s private residence.
**Maintenance** is care of single or multiple lumen infusion catheters or implanted access devices, including dressing changes and flushes necessary to maintain patency between ordered episodes of care with therapeutic agents. (e.g. Monthly flushes of implanted access devices when no active HIT therapy is in progress, IV access flushes and dressing changes during week(s) between chemotherapy episodes or "rounds" of antibiotic therapy while awaiting laboratory results and new orders.)

- Maintenance per diem is only separately billable when this maintenance service is the only service provided on that date of service (DOS) and catheter care is actually administered.
- Maintenance services provided on the same DOS as HIT with therapeutic agents are included in the per diem for that infusion therapy and not separately billable.

**Multiple Infusion Therapies** are defined as more than one class of service (i.e. pain management, chemotherapy, Epoprostenol, Tocolytic, Hydration, Total Parenteral Nutrition (TPN), anti-infective and miscellaneous) provided concurrently on the same date of service.

**Adjunctive medications** are additional therapeutic agents, administered parenterally, that are included in a concurrent Practitioner ordered HIT regimen (e.g. IVP anti-emetic administered PRN for nausea related to chemotherapy or IV H₂ receptor antagonist administered concurrently with TPN.)

**Flushes** for catheter maintenance are not considered adjunctive therapeutic agents and are not separately billable or reimbursable. These supplies (e.g. heparin, sterile saline, sterile water, ethanol lock solution, etc.) are included in the per diem reimbursement. (See **Per Diems** section below.)

**Fluids** utilized as diluents or vehicles for administration of other therapeutic agents are not considered adjunctive therapeutic agents and are not separately billable or reimbursable. These supplies are included in the per diem reimbursement. (See **Per Diems** section below.)

**Intravenous push (IVP)** is an injection/infusion of a therapeutic agent requiring the continuous presence of the health care professional during administration into a vein or an intravenous injection infusion of a therapeutic agent over 15 minutes or less.

- Therapeutic medication(s) administered by IVP, dispensed as adjunctive to HIT, may be billed with the appropriate HCPCS code for that ordered medication, but a separate per diem is not billable or reimbursable.
- Length of infusion is determined based on administration recommendations from recognized sources (e.g. drug handbooks, PDR, and drug package inserts).
- IVP medication(s) dispensed as the sole agent(s), not included in a concurrent Practitioner ordered HIT regimen, for a DOS or span date are not billable or reimbursable as part of HIT.

**Other parenteral medications** are those therapeutic agents administered by intramuscular (IM) injection or subcutaneous (SQ) injection.

- Other therapeutic parenteral medication(s), dispensed as adjunctive to HIT and not self-administered, may be billed with the appropriate HCPCS code, but a separate per diem is not billable or reimbursable.
Other parenteral medication(s) dispensed as the sole agent(s), not included in a concurrent Practitioner ordered HIT regimen, for a DOS or span date are **not** billable or reimbursable as part of HIT.

**Self-administered medications** are defined as Oral, Topical, or self-administered injectable medications, including those indicated as Self-Administered Specialty Pharmacy Products. (Refer to the Specialty Pharmacy Program in Section XIX of this Manual.)

These are considered a pharmacy benefit and are **not** billable or reimbursable as HIT.

**Claim Form**

Home Infusion Therapy must be billed on a Professional claim form as follows:

**Block 19 – Reserved for Local Use**

Utilize this section for additional information. (See Additional Information section below).

- Additional NDC information when varying packaged products must be utilized to obtain the most economical packaging to achieve the Practitioner ordered dosage for the Member.
- Practitioner’s order for therapeutic agent(s) including dosage, route, frequency and duration of therapy.

**Block 24a – From and To Date(s) of Service (DOS)**

Enter the month, day and year for each per diem and therapeutic agent as follows:

- Therapeutic agents billed with a specifically assigned HCPCS code, whose description includes a set amount per unit of the code, may be billed with “span dates” if additional information is submitted to indicate the Practitioner order for the daily dosage amount. (See example in Additional Information section below.)
- Therapeutic agents billed with unlisted, miscellaneous, non-specific, or Not Otherwise Classified (NOC) codes must be billed on a separate line item for each DOS (no span dates) along with additional information including NDC, daily dosage, and drug name. Submitting NOC codes with span dates may result in errors and/or delayed reimbursement. (See example in Additional Information section below.)
- Per Diem codes must be billed on a separate line item for each DOS (no span dates). Submitting per diem codes with span dates may result in errors and/or delays in reimbursement.

**Block 24b – Place of Service**

The place of service (POS) should indicate where the therapeutic agent is administered/instilled rather than where it is dispensed.

**Block 24d – Codes, Modifiers and Additional Information (shaded area)**

- Additional information should be submitted in the following format: National Drug Code (NDC) preceded by the N4 qualifier, dosage administered per day preceded by appropriate “basis of measurement qualifier” (i.e. GM, ME, ML, etc., as ordered by Practitioner) and name of drug preceded by narrative description modifier, ZZ. (See examples in Additional Information section below.)
- All per diems codes and related therapeutic agent codes for the same DOS or span date must be billed on the same claim submission. Splitting these services into multiple claims may result in errors and/or delays in reimbursement. (See specific guidelines in Therapeutic agents, Per Diems and Modifiers for Multiple Therapies sections below.)
- More than one medication may be associated with a single per diem (e.g., adjunctive therapeutic agents administered as part of the primary therapy ordered by the Physician). Therapeutic agents billed without an associated per diem are considered a pharmacy benefit and should be billed to the Member’s Pharmacy Benefits Manager (PBM).
Block 24g – Days or Units

Enter the number of units for each per diem and therapeutic agent as follows:

- Units for therapeutic agents, billed with specific HCPCS codes containing a defined “unit” amount, must be reported in accordance with code definition in effect for the DOS and the Practitioner’s orders.
- Units for therapeutic agents, billed with NOC codes or codes without a defined “unit” amount, must be reported with a unit of (1) per line item / DOS. Reporting multiple units may result in errors and/or delayed reimbursement.
- Units for per diem codes must be reported with a unit of (1) per line item / DOS.

Additional Information

- Additional NDC information related to varying packaged products assigned to the same CPT® or HCPCS code should be indicated in Block 19 (Reserved for Local Use), its electronic equivalent, or submitted as an attachment.

Example for varying packaged products assigned the same CPT® or HCPCS code:
Practitioner order of Octagam 500 mg/kg IV in divided doses over 2 days @ 0.5 mg/kg/min q3wks.

<table>
<thead>
<tr>
<th>N468209084301</th>
<th>Octagam 500 mg/kg IV divided Wt. 150 lbs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>N468209084304</td>
<td>GM17 ZOctagam</td>
</tr>
<tr>
<td>12 01 XX</td>
<td>12 02 XX 12 J1568 A XXXX xx 68</td>
</tr>
<tr>
<td>12 01 XX</td>
<td>12 01 XX 12 S9379 A XX xx 1</td>
</tr>
<tr>
<td>12 02 XX</td>
<td>12 02 XX 12 S9379 A XX xx 1</td>
</tr>
</tbody>
</table>

The Practitioner’s order for therapeutic agent(s) including dosage, route, frequency and duration should be indicated in Block 19, its electronic equivalent, or submitted as an attachment.

Example for specific HCPCS code billed with span dates:
Practitioner order of Rocephin 1 Gm IV q12h x 5 days is started at 8:00 p.m. on 12/01/XX.

<table>
<thead>
<tr>
<th>N4xxxxxxxxxxxx</th>
<th>GM2 ZRocephin</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 01 XX</td>
<td>12 06 XX 12 J0696 A XXXX xx 40</td>
</tr>
<tr>
<td>12 01 XX</td>
<td>12 01 XX 12 S9501 A XX xx 1</td>
</tr>
<tr>
<td>12 02 XX</td>
<td>12 02 XX 12 S9501 A XX xx 1</td>
</tr>
<tr>
<td>12 03 XX</td>
<td>12 03 XX 12 S9501 A XX xx 1</td>
</tr>
<tr>
<td>12 04 XX</td>
<td>12 04 XX 12 S9501 A XX xx 1</td>
</tr>
<tr>
<td>12 05 XX</td>
<td>12 05 XX 12 S9501 A XX xx 1</td>
</tr>
<tr>
<td>12 06 XX</td>
<td>12 06 XX 12 S9501 A XX xx 1</td>
</tr>
</tbody>
</table>
Example for NOC code:
Practitioner order of Abcxyz 400 mg IV q8h x 3 days is started at 4:00 p.m. on 12/01/XX.

<table>
<thead>
<tr>
<th>Period</th>
<th>DOB</th>
<th>Service Date</th>
<th>CPT Code</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>12 01 XX</td>
<td>12 01</td>
<td>12 01</td>
<td>J3490</td>
<td>A XXX xx 1</td>
</tr>
<tr>
<td>12 02 XX</td>
<td>12 02</td>
<td>12 02</td>
<td>J3490</td>
<td>A XXX xx 1</td>
</tr>
<tr>
<td>12 03 XX</td>
<td>12 03</td>
<td>12 03</td>
<td>J3490</td>
<td>A XXX xx 1</td>
</tr>
<tr>
<td>12 04 XX</td>
<td>12 04</td>
<td>12 04</td>
<td>J3490</td>
<td>A XXX xx 1</td>
</tr>
</tbody>
</table>

Per Diem (S9502) should be submitted as indicated in examples above for each of the dates of service therapeutic agent is administered.

**Therapeutic agents**

- Each therapeutic agent must be billed using the most specific CPT®/HCPCS code in effect for the DOS and the NDC. If these codes are billed with span dates, additional information indicating the Practitioner ordered daily dosage amount must be submitted. (See Additional Information section.)

- In the event there is not a specific CPT®/HCPCS code for a therapeutic agent ordered, the most appropriate unlisted code (e.g. J3490, J3590, J9999) in effect for the DOS may be used.

- Unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) codes should only be used when a more specific CPT®/HCPCS code is not available or appropriate. Submitting a NOC code when a more specific code is more appropriate may result in errors and/or delay in reimbursement.

- Therapeutic agents billed with an unlisted miscellaneous, non-specific, and Not Otherwise Classified (NOC) code must be accompanied by additional information as noted in the “Additional Information” section above. Failure to submit this information may result in reimbursement errors and/or delay of reimbursement.

- Reimbursement for therapeutic agent(s) is limited to that amount actually prescribed and administered to the Member.

- HIT Provider is responsible for using the most economical packaging of therapeutic agent(s) to achieve the required dosage for the Member with the least amount of wastage.

- BCBST reserves the right to request submission of a copy of the original Practitioner orders for home infusion therapy, if determined necessary for clarification.

**Per Diems**

Maintenance or Home Infusion Therapy per diems must be billed using the most appropriate maintenance or “class of service” HCPCS code from one of the following tables:
MAINTENANCE

Maintenance per diems may only be billed, as a “stand alone service”, on days when catheter care is actually administered and these maintenance services are not part of the per diem of another class of service code.

Maintenance per diems are **not** billable or reimbursable as secondary, tertiary or concurrent therapy.

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S5498</td>
<td>Single Lumen</td>
<td>Home infusion therapy, catheter care/maintenance, simple (single lumen), includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment, (drugs and nursing visits coded separately), per diem</td>
</tr>
<tr>
<td>S5501</td>
<td>Multiple Lumens</td>
<td>Home infusion therapy, catheter care/maintenance, complex (more than one lumen), includes administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
<tr>
<td>S5502</td>
<td>Implanted Access Device</td>
<td>Home infusion therapy, catheter care/maintenance, implanted access device, includes administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem (use this code for interim maintenance of vascular access not currently in use)</td>
</tr>
</tbody>
</table>

PAIN MANAGEMENT

Only one of these class of service codes may be billed per day.

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9326</td>
<td>Continuous Infusion</td>
<td>Home infusion therapy, continuous (24 hours or more) pain management infusion; administrative services, professional pharmacy services, care coordination and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
<tr>
<td>S9327</td>
<td>Intermittent Infusion</td>
<td>Home infusion therapy, intermittent (less than 24 hours) pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
<tr>
<td>S9328</td>
<td>Implanted Pump Instillation</td>
<td>Home infusion therapy, implanted pump pain management infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
</tbody>
</table>

CHEMOTHERAPY

Only one of these class of service codes may be billed per day.

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9330</td>
<td>Continuous Infusion</td>
<td>Home infusion therapy, continuous (24 hours or more) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
<tr>
<td>S9331</td>
<td>Intermittent Infusion</td>
<td>Home infusion therapy, intermittent (less than 24 hours) chemotherapy infusion; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
</tbody>
</table>

Rev 12/14
## EPOPROSTENOL

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9347</td>
<td>Uninterrupted Infusion</td>
<td>Home infusion therapy, uninterrupted, long-term, controlled rate intravenous or subcutaneous infusion therapy (e.g., epoprostenol); administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
</tbody>
</table>

## TOCOLYTIC

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9349</td>
<td>Infusion Therapy</td>
<td>Home infusion therapy, tocolytic infusion therapy; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
</tbody>
</table>

## HYDRATION

IV fluids utilized as a diluent or vehicles for administration of other therapeutic agents are **not** hydration services. Hydration per diems apply only when services are for the infusion of IV fluids in 1-liter increments solely for the therapeutic treatment of dehydration or other volume related conditions. Only one of these class of service codes may be billed per day.

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9374</td>
<td>1 Liter</td>
<td>Home infusion therapy, hydration therapy; 1 liter per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
<tr>
<td>S9375</td>
<td>2 Liters</td>
<td>Home infusion therapy, hydration therapy; more than 1 liter but no more than 2 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
<tr>
<td>S9376</td>
<td>3 Liters</td>
<td>Home infusion therapy, hydration therapy; more than 2 liters but no more than 3 liters per day, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
</tbody>
</table>

## TOTAL PARENTERAL NUTRITION

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9379</td>
<td>TPN and / or lipids</td>
<td>Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
</tbody>
</table>
ANTI-INFECTIVE

Only one of these class of service codes may be billed per day.

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9500</td>
<td>Q 24 hours</td>
<td>Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 24 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
<tr>
<td>S9501</td>
<td>Q 12 hours</td>
<td>Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 12 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
<tr>
<td>S9502</td>
<td>Q 8 hours</td>
<td>Home infusion therapy, antibiotic, antiviral, or antifungal therapy; once every 8 hours, administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
<tr>
<td>S9503</td>
<td>Q 6 hours</td>
<td>Home infusion therapy, antibiotic, antiviral, or antifungal; once every 6 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
<tr>
<td>S9504</td>
<td>Q 4 hours</td>
<td>Home infusion therapy, antibiotic, antiviral, or antifungal; once every 4 hours; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
</tbody>
</table>

MISCELLANEOUS

<table>
<thead>
<tr>
<th>Code</th>
<th>Type of Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S9379</td>
<td>Infusion Therapy</td>
<td>Home infusion therapy, infusion therapy, not otherwise classified; administrative services, professional pharmacy services, care coordination, and all necessary supplies and equipment (drugs and nursing visits coded separately), per diem</td>
</tr>
</tbody>
</table>

- Per Diem(s) for class(es) of service not indicated in the above tables must be billed with the “miscellaneous” per diem code.

- The reimbursement allowed for the above noted per diem codes includes all necessary supplies and equipment, including but not limited to the following. These items should not be separately billed.
  - IV Start Kits and sterile site dressing materials (e.g. angio-caths, tape, antimicrobial ointments/pads, alcohol pads, betadine swabs, transparent film dressings, gauze dressings, etc.)
  - IV fluids utilized as vehicles for administration of other therapeutic agents (e.g. keep-vein-open (KVO) solutions, partial-fills, etc.)
  - Sterile saline or water utilized as a diluent for other therapeutic agents.
  - Flush solutions (e.g. heparin, sterile saline, sterile water, ethanol lock solution, etc.)
  - Tubing, filters, needles and syringes (e.g. pump cassettes with tubing, extension tubing, secondary sets, injection caps, in-line filters, etc.)
  - Disposable drug delivery systems (e.g. elastomeric technology based devices).
  - Daily rental of ambulatory infusion pumps.
  - Anaphylactic agents (e.g. EpiPen, etc.)

- Per Diems for multiple drugs administered in a single class of service (e.g. three antibiotics) will be reimbursed as a single per diem based on the highest administration frequency.
Modifiers for Multiple Therapies

- The primary class of service per diem must be billed using the most appropriate HCPCS code from the tables above without a modifier.

- The secondary class of service per diem must be billed using the appropriate HCPCS code from the tables above with the “SH” modifier in the 1st modifier field to indicate the second concurrently administered class of service on the same DOS.

- The tertiary or concurrent class of service per diems must be billed using the appropriate HCPCS code from the tables above with the “SJ” modifier in the 1st modifier field to indicate the third or more concurrently administered class of service on the same DOS.

General Billing Guidelines

- For Members with primary Medicare coverage:
  - Supplies, drugs and equipment utilized in conjunction with HIT must be filed to the appropriate Medicare carrier prior to filing to BCBST for secondary payment.
  - Secondary claims for HIT services must be filed with the appropriate Medicare Part B and D electronic remittance advices indicating payment or denial of the services.
  - If Part D covers the drug, Providers should submit a $0.00 charge for the drug to BCBST. The $0.00 charge indicates that Part D covered the drug and no additional payment is expected.
  - Additional information on billing HIT services can be found on the CGS Administrators, LLC website at http://www.cgsmedicare.com/.

28. Durable Medical Equipment, Prosthetics, Orthotics and Medical Supplies (DMEPOS)
   a. Durable Medical Equipment (DME) and Medical Supplies

   Durable Medical Equipment (DME) is any equipment that provides therapeutic benefits or enables the beneficiary to perform certain tasks that he or she is unable to undertake otherwise due to certain medical conditions and/or illnesses. DME is considered to be equipment, which can withstand repeated use and is primarily and customarily used to serve a medical purpose. It is generally not useful to a person in the absence of an illness or injury and is appropriate for use in the home. There are items, although durable in nature, which may fall into other coverage categories such as braces, prosthetic devices, artificial arms, legs and eyes.

   CMS defines customized Durable Medical Equipment (DME) as being items of DME which have been uniquely constructed or substantially modified for a specific beneficiary according to the description and orders of the beneficiary’s treating Physician.

   Source: https://www.cms.gov

   Medical Supplies are items for health use other than drugs, prosthetic or orthotic appliances, or durable medical equipment that have been ordered by a qualified Practitioner in the treatment of a specific medical condition and that are: consumable, non-reusable, disposable, for a specific rather than incidental purpose and generally have no salvageable value.

Claim Form
Durable medical equipment and medical supplies must be billed on a Professional claim form.

Block 24b – Place of Service
The place of service (POS) should represent where the item is being used, not where it is dispensed.
Block 24a – From and To Date(s) of Service
Enter the month, day and year for each procedure, service or supply.

The following items require the use of span dates (i.e. a span of time between the “from and to” dates of service). Failure to use span dates will result in incorrect payment for the following items:

- Enteral Feeding Supply kits
- Continuous passive motion device
- Enteral Formulae
- Food Thickener
- External Insulin Pump Supplies

EX: Code A4221 also includes all cannulas, needles, dressings and infusion supplies (excluding insulin reservoir K0552, (Supplies for external infusion pump, syringe type cartridge, sterile each) related to continuous subcutaneous insulin infusion via external insulin infusion pump (E0784) and the infusion sets and dressings related to subcutaneous immune globulin administration. Billing for more than one (1) unit of service per week is incorrect use of the code and will be denied accordingly.


Suppliers who elect to bill for partial months should enter the date of service the rental period begins in the “From” field and the ending rental date of service in the “To” field of the CMS-1500/ANSI-837P for each partial month of billing. In this case, the HCPCS code should be billed with the RR modifier in the first modifier field and the KR modifier in the second modifier field.

DO NOT SPAN DATES FOR ITEMS OTHER THAN THOSE LISTED.
All DME monthly rentals must not be billed with a DOS span and must bill only one (1) unit per month.

Block 24d - Codes and Modifiers
Durable medical equipment must be billed using the most appropriate HCPCS code and applicable modifiers in effect for the date of service. Pricing modifiers published on the Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) Fee Schedule are required for correct claim adjudication. In some cases, more than one pricing modifier is required. This document is located on the CGS Administrators, LLC website at http://www.cgsmedicare.com.

Claims billed with an inappropriate code and modifier combination will be returned to the Provider for submission of corrected claim and result in delay in reimbursement.

- Unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) codes (e.g., E1399) should only be used when a more specific CPT® or HCPCS code is not available or appropriate. Components of the primary equipment should be billed with the most specific CPT® or HCPCS code or the most specific Unlisted, Miscellaneous code.

- Durable medical equipment billed with an unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) codes must be billed with the name of the manufacturer, product name, product number, and quantity provided.

Pricing modifiers are always appended first in the modifier fields. These will always impact the reimbursement. Information/descriptive modifiers are used in the subsequent modifier fields. These modifiers are informational or utilized for benefit management by Medicare but do not impact reimbursement amounts.

The following is a partial list of common pricing HCPCS modifiers reported with HCPCS durable medical equipment codes:
<table>
<thead>
<tr>
<th>Modifier</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AU</td>
<td>Item furnished in conjunction with a urological, ostomy, or tracheostomy supply</td>
</tr>
<tr>
<td>AV</td>
<td>Item furnished in conjunction with a prosthetic device, prosthetic or orthotic</td>
</tr>
<tr>
<td>AW</td>
<td>Item furnished in conjunction with surgical dressing</td>
</tr>
<tr>
<td>KF</td>
<td>Item designated by FDA as class III device</td>
</tr>
<tr>
<td>KR</td>
<td>Rental item, billing for partial month</td>
</tr>
<tr>
<td>NU</td>
<td>New equipment</td>
</tr>
<tr>
<td>RR</td>
<td>Rental (use the 'RR' modifier when DME is to be rented)</td>
</tr>
<tr>
<td>UE</td>
<td>Used durable medical equipment</td>
</tr>
<tr>
<td>KL</td>
<td>DMEPOS item delivered by mail</td>
</tr>
<tr>
<td>KE</td>
<td>Bid under round one of DMEPOS competitive bidding program for use with noncompetitive bid base equipment</td>
</tr>
</tbody>
</table>

Labor for DME repairs to Member-owned equipment is to be billed using the most appropriate 5-digit HCPCS code. A modifier will not be required with the labor codes.

**Codes and modifiers must be billed in accordance with the following:**

- Durable Medical Equipment Medicare Administrative Contractor (DME MAC*) for Jurisdiction C guidelines which include, but are not limited to the following:
  - DMEPOS Supplier Manual and Revisions
  - DME MAC Jurisdiction C Fee Schedule
  - Pricing, Data Analysis and Coding Contractor (PDAC**) Product Classification Lists
  - Pricing, Data Analysis and Coding Contractor (PDAC**) Coding Bulletins

*This document is located on the CGS Administrators, LLC website at [http://www.cgsmedicare.com](http://www.cgsmedicare.com).

**This document is located on the Noridian Administrative Services, LLC (NAS) Web site at [http://www.dmepdac.com](http://www.dmepdac.com).

**Block 24g - Days or Units**

For monthly rentals, one unit should be billed for each month the item is rented as the maximum allowable for the rental is for a whole month.

For partial month rentals, one unit should be billed for each month the item is rented. BCBST reserves the right to prorate the maximum allowable to reflect the partial month rental.

For rentals with DME codes and supply kits requiring span dates, one unit should be billed for each day the item is rented or supplied as the maximum allowable is for one day. For enteral, food thickener and external insulin supplies requiring span dates, the units are to be billed in accordance with the unit defined in the code description.

**General Billing Guidelines**

- The maximum allowable for durable medical equipment constitutes full reimbursement for the item including all labor charges involved in the assembly and support services such as emergency services, delivery, set-up, education, and on-going assistance with the item. These services including mileage are not separately billable.

- Warranties-Supplier must honor all product warranties, express and implied, under applicable state law.
● Maintenance and/or service charges for durable medical equipment covered under a
manufacturer or supplier's warranty are not billable unless such charges are excluded from
the warranty.

● Supplies and accessories related to DME must be billed in accordance with DME MAC for
Jurisdiction C guidelines and be on the same claim form as the rented DME.

● There must be a valid detailed order on file prior to submitting claims for supplies.

● Regular submission of claims for supplies that exceed the usual utilization may prompt a
request for medical records to support the need for additional supplies.

● Additional supplies must be requested by a Member or caregiver before being dispensed.
Supplies are not to be automatically dispensed on a predetermined regular basis.

● Codes without a published Medicare fee - BCBST reserves the right to request the name of the
manufacturer, product name, product number, and quantity provided.

● Leased DME should be billed in accordance with guidelines for rented DME. Reimbursement for
leased DME will be based on the reimbursement provisions for rented DME.

Aerosol Therapy

● Equipment used in conjunction with aerosol therapy must be billed by a durable medical
equipment Provider.

● Supplies used in conjunction with aerosol therapy must be billed by a durable medical
equipment Provider or medical supplier.

● Inhalation medication used in conjunction with aerosol therapy must be billed through
Member's pharmacy program.

Enteral Therapy

● Equipment used with enteral therapy must be billed by a durable medical equipment Provider.

● Supply kits, pumps and formulae used with enteral therapy must be billed by a durable
medical equipment Provider or medical supplier. These items must be billed with the most
appropriate HCPCS code and modifier, if applicable. DME used for enteral feedings should be
billed as follows:

  ● Supply Kits – The appropriate "B" HCPCS code should be billed with span dates using
one unit for each day a kit is used. These are disposable supply items and no modifier is
required to indicate a purchase. A span date indicates the time period services were
provided; i.e., 01012015 to 01152015. Because of the use of span dates, a separate line
item is not required for each day.

The codes for enteral feeding supplies include all supplies, other than the feeding tube
itself, required for the administration of enteral nutrients to the beneficiary for one day.
These supply kit codes describe a daily supply fee rather than a specifically defined "kit".
Some items are changed daily; others may be used for multiple days. Items included in
these codes are not limited to pre-packaged "kits" bundled by manufacturers or
distributors. These supplies include, but are not limited to, feeding bag/container, flushing
solution bag/container, administration set tubing, extension tubing, feeding/flushing
syringes, gastrostomy tube holder, dressings (any type) used for gastrostomy tube site,
tape (to secure tube or dressings), Y connector, adapter, gastric pressure relief valve,
declogging device, etc. These items must not be separately billed using the miscellaneous
code (B9998) or using specific codes for dressings or tape. The use of individual items
may differ from beneficiary to beneficiary and from day to day. Only one unit of service may be billed for any one day. Units of service in excess of one per day will be rejected as incorrect coding.

Source: [http://www.cgsmedicare.com/](http://www.cgsmedicare.com/)

- **Pump** (if used) – Pumps are considered as monthly rentals. The “from” and “to” dates on the claim should indicate the month, day and year for the rental; i.e., 01012015 to 01012015. One unit should be used for each month the pump is rented.

- **Formulae** – Span dates should be used to indicate the period formulae were provided. Formulae are billed with one unit for 100 calories. If formulae has not been assigned a specific HCPCS code by Pricing, Data Analysis and Coding Contractor (PDAC), bill formulae using B9998 with one unit for each 100 calories. BCBST requires the complete brand name and NDC for formulae billed with this miscellaneous code to determine appropriate reimbursement.

- **Food Thickener** - Span dates should be used to indicate the period thickener was provided. Food thickener is billed with one unit for each ounce of product. All brands of commercially manufactured food thickener, used as an additive, should be billed with the specific HCPCS code assigned Pricing, Data Analysis and Coding Contractor (PDAC). Bill pre-thickened foods, juices and other liquids using B9998 with one unit for each bottle, box, or container. BCBST requires the complete brand name, volume of container supplied, manufacturer's name, and product number for pre-thickened foods billed with this miscellaneous code to determine appropriate reimbursement.

  **Note**: Claims for orally administered nutrition must include the appropriate HCPCS code and BO modifier or they will be considered an enteral tube feeding.

**DME Repairs, Adjustments, and Replacements**

- If the item is rented, the repair, adjustment or replacement of the equipment and its components are included in the maximum allowable for the rental for the equipment and are not separately billable.

- Reimbursement for reasonable and necessary parts and labor to Member-owned equipment which are not covered under any manufacturer or supplier warranty, may be allowed. Parts should be billed using the most appropriate HCPCS code with the appropriate new or used purchase modifier in the modifier 1 field. Labor should be billed using the most appropriate HCPCS code. A modifier will not be required with the labor codes.

- Repairs to Member-owned durable medical equipment are billable when necessary to make the item functional. If the expense for repairs exceeds the estimated expense of purchasing another entire item, no payments can be made for the amount of the excess.

- Billable parts and labor must be billed on the same claim form.

- Mileage is not separately reimbursed or billable.

- Temporary replacement for Member-owned equipment while being repaired billed a K0462 require a description and procedure code of the Member-owned equipment being repaired.

- Thirty (30) days is allowed for rental or loaner equipment when Member-owned equipment is being repaired.
Guidelines for Wheelchairs

- All accessories related to the purchase of a wheelchair base must be billed on the same claim form as the wheelchair base itself.
- If multiple accessories are provided using the miscellaneous code K0108, each should be billed on a separate claim line.
- Code E1028 is appropriate for swingaway, removable or retractable hardware (e.g., joystick, headrest or laterals). E1028 is inappropriate for screws, bolts or any fixed hardware (e.g., hardware for seat, back or tray).
- A separate claim line is required for each item billed with code E1028. Submission of multiple units of E1028 on a single claim line may result in delayed claim adjudication.

For information on items appropriately billed with code E1028, refer to DME Product Classification List located on the Noridian Administrative Services, LLC (NAS) website at http://www.dmepdac.com.

b. Reimbursement Guidelines for Durable Medical Equipment (DME) Purchase and Rentals

This policy applies to durable medical equipment purchases and rentals billed on a Professional claim form for Blue Networks E, M, P, and S.

The maximum allowable for durable medical equipment classified as Capped Rental, Inexpensive/Routinely Purchased, TENS, and enteral nutrition infusion pumps (i.e. purchases and rentals) will be the lesser of total Covered charges or the contracted network percentage of the DME MAC for Jurisdiction C DMEPOS Fee Schedule for Tennessee.

Durable medical equipment will be considered purchased after the equipment has been rented for a period of 10 months.

The published Medicare fees for durable medical equipment classified as Capped Rentals are based on a 13-month rental period where the Medicare allowable for the first 3 months is at 100 percent and the Medicare allowable for the remaining 10 months is at 75 percent. Since BCBST considers durable medical equipment purchased after the equipment has been rented for a period of 10 months, the published Medicare fees for durable medical equipment classified as Capped Rentals (except Power-Driven wheelchairs) will be adjusted as follows:

\[
\text{Published Medicare Fee for Capped Rental} \times 3 \text{ months} \times 100\% + \text{Published Medicare Fee for Capped Rental} \times 10 \text{ months} \times 75\% = \text{Medicare Purchase Fee}
\]

BCBST Purchase Allowable = Medicare Purchase Fee x Contracted Network %

BCBST Rental Allowable = BCBST Purchase Allowable/10 months

Capped Rental for Power-Driven Wheelchairs:

Since BCBST considers durable medical equipment purchased after the equipment has been rented for a period of 10 months, the published Medicare fees for durable medical equipment classified as Capped Rentals for Power Driven Wheelchairs will be adjusted as follows:

\[
\text{Published Medicare Fee for Capped Rental} \times 3 \text{ months} \times 150\% + \text{Published Medicare Fee for Capped Rental} \times 10 \text{ months} \times 60\% = \text{Medicare Purchase Fee}
\]
BCBST Purchase Allowable = Medicare Purchase Fee x Contracted Network %

BCBST Rental Allowable = BCBST Purchase Allowable/10 months

If the Member changes to different but similar equipment (e.g. from a non-heated humidifier to a heated humidifier) when the equipment is medically needed (i.e. the Member's medical needs have substantially changed and the new equipment is necessary), a new 10-month rental period begins with the new equipment. Otherwise, BCBST will reimburse the least expensive piece of equipment (continuing to count against the current 10-month period). If the 10-month rental period has already expired, then no additional rental payments can be made.

Reimbursement for supplies used in conjunction with durable medical equipment rentals will be determined by the DME MAC for Jurisdiction C guidelines.

Rental rates include reimbursement for repair, adjustment, maintenance and replacement of equipment and its components related to normal wear and tear, defects, or obsolescence or aging.

The maximum allowable for durable medical equipment constitutes full reimbursement for the item including all labor charges involved in the assembly and support services such as emergency services, delivery, set-up, education, and on-going assistance with the item.

All maximum allowables for rentals are monthly rates unless specified otherwise on the Maximum Allowable Detail Report.

BCBST reserves the right to pro-rate the maximum allowable for partial month rentals.

Providers are contractually obligated to provide services at the agreed upon rates, regardless of patient acuity or nursing skill level. DME Providers must follow the DME Quality Standards set forth by CMS, which include:

- Assistive Technology certification for custom wheelchair suppliers;
- Certified Respiratory Therapists on staff when respiratory equipment supplied; and
- Accreditation as verified by the BCBST Credentialing Department.

c. Oxygen, Oxygen Contents, Oxygen Supplies

This policy for Oxygen systems, supplies, and contents billed on a Professional claim form applies for all BCBST lines of business.

BCBST reserves the right to pay the rental of oxygen systems to include oxygen contents, oxygen supplies and accessories for as long as the patient’s need continues.

Reimbursement for rental of oxygen, contents, supplies and accessories will be based on the lesser of total covered charges or the BCBST contracted percentage of the Medicare Region C DMEPOS Fee Schedule for Tennessee as stipulated in the Provider Agreement.

Reimbursement for rental of oxygen systems, contents, supplies and accessories for all BCBST networks including BlueCare and Corporate Medicare will be limited to services eligible for separate reimbursement per the Durable Medical Equipment Medicare Administrative Contractor (DME MAC) for Jurisdiction C Durable Medical Equipment, Prosthetics, Orthotics and Supplies Supplier Manual (DMEPOS) in effect for date of service prior to 1/1/2006.

The maximum allowable for durable medical equipment constitutes full reimbursement for the item including all labor charges involved in the assembly and support services such as emergency services, delivery, set-up education, and on-going assistance with the item.

All maximum allowables for reimbursement rentals are monthly rates unless specified otherwise.
To be considered for reimbursement, oxygen systems, contents, supplies and accessories for eligible services must be billed in accordance with standard coding and billing guidelines.

Rental rates include reimbursement for repair, adjustment, maintenance and replacement of equipment and its components related to normal wear and tear, defects, or obsolescence or aging.

d. Reimbursement Guidelines for Home Pulse Oximetry

Spot Home Pulse Oximetry
A spot home pulse oximetry check is a single measurement of oxygen saturation that may provide adjunctive information for the clinician. It is no different than any other routine vital sign (e.g. blood pressure) obtained as part of a general patient assessment. Reimbursement for home pulse oximetry is included in the reimbursement for the rental of oxygen equipment or home health service when used as a spot oxygen saturation check. When used as a spot oxygen saturation check, home pulse oximetry should not be billed separately from the rental of oxygen equipment or the home health visit.

Continuous Home Pulse Oximetry
Reimbursement for Medically Appropriate continuous home pulse oximetry will be limited to the rental of the pulse oximetry equipment. Medically appropriate home pulse oximetry equipment will be considered purchased when the rental payments have reached the network cap limitation.

This policy applies to home pulse oximetry services billed with HCPCS code E0445 on a Professional claim form for all BCBST business.

e. Prosthetics and Orthotics – Blue Networks E, M, P, and S

Qualified Providers - Providers billing prosthetic and orthotic equipment must meet credentialing requirements outlined in Section XIV.Credentialing, in this Manual.

Prosthetic devices (other than dental) are devices that replace all or part of an Internal or external body organ or replace all or part of the function of a permanently inoperative or malfunctioning internal or external body organ. Source: https://www.cms.gov.

Orthotics are rigid or semi-rigid devices, often called braces, which are applied to the outside of the body as a means used either to support a weak or deformed body part or to restrict or eliminate motion in a diseased or injured part of the body. A prefabricated or custom-fitted orthosis is one, which is manufactured in quantity without a specific beneficiary in mind. A prefabricated orthosis may be trimmed, bent, molded (with or without heat), or otherwise modified for use by a specific beneficiary (i.e., custom fitted). An orthosis that is assembled from prefabricated components is considered prefabricated. Any orthosis that does not meet the definition of a custom-fabricated orthosis is considered prefabricated.

Custom fitted orthotics are:
- Devices that are prefabricated.
- They may or may not be supplied as a kit that requires some assembly. Assembly of the item and/or installation of add-on components and/or the use of some basic materials in preparation of the item does not change classification from OTS to custom fitted.
- Classification as custom fitted requires substantial modification for fitting at the time of delivery in order to provide an individualized fit, i.e., the item must be trimmed, bent, molded (with or without heat), or otherwise modified resulting in alterations beyond minimal self-adjustment.
- This fitting at delivery does require expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthosis to fit the item to the individual beneficiary.
Off-the-shelf (OTS) orthotics are:
- Items that are prefabricated.
- They may or may not be supplied as a kit that requires some assembly. Assembly of the item and/or installation of add-on components and/or the use of some basic materials in preparation of the item does not change classification from OTS to custom fitted.
- OTS items require minimal self-adjustment for fitting at the time of delivery for appropriate use and do not require expertise in trimming, bending, molding, assembling, or customizing to fit an individual.
- This fitting does not require expertise of a certified orthotist or an individual who has equivalent specialized training in the provision of orthoses to fit the item to the individual beneficiary. It is inherent in the definition of “prefabricated” that a particular item is complete. Custom-fabricated additions are appropriate only for custom-fabricated base orthotics and will be denied as not reasonable and necessary if billed with prefabricated base orthotics.

Source: [https://www.cms.gov](https://www.cms.gov)

**Claim Form**
Prosthetics and orthotics must be billed on a Professional claim form.

**Block 24b - Place of Service**
The place of service (POS) should represent where the item is being used, not where it is dispensed.

**Block 24a - From and To Date(s) of Service**
Enter the month, day and year for each procedure, service or supply.

**Block 24d - Codes and Modifiers**
Prosthetics and orthotics must be billed using the most appropriate HCPCS code and applicable modifiers in effect for the date of service.

Claims billed with inappropriate code and modifier combinations will be returned to the Provider for submission of corrected claim and result in delay in reimbursement.
- Unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) codes (e.g. L0999, L1499, L2999, L3649, L3999, L5999, L7499, L8039, L8499, L8699, L9900) should only be used when a more specific CPT® or HCPCS code is not available or appropriate.
- Failure to submit the most specific CPT® or HCPCS code or the omission of modifiers will result in denial and return of claim to Provider for most appropriate coding.
- Prosthetics or orthotics billed with an unlisted, miscellaneous, non-specific, and Not Otherwise Classified (NOC) codes must be billed with the name of the manufacturer, product name, product number, and quantity provided.
- Codes without a published Medicare fee - BCBST reserves the right to request the name of the manufacturer, product name, product number, and quantity provided

To facilitate claim adjudication claims for bilateral orthotics coded with a single code and provided on the same DOS are to be submitted as a single claim line using the LTRT modifiers and 2 units of service.

**Codes and modifiers must be billed in accordance with the following:**
- Durable Medical Equipment Medicare Administrative Contractor (DME MAC*) for Jurisdiction C guidelines which includes, but are not limited to the following:
  - DMEPOS Supplier Manual and Revisions
  - DME MAC for Jurisdiction C Fee Schedule
  - Pricing, Data Analysis and Coding Contractor (PDAC**) Product Classification Lists
  - Pricing, Data Analysis and Coding Contractor (PDAC**) Coding Bulletins

Rev 12/14
Prosthetics

- Repairs, Adjustments, and Replacements
  - An adjustment is any modification to the prosthesis due to change in the patient's condition or to improve the function of the prosthesis.
  - A repair is a restoration of the prosthesis to correct problems due to wear or damage.
  - A replacement is the removal and substitution of a component of a prosthesis that has a HCPCS definition.

- The following items are included in the reimbursement for a prosthesis and, therefore, are not separately billable:
  - Evaluation of the residual limb and gait
  - Fitting of the prosthesis
  - Cost of base component parts and labor contained in HCPCS base codes
  - Repairs due to normal wear or tear within 90 days of delivery
  - Adjustments of the prosthesis or the prosthetic component made when fitting the prosthesis or component and for 90 days from the date of delivery when the adjustments are not necessitated by changes in the residual limb or the patient's functional abilities

- Routine periodic servicing, such as testing, cleaning, and checking of the prosthesis is not separately billable.

- Repairs to prosthesis are billable when necessary to make the prosthesis functional. If the expense for repairs exceeds the estimated expense of purchasing another entire prosthesis, no payment can be made for the amount of the excess. Maintenance, which may be necessitated by manufacturer's recommendations or the construction of the prosthesis and must be performed by the prosthetist, is billable as a repair.

- Reimbursement for reasonable and necessary parts and labor, which are not covered under any manufacturer or supplier warranty, may be allowed. Parts should be billed using the most appropriate HCPCS code. Labor should be billed using the most appropriate HCPCS code (e.g. L7500, L7520).

Billable parts and labor must be billed on the same claim form.

Orthotics

- Evaluation of the patient, measurement and/or casting, and fitting of the orthosis are included in the allowance for the orthosis and are not separately billable. There is no separate payment for these services.

- Repairs to an orthotic due to wear or to accidental damage are billable when they are necessary to make the orthosis functional. The reason for the repair must be documented in the supplier's record. If the expense for the repairs exceeds the estimated expense of providing another entire orthosis, no payment will be made for the amount in excess.

- Replacement of a complete orthotic or component of an orthotic due to loss, significant change in the Member's condition, irreparable wear, or irreparable accidental damage is billable if the device is still Medically Necessary. The reason for the replacement must be documented in the supplier's record.

- The allowance for the labor involved in replacing an orthotic component that is coded with a specific L code is included in the allowance for that component and is not separately billable.
The allowance for the labor involved in replacing an orthotic component that is coded with the miscellaneous code L4210 is separately billable in addition to the allowance for that component.

Billable orthotic components and labor must be billed on the same claim form.

### f. Reimbursement and Billing Guidelines for Hearing Services/Equipment

BCBST reimbursement and billing guidelines for hearing-related services and equipment are as follows:

- For children under age eighteen (18) years.
- Limited to one (1) per ear every three (3) years, including ear molds and services to select, fit and adjust the hearing aids. Does not include accessories (such as batteries and cords).
- Hearing examinations, screenings, assessments and conformity evaluations will be reimbursed based on the lesser of total covered charges or the network maximum allowable fee schedule. These services should be billed using the most appropriate CPT® or HCPCS code.
- Hearing aids, hearing aid batteries, hearing aid accessories, assisted listening devices, and dispensing fees will be reimbursed based on total covered charges. These items should be billed using the most appropriate “V” HCPCS code and number of units as defined by HCPCS.
- Reimbursement for the dispensing fee includes reimbursement for fabrication and fitting of the ear mold, fitting tubing to ear mold, hearing aid orientation and instruction, shipping/handling, and sales tax.
- A manufacturer’s invoice is not required on claims for these items.
- Covered as DME benefit.

**Note:** In order to process claims, Providers must include the right side or left side (RT or LT) modifier with the appropriate HCPCS code for the hearing aid device. The claim must have the hearing aid device and appropriate modifier for the left or right side submitted as the first line item on the claim. Claims for hearing aid devices and accessories filed without the appropriate right side or left side modifiers will be denied. No modifier is required for codes identifying bilateral procedures, devices or accessories.

These guidelines apply to services billed on a Professional claim form for all BCBST commercial business.

**Note:** It is important to know that Member benefits for hearing-related services and equipment can vary.

### g. Reimbursement Guidelines for Codes Classified as Durable Medical Equipment, Medical Supplies, Orthotics and Prosthetics without an Established Maximum Allowable

Codes classified as durable medical equipment, medical supplies, orthotics, and prosthetics without an established maximum allowable may require submission of the manufacturer name, product name, product number, and quantity.
The maximum allowable for these services will be based on the lesser of total covered charges or the following percentages of the manufacturer's published list price as defined by BCBST:

- 100% Medical Supplies
- 100% Durable Medical Equipment
- 100% Orthotics
- 100% Prosthetics

Sources used by BCBST to determine the manufacturer's published list price include, but are not limited to:

- Information provided to BCBST by manufacturer (e.g. product catalogs, product price listings, direct inquiries to manufacturers, manufacturer order forms and Provider submitted invoices with list price).

In the event BCBST is unable to determine the manufacturer's published list price using one of the aforementioned sources, BCBST reserves the right to request submission of an unaltered manufacturer/supplier's invoice indicating the product acquisition cost after all discounts and rebates. The maximum allowable for these items will be the lesser of total covered charges or 120% of the acquisition cost after all discounts and rebates per the manufacturer/supplier's invoice.

This policy applies to:

- durable medical equipment, medical supplies, orthotics, and prosthetics billed on the Professional claim form; and
- medical supplies on the BCBST Home Health Non-routine Supply List billed by a home health agency on the Institutional claim form.

Reimbursement for codes classified as durable medical equipment, medical supplies, orthotics, and prosthetics without an established maximum allowable is subject to the Medicare Administrative Contractor for Jurisdiction C (DME MAC) guidelines, BCBST reimbursement guidelines and BCBST billing guidelines.

29. Billing Telehealth Originating Site Fees
BCBST reimburses for services rendered via Telehealth in accordance with Tennessee Telehealth mandate (TCA 56-7-10) effective Jan. 1, 2015. Qualifying codes for BlueCross Commercial and BlueAdvantage lines of business are consistent with the Centers for Medicare & Medicaid Services (CMS) and TennCare guidance. By filing claims for encounters rendered via Telehealth, Providers are attesting that said claims are rendered according to these rules and guidelines. This reimbursement may not apply to certain self-funded groups if Telehealth is listed as a coverage exclusion in their contract.

Beginning Jan. 1, 2015, Commercial and BlueAdvantage Originating Site Practitioners may bill and receive a $20 flat fee payment for Q3014 when the Originating Site Practitioner is not affiliated with the Distant Site Practitioner. For the Originating Site, code Q3014 is allowed for each qualifying unit of service received via Telehealth for all appropriate Provider claims.

For Distant Site Practitioners, the qualifying encounter code should include a GT modifier to indicate the service was delivered via Telehealth. In the event that CMS designates a replacement code for Q3014 or establishes a fee for Q3014 or its replacement code, BlueCross will utilize the new code reimbursement to replace the current $20 flat fee. While it is acceptable to render services via Telehealth from satellite to satellite as a convenience for multi-site Providers (as indicated by a GT modifier), it is not appropriate to bill Q3014 under these circumstances. Q3014 billing will be audited in dollars recouped for billing outside policy and/or billing when no corresponding GT
encounter is on file for the date of service. Medicare guidance can be found at the website at the following websites:

www.cms.gov/Medicare/Medicare-General-Information/Telehealth

Final HIPAA Privacy Rules, including a section on "How might HIPAA affect Telemedicine Providers?" http://www.hrsa.gov/telehealth.

D. Institutional Claim Billing and Reimbursement Guidelines –
Section 1

1. Revenue Codes (CMS-1450)
BCBST will use the Uniform Billing Editor published by OPTUM, Appendix 3, "Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments", or its successor, as a guide to determine appropriate billing services rendered. Otherwise, based on Institutional contract.

2. Split and Interim Billing
All services rendered must be reported on the claim. For example, an emergency room revenue code with the related CPT® code cannot be omitted, if in fact the patient received care or was admitted through the emergency room. Such omissions are recoverable by BCBST and if deemed to be intentional, the network contract is subject to cancellation. To correct a claim with a coding error the entire claim must be refiled.

A split bill is appropriate only when requested by BCBST. Split bills are used to reflect covered charges allocated for approved and denied days. Split bills that have not been requested by BCBST are subject to denial or recovery.

Interim bills are claims filed for a portion of a large inpatient hospital stay. All interim billing submitted by a facility is required in no less than (30) thirty-day increments, with the exception of final billing. Any interim bill, with the exception of that associated with final billing, which contains fewer than (30) thirty days is subject to denial or recovery.

Interim bills are identified by the last digit of the Type of Bill code found in field locator #4 on the Institutional claim form. When billing electronically, the ANSI-837I (Institutional) format must be used.

<table>
<thead>
<tr>
<th>First Claim</th>
<th>Type of Bill (last digit) =2</th>
<th>112 or 122</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuing Claim</td>
<td>Type of Bill (last digit) =3</td>
<td>113 or 123</td>
</tr>
<tr>
<td>Last Claim</td>
<td>Type of Bill (last digit) =4</td>
<td>114 or 124</td>
</tr>
</tbody>
</table>

3. Electronic Billing Instruction
For those facilities wishing to submit claims electronically, additional information may be obtained from BCBST e-Business Solutions. If desired, a copy of the Electronic Billing Format Specifications is available for download from the Provider page on our company website, www.bcbst.com. You may make additional electronic billing inquiries to:

BlueCross BlueShield of Tennessee, Inc.            Phone: 423-535-5775
Provider Network Services                        Fax: 423-535-7523
1 Cameron Hill Circle, Ste 0007                   e-mail: eBusiness_Service@bcbst.com
Chattanooga, TN. 37402-0007
4. **Explanation Codes**

Explanation Codes are the processing codes found on the Member Explanation of Benefits (EOB) and Provider Remittance Advice. A list of these codes can be found on the BCBST website, [www.bcbst.com](http://www.bcbst.com).

5. **Adjusted Claims**

To adjust a claim previously filed with BCBST, a complete corrected claim must be resubmitted.

6. **Late Charges**

BCBST does not accept late charges. To receive consideration for late charges, a corrected claim should be resubmitted.

*Note:* Beginning August 1, 2015, Institutional claims (UB-04 and 837I) filed with Types of Bill ending in ‘S’ will be returned with the following rejection:

- 150168 CLM FREQUENCY CODE 5 NOT ACCEPTED

7. **Member Liability**

Revenue codes considered Member liability and may be billed to BCBST Member follow:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>0624</td>
<td>FDA Investigational Devices (requires Member consent)</td>
</tr>
<tr>
<td>0990</td>
<td>General - Patient Convenience Items</td>
</tr>
<tr>
<td>0991</td>
<td>Cafeteria/Guest tray</td>
</tr>
<tr>
<td>0992</td>
<td>Private Linen Service</td>
</tr>
<tr>
<td>0993</td>
<td>Telephone/Telegraph</td>
</tr>
<tr>
<td>0994</td>
<td>TV/Radio</td>
</tr>
<tr>
<td>0995</td>
<td>Non patient Room Rentals</td>
</tr>
<tr>
<td>0996</td>
<td>Late Discharge Charge</td>
</tr>
<tr>
<td>0997</td>
<td>Admission Kits</td>
</tr>
<tr>
<td>0998</td>
<td>Beauty Shop/Barber</td>
</tr>
<tr>
<td>0999</td>
<td>Other Patient Convenience Items</td>
</tr>
</tbody>
</table>

8. **Lesser Of Calculation**

There are two methodologies for calculating lesser of, the line item level and the claim level. Both represent a lesser of calculation but incorporate a different methodology for calculating each. The lesser of methodology utilized in adjudicating the claim is dependent on the facility’s contract in effect on the date the services are rendered. Claims processed under facility contracts containing claim level lesser of language are adjudicated using a claim level lesser of calculation. All other claims are adjudicated using a line item lesser of calculation.

*Note:* In accordance with Medicare anti-fraud statutes at 42 USC 1320 et seq, when Medicare is primary, Providers may not accept secondary payments above the Medicare allowed amounts. This rule overrides any lesser of contractual agreements allowing amounts greater than charges.

**Methodologies for calculating lesser of follow:**

a. **Claim Level Lesser Of Calculation:**

Acute Care facilities holding contracts with Claim Level Lesser Of language will have claims with dates of services on or after the contract effective date processed according to the following methodology. Claim Level Lesser Of calculation compares the lesser of total
covered charges for Covered Services against the contracted rates outlined in Schedules 1 and 2 of the Institution Contract. If the total covered charges filed on the claim are less than the amounts outlined in the contract, BCBST will allow the lesser of the total covered charges as submitted by the facility. Claims adjudicated using Claim Level Lesser Of Calculation are dependent upon the date of service and the contract in effect at the time of service.

**Items excluded from Claim Level Lesser Of Calculation**

When calculating the lesser of total covered charges for inpatient or outpatient services, there are three categories of services that are excluded. Examples of these exclusions are listed below:

- Services reimbursed based on a percentage of total covered charges, or discount off of charges.
- Services that are considered incidental, or part of the primary service.
- Services that are identified as non-covered under the Institution Contract, or the Member’s health care plan.

b. **Line Item Lesser Of Calculation:**

- In the Line Item Lesser Of Calculation, the lesser of calculation for an inpatient claim is based on a per day methodology. The covered ancillary charges shown on each claim are totaled and divided by the number of total days shown on the claim to calculate an average covered ancillary charge per day. This average covered ancillary charge per day is then added to the actual room charge per day for each service category (defined by each facility’s contract) to arrive at a total charge per day for that service category. The total covered charge per day applicable to each service category is multiplied by total days associated with same and a comparison of total covered charges by service category is made to that of negotiated payment per contract for that same category. The lower of these two amounts is the amount that will be paid on the claim for that service category.

- This same methodology is used for the outpatient lesser of calculation when it is applicable. Some outpatient services stand alone and do not receive allocations while others roll to a case or per procedure pricing method. If an outpatient claim has two or more of these cases or per procedure items then the appropriate ancillary lines will be allocated to each, based on a percentage of number of cases/procedures to total. Total covered charges for the case/procedure will then be compared to the negotiated rate for each and the lower of the two amounts is paid.

The following examples show two inpatient Per Diem contract scenarios, one is not impacted by lesser of while the other is:

**2 days @ $900**

<table>
<thead>
<tr>
<th>Days</th>
<th>Type of Service</th>
<th>Charges</th>
<th>Allocation</th>
<th>Re-allocated</th>
<th>Per Diem</th>
<th>Reimb.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Medical</td>
<td>$700</td>
<td>$1,533</td>
<td>$2,233</td>
<td>*$1800</td>
<td>$1800</td>
</tr>
<tr>
<td>1</td>
<td>ICU</td>
<td>500</td>
<td>767</td>
<td>1,267</td>
<td>1,200</td>
<td>1,200</td>
</tr>
<tr>
<td></td>
<td>Ancillary Charges</td>
<td>2,300</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td>$3,500</td>
<td>$2,300</td>
<td>$3,500</td>
<td>$3,000</td>
<td>$3,000</td>
</tr>
</tbody>
</table>

**3 days @ $900**

<table>
<thead>
<tr>
<th>Days</th>
<th>Type of Service</th>
<th>Charges</th>
<th>Allocation</th>
<th>Re-allocated</th>
<th>Per Diem</th>
<th>Reimb.</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>Medical</td>
<td>$1,050</td>
<td>$1,875</td>
<td><strong>$2,925</strong></td>
<td><strong>$2,700</strong></td>
<td>$2,700</td>
</tr>
<tr>
<td>1</td>
<td>ICU</td>
<td>500</td>
<td>625</td>
<td>1,125</td>
<td>1,200</td>
<td>1,125</td>
</tr>
<tr>
<td></td>
<td>Ancillary Charges</td>
<td>2,500</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Total</strong></td>
<td>$4,050</td>
<td>$2,500</td>
<td><strong>$4,050</strong></td>
<td>$3,900</td>
<td>$3,825</td>
</tr>
</tbody>
</table>
Note for Per Diem Contracts: Only the Per Diem amount will be allowed for inpatient services. No reimbursement will be given for any other Revenue Code, unless specifically contracted.

9. Acute Care Facilities – Inpatient

a. Diagnosis Related Groups (DRG) Business Rules

The following guidelines apply to all hospitals having DRG contracts with BCBST that participate in Blue Networks E, M, S, and P.

1. Grouper
BCBST will make DRG assignment via CMS Based Grouper as defined by Provider’s contract purchased from Third Party Software Vendor.

2. DRG Payment Application
The DRG assignment will be based on the principal diagnosis, up to twenty-four (24) other secondary diagnoses, additional associated present on admission codes, as well age, sex, and discharge status of patient. If CMS changes the DRG assignment criteria, BCBST will remain on current grouper assignment until a time and in a manner mutually agreed upon by the parties to ensure revenue neutrality to both parties. Until such time that the parties mutually agree, the contracted DRGs will be utilized. In the event the parties cannot reach an agreement, the dispute shall be resolved by the Provider Dispute Resolution Procedure as described in this Manual. The base rate and relative weights in effect at the admission date are used to calculate the payment level.

- **Regular DRG Payment** The formula to calculate the Regular DRG Allowed follows:

  Regular DRG Allowed = DRG Relative Weight \times \text{Institution Base Rate}

  Total Payment = Regular DRG Allowed – Deductible and Coinsurance

- **Outlier Payments**
The formula for calculating the Total Allowed Amount for an inpatient stay qualifying as an Outlier Stay is as follows:

  Total Allowed Amount = \text{Regular DRG Payment} + ((\text{Regular DRG Payment/ALOS x 70%}) \times (\text{Approved LOS – Outlier Day Threshold}))

### Claim Assumptions

<table>
<thead>
<tr>
<th>Claim Assumptions</th>
<th>Allowed Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admit Date</td>
<td>July 1, 2015</td>
</tr>
<tr>
<td>Discharge Date</td>
<td>July 18, 2015</td>
</tr>
<tr>
<td>Authorization Date</td>
<td>July 8, 2015</td>
</tr>
<tr>
<td>DRG</td>
<td>014</td>
</tr>
<tr>
<td>DRG (ALOS)</td>
<td>4</td>
</tr>
<tr>
<td>Relative Weight</td>
<td>1.1120</td>
</tr>
<tr>
<td>Outlier Threshold</td>
<td>12</td>
</tr>
<tr>
<td>Base Rate</td>
<td>$3,992</td>
</tr>
<tr>
<td>Outlier Per Diem</td>
<td>$777</td>
</tr>
<tr>
<td>Length of Stay</td>
<td>17</td>
</tr>
<tr>
<td>Normal DRG:</td>
<td></td>
</tr>
<tr>
<td>Base Rate</td>
<td>$3,992</td>
</tr>
<tr>
<td>Relative Weight</td>
<td>1.1120</td>
</tr>
<tr>
<td>Normal DRG Allowed</td>
<td>$4,439</td>
</tr>
<tr>
<td>Outlier:</td>
<td></td>
</tr>
<tr>
<td>Total Outlier Days</td>
<td>5*</td>
</tr>
<tr>
<td>Outlier Per Diem</td>
<td>$777</td>
</tr>
<tr>
<td>Outlier Allowed</td>
<td>$3,885*</td>
</tr>
<tr>
<td>Total Claim Allowed</td>
<td>$8,324*</td>
</tr>
</tbody>
</table>

*Outlier days will be reviewed for Medical Necessity.
3. Exclusions from DRG Reimbursement

The following conditions and/or treatments are specifically excluded under the DRG Network Attachment. Facilities intending to provide these services for BCBST Members must execute a separate Network Attachment covering the provision of these services.

- Mental Disease and Disorders (MDC 19*)
- Alcohol and Drug Use (MDC 20*)
- Heart Transplant
- Liver Transplant
- Bone Marrow Transplant
- Lung Transplant

*For these services, in the event that a Member is admitted under a covered medical diagnosis, BCBST will allow reimbursement based on the Provider’s contracted type of reimbursement methodology (e.g., CMS-DRG, MS-DRG, Per Diem).

4. Ungroupable DRG(s)

Claims that are linked to an ungroupable DRG will receive no reimbursement and require the institution to file a corrected claim for payment.

b. Relative Weight Revisions

Relative weights are updated according to one of two schedules for revisions. To determine which schedule you are on refer to your contract.

c. Annual Base Rate Adjustments

Base rates are updated annually on January 1 of each year in accordance with the contract.

d. Private Room Differential

The DRG payment is a total payment to include all room and board services provided during the inpatient stay. Private room differentials are considered part of the DRG and are not to be balance billed to any BCBST Member.

e. Mother and Newborn

A combined claim is required for both mother and newborns. A separate DRG payment will not be made for a Normal Newborn because payment for this claim is combined with the mother’s DRG payment.

f. Implants and Prosthetics

Implants and prosthetics are not reimbursed separately. Reimbursement for these items is included in the base rate and relative weights that determine DRG payment.

g. Kidney Transplants

Kidney transplants are reimbursed under BCBST’s DRG agreement.

Every participating hospital is contracted for both the DRG and the Organ Acquisition Cost. The Schedule of Payments in the contract contains the Relative Weight, Base Rate, and Outlier Per-Diem for the appropriate Kidney Transplant DRG. Organ Acquisition Cost has been included in the relative weight and is reimbursed through the DRG payment. Organ Acquisition Cost as defined below is the responsibility of the Transplant hospital.
Administrative and Payment Policies in regards to Kidney Transplants are:

- Requires prior authorization and must be within BCBST Utilization Management Guidelines.

- The claim should be filed in accordance with the Tennessee Uniform Billing Guidelines.

- Organ acquisition costs, which are billed by other Providers to and subsequently paid by BCBST will be accumulated by BCBST and deducted from the DRG payment to the transplant hospital via BCBST’s retrospective audit process.

- Practitioner costs associated with organ acquisition cost are not included in the definition of organ acquisition cost and are to be billed separately to BCBST on a Professional claim form.

- The lesser of total covered charges or DRG allowed adjusted for deductible and coinsurance represents payment for the transplant including the organ acquisition cost.

- Hospitals not contracted under a DRG reimbursement methodology need to contact BCBST to negotiate a single patient agreement prior to providing services to a BCBST Member.

- Refer to “Tips for Completing CMS-1500, CMS-1450 and Electronic Claims Filing” section of this Manual for Donor/Recipient special billing instructions.

Organ Acquisition Costs Include:

Living Donor:
- Kidney recipient registration fees
- Laboratory test (including tissue typing of recipient and donor)
- Hospital services that are directly related to the excision of the kidney

Cadaver Kidneys:
- Operating room services
- Intensive care cost
- Preservation supplies (perfusion materials and equipment)
- Preservation technician’s services
- Transportation cost
- Tissue typing of the cadaver organ

Pre-Admission Services

Pre-admission Diagnostic Services performed on an outpatient basis by the admitting hospital, or by an entity wholly owned or operated by the facility (or by another entity under arrangements with the facility) within three (3) days of an inpatient admission will be covered under the inlier portion of the DRG payment. No separate payment will be made for pre-admission diagnostic services within the three-day period. Other Pre-admission Non-Diagnostic Services that are related to the Member's facility admission and performed by the admitting facility, or by an entity wholly owned or operated by the facility (or by another entity under arrangements with the facility) during the three days immediately preceding the date of admission will be covered under the inlier portion of the DRG payment for approved admissions. No separate payment will be made for these services. All testing performed on the day of discharge or within one day following the discharge will also be covered under the inlier portion of the DRG payment. No separate payments will be made for outpatient testing within the one-day period.
i. **Transfer Payments**

BCBST allows a transfer per diem times the number of days not to exceed the amount allowed under the DRG to the transferring hospital. These claims are identified by the discharge status codes 02 or 05, 82 or 85. The receiving hospital is reimbursed according to its acute care contract with BCBST.

j. **Readmissions (Does not apply to MedAdvantage)**

A readmission is defined as a preventable, unplanned admission occurring within fourteen (14) days after a hospital discharge to the same facility for a condition related to, or complication of the original hospital stay or admission resulting from a modifiable cause. The following conditions are eligible for 14-day readmission review: CHF, COPD, and Class I surgeries. Claims for patients at either a DRG or Per Diem facility that are readmitted under these circumstances are not eligible for multiple payments. Only a single payment will be made by BCBST. These guidelines are subject to the Provider’s contract.

In the instance where more than one payment has been made, BCBST reserves the right to re-coup the overpayment.

Some examples of readmissions that MAY NOT be authorized:

- respiratory admissions, e.g., COPD;
- complications from surgical procedures; or
- congestive heart failure (CHF).

Some examples of readmissions that MAY be authorized are:

- NICU admissions;
- planned admissions;
- cancer diagnoses for chemotherapy;
- complications of pregnancy;
- admissions for coronary artery bypass surgery following an admission for chest pain;
- children 18 years and under admitted to any facility; or
- admissions for complication due to rejection of transplant/implant surgery.

**Note:** The Member cannot be held liable for payment of services received when not authorized.

k. **Reimbursement Guidelines for Inpatient Services Based on Admission**

BCBST updated its reimbursement policy for inpatient facilities participating in Blue Networks E, M, P, and S. These facilities were transitioned to a reimbursement methodology based on the earliest agreement date.

For these Providers, reimbursement for inpatient services will be based on the contracted rates in effect at the time of admission. The contracted rates in effect on the admit date will be used in calculating payment for the entire stay. In some instances, a patient’s admission date may span multiple Provider Agreements. In this situation, charges for all approved days will still be reimbursed based on the rates that were in effect on the date of admission and will remain in effect until the patient’s discharged.

The grid below lists Provider types that may be affected by this methodology. Please refer to your specific contract in effect on the date of the patient’s admission to determine applicable reimbursement rates.

<table>
<thead>
<tr>
<th>Provider’s affected by Earliest Agreement Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Hospital</td>
</tr>
<tr>
<td>Freestanding Inpatient Rehabilitation Hospital</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
</tr>
<tr>
<td>Hospice Facility</td>
</tr>
</tbody>
</table>

Rev 06/16
I. Policy for Present On Admission (POA) Indicators
This policy applies to claims billed on an Institutional claim form for all BCBST lines of business.

For all inpatient admissions to general acute care hospitals, BCBST requires the Present on Admission code on primary and secondary diagnoses (Form Locator 67) for all discharges, by using National Coding Standard guidelines. This may impact reimbursement.

POA indicators are needed when Acute Inpatient Prospective Payment System (IPPS) Hospital Providers bill for selected Hospital Acquired Conditions (HACs), including some conditions on the National Quality Forum’s (NQF) list of Serious Reportable Events (commonly referred to as "Never Events"), these certain conditions have been selected according to the criteria in section 5001(c) of the Deficit Reduction Act (DRA) of 2005 and are reportable by CMS POA Indicator Options:

**Note:** For all inpatient admissions to general acute care hospitals, based on National Coding Standard guidelines, the following POA Indicator Option “1” reporting guidelines apply.

<table>
<thead>
<tr>
<th>Indicator Option</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Y</td>
<td>Diagnosis was present at time of inpatient admission.</td>
</tr>
<tr>
<td>N</td>
<td>Diagnosis was not present at time of inpatient admission.</td>
</tr>
<tr>
<td>U</td>
<td>Documentation insufficient to determine if the condition was present at the time of inpatient admission.</td>
</tr>
<tr>
<td>W</td>
<td>Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission.</td>
</tr>
<tr>
<td>1</td>
<td>Unreported/Not used. Exempt from POA reporting on paper claims. A blank space is only valid when submitting this data via the ANSI 837 5010 version.</td>
</tr>
</tbody>
</table>

When filing electronic ANSI 837 Inpatient facility claims, Providers should no longer enter Indicator Option “1” in the POA field when exempt POA reporting. The POA field should be left blank for EDI format 5010 claims.

When filing paper CMS-1450 inpatient facility claims, Providers should enter a “1” in the POA field when exempt from POA reporting.

When any other POA Indicator Options apply, they should be reported in the POA field on both electronic and paper claims.

**Claims will reject if:**
- POA “1” is submitted on an electronic “ANSI 837 inpatient claim; or
- POA is left blank on a paper CMS-1450 (UB04) inpatient claim; or
- POA is required, but not submitted.

The guidelines for reporting POA Indicators can be found on the CMS website at [www.cms.gov/HospitalAcqCond/](http://www.cms.gov/HospitalAcqCond/).

m. Reimbursement Policy for Selected Hospital Acquired Conditions (HACs) Not Present On Admission (POA)
This policy applies to claims billed on an Institutional claim form for all BCBST lines of business.

BCBST will use POA indicators to determine DRG assignment for selected HACs (a.k.a. avoidable hospital conditions) not present on admission as outlined by CMS National Reimbursement Policy.
POA adjustment reimbursement for Commercial lines of business will be based on individual Provider contracts. In addition to the Provider contracts, any reimbursement adjustments for Hospital Acquired Conditions (HACS) that are recognized as Serious Reportable Adverse Events will be made as defined by CMS guidelines.

BCBST began accepting POA Indicator codes on inpatient hospital claims effective January 1, 2008.

**Note:** MedAdvantage lines of business will follow CMS guidelines regarding both reimbursement and reporting.

### n. Billing and Reimbursement Guidelines for Durable Medical Equipment, Medical Supplies, Orthotics and Prosthetics (O&P) (DMEPOS) Dispensed by a Facility (Inpatient or Outpatient)

When a facility partners with a durable medical equipment (DME) supplier for the provision of equipment, supplies, or O & P used in conjunction with surgical or other procedures, the facility is responsible for submitting all charges associated with the service. Separate claims submitted by the DME supplier for any unbundled charges related to the facility service will result in zero reimbursement. The Member cannot be held liable in these cases, as reimbursement for DME is part of the all-inclusive global payment for inpatient and/or outpatient surgeries to contracted facilities.

Should a facility choose to partner with a DME supplier for the provision of equipment associated with the facility services, the facility will be responsible for submitting all charges to BCBST as well as responsible for payment of the DME supplier. Unbundling of charges is a violation of contract, National Coding Conventions, and legal requirements. Under certain situations, inappropriate bundling could be considered abusive or even possibly fraudulent.

These guidelines are in accordance with the BCBST Institution Agreement. Please contact your local Provider Relations Consultant for any questions concerning your Provider Contract.

### o. Reimbursement Policy and Billing Guidelines for Unclassified Infusion Therapy, Immunosuppressive, Immune Globulin, Nebulizer, Chemotherapy and Other Injectable Drugs Billed by an Acute Care Facility

This policy applies to all eligible, infusion therapy, immnosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs filed on an Institutional claim form by a facility contracted for Commercial Acute Care Drug Schedule for the drugs considered unclassified drugs and exceed $1,000 per line. If preceding qualifications are not met for institutional claims the reimbursement will be set at $0.00. All other eligible infusion therapy, immnosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs filed on an Institutional claim form with the appropriate revenue code/CPT® code will be reimbursed at the Provider’s contracted percentage.

**Reimbursement Guidelines**

The maximum allowable for eligible infusion therapy, immnosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs for Acute Care Facility Providers is based on a percentage of the published Medicare allowable. Maximum allowables not published by Medicare will be calculated based on a percentage of Average Wholesale Price (AWP) or Wholesale Acquisition Cost (WAC) if there is no published AWP, using one of the following methods:
Method 1

1. The AWP/WAC based on the National Drug Code (NDC) for the specific drug billed.

Method 2

1. For a single-source drug, the AWP/WAC equals the AWP/WAC of the single product.

2. For a multi-source drug, the AWP/WAC is equal to the lesser of the median AWP/WAC of all the generic forms of the drug or the lowest brand name product AWP/WAC.

BCBST reserves the right to select the method used to calculate AWP/WAC and the source for AWP/WAC for infusion therapy, immunosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs not published by Medicare. Examples of sources for AWP/WAC include, but are not limited to First Data /Medispan, Redbook, and information provided by the drug manufacturer.

To determine eligibility and reimbursement for an injectable drug, BCBST reserves the right to request the name of the drug, National Drug Code (NDC), dosage and number of units for items billed with an unlisted, miscellaneous, not otherwise classified HCPCS code or for HCPCS codes not published by Medicare.

Source B

The AWP/WAC based on the National Drug Code (NDC) for the specific drug billed per First Data/Medispan and Redbook.

Infusion therapy, immunosuppressive, immune globulins, nebulizer, chemotherapy and other injectable drugs provided in a facility setting are not billable to or reimbursable by BCBST filed on a Professional claim form. These are considered facility services and must be billed by the facility.

p. Reimbursement Policy and Billing Guidelines for Unclassified Radiopharmaceuticals and Contrast Materials Billed by an Acute Care Facility

This policy applies to all eligible Radiopharmaceuticals and Contrast Materials filed on an Institutional claim form by a facility contracted for the Commercial Acute Care Drug Schedule for the drugs that are considered unclassified drugs and exceed $1,000 per line. If preceding qualifications are not met for institutional claims the reimbursement will be set at $0.00. All other eligible radiopharmaceuticals and contrast materials filed on an Institutional claim form with the appropriate revenue code/CPT® code will be reimbursed at the Provider’s contracted percentage.

The maximum allowable for eligible radiopharmaceuticals and contrast materials is based on a percentage of the published Medicare allowable.

Maximum allowables for eligible radiopharmaceuticals and contrast materials not published by Medicare will be calculated is based on a percentage of Average Wholesale Price (AWP), or Wholesale Acquisition Cost (WAC), if there is no published AWP, according to one of the following methods:

Method 1

1. The AWP/WAC based on the National Drug Code (NDC) for the specific radiopharmaceutical or contrast material billed per First Data/Medispan, Redbook, and information provided by the radiopharmaceutical or contrast material manufacturer.

Method 2

1. For a single-source radiopharmaceutical or contrast material, the AWP/WAC equals the AWP/WAC of the single product.
2. For a multi-source radiopharmaceutical or contrast material, the AWP/WAC is equal to the lesser of the median AWP/WAC of all the generic forms of the radiopharmaceutical or contrast material or the lowest brand name product AWP/WAC.

Updates to maximum allowables for radiopharmaceuticals and contrast materials published by CMS will be made in accordance with the BCBST Policy - Quarterly Reimbursement Changes.

BCBST reserves the right to select the method used to calculate AWP/WAC and the source for AWP/WAC for radiopharmaceuticals and contrast materials without an ASP published by CMS. Examples of sources for AWP/WAC include, but are not limited to First Data/Medispan, Redbook, and information provided by the radiopharmaceutical or contrast material manufacturer.

For codes where it is not feasible to establish a maximum allowable for a radiopharmaceutical or contrast material (e.g. when the radiopharmaceutical or contrast material does not have a NDC, when the dosage depends on the weight of the patient), the maximum allowable will be based on a reasonable allowable as determined by BCBST.

In order to determine a reasonable allowable, BCBST reserves the right to request one of the following:

- The name of the radiopharmaceutical or contrast material, NDC, dosage, and quantity
- The manufacturer/supplier’s invoice. When a manufacturer/supplier’s invoice is requested, the name of the patient, name of the specific radiopharmaceutical or contrast material, dosage, and number of units must be provided. If multiple patients are listed on the manufacturer/supplier’s invoice, the radiopharmaceutical or contrast material, dosage and number of units for the patient being billed should be clearly indicated.

Radiopharmaceuticals and contrast materials provided in a facility setting are not billable to or reimbursable by BCBST on a CMS-1500/ANSI-837P. Radiopharmaceuticals and contrast materials provided in a facility setting are considered facility services and must be billed by the facility.

10. Acute Care Outpatient Services

a. Outpatient Surgery

Outpatient Surgery is reimbursed based on an All-Inclusive Rate. This All-Inclusive will fully compensate Facility for all related facility services and supplies provided in association with a particular surgical procedure. Pre-admission testing which is provided by the facility or any facility wholly owned or operated by the facility at which the surgery is performed up to three (3) days prior to the surgery is included in the all-inclusive rate and must be filed on the same claim as the outpatient surgery.

The maximum allowable for eligible multiple procedures billed on the same date of service by the same Provider will be based on the lesser of covered charges or 100 percent of the base maximum allowable for the primary procedure and the lesser of covered charges or 50 percent of the base maximum allowable for the secondary and each subsequent procedure. When a procedure is repeated on the same day, no additional amount will be allowed on the second procedure. The primary procedure will be determined by the code with the greatest base maximum allowable.

The aggregate maximum allowable for eligible bilateral procedures will be based on the lesser of covered charges or 150 percent of the base maximum allowable. When a bilateral procedure is performed in conjunction with other surgeries, the reimbursement for the bilateral procedure will be the lesser of covered charges or 75 percent of the fee schedule, when determined that the bilateral procedure is not the primary procedure.
Per HIPAA guidelines, Bilateral procedures filed on an Institutional claim/Transaction must be filed as a single item using the most appropriate CPT® code with modifier 50. One (1) unit should be reported. For BCBST, only surgical procedures filed on an Institutional claim form as indicated above will receive bilateral reimbursement.

However, in certain situations, Modifier 50 should not be added to a procedure code. Some examples, but not limited to, are when:
- a bilateral procedure is performed on different areas of the right and left sides of the body (e.g. reduction of fracture, left and right arm),
- the procedure code description specifically includes the word “bilateral”; and/or
- the procedure code description specifically indicates the words “one or both”

Therefore, sometimes it is appropriate to bill a bilateral procedure with:
- a single line with no modifier and 1 unit
- a single line with modifier 50 and 1 unit; and/or if procedure is “other” than surgical such as radiology CPT® codes then bill as:
- two lines with modifier LT and 1 unit on one line and modifier RT and 1 unit on another line.

Outpatient Surgery Groupings are defined in the applicable Schedule in the contract. All procedures performed in an Outpatient Surgery setting and not shown in the applicable Schedule in the contract will be assigned to an Outpatient Surgery Grouping for payment by BCBST. Rebundling of charges will occur when appropriate.

Revenue Codes 0360, 0490 and 0499 are only to be billed when the surgery service is rendered in the Operating Room. BCBST will assign the code to an Outpatient Surgery Grouping when applicable. The outpatient surgery is considered to be an all-inclusive service. Rebundling of charges will occur when appropriate.

**Note:** Procedures that cannot be consistently assigned will deny as “W26 – see billing guidelines” and are subject to reconsideration and manual pricing.

b. **Endoscopic Gastrointestinal Procedures**
Revenue Code 0750 indicates Endoscopic Gastrointestinal procedures that are performed in the GI Lab and not in an Operating Room. The Endoscopic Gastrointestinal procedure is considered an all-inclusive service when filed with a contracted surgical grouper CPT® Code. Rebundling of charges will occur when appropriate.

**Note:** For Donor Lymphocyte Infusion (DLI) - Effective 9/1/2013, for commercial acute care facilities, any eligible outpatient surgical HCPCS/CPT® codes appropriately filed with Revenue Codes 0362, 0810, or 0819 that are included within an all-inclusive transplant rate will be reimbursed according to the Outpatient Surgical Facility (OSF) guidelines, unless otherwise contracted. All surgical reimbursement policies will apply.

c. **Minor Surgery**
Minor Surgery (Revenue Code 0361) Codes are outpatient surgery codes that according to BCBST’s medical staff should be performed in a Physician office setting. These codes have been assigned to Group 0. The agreed upon Maximum Allowed between the Facility and BCBST is $0.00. BCBST will not make any payment for the supplies or room charges when these procedures are performed in the facility.

If a minor surgery is performed in conjunction with an all-inclusive service, the minor surgery will bundle to the all-inclusive service. If an all-inclusive service is not billed on a claim then the line item will disallow.

d. **Observation Services Billing & Reimbursement Guidelines**
Observation Services include the use of a bed and periodic monitoring by a hospital’s nursing staff, which are reasonable and necessary to evaluate a patient’s condition.
BCBST will consider reimbursement for the following outpatient Observation Services:
- Observation Services for Members, who, after six hours of recovery for outpatient services, are not medically stable for discharge, provided an authorization is obtained.

BCBST will base the observation time on when the Member arrives in a designated observation bed and when he/she leaves observation, after the six (6)-hour recovery time, if applicable.

BCBST will not consider reimbursement for the following outpatient Observation Services:
- Observation Services the day before an elective inpatient surgery;
- Inpatient stays which are billed as Observation Services. Those Members who are inpatient must have an authorization within one business day from the date of admission;
- Charges for Observation Services in addition to payment for inpatient services;
- Charges for Observation Services following an outpatient surgical procedure unless authorization is given. On those authorized, Observation Services may not be billed until six (6) hours after surgery. Recovery times up to six (6) hours are included in the Outpatient Surgery All-Inclusive Rates.
- Observation Services billed for convenience such as holding a Member overnight in the hospital if his or her regular post-surgery recovery period ends late at night.

Observation Services require prior authorization. BCBST does not reimburse Labor Room/Delivery services billed under Revenue Code 0721 “Labor Room/Delivery – Labor” or 0722 “Labor Room / Delivery – Delivery”. These services should be billed under Revenue Code 0762 “Treatment or Observation Room – Observation Room” *

*Note: Fetal stress and fetal non-stress tests are considered Observation and are to be billed as Observation under revenue code 0762 with the number of hours as units. However, these fetal stress tests do not require prior authorization.

Observation services billed with Revenue Code 0762 do not require a HCPCS/CPT® code in Form Locator 44 on an Institutional claim form unless the Provider is billing for fetal stress and non-stress tests. Adding an Evaluation and Management code with the Observation code may result in delayed or denied payment of the service.

BCBST will allow up to 23 hours for the Observation Services if Medically Necessary and Medically Appropriate. Hours billed in excess of 23 hours will not be allowed.

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Type of Service</th>
<th>HCPCS/CPT® Code</th>
<th>Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>0762</td>
<td>Observation Room</td>
<td>N/A</td>
<td>Allowed at an hourly rate per contract, not to exceed 23 hours.</td>
</tr>
</tbody>
</table>

How to calculate Observation Services

### Less than 23 Hour Stay

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation Service Charges Billed by Facility</td>
<td>$1,500.00</td>
</tr>
<tr>
<td>Observation Services Maximum Allowed Charge</td>
<td>$900.00</td>
</tr>
<tr>
<td>Hourly Rate (Indicated by Provider Contract)</td>
<td>$39.13</td>
</tr>
<tr>
<td>Total Hours Billed by Facility (1-hour increments)</td>
<td>3</td>
</tr>
<tr>
<td>Total Allowed Amount for Revenue Code 762</td>
<td>$117.39</td>
</tr>
</tbody>
</table>

### Greater than 23 Hour Stay

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observation Service Charges Billed by Facility</td>
<td>$1,500.00</td>
</tr>
<tr>
<td>Hourly Rate</td>
<td>$39.13</td>
</tr>
<tr>
<td>Total Hours Billed by Facility (1-hour increments)</td>
<td>30</td>
</tr>
<tr>
<td>Total Hours Allowed by BCBST (1-hour increments)</td>
<td>23</td>
</tr>
<tr>
<td>Total Allowed Amount for Revenue Code 762</td>
<td>$900.00</td>
</tr>
</tbody>
</table>
e. **Acute Care Emergency Room Services**

Emergency room services for an emergency condition do not require prior authorization. However, if the Member is admitted to the hospital as inpatient from the emergency room, the facility is required to obtain an authorization within 24 hours or the next business day of the date of admission. These claims will be reimbursed an all-inclusive negotiated case rate or total covered charges, subject to the lesser of provision found in the facility's contract. Only the contracted HCPCS Codes will be reimbursed when filed with Revenue Code 0450, 0451, and/or 0459. Any other HCPCS code filed with Revenue Code 0450, 0451 and/or 0459 will be reimbursed at zero.

11. **Acute Care All-Inclusive Rates**

a. **Cardiac Catheterization and Ablation Services**

Cardiac Catheterization and Ablation services are all-inclusive and reimbursement will fully compensate the facility for all Covered Services provided in connection with these services and the exceptions based on Provider's contract. Claims billed with multiple contracted codes for RCs 0480 and 0481 may be reviewed for rebundling.

b. **Angioplasty Services**

Angioplasty services, including stents, are all-inclusive and reimbursement will fully compensate the facility for all Covered Services provided in connection with these services with the exception of outpatient surgery, approved observation services, and the exceptions based on Provider’s contract. Claims billed with multiple contracted codes for RCs 0480 and 0481 may be reviewed for rebundling.

**Note:** Due to significant HCPCS/CPT® code set changes where single codes were deleted and replaced with multiple codes, BCBST will only allow reimbursement for one cardiac ablation case rate per day, one cardiac catheterization case rate per day, and one angioplasty case rate per day.

c. **Lithotripsy Services**

Lithotripsy will reimburse the contracted rate when billed with RC 790. Lithotripsy services are all-inclusive services.

12. **Acute Care Fee Schedules**

BCBST will update the BCBST Facility Fee schedule for quarterly additions and deletions to HCPCS/CPT® codes that are effective January 1, April 1, July 1, and October 1 of each year in accordance with the American Medical Association (AMA). For new HCPCS/CPT® codes, the allowable reimbursed by BCBST beginning with the effective date of the code from January 1 until March 31 will be considered an interim allowable based on the reimbursement pricing methodology below. Revisions for the existing HCPCS/CPT® codes allowable reimbursement will be updated effective April 1 of each year in accordance with the Provider’s Contract.

a. **Laboratory Services**

Laboratory Services will be allowed according to the contract unless performed with an all-inclusive service. When filed with an all-inclusive service, the Laboratory Services will be bundled with the all-inclusive service. The Fee Schedule will be allowed when filed separately. These Fee Schedules are priced at the current Medicare reimbursement rate and updated on April 1 of each year.
Revenue Code | Type of Service | HCPCS/CPT® Code | Allowed
--- | --- | --- | ---
0300 | Laboratory | Requires a valid HCPCS/CPT® Code. | Reimbursement is based upon the contract. Refer to Laboratory Fee Schedule.
0301 | Chemistry
0302 | Immunology
0304 | Non-Routine Dialysis
0305 | Hematology
0306 | Bacteriology & Microbiology
0307 | Urology
0309 | Other Laboratory
0310 | General
0311 | Cytology
0312 | Histology
0314 | Biopsy
0319 | Other

b. Radiology Services
When filed with all-inclusive services, the radiology procedure will be bundled with the all-inclusive service. The Fee Schedule will be allowed when filed separately. These Fee Schedules are priced at the current Medicare reimbursement rate and updated on April 1 of each year.

Revenue Code | Type of Service | HCPCS/CPT® Code | Allowed
--- | --- | --- | ---
0320 | Radiology Diagnostic | Requires a valid HCPCS/CPT® Code. | Reimbursement is based upon the contract. Refer to Radiology Fee Schedule.
0321 | Angiocardiography
0322 | Arthrography
0323 | Arteriography
0324 | Chest X-ray
0329 | Other Radiology Services
0330 | Radiology Therapeutic
0333 | Radiation Therapy
0340 | General Radiology
0341 | Diagnostic Procedures
0342 | Therapeutic Procedures
0349 | Other Radiology Services
0400 | Other Imaging Services
0401 | Diagnostic Mammography
0402 | Ultrasound
0403 | Screening Mammography
0404 | Positron Emission Tomography (PET)
0409 | Other imaging Services

c. MRI/MRA/CT Scan
MRI/MRA/CT Scan reimbursement includes pharmacy, anesthesia, and/or supplies used in conjunction with the Radiology Services. MRI/MRA/CT Scan claims are allowed via a Fee Schedule. These Fee Schedules are priced at the current Medicare reimbursement rate and updated on April 1 of each year. These services are allowed in addition to the all-inclusive rate(s).
### BCBST Facility Fee Schedule Reimbursement Methodology Policy

This policy applies to claims filed on an Institutional claim form/transaction. It defines the reimbursement methodology used for all new codes and existing HCPCS/CPT® codes for BCBST lines of business on the BCBST Facility Fee Schedule. The purpose is to establish consistent method to add and update HCPCS/CPT® codes on the BCBST Facility Fee Schedule for all contracts.

BCBST will update the BCBST Facility Fee Schedule for quarterly additions and deletions to HCPCS/CPT® codes that are effective January 1, April 1, July 1, and October 1 of each year in accordance with the American Medical Association (AMA). For new HCPCS/CPT® codes, the allowable reimbursed by BCBST beginning with the effective date of the code from January 1 until March 31 will be considered an interim allowable based on the reimbursement pricing methodology below. Revisions for the existing HCPCS/CPT® codes allowable reimbursement will be updated effective April 1 of each year in accordance with the Provider’s contract.

To establish the codes that are added to the BCBST Facility Fee Schedule, BCBST will utilize Appendix 3, “Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments,” of the *OPTUM Uniform Billing (UB) Editor* or its successor. These codes will be updated annually on July 1st from the First Quarter *OPTUM Uniform Billing (UB) Editor Updates*.

The reimbursement methodology within this policy does not apply to “C” codes such as drugs, biologicals, radiopharmaceuticals, and devices that have alternate reimbursement methodologies.

The established BCBST Facility allowable will be based on the published maximum allowable non-facility rate. BCBST will not establish an allowable for an unlisted code. Some exceptions may apply.

**To determine the allowable, BCBST will utilize the following reimbursement pricing methodology hierarchy excluding laboratory (see laboratory pricing grid):**

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Type of Service</th>
<th>HCPCS/CPT® Code</th>
<th>Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>0350</td>
<td>General Scans</td>
<td>Requires a valid HCPCS/CPT® Code.</td>
<td>Reimbursement is based upon the contract. Refer to MRI/CT Scan Fee Schedule.</td>
</tr>
<tr>
<td>0351</td>
<td>Head Scan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0352</td>
<td>Body Scan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0359</td>
<td>Other CT Scan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0610</td>
<td>Magnetic Resonance Technology (MRT) General MRI Technology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0611</td>
<td>MRI – Brain (including brainstem)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0612</td>
<td>MRI – Spinal Cord (including spine)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0614</td>
<td>MRI – Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0615</td>
<td>Magnetic Resonance Angiography – (MRA) Head and Neck</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0616</td>
<td>MRA – Lower Extremities</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0618</td>
<td>MRA - Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0619</td>
<td>MRT – Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0621</td>
<td>Supplies incidental to radiology</td>
<td>HCPCS/CPT® Code does not affect reimbursement</td>
<td>Reimbursement is based upon the contract.</td>
</tr>
<tr>
<td>0622</td>
<td>Supplies incidental to other diagnostic services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
To determine the allowable, BCBST will utilize the following reimbursement pricing methodology hierarchy for laboratory:

<table>
<thead>
<tr>
<th>Order</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st</td>
<td>Current Year Cahaba GBA (or its successor) Clinical Laboratory fee schedule TC component x contract multiplier.</td>
</tr>
<tr>
<td>2nd</td>
<td>Current Year Medicare Physician fee schedule TC component (Calculated using the CMS formula) x contract multiplier %.</td>
</tr>
<tr>
<td>3rd</td>
<td>Current Year Medicare Physician fee schedule *Global (Calculated using the CMS formula) x contract multiplier %.</td>
</tr>
<tr>
<td>4th</td>
<td>Current Year Cahaba GBA (or its successor) Physician fee schedule TC component x contract multiplier %.</td>
</tr>
<tr>
<td>5th</td>
<td>Current Year Cahaba GBA (or its successor) Physician fee schedule *Global x contract multiplier %.</td>
</tr>
<tr>
<td>6th</td>
<td>Current Year OPTUM (or its successor) Complete RBRVS TC component (Calculated using the CMS formula) x contract multiplier.</td>
</tr>
<tr>
<td>7th</td>
<td>Current Year OPTUM (or its successor) Complete RBRVS *Global (Calculated using the CMS formula) x contract multiplier %.</td>
</tr>
<tr>
<td>8th</td>
<td>Allowables that were not priced by any source mentioned above remain at zero dollars with “BR – By report” to be reviewed and priced by using a similar HCPCS/CPT® code.</td>
</tr>
</tbody>
</table>

* Global represents the 5-digit code on fee schedule with no modifiers.

e. **Reimbursement Policy and Billing Guidelines for the Commercial Acute Care Drug Schedule**

This policy is to establish the codes that are added to the Drug and Radiopharmaceutical Fee Schedule, BCBST will utilize Appendix 3, "Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments," of the OPTUM Uniform Billing (UB) Editor or its successor. CPT®/HCPCS codes that are appropriate to be billed under RC(s) 0250, General Drugs; 0343, Radiopharmaceuticals Diagnostic; 0344, Radiopharmaceuticals Therapeutic; and 0636, Drugs Requiring Detail Coding will be added to the fee schedule annually on July 1 from the First Quarter OPTUM Uniform Billing (UB) Editor Updates.
A drug or radiopharmaceutical that is not addressed by OPTUM may be added to the fee schedule at BCBST discretion in accordance with BCBST Policy, "Quarterly Reimbursement Changes," if it is appropriate to be reimbursed to an Acute Care Hospital under the CMS Hospital Outpatient Prospective Payment System (OPPS) methodology. OPTUM updates the UB-Editor periodically. In this instance, the Schedule may be adjusted if OPTUM addresses the code in a subsequent publication of the UB-Editor. These periodic updates to the Drug and Radiopharmaceutical Fee Schedule will be made in accordance with BCBST Policy, "Quarterly Reimbursement Changes."

The base allowed is the equivalent of the CMS National APC Payment Rate under the Medicare OPPS methodology. Drugs and radiopharmaceuticals not priced by CMS that are on the Fee Schedule are to be presented with a zero allowed indicating BCBST will not make payment. The BCBST allowed is a negotiated percentage of the base allowed that is defined in the hospital contract.

**Unclassified drugs or radiopharmaceuticals** must exceed $1,000 per line to be considered for manual pricing, otherwise reimbursement will be set at $0.00. Drugs will be priced in accordance with BCBST Policies for Vaccines, and Toxoids, or "Unclassified Infusion Therapy, Immunosuppressive, Immune Globulins, Nebulizer, Chemotherapy and Other Injectable Drugs Billed by Facility. Radiopharmaceuticals will be priced in accordance with BCBST Policy for "Unclassified Radiopharmaceuticals and Contrast Materials Billed by an Acute Care Facility." Drugs and radiopharmaceuticals billed without a valid CPT®/HCPCS code under RC(s) 0250, 0343, 0344, and 0636 will not be considered for payment.

The Drug and Radiopharmaceutical Fee Schedule is to be updated quarterly in conjunction with the CMS quarterly updates.

Only those CPT®/HCPCS codes on the fee schedule will be considered for reimbursement when filed with one of the RC(s) listed in the table below. Services billed outside of the Agreement are subject to recovery.

**Note:** **BCBST will not make a payment to an Acute Care Facility for any CPT®/HCPCS code where the UB-Editor indicates it is not appropriate to reimburse for these codes in an Acute Care Hospital Outpatient setting. In the circumstance that an inappropriate payment has occurred, BCBST reserves the right to re-coup the reimbursement as necessary.**

The appropriate CPT®/HCPCS code should be billed in conjunction with the corresponding RC according to the following chart:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
<th>CPT®/HCPCS Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>0250</td>
<td>General Drugs</td>
<td>Required</td>
</tr>
<tr>
<td>0251</td>
<td>Generic Drugs</td>
<td>Required</td>
</tr>
<tr>
<td>0252</td>
<td>Non-generic Drugs</td>
<td>Required</td>
</tr>
<tr>
<td>0254</td>
<td>Drugs Incident to Other Diagnostic Services</td>
<td>Required</td>
</tr>
<tr>
<td>0255</td>
<td>Drugs Incident to Radiology</td>
<td>Required</td>
</tr>
<tr>
<td>0257</td>
<td>Non-prescription</td>
<td>Required</td>
</tr>
<tr>
<td>0258</td>
<td>IV Solutions</td>
<td>Required</td>
</tr>
<tr>
<td>0259</td>
<td>Other Pharmacy</td>
<td>Required</td>
</tr>
<tr>
<td>0343</td>
<td>Radiopharmaceuticals Diagnostic</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>0344</td>
<td>Radiopharmaceuticals Therapeutic</td>
<td>Required, if applicable</td>
</tr>
<tr>
<td>0636</td>
<td>Drugs Requiring Detail Coding</td>
<td>Required, if applicable</td>
</tr>
</tbody>
</table>

Providers filing electronic claims should refer to the Electronic Billing Instructions of this Manual.
f. **Reimbursement Policy and Billing Guidelines for the Facility Drug Schedule**

This policy is to establish the codes that are added to the BCBST Facility Drug Fee Schedule. BCBST will utilize Appendix 3, "Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments," of the **OPTUM Uniform Billing (UB) Editor** or its successor.

BCBST will identify the HCPCS codes that are appropriate to be billed under RC(s) 0250, General Drugs; 0251, Generic Drugs; 0252, Non-generic Drugs; 0254, Drugs Incident to Other Diagnostic Services; 0255, Drugs Incident to Radiology; 0257, Non-prescription; 0258, IV Solutions; 0259, Other Pharmacy; 0343, Radiopharmaceuticals Diagnostic; 0344, Radiopharmaceuticals Therapeutic; and 0636, Drugs Requiring Detail Coding, as indicated in the **OPTUM Uniform Billing (UB) Editor** or its successor and add these codes to the fee schedule.

Drug codes submitted for consideration, but not listed in the BCBST Facility Drug Fee Schedule are not eligible for reimbursement and will be denied as non-contracted. Effective 3/17/14, any of the above indicated RC(s) filed without a HCPCS/CPT® code will also be denied as non-contracted. Drug codes submitted that are on this schedule with a $0.00 fee and no indicator in note to review for manual pricing will be denied – exceeds the scheduled rate. In the circumstance that an inappropriate payment has occurred, BCBST reserves the right to re-coup the reimbursement as necessary.

BCBST shall reimburse acute care hospitals contracted for BCBST Facility Drug Fee Schedule for eligible outpatient drug codes based on a percentage of the Average Sales Price (ASP), or in the absence of a published ASP, Wholesale Acquisition Cost (WAC) or Average Wholesale Price (AWP). The table below indicates the Base Facility Drug Fee Schedule pricing for each of the above methodologies.

<table>
<thead>
<tr>
<th>Pricing Methodology</th>
<th>Percentage of Base Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Sales Price (ASP)</td>
<td>X %</td>
</tr>
<tr>
<td>Wholesale Acquisition Cost (WAC)</td>
<td>X %</td>
</tr>
<tr>
<td>Average Wholesale Price (AWP)</td>
<td>X %</td>
</tr>
</tbody>
</table>

Eligible outpatient drugs will be reimbursed in addition to other outpatient services filed on the CMS-1450 (UB-04 or successor) claim form, including but not limited to Outpatient Surgery, Emergency Room, Observation and Cardiac Care.

In the event a valid outpatient drug C code is considered to be a covered procedure and there is not an acceptable CPT® code that could be used, BCBST will reimburse the C code by using ASP multiplied by an indicated contract percentage. The source for this reimbursement is derived from the Medicare Hospital Outpatient Prospective Payment System (OPPS) methodology.

Any new eligible outpatient drug codes that apply to this schedule and do not have a fee will be added to schedule with $0.00 allowable and “BR” indicator. These codes as well as Not Otherwise Classified (NOC) and Unlisted/Miscellaneous/Non-Specific HCPCS Codes will be reviewed for manual pricing according to BCBST’s policy for Unlisted, Miscellaneous, Non-specific, and Not Otherwise Classified Procedures/Services until a CMS fee has been established. In situations where fees may not be established for an eligible drug then invoice pricing may be utilized. These fees will be updated in accordance with BCBST’s Policy “Quarterly Reimbursement Changes”. Failure to submit the following information for these codes will result in delay of reimbursement.

**Not Otherwise Classified (NOC) and Unlisted/Miscellaneous/Non-Specific HCPCS Codes:**

- Must be billed with a unit of one (1); and
BlueCross BlueShield of Tennessee Provider Administration Manual

- Requires submission of drug name; National Drug Code (NDC) in field 43, "Revenue Description/ IDE/ Medicaid Drug Rebate", on the CMS-1450 claim form; and dosage administered

**Note:** Percentages and base allowables as set forth in the Base Facility Drug Fee Schedule are not eligible for an annual contract increase pursuant to the Outpatient language excluding services reimbursed at a percentage of Medicare or percent of Covered charges. Also, any items identified as over the counter or drugs not requiring a prescription, self-administered and oral medications and medications not reimbursed by Medicare have been excluded from this BCBST Facility Drug Fee Schedule.

g. **Ambulance Services**
Ambulance services shall be paid in accordance with the Institutional Ambulance Fee Schedule. The ambulance codes are based on those established by CMS codes. These codes are reimbursed based on Provider’s contract and updated April 1 of each year.

h. **Implants and Pacemaker and Orthotic/Prosthetic Devices**
Facilities that bill BCBST in excess of the contracted amount are subject to recovery. Likewise, hospitals that cannot support a charge for an Implant or Pacemaker with a manufacturer’s invoice, or other documentation, meeting BCBST satisfaction verifying the cost, *(that excludes shipping & handling and state sales tax)* and a medical record indicating that it was provided to a BCBST Member are subject to recovery.

Orthotic and Prosthetic (O & P) devices must be billed with an appropriate HCPCS code under RC 0274. The reimbursement for all these services is based on the Provider’s contract. When not specifically contracted, the allowable will be zero.

BCBST requires Providers to file the most appropriate HCPCS codes in accordance with the National Uniform Billing Guidelines on an Institutional claim form for Implant RCs 0274, 0275, and 0278.

13. **Other Acute Care Outpatient Services**

a. **Clinic Visits**
BCBST does not make payment for the clinic revenue codes. BCBST will allow other eligible services based on the contracted rate or total covered charges, whichever is less when filed in conjunction with clinic visits.

b. **Venipuncture**
Venipuncture services will be allowed according to the contract unless performed with an all-inclusive service.

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Type of Service</th>
<th>HCPCS/CPT® Code</th>
<th>Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>0300</td>
<td>Venipuncture</td>
<td>Requires a valid HCPCS/CPT® Code</td>
<td>Reimbursement is based upon the contract.</td>
</tr>
</tbody>
</table>

c. **Cardiac and Pulmonary Rehabilitation**
Prior Authorization requirements for cardiac and pulmonary rehabilitation services will be driven by the Member’s health care benefits plan.

To ensure appropriate payment is made for cardiac and pulmonary rehabilitation services, Providers are encouraged to verify available benefits and prior authorization requirements under the Member’s health care benefits play by calling the Provider Services line at
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1-800-924-7141 or via e-health Services® located on BlueAccess, our secure area on www.bcbst.com. For those health care benefits plans requiring prior authorization penalties will continue to apply for non-compliance.

d. Wound Care
BCBST may reimburse Wound Care services if they have been contracted. Wound Care services **will not** be reimbursed if they have not been contracted.

Wound Care services must be performed by a certified wound care nurse or other qualified health care professional. The services must be considered Medically Necessary as determined by BCBST’s clinical decision process.

At least one of the HCPCS codes listed in the contract must be billed in Form Locator 44 on the CMS-1450 claim form. HCPCS codes not listed should not be billed. All Wound Care services should be billed with Revenue Code 0519, Other Clinic, in Form Locator 42. Only Wound Care services should be billed under Revenue Code 0519. Any Non-Wound Care services billed with Revenue Code 0519 are subject to recovery by BCBST.

e. Sleep Study
Sleep studies must be performed in a certified place of service, as required by applicable state and federal regulations, and accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and/or American Osteopathic Association (AOA) and/or the American Academy of Sleep Medicine. The evaluating physician and staff are required to have specialized training that meets the standards set forth by the American Academy of Sleep Medicine. To help ensure the most appropriate Member benefit is applied, Providers are reminded to submit claims with the most appropriate Revenue Code, Procedure Code and HCPCS code in effect on the date of service. The appropriate Revenue Code can be determined by utilizing the Uniform Billing Editor by OPTUM Appendix 3, “Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments”, and/or the Revenue Codes indicated on the fee schedule in Provider’s Contract.

f. Other Diagnostic Services
The Other Diagnostic Services will be allowed according to the contract unless performed with an all-inclusive service.

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Type of Service</th>
<th>HCPCS/CPT® Code</th>
<th>Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>0920</td>
<td>Other Diagnostic Services</td>
<td>Requires a valid HCPCS/CPT® Code.</td>
<td>Reimbursement is based upon the contract.</td>
</tr>
<tr>
<td>0921</td>
<td>Peripheral Vascular Lab</td>
<td></td>
<td>Also See All Other Outpatient Services, if contracted</td>
</tr>
<tr>
<td>0922</td>
<td>Electromyelogram</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0923</td>
<td>Pap Smear</td>
<td>Requires a valid HCPCS/CPT® Code.</td>
<td>Reimbursement is based upon the contract.</td>
</tr>
<tr>
<td>0924</td>
<td>Allergy Test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0925</td>
<td>Pregnancy Test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0929</td>
<td>Other Diagnostic Services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
g. Other Therapeutic Services

Other Therapeutic Services will be allowed according to the contract unless performed with an all-inclusive service.

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Type of Service</th>
<th>HCPCS/CPT® Code</th>
<th>Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>0940</td>
<td>Other Therapeutic Services</td>
<td>Requires a valid HCPCS/CPT® Code.</td>
<td>Reimbursement is based upon the contract.</td>
</tr>
<tr>
<td>0941</td>
<td>Recreational Therapy</td>
<td>Requires a valid HCPCS/CPT® Code.</td>
<td>Reimbursement is based upon the contract.</td>
</tr>
<tr>
<td>0944</td>
<td>Drug Rehabilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0945</td>
<td>Alcohol Rehabilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0946</td>
<td>Complex medical equipment - routine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0947</td>
<td>Complex medical equipment - ancillary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0948</td>
<td>Pulmonary Rehabilitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0949</td>
<td>Other therapeutic services</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

h. Acute Care Dialysis

BCBST will allow an all-inclusive composite rate for qualified Acute Care Dialysis services as negotiated in the Provider's Contract. Except where specifically noted in the contract, the composite rate includes all services, drugs, and supplies associated with dialysis, dialysis training, or a combination of dialysis and training. The composite rate may only be billed to BCBST when an actual dialysis treatment has been performed within the acute care facility.

This standard applies to all BCBST commercial networks for Acute Care Facility agreements and reimbursement is based upon negotiated rates as established in Provider's Contract. This standard does not apply to inpatient services. In situations where Acute Care services have not been contracted, reimbursement will be set at zero.

To be considered for reimbursement, qualified dialysis services must be billed with Revenue Code (RC) 0829* and one of the following diagnosis codes for Acute Renal Failure: 584.5, 584.6, 584.7, 584.8 or 584.9. These diagnosis codes were established and will be updated per CMS as outlined in ICD Code Manual.

Effective 10/1/15, for ICD-10 for ICD-10 conversion, the diagnosis codes for Acute Renal Failure as follows: N17.0, N17.1, N17.2, N17.8, or N17.9.

*RC 0829 will be reimbursed in addition to primary outpatient services (e.g. Observation, Emergency Room, Outpatient Surgery, Case Rates, etc.).

In the instance that an overpayment has been made, BCBST reserves the right to re-coup the reimbursement as necessary.

i. Birthing Center Payment Reimbursement Policy

This policy applies to charges billed on an Institutional claim form for all BCBST lines of business to establish a consistent reimbursement methodology for payment when the delivery is at the Birthing Center and Member transfers to an Acute Care Facility.

In the instance that a Member delivers the baby at the Birthing Center then has to be transferred to an Acute Care Facility for follow-up care related to the delivery or for other medical conditions, BCBST will allow the delivery rate, not the transfer rate.

The Birthing Center will receive the transfer rate when the Member is in labor but is transferred to an Acute Care Facility for delivery.

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14. All Other Outpatient Services

All other Outpatient Services are defined as those services that cannot be appropriately categorized for reimbursement in other sections within the Outpatient Services in Schedule 2 of the applicable Schedule in the facility’s contract and that are approved for reimbursement by BCBST.

The following RCs will be considered according to the All Other Outpatient Services section of the contract unless performed with an all-inclusive service. **If any of the following RCs are on any other fee schedules, these guidelines do not apply.**

**Note:** This is not an all-inclusive list of “All Other Outpatient Service” RCs:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Type of Service</th>
<th>HCPCS/CPT® Code</th>
<th>Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>0250</td>
<td>Pharmacy</td>
<td></td>
<td>HCPSC/CPT® Code does not affect reimbursement. Facility is required to file a valid HCPSC/CPT® Code when appropriate.</td>
</tr>
<tr>
<td>0251</td>
<td>Generic Drugs</td>
<td></td>
<td>Reimbursement is based upon the contract.</td>
</tr>
<tr>
<td>0252</td>
<td>Non-Generic Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0257</td>
<td>Non-Prescription</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0258</td>
<td>IV Solutions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0263</td>
<td>IV Therapy/Drug Supply Delivery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0272</td>
<td>Sterile Supply</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0280</td>
<td>Oncology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0289</td>
<td>Other oncology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0331</td>
<td>Radiology/Therapeutic and/or chemotherapy administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0332</td>
<td>Radiology/Therapeutic/ chemotherapy - oral</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0335</td>
<td>Radiology/therapeutic chemotherapy - IV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0370</td>
<td>Anesthesia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0379</td>
<td>Other Anesthesia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0380</td>
<td>Blood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0381</td>
<td>Blood - packed red cells</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0382</td>
<td>Blood - whole blood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0383</td>
<td>Blood - plasma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0384</td>
<td>Blood - platelets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0385</td>
<td>Blood - leucocytes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0386</td>
<td>Blood - other components</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0387</td>
<td>Blood - other derivatives (Cryopricipitates)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0389</td>
<td>Blood - other blood</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0390</td>
<td>Blood storage &amp; processing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0391</td>
<td>Blood storage &amp; processing - blood administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0399</td>
<td>Blood storage &amp; processing - other blood storage &amp; processing</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0410</td>
<td>Respiratory services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0412</td>
<td>Respiratory services - inhalation services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0413</td>
<td>Respiratory services - Hyperbaric oxygen therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0419</td>
<td>Respiratory services - other respiratory services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0420</td>
<td>Physical therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0421</td>
<td>Physical therapy - visit charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0422</td>
<td>Physical therapy - hourly charge</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0423</td>
<td>Physical therapy - group rate</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0424</td>
<td>Physical therapy - evaluation or re-evaluation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0429</td>
<td>Physical therapy - other physical therapy</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0479</td>
<td>Audiology - other Audiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0482</td>
<td>Cardiology - stress test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0483</td>
<td>Cardiac Echocardiology</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
All Other Outpatient Services

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Type of Service</th>
<th>HCPCS/CPT® Code</th>
<th>Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>0489</td>
<td>Cardiology – other cardiology</td>
<td>HCPCS/CPT® Code does not affect</td>
<td>Reimbursement is based upon the contract.</td>
</tr>
<tr>
<td>0636</td>
<td>Drugs Requiring Detailed Coding</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0637</td>
<td>Drugs Requiring Specific Identification – Self-</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Administrable Drugs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0730</td>
<td>EKG/ECG (Electrocardiogram)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0731</td>
<td>EKG/ECG (Electrocardiogram) – Holter Monitor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0732</td>
<td>EKG/ECG (Electrocardiogram) - Telemetry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0739</td>
<td>EKG/ECG (Electrocardiogram) – Other EKG/ECG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0740</td>
<td>EEG (Electroencephalogram)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0749</td>
<td>EEG (Electroencephalogram) – Other EEG</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0770</td>
<td>Preventive Care Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0771</td>
<td>Vaccine Administration</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0779</td>
<td>Other Preventive Care Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0921</td>
<td>Peripheral Vascular lab</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0922</td>
<td>Electromylegram</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

15. Other Acute Care Exclusions

a. Outpatient Revenue Code Treatment

BCBST has three categories of revenue codes that are not paid under the outpatient agreement.Outlined below is a brief description of those codes:

- **Incidental to Acute Service**: Services that are considered part of the contracted rate and not paid in addition to the rate. For example, Ancillary Services, inpatient or outpatient (e.g., Revenue Code 0220 or 0235, for Special Charges and Incremental Nursing Services) would not be paid in addition to a case rate or fee schedule.

- **Invalid/Excluded Revenue Codes**: Revenue codes associated with services not covered under the acute care contract, and those, which are invalid via the revenue code description.

- **Revenue Codes that Require a More Detailed Revenue Code**: In some cases BCBST requires the detail revenue code in lieu of the general revenue code.

b. Non-Contracted Services

BCBST has contracted specific outpatient services for each facility network and line of business. In situations where services shown on these contracts have not been contracted, a rate must be negotiated prior to billing those services or reimbursement will be set at zero. In addition, services not included in the contract that would require a separate contract for payment of those services are listed in the following table:

For specific information regarding the services listed below or to discuss contracting those services not currently contracted, please call your Provider Relations Consultant.

Rev 12/15
16. Other Institutional Facility Types

a. Ambulatory Surgery Centers

Outpatient Surgery is reimbursed based on an All-Inclusive Rate. This All-Inclusive Rate will fully compensate Institution for all related facility services and supplies provided in association with a particular surgical procedure. Pre-admission testing which is provided by the facility or any facility wholly owned or operated by the facility at which the surgery is performed up to three (3) days prior to the surgery is included in the all-inclusive rate and must be filed on the same claim as the outpatient surgery.

Services paid at an All-Inclusive Rate are assigned to an Outpatient Surgery Group for payment by BCBST. Current Outpatient Surgery Group assignments are contained in Provider’s contract. For services payable under this Section without an assigned Outpatient Surgery Group, assignment may be made in a method consistent with that used in previous Outpatient Surgery Group assignments.

When multiple outpatient procedures are performed on the same day, the rate for the second and subsequent procedures shall be fifty percent (50%) of the All-Inclusive Rate assigned to the Outpatient Surgery Group for the procedure, subject to the lesser of total covered charges. When a procedure is repeated on the same day, no additional amount will be paid for the second procedure.

For more detailed billing and reimbursement guidelines regarding bilateral and multiple surgery procedures, refer to Outpatient Surgery under Acute Care Outpatient Services section of this manual.

b. Inpatient Rehabilitation

- Inpatient Rehabilitation claims must be billed following the CMS-1450 format.
- Inpatient services must be billed with a Type of Bill 11X in Form Locator 4.

```
<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0118</td>
<td>Private Room and Board</td>
</tr>
<tr>
<td>0128</td>
<td>Semi-Private Room and Board (2 Beds)</td>
</tr>
<tr>
<td>0138</td>
<td>Semi-Private Room and Board (3 or 4 Beds)</td>
</tr>
<tr>
<td>0148</td>
<td>Private Deluxe Room and Board</td>
</tr>
<tr>
<td>0158</td>
<td>Ward Room and Board</td>
</tr>
</tbody>
</table>
```

When incidental revenue codes are filed, they will be included with the room and board charges and the appropriate per diem rate will be applied.

The appropriate admitting, principal, and subsequent diagnosis codes are to be filed in accordance to the current International Classification of Diseases Clinical Modification (ICD CM) according to the patient’s date(s) of service. Form Locator 67 is reserved for the principal diagnosis code, whereas the subsequent diagnosis codes would be indicated in Form Locators 67 – A through Q. Form Locator 69 is to be used for the admitting diagnosis code.
Prior authorization is required for all inpatient admissions. When obtaining prior authorization for a patient on a ventilator, the Provider must specify authorization is for a vent patient in order to receive the vent per diem.

c. **Outpatient Rehabilitation – Not Applicable to Acute Care**

Units being billed should be appropriate for each code as described in the “Current Procedural Terminology” (CPT®) and/or in the HCPCS Level II codes for the current year codes.

Outpatient rehabilitation services should be billed with an appropriate Type of Bill in Form Locator 4 according to Type of Facility as indicated below:

<table>
<thead>
<tr>
<th>Type of Bill</th>
<th>Type of Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>13X</td>
<td>Freestanding Inpatient Rehabilitation Facilities Providing outpatient therapy services</td>
</tr>
<tr>
<td>23X</td>
<td>Skilled Nursing Facilities Providing outpatient therapy services</td>
</tr>
<tr>
<td>74X or 75X</td>
<td>Freestanding Outpatient Rehabilitation Facilities</td>
</tr>
</tbody>
</table>

The appropriate RC should be billed according to the following:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0270</td>
<td>General Supplies</td>
</tr>
<tr>
<td>0413</td>
<td>Hyperbaric Oxygen Therapy</td>
</tr>
<tr>
<td>042X</td>
<td>Physical Therapy</td>
</tr>
<tr>
<td>043X</td>
<td>Occupational Therapy</td>
</tr>
<tr>
<td>044X</td>
<td>Speech Therapy</td>
</tr>
<tr>
<td>047X</td>
<td>Audiology</td>
</tr>
<tr>
<td>051X</td>
<td>Clinic Visit</td>
</tr>
<tr>
<td>055X</td>
<td>Skilled Nursing Visit</td>
</tr>
<tr>
<td>0623</td>
<td>Surgical Dressings</td>
</tr>
</tbody>
</table>

- Only those CPT® and HCPCS codes that are appropriate to bill under the Revenue Codes listed in the previous table will be paid. Codes that are not appropriate to the Revenue Codes billed will be subject to recovery by audit.

- Revenue Code 0413, Hyperbaric Oxygen Therapy, can only be billed when Medically Necessary. Unit being billed under Revenue Code 0413 should be appropriate for each code as described in the *Current Procedural Terminology* (CPT®) and/or the HCPCS Level II Codes for the year of the codes.

- Evaluation and Management (E&M) codes are not reimbursed in addition to Rehabilitation Therapies.

- The following guidelines apply when billing G0128:
  - G0128 cannot be billed with any other codes other than supplies and 99211.
  - G0128 can be billed when a registered nurse provides direct (face to face with the patient) skilled nursing services in a comprehensive outpatient rehabilitation facility, each 10 minutes beyond the first 5 minutes. The first 5 minutes can be billed with CPT® code 99211.
  - G0128 and 99211 can be billed to BCBST only in conjunction with wound care services and must be provided by a certified wound care nurse. Practitioner cannot bill for these codes. All other evaluation and management (E&M) codes for Practitioner are not reimbursed unless wound care services are contracted.
  - G0128 cannot be billed when debridement services are performed.
Visit/Unit/Service – Bill in increments of one (1) each time Visit/Unit/Service is performed.

Modalities are limited to:

- A limit of three charged modalities to one specific body area per treatment session should be used as a billing practice.
- Any billing beyond three modalities per body part per treatment session will be subject to review of documentation by BCBST auditors for appropriate billing practice.
- When billing multiple modalities, redundancies of the same CPT® code will also be subject to audit for appropriate billing practice.

d. Skilled Nursing Facility

Skilled Nursing Facility (SNF) claims must be billed on an Institutional claim form. Inpatient services billed on an Institutional claim form must be billed with a Type of Bill 21X or 22X in Form Locator 4. The related levels of care outlined in the Skilled Nursing Fee Schedule must be billed according to the table listed below. Reimbursement for SNF services will be based on the lesser of total covered charges or the listed per diem.

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0191</td>
<td>Level I ~ Skilled Care</td>
</tr>
<tr>
<td>0192</td>
<td>Level II ~ Comprehensive Care</td>
</tr>
<tr>
<td>0193</td>
<td>Level III ~ Complex Care</td>
</tr>
</tbody>
</table>

- Outpatient services must be billed with a Type of Bill of 23x in Form Locator 4.
- The revenue codes for eligible ancillaries will be combined with the appropriate per diem code. The revenue codes for non-Covered Services will be denied as Member liability.
- A participating DME Provider must submit charges/claims for customized wheelchairs.
- All other DME/supplies are to be submitted by the Skilled Nursing Facility.
- The per diems are all inclusive (excluding customized wheelchairs).

e. Home Health and Private Duty Nursing

In order to comply with NUBC guidelines, Providers should use TOB 032X for claims filed for home health services. All Home Health and Private Duty Nursing services should be billed on the Institutional claim form. When submitting electronic claims, the Institutional format must be used.

Home Health visits and Private Duty Nursing services should be billed using the following RCs and billing units:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Description</th>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Billing Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Agency Visits</td>
<td>Home Health Agency Physical Therapy</td>
<td>0421</td>
<td>Not required</td>
<td>1 unit per visit</td>
</tr>
<tr>
<td></td>
<td>Home Health Agency Occupational Therapy</td>
<td>0431</td>
<td>Not required</td>
<td>1 unit per visit</td>
</tr>
<tr>
<td></td>
<td>Home Health Agency Speech Therapy</td>
<td>0441</td>
<td>Not required</td>
<td>1 unit per visit</td>
</tr>
<tr>
<td></td>
<td>Home Health Agency Skilled Nursing (RN or LPN)</td>
<td>0551</td>
<td>Not required</td>
<td>1 unit per visit</td>
</tr>
<tr>
<td></td>
<td>Home Health Agency Medical Social Services</td>
<td>0561</td>
<td>Not required</td>
<td>1 unit per visit</td>
</tr>
<tr>
<td></td>
<td>Home Health Agency Home Health Aide</td>
<td>0571</td>
<td>Not required</td>
<td>1 unit per visit</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>Private Duty Nursing (RN or LPN)</td>
<td>0552</td>
<td>Not required</td>
<td>1 unit per hour</td>
</tr>
<tr>
<td></td>
<td>Private Duty Nursing (Home Health Aide)</td>
<td>0572</td>
<td>Not required</td>
<td>1 unit per hour</td>
</tr>
</tbody>
</table>

One unit per hour should be billed for Private Duty Nursing Services. Fractional hours should be rounded to the nearest whole hour (e.g., 1 hour 15 minutes should be rounded
to 1 unit, 1 hour 29 minutes should be rounded to 1 unit, 1 hour 30 minutes should be rounded to 2 units, 1 hour 31 minutes should be rounded to 2 units, 1 hour 45 minutes should be rounded to 2 units).

Home Health visits and Private Duty Nursing services not billed with the indicated RCs will be rejected or denied. A procedure code may be billed to further identify the service provided, but is not required.

To facilitate claims administration, a separate line item must be billed for each date of service and for each service previously indicated.

Supplies on the BCBST Home Health Agency Non-Routine Supply List should be billed using the indicated RCs and HCPCS codes. Units should be billed based on the HCPCS code definition in effect for the date of service. HCPCS code definitions can be found in the Healthcare Common Procedure Coding System (HCPCS) Manual.

Supplies not billed with the indicated RCs and HCPCS codes will be rejected or denied.

Reimbursement for supplies not indicated on the BCBST Home Health Agency Non-Routine Supply List used in conjunction with the above services are included in the maximum allowable for the Home Health or Private Duty Nursing service and will not be reimbursed separately.

Billing of supplies including those provided by third party vendors such as medical supply companies that are used in conjunction with a Home Health visit or Private Duty Nursing service are the responsibility of the Home Health Agency.

Supplies not used in conjunction with a Home Health visit or Private Duty Nursing services are not billable by the Home Health Agency or Private Duty Nursing Provider.

The only supplies that may be billed in addition to the above services are those indicated on the following BCBST Home Health Agency Non-Routine Supply List.

**The following codes should be used when billing Home Health Agency Non-Routine Supplies with Revenue Code 0270:**

<table>
<thead>
<tr>
<th>A4212</th>
<th>A4331</th>
<th>A4357</th>
<th>A4390</th>
<th>A4407</th>
<th>A4422</th>
<th>A4455</th>
<th>A5056</th>
<th>A5112</th>
<th>A7504</th>
<th>S8185</th>
<th>T4533</th>
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</thead>
<tbody>
<tr>
<td>A4248</td>
<td>A4333</td>
<td>A4358</td>
<td>A4391</td>
<td>A4408</td>
<td>A4423</td>
<td>A4456</td>
<td>A5057</td>
<td>A5113</td>
<td>A7505</td>
<td>S8210</td>
<td>T4534</td>
</tr>
<tr>
<td>A4310</td>
<td>A4334</td>
<td>A4360</td>
<td>A4392</td>
<td>A4409</td>
<td>A4424</td>
<td>A4459</td>
<td>A5061</td>
<td>A5114</td>
<td>A7506</td>
<td>T4521</td>
<td>T4535</td>
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<td>A4311</td>
<td>A4338</td>
<td>A4361</td>
<td>A4378</td>
<td>A4410</td>
<td>A4425</td>
<td>A4461</td>
<td>A5062</td>
<td>A5121</td>
<td>A7507</td>
<td>T4522</td>
<td>T4537</td>
</tr>
<tr>
<td>A4312</td>
<td>A4340</td>
<td>A4362</td>
<td>A4379</td>
<td>A4394</td>
<td>A4411</td>
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<td>A4463</td>
<td>A5063</td>
<td>A5122</td>
<td>A7508</td>
<td>T4523</td>
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<td>A4313</td>
<td>A4344</td>
<td>A4363</td>
<td>A4380</td>
<td>A4395</td>
<td>A4412</td>
<td>A4427</td>
<td>A4481</td>
<td>A5071</td>
<td>A5126</td>
<td>A7509</td>
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<td>A4314</td>
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<td>A4364</td>
<td>A4381</td>
<td>A4396</td>
<td>A4413</td>
<td>A4428</td>
<td>A4623</td>
<td>A5072</td>
<td>A5131</td>
<td>A7520</td>
<td>T4525</td>
</tr>
<tr>
<td>A4315</td>
<td>A4349</td>
<td>A4366</td>
<td>A4382</td>
<td>A4397</td>
<td>A4414</td>
<td>A4429</td>
<td>A4625</td>
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<td>A6413</td>
<td>A7521</td>
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<td>A4316</td>
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<td>A4398</td>
<td>A4415</td>
<td>A4430</td>
<td>A4626</td>
<td>A5081</td>
<td>A6531</td>
<td>A7522</td>
<td>T4527</td>
</tr>
<tr>
<td>A4320</td>
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<td>A4368</td>
<td>A4384</td>
<td>A4399</td>
<td>A4416</td>
<td>A4431</td>
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<td>A5082</td>
<td>A6532</td>
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<td>A4353</td>
<td>A4369</td>
<td>A4385</td>
<td>A4400</td>
<td>A4417</td>
<td>A4432</td>
<td>A5052</td>
<td>A5083</td>
<td>A7047</td>
<td>A7045</td>
<td>T4529</td>
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<td>A4326</td>
<td>A4354</td>
<td>A4371</td>
<td>A4387</td>
<td>A4404</td>
<td>A4418</td>
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<td>A7524</td>
<td>T4530</td>
</tr>
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<td>A4328</td>
<td>A4355</td>
<td>A4372</td>
<td>A4388</td>
<td>A4405</td>
<td>A4419</td>
<td>A4434</td>
<td>A5054</td>
<td>A5102</td>
<td>A7502</td>
<td>A7526</td>
<td>T4531</td>
</tr>
<tr>
<td>A4330</td>
<td>A4356</td>
<td>A4373</td>
<td>A4389</td>
<td>A4406</td>
<td>A4420</td>
<td>A4435</td>
<td>A5055</td>
<td>A5105</td>
<td>A7503</td>
<td>A7527</td>
<td>T4532</td>
</tr>
</tbody>
</table>
The following codes should be used when billing Home Health Agency Non-Routine supplies with Revenue Code 0623:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>A6010</td>
<td>A6205</td>
<td>A6221</td>
<td>A6237</td>
<td>A6252</td>
</tr>
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<td>A6011</td>
<td>A6206</td>
<td>A6222</td>
<td>A6238</td>
<td>A6253</td>
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<td>A6022</td>
<td>A6208</td>
<td>A6224</td>
<td>A6240</td>
<td>A6255</td>
</tr>
<tr>
<td>A6023</td>
<td>A6209</td>
<td>A6228</td>
<td>A6241</td>
<td>A6256</td>
</tr>
<tr>
<td>A6024</td>
<td>A6210</td>
<td>A6229</td>
<td>A6242</td>
<td>A6258</td>
</tr>
<tr>
<td>A6154</td>
<td>A6211</td>
<td>A6230</td>
<td>A6243</td>
<td>A6259</td>
</tr>
<tr>
<td>A6196</td>
<td>A6212</td>
<td>A6231</td>
<td>A6244</td>
<td>A6261</td>
</tr>
<tr>
<td>A6197</td>
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<td>A6232</td>
<td>A6245</td>
<td>A6262</td>
</tr>
<tr>
<td>A6198</td>
<td>A6214</td>
<td>A6233</td>
<td>A6246</td>
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</tr>
<tr>
<td>A6199</td>
<td>A6215</td>
<td>A6234</td>
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<td>A6402</td>
</tr>
<tr>
<td>A6203</td>
<td>A6219</td>
<td>A6235</td>
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<td>A6403</td>
</tr>
<tr>
<td>A6204</td>
<td>A6220</td>
<td>A6236</td>
<td>A6251</td>
<td>A6404</td>
</tr>
</tbody>
</table>

f. **Home Obstetrical Management**

All Home Obstetrical Management services should be billed on the Institutional claim form using Type of Bill 33X. When submitting electronic claims, the Institutional format must be used.

Home Obstetrical Management services must be billed using the following RCs, procedure codes, and billing units:

<table>
<thead>
<tr>
<th>Description</th>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Billing Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home management of preterm labor</td>
<td>0559</td>
<td>S9208</td>
<td>1 unit per day</td>
</tr>
<tr>
<td>Home management of gestational hypertension</td>
<td>0559</td>
<td>S9211</td>
<td>1 unit per day</td>
</tr>
<tr>
<td>Home management of preeclampsia</td>
<td>0559</td>
<td>S9213</td>
<td>1 unit per day</td>
</tr>
<tr>
<td>Home management of gestational diabetes</td>
<td>0559</td>
<td>S9214</td>
<td>1 unit per day</td>
</tr>
</tbody>
</table>

Home Obstetrical Management services not billed with the indicated RCs and procedure codes will be rejected or denied. To facilitate claims administration, a separate line item must be billed for each date of service for the above services.

The maximum allowable for Home Obstetrical Management services per diems constitutes full reimbursement for all administrative services, professional pharmacy services, care coordination, and all necessary supplies or equipment.

The per diem does not include home health agency skilled nursing (RN or LPN) visits. Home health agency skilled nursing (RN or LPN) visits should be billed in accordance with the BCBST Home Health Billing Guidelines.

g. **Dialysis Freestanding Facility**

The following Dialysis Billing and Reimbursement Guidelines were effective on 12/1/2013 for all participating Dialysis Providers based on the contract date.

- **Treatment Rate** – The base composite rate is adjusted by the treatment multiplier to arrive at the Treatment Rate BCBST will allow for ESRD-related services. The adjusted Treatment Rate is considered to be an all-inclusive charge for services, teaching, supplies, lab and drugs. BCBST allows the lesser of total covered charges or the treatment rates negotiated in the contract.

The Treatment Rate should only be billed to BCBST when an actual dialysis treatment has been performed. Reimbursement for these services is an all-inclusive rate.
BCBST will not reimburse for services billed in addition to the Treatment Rate as indicated in the following chart. Any “other” services billed without a treatment RC as “stand alone” will deny as “Not paid in addition to primary service”. The relevant CPT® or HCPCS code is required in FL 44 in conjunction with appropriate RC in FL 42 for proper reimbursement. Claims submitted without required coding will be returned to the Provider or denied per billing guidelines as “Non-contracted Service”. Codes not specifically listed in the contract are not allowed and may not be billed to a BCBST Member.

Form locators related to the composite rate should be completed on the Institutional claim form as described in the following table. Use the Institutional format when submitting electronic claims.

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Revenue Code FL 42</th>
<th>CPT® Code/Required FL 44</th>
<th>Unit/Frequency FL 46</th>
<th>Treatment Rate FL 47</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemodialysis, in-center - Composite or Other Rate</td>
<td>0821</td>
<td>90999</td>
<td>Per Visit</td>
<td>Treatment Rate</td>
</tr>
<tr>
<td>Hemodialysis, home - Composite or Other Rate</td>
<td>0821</td>
<td>90989</td>
<td>Per Visit</td>
<td>Treatment Rate</td>
</tr>
<tr>
<td>IPD, in-center - Composite or Other Rate</td>
<td>0831</td>
<td>90999</td>
<td>Per Visit (Daily)</td>
<td>Treatment Rate</td>
</tr>
<tr>
<td>CAPD, treatment per day - Composite or Other Rate</td>
<td>0841</td>
<td>90945</td>
<td>Per Visit (Daily)</td>
<td>Treatment Rate</td>
</tr>
<tr>
<td>CAPD, training - Composite or Other Rate</td>
<td>0841</td>
<td>90993</td>
<td>Per Visit (Daily)</td>
<td>Treatment Rate</td>
</tr>
<tr>
<td>CCPD, treatment per day - Composite or Other Rate</td>
<td>0851</td>
<td>90945</td>
<td>Per Visit (Daily)</td>
<td>Treatment Rate</td>
</tr>
<tr>
<td>CCPD, training - Composite or Other Rate</td>
<td>0851</td>
<td>90993</td>
<td>Per Visit (Daily)</td>
<td>Treatment Rate</td>
</tr>
<tr>
<td>Ultrafiltration, in center</td>
<td>0881</td>
<td>90999</td>
<td>Per Visit (Daily)</td>
<td>Treatment Rate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition Code Descriptions</th>
<th>Condition Code</th>
<th>Informational Only/ Does not affect reimbursement FL(s) 18 - 28</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home – Self-Administered Anemia Management Drug</td>
<td>70</td>
<td>Required</td>
</tr>
<tr>
<td>Full care in unit</td>
<td>71</td>
<td>Required</td>
</tr>
<tr>
<td>Self care in unit</td>
<td>72</td>
<td>Required</td>
</tr>
<tr>
<td>Self care training</td>
<td>73</td>
<td>Required</td>
</tr>
<tr>
<td>Home</td>
<td>74</td>
<td>Required</td>
</tr>
<tr>
<td>Home – 100% reimbursement</td>
<td>75</td>
<td>Required</td>
</tr>
<tr>
<td>Back-up in facility Dialysis</td>
<td>76</td>
<td>Required</td>
</tr>
</tbody>
</table>

- **No Shows** – If a facility sets up in preparation for a dialysis treatment, but the treatment is never started (the patient never arrives), no payment is made.

- **Non-Reimbursable Revenue Codes (RCs)** – Unless specifically indicated in the contract, BCBST will not reimburse for services billed in addition to the composite rate. In order to administer the contract, BCBST does not utilize the general RCs. Detail RCs and CPT® or HCPCS codes are required.

Rev 12/15
h. Hospice (These guidelines do not apply to Medicare Advantage)
   Hospice services must be billed in accordance with BCBST Billing Guidelines:
   - Hospice claims must be billed on an Institutional claim form.
   - To facilitate claims administration, a separate line item must be billed for each date of service.
   - Hospice Providers may bill with either Type of Bill (TOB) 081X or 082X in Form Locator 4 as long as the inpatient and outpatient services are on separate claims.
   - TOB should determine Place of Service (POS). Only when a patient expires in a Hospice facility will the inpatient per diem be reimbursed. If a patient expires at home, the POS should be Home, NOT the Hospice facility.
   - The Statement From/Thru Dates must also correspond with the total days billed on the inpatient care.
   - Hospice discharge date is eligible for payment and will not be considered as an exclusion.
   - Discharge status should reflect where the patient expired.
   - Hospice claims should be billed with the Hospice Provider number and/or NPI referenced in the Network Attachment.
   - Reimbursable allowable rate per unit will be rounded up to the second decimal amount (e.g., $8.7110 would reimburse as $8.72).

In all cases reimbursement for Hospice services is based on:
   - Per diems allowed on a per day, not per visit;
   - The lesser of total covered charges or maximum allowable Hospice Fee Schedule;

**Note:** Charges submitted for non-Covered Services are not eligible for meeting the per diem amount.

The related levels of care outlined in the Hospice Fee Schedule should be billed according to the following table:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Description/Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>0651</td>
<td>Routine Home Care (RHC) – less than 8 hours of care  (1 day = 1 unit)</td>
</tr>
<tr>
<td>0652</td>
<td>Continuous Home Care Full Rate - 24 hours of care based on an hourly rate. A separate line item must be billed for each date of service using the appropriate number of units in the unit field.(Billed in 15 minute increments)</td>
</tr>
<tr>
<td>0653</td>
<td>Invalid</td>
</tr>
<tr>
<td>0654</td>
<td>Invalid</td>
</tr>
<tr>
<td>0655</td>
<td>Inpatient Respite Care – Family member or other caregiver requiring a short relief period (limited to 5 consecutive days)</td>
</tr>
<tr>
<td>0656</td>
<td>General Inpatient Care – Inpatient stays, which meet general inpatient care criteria.</td>
</tr>
</tbody>
</table>

**Note:** For Continuous Home Care (CHC), one unit will equal 15 minutes. Continuous Home Care will not be reimbursed when less than 8 hours (32 units) and will be capped at 24 hours (96 units) per calendar day. Continuous home care hours are defined as being between 8 and 24 cumulative hours within a 24-hour period, as defined by Medicare.
Providers are contractually obligated to provide service at the agreed upon rates regardless of patient acuity.

Allowed amounts are all-inclusive with the exception of Practitioner services not related to Hospice care. This includes but is not limited to Hospice Practitioner services, drugs, DME, medical supplies, etc. Practitioner services are excluded from the Hospice allowed amounts when not related to Hospice care and should be billed to BCBST on a Professional claim form.

When a Member is receiving care for Hospice services and is admitted as “Inpatient” for Hospice related care, the assigned Hospice Provider is to bill BCBST for the services and will receive the contracted rates for Covered Services. BCBST should not receive any claims from the “Admitting Facility”. It is the responsibility of the Hospice Provider to reimburse the “Admitting Facility”. BCBST reserves the right to audit. (See Section XXIII. Provider Audit Guidelines in this Manual.)

Prior authorization is required for these services for commercial fully insured products. Benefits should be verified prior to providing services for other commercial business.

Effective January 1, 2016, BCBST implemented the CMS rule that changes payment methodology for RHC (RC 0651). These changes are:

- **Day 1-60:** Allow higher rate based on admission date.
- **Day 61- thereafter:** Allow lower rate based on admission date.
- **Service Intensity Add-on (SIA Payment):** SIA payment is equal to RC 0652 hourly rate for services billed by either RC 0561-Social Worker Services or RC 0551-Registered Nurse visits for a maximum of combined 4 hours per day with a minimum of one (1) unit to a maximum of sixteen (16) units billed. These services are only eligible when billed in conjunction with RHC services. To receive the SIA add-on payment, claims must include the appropriate discharge status code.

**Note:** BCBST utilizes the Medicare Hospice rates for Continuous Home Care, Inpatient Respite Care and General Inpatient Care that reflect compliance with the quality reporting requirements.

### E. Institutional Claim Billing and Reimbursement Guidelines – Section 2

The following guidelines/policies apply to Ambulatory Surgical Facilities that have contracted for the new surgical groupers 1-10 and UL (Unlisted) and Acute Care Facilities that have contracted for the new surgical groupers 1-10 and UL with the BCBST Facility Base Fee Schedule version 6 or later. The guidelines/policies indicated below will apply. Otherwise, refer to applicable category in D. Institutional - Section 1.

#### 1. Lesser Of Calculation

Acute Care facilities will adjudicate contracts with lesser of calculation language. This language compares the lesser of total covered charges minus non-covered services against the contracted rates outlined in Schedules 1 and 2 of the Institution Contract. If the total covered charges filed on the claim are less than the amounts outlined in the contract, BCBST will allow the lesser of the total covered charges as submitted by the facility. Claims adjudicated using Lesser of Calculation are dependent upon the date of service and the contract in effect at the time of service.
**Items excluded from Lesser of Calculation**

When calculating the lesser of total covered charges for inpatient or outpatient services, there are three categories of services that are excluded. Examples of these exclusions are listed below:

- Services reimbursed based on a percentage of total covered charges, or discount off of charges.
- Services that are considered incidental, or part of the primary service.
- Services that are identified as non-covered under the Institution Contract, or the Member’s health care plan.

**Note:** In accordance with Medicare anti-fraud statutes at 42 USC 1320 et seq, when Medicare is primary, Providers may not accept secondary payments above the Medicare allowed amounts. This rule overrides any lesser of contractual agreements allowing amounts greater than charges.

2. **Acute Care Outpatient Surgery**

BCBST has established new all-inclusive surgery groupers between 0 through 10 and UL. Providers must refer to their contract for applicable services. A published list of new surgery HCPCs codes and Revenue codes (RC) is provided when contracted. All services must be billed based on where services are rendered.

BCBST may revise the information in the outpatient surgery grouper listing based on newly published and/or deleted codes and updated outpatient surgery information developed by CMS, which may be modified by BCBST to include procedures that are not maintained by CMS but are considered for reimbursement. Updates to the Outpatient Surgery Groupers will occur annually on April 1.

3. **Acute Care Fee Schedules**

There will be no revisions for the existing HCPCS/CPT® codes allowable reimbursement for the Acute Care Fee Schedules indicated below as they will remain static to January 1, 2014, CMS rates until contract renewal. Refer to D. Institutional - Section I for any new or deleted code updates. A published list of HCPCs Codes and Revenue Codes is provided when contracted.

- BCBST Facility Fee Schedule Version 6 or later
  - Laboratory
  - MRI/MRA/CT Scan
  - Radiology

4. **Reimbursement Policy and Billing Guidelines for the Separately Reimbursed Facility Drug Fee Schedule**

This policy is to establish the codes that are added to the Separately Reimbursed Facility Drug Fee Schedule. BCBST will utilize Appendix 3, “Numeric List of HCPCS Codes with Recommended Revenue Code (RC) Assignments,” of the OPTUM Uniform Billing (UB) Editor or its successor.

BCBST will identify the eligible outpatient drug HCPCS codes that are appropriate to be billed under RC(s) 0343, Radiopharmaceuticals Diagnostic; 0344, Radiopharmaceuticals Therapeutic; and 0636, Drugs Requiring Detail Coding, as indicated in the OPTUM Uniform Billing (UB) Editor or its successor and add these codes to the fee schedule.
Drug codes submitted for consideration, but not listed in the Separately Reimbursed Facility Drug Schedule are not eligible for separate reimbursement. Any of the above indicated RC(s) filed without a HCPCS/ CPT® code will be denied as procedure code required for RC. Drug codes submitted that are on this schedule with a $0.00 fee and no indicator in note to review for manual pricing are not eligible for separate reimbursement.

In the circumstance that an inappropriate payment has occurred, BCBST reserves the right to re-coup the reimbursement as necessary.

BCBST shall reimburse acute care hospitals contracted for the Separately Reimbursed Facility Drug Fee Schedule for eligible outpatient drug codes based on a percentage of the Average Sales Price (ASP), or in the absence of a published ASP, Wholesale Acquisition Cost (WAC) or Average Wholesale Price (AWP). The table below indicates the Base Facility Drug Fee Schedule pricing for each of the above methodologies.

<table>
<thead>
<tr>
<th>Pricing Methodology</th>
<th>Percentage of Base Allowed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Sales Price (ASP)</td>
<td>108%</td>
</tr>
<tr>
<td>Wholesale Acquisition Cost (WAC)</td>
<td>100%</td>
</tr>
<tr>
<td>Average Wholesale Price (AWP)</td>
<td>84%</td>
</tr>
</tbody>
</table>

If facility is contracted with this schedule, eligible outpatient drugs on the schedule will be reimbursed in addition to all other services filed on the CMS-1450 (UB-04 or successor) claim form. In the event a valid outpatient drug C code is considered to be a covered procedure and there is not an acceptable HCPCS/ CPT® code that could be used, BCBST will reimburse the C code by using ASP multiplied by an indicated contract percentage, where applicable. The source for this reimbursement is derived from the Medicare Hospital Outpatient Prospective Payment System (OPPS) methodology.

Any new eligible outpatient drug codes that apply to this schedule and do not have a fee will be added to schedule with a $0.00 allowable and “BR” indicator. These codes as well as Not Otherwise Classified (NOC) and Unlisted/Miscellaneous/Non-Specific HCPCS Codes will be reviewed for manual pricing according to BCBST’s policy for Unlisted, Miscellaneous, Non-specific, and Not Otherwise Classified Procedures/Services until a CMS fee has been established. In situations where fees may not be established for an eligible drug then invoice pricing may be utilized. These fees will be updated in accordance with BCBST’s Policy “Quarterly Reimbursement Changes.” Failure to submit the following information for these codes will result in delay of reimbursement.

**Not Otherwise Classified (NOC) and Unlisted/Miscellaneous/Non-Specific HCPCS Codes:**

- Must be billed with a unit of one (1); and
- Requires submission of drug name; National Drug Code (NDC) in field 43, “Revenue Description/ IDE/ Medicaid Drug Rebate”, on the CMS-1450 Claim form; and dosage administered.

**Note:** Percentages and base allowables as set forth in the Separately Reimbursed Facility Drug Fee Schedule are not eligible for an annual contract increase pursuant to the Outpatient language excluding services reimbursed at a percentage of Medicare or percent of covered charges. Also, any items identified as over the counter or drugs not requiring a prescription, self-administered or oral medications, and medications not reimbursed by Medicare have been excluded from this Facility Drug Fee Schedule.
5. All Other Outpatient Services:

BCBST has established a new All Other class for services that are not categorized for reimbursement within other sections of the Acute Care Outpatient Schedule 2 facility contract.

The following RCs will be considered according to the new All Other Outpatient Services section of the contract unless performed with an all-inclusive service. If any of the following RCs are on any other fee schedules, these guidelines do not apply.

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Type of Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>0240</td>
<td>All -Inclusive Ancillary-General</td>
</tr>
<tr>
<td>0241</td>
<td>All -Inclusive Ancillary-Basic</td>
</tr>
<tr>
<td>0242</td>
<td>All -Inclusive Ancillary-Comprehensive</td>
</tr>
<tr>
<td>0243</td>
<td>All -Inclusive Ancillary-Specialty</td>
</tr>
<tr>
<td>0249</td>
<td>All -Inclusive Ancillary-Other</td>
</tr>
<tr>
<td>0623</td>
<td>Surgical dressings</td>
</tr>
<tr>
<td>0770</td>
<td>Preventive care services</td>
</tr>
</tbody>
</table>
VII. PRIMARY CARE PRACTITIONER (PCP)  
POINT-OF-SERVICE (POS) BENEFIT PLANS

Information in this section has been removed. Effective January 1, 2004, BlueCross BlueShield of Tennessee no longer requires Blue Network S Point-of-Service (POS) members to:

- choose a Primary Care Practitioner; or
- obtain a referral when seeking in-network or out-of-network specialist care.

However, to receive maximum benefits, POS members should continue to seek health care services from Providers that participate in Blue Network S. When Members utilize Providers outside their network, benefits are substantially reduced.
VIII. UTILIZATION MANAGEMENT PROGRAM

A. Program Overview

BlueCross BlueShield of Tennessee’s Utilization Management Program (UM) is committed to providing quality and cost effective health care services to its Members. The UM program is designed to manage, evaluate and improve the quality, appropriateness and accessibility of health care services while achieving Member and Provider satisfaction.

The UM Program monitors compliance with URAC and the National Committee for Quality Assurance (NCQA) standards in order to maintain accreditation. BlueCross BlueShield of Tennessee’s UM decision-making is based only on appropriateness of care and service and existence of coverage. The Organization does not specifically reward Practitioners or other individuals for issuing denials of coverage or care and financial incentives for UM decision-makers do not encourage decisions that result in underutilization.

The program is directed, guided and monitored by the Corporate Medical Director who actively seeks input from network-participating Practitioners and other regulatory agencies. The Corporate Medical Director is ultimately responsible for facilitating medical management in the following UM areas:

- Prior Authorization Review
- Provider Appeals
- Medical Quality Management
- Specialty Services
- Concurrent Review
- Medical Policy
- Retrospective Review
- Delegate Oversight
- Disease Management
- Technology Assessment
- Transition of Care/Discharge Planning

Evaluation of the UM Program

- The UM Program is formally evaluated on an annual basis and revised as needed. Designated staff evaluate the consistency with which health care professionals involved in the UM process apply criteria in decision making through Physician and non-Physician inter-rater Reliability (IRR). The program is reviewed to add or modify activities necessitating the quality improvement of effective and efficient service to BlueCross BlueShield of Tennessee Members.
- Marketing, Customer Services and UM departments provide Member satisfaction data which are reviewed to add or modify activities necessitating the quality improvement of effective and efficient service to BlueCross BlueShield of Tennessee Members.
- UM nurses coordinate referrals to the Clinical Risk Management Department and the Medical Director. Trend reports are utilized to determine areas of need for corrective action, as well as areas that show improvement.

B. Medical Review

Medical reviews are prospective concurrent, or retrospective of selected interventions and are performed where evidence suggests safe, effective alternatives exist or because of mandates from oversight agencies. Prior authorization review results in efficient use of covered health care services and helps to ensure Members receive the appropriate level of care in the appropriate setting.

Note: BlueCross BlueShield of Tennessee administers both insured and self-funded arrangements. Because of differences in relationships, some prior authorization requirements may differ. Benefits are always subject to verification of eligibility and coverage at the time services are rendered. If the Member is still within his/her pre-existing condition waiting period, benefits will not be available if the condition is determined to be pre-existing on Short Term Care policies.

If the Provider chooses to render services that have not received prior authorization, or that do not meet Medical Necessity criteria according to BlueCross BlueShield of Tennessee’s Clinical Decision Process, the Member is not financially liable for the charges.
However, if the Provider obtains an Acknowledgement of Financial Responsibility for the Cost of Services for the specific procedure, and any related services prior to the services being rendered, the Member may be held liable. When obtaining services out of network or outside the state of Tennessee from a non-BlueCard PPO Provider, the Member may be responsible for all or a substantial share of the charges.

Review is required for all hospital admissions (excluding deliveries), observation admissions (see Observation Stay), select procedures and skilled nursing facility/restorative care unit admissions. Based on the line of business, home health services, e.g., skilled nursing visits, private duty nursing, home infusion therapy, certain outpatient or office procedures or tests, and hospice may require prior authorization. Some health care benefit plans also require review for speech therapy, occupational therapy, physical therapy, pulmonary rehabilitation (if applicable), durable medical equipment, (if applicable), and cardiac rehabilitation (if applicable).

To promote consistent utilization management across all product lines, BlueCross uses the following clinical decision process, 1) Member’s Benefit Plan, 2) BlueCross BlueShield of Tennessee Medical Policy, 3) Utilization Management Guidelines and MCG Care Guidelines to make utilization management decisions. MCG Care Guidelines are nationally recognized guidelines that are updated annually by a panel of consultants including, but not limited to Practitioners and registered nurses. A MCG Care Guideline used in a specific medical decision can be obtained by submitting a written request to the UM Department. BlueCross BlueShield of Tennessee will supply, at no charge, up to three MCG Care Guidelines as they pertain to a specific medical decision.

BCBST Utilization Management Guidelines

BlueCross BlueShield of Tennessee uses MCG Care Guidelines to assist in its clinical decision-making processes. There are times when BlueCross BlueShield of Tennessee must modify, supplement, or customize certain MCG criteria to meet practice patterns in Tennessee (i.e., a guideline does not exist, the length of stay needs to be customized, or the decision criteria needs to be modified). MCG criteria that have been modified and/or customized by BlueCross BlueShield of Tennessee are published on the company website, www.bcbst.com. This allows Providers the opportunity to review and be aware of any changes or variances made to MCG criteria by BlueCross BlueShield of Tennessee. Providers are notified through BlueAlert, BlueCross BlueShield of Tennessee’s monthly Provider newsletter, 30 days in advance of subsequent changes to these guidelines. Providers may appeal BlueCross BlueShield of Tennessee Utilization Management Guidelines (UMGs) by following the Utilization Management Guideline Appeals Process available in the Utilization Management section on the Provider Page of the company website, www.bcbst.com.

Prior Authorization Reviews

Prior authorization reviews can be initiated by the Member, designated Member advocate, Practitioner, or facility. However, it is ultimately the facility and Practitioner’s responsibility to contact BlueCross BlueShield of Tennessee to request an authorization and to provide the clinical and demographic information that is required to complete the authorization. Scheduled admissions/services must be authorized at least 24 hours prior to admission. Emergent inpatient admissions/services must be authorized within 24 hours or next business day of an admission.

When a request for an authorization of a procedure, an admission/service or a concurrent review of the days is denied, the penalty for not meeting authorization guidelines will apply to both the facility and the Practitioner rendering care for the day(s) or service(s) that have been denied. BlueCross BlueShield of Tennessee’s non-payment is applicable to both facility and Practitioner rendering care. The Member is held harmless if the Member is eligible at the time services are rendered and the Covered Services are received from a network Provider.

Nurse reviewers receive requests for prior authorization, including necessary medical information. The nurse reviews the medical information, applying benefits, medical policies, BlueCross Utilization
Management Guidelines and/or MCG criteria, to render decisions. Nurses have the authority to approve all situations that meet those guidelines, e.g., approve admissions, assign lengths of stay, and number of services.

For **Urgent Care**, the decision must be completed as soon as possible based on the clinical situation, but no later than 24-72 hours of the receipt of the request for a UM determination. For **Non-urgent Care**, the decision must be made within 15 calendar days.

The Practitioner and/or the facility are notified via telephone and/or fax of the decision determination. Written confirmation to the Practitioner, facility and Member follows. Timeframes begin with receipt of the UM requests and include the issuance of the initial notification and/or written confirmation of the decision.

Nurse reviewers refer potential denials or questionable cases to a Medical Director for review. Additional information may be submitted via the regular authorization process when an adverse determination is issued by BlueCross BlueShield of Tennessee. This information may be submitted to BlueCross BlueShield of Tennessee from the Provider or Provider representative. If a BlueCross BlueShield of Tennessee Medical Director denies a request for prior authorization, the Provider or Member may appeal the decision. (See Provider Appeals Process at the end of this section.)

Concurrent/extended stay reviews are performed for inpatient admissions and concurrent/extended service reviews are performed for ancillary services. Approval of the admission or an initial length of stay is assigned upon admission to a facility and an initial length of service is assigned upon onset of ancillary service. However, to receive payment beyond the initial length of stay or length of service, additional medical information, which meets criteria and/or demonstrates Medical Necessity, must be submitted by the facility/Practitioner contacting the Utilization Management Department either by telephone, fax or electronically with the additional information to support the request.

BlueCross Providers can submit authorization requests (excludes Cover Tennessee) for inpatient and 23-hour observation via telephone, facsimile or **e-Health Services® via BlueAccess, the secure area on the company website, www.bcbst.com.** Facsimile transmissions will be received Monday through Thursday, 24-hours-a-day, and Friday until 4 p.m., ET. The facsimile will be turned off from 4 p.m. Friday until 6 a.m. Monday, and will be turned off on holidays until the next business day at 6 a.m. Otherwise, the requests should be received via telephone, facsimile or **e-Health Services®** on the next business day. To access **e-Health Services®**, enter your ID number and password in the BlueAccess secure login box or for first-time users, click on the “register now” tab. A voicemail line will be available after business hours and on weekends/holidays for Providers to contact BlueCross BlueShield of Tennessee regarding **concurrent or urgent** information. These calls will be returned the next business day. Providers submitting requests via facsimile should utilize the authorization request form located on the company website at [http://www.bcbst.com/providers/forms/Commercial_Auth_Fax_Form.pdf](http://www.bcbst.com/providers/forms/Commercial_Auth_Fax_Form.pdf). The form must be completed in its entirety; any authorization requests received that are not on this form will be returned.

Prior authorization requests for Inpatient, Outpatient Procedures and 23-hour Observation can receive online approval. Simply select the option to apply MCG criteria and answer a few clinical questions. If the authorization meets specific criteria you will receive online approval and a reference number. Your request will be recorded in our computer system real time as it is received. This service is available 24-hours-a-day, 7-days-a-week for all registered BlueCross BlueShield of Tennessee Providers.

**DRG Inpatient Stays**
- Contact the BlueCross BlueShield of Tennessee UM Department on the date specified with current clinical information.
- Clinical information is needed in order to implement and to discuss discharge planning efforts. Date of update will be determined at the time of call from Provider requesting additional days.
- DRG admissions will be assigned a length of stay. Date of update will be determined at the time of call from Provider requesting additional days.
- All claims submitted for DRG reimbursement with outlier days will be reviewed for Medical Necessity.

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Per Diem Admissions Needing Extensions

- Contact the BlueCross BlueShield of Tennessee UM Department with the required clinical information on the originally scheduled day of discharge when a Member’s condition indicates a need for additional days. Extension requests can also be arranged via telephone, facsimile, or eHealth Services® via BlueAccess, the secure area on BCBST’s website, www.bcbst.com.

- Discharge information should be sent daily to BCBST to help ensure appropriate Member follow up and coordination of care. Discharge dates may be entered via the web, e-mailed to dcdates@bcbst.com, or faxed to (423)591-9501 for all lines of business. If faxing or e-mailing, Providers may submit one list with all Member names as long as the appropriate line of business to which the Member belongs is indicated. Provider cover sheets should include the facility name and NPI number to help ensure appropriate and efficient processing.

C. Medical Review Requirements

Types of reviews required are subject to change. Providers will be notified of any changes in review requirements through quarterly updates to the BlueCross BlueShield of Tennessee Provider Administration Manual, BlueAlert monthly provider newsletter, and other BlueCross communications, including the BlueCross company website, www.bcbst.com. All information is subject to verification by review of the medical record and other sources. (See Medical record submission guidelines later under “Provider Appeal Process”.)

When prior authorization* is required, Providers must obtain authorization prior to scheduled services and within 24 hours or the next business day of emergent services. Failure to comply within specified authorization timeframes will result in a denial or reduced benefits due to non-compliance, and BlueCross participating Providers will not be allowed to bill Members for Covered Services rendered, except for any applicable copayment/deductible and coinsurance amounts. Prior authorization requests may be requested via e-Health Services® via BlueAccess, the secure area on the company website, www.bcbst.com, called in to 1-800-924-7141 or faxed to 1-866-558-0789 using the appropriate BCBST fax form located at http://www.bcbst.com/providers/forms/.

Requests for tests, procedures, or services requiring prior authorization must contain adequate information for review. Requests for authorization where additional information is requested but not received by the end of the next calendar day will be denied for lack of information. Covered Services that have not been authorized may not be billed to the Member. The Practitioner may appeal a denial due to lack of information to BlueCross within 180 days of notification of denial.

*BlueCross administers both insured and self-funded arrangements. Because of differences in relationships, some prior authorization requirements as well as benefit coverages may differ. Benefits are always subject to verification of eligibility and coverage at the time services are rendered. If the Member is still within his/her pre-existing condition waiting period, benefits will not be available if the condition is determined to be pre-existing on Short-Term Care policies.

The following describes specific medical review guidelines:

1. Inpatient Admission
   a. Acute Care Facility
      All inpatient stays require prior authorization. Authorization will be issued when care and treatment are determined to be Medically Necessary and Appropriate in an inpatient setting. Scheduled inpatient stays require admission the morning of a procedure in nearly all instances.
Basic information needed for processing a prior authorization request:
- Member’s identification number and name;
- Patient’s name and date of birth;
- Practitioner’s name, provider number and/or National Provider Identifier (NPI), address, telephone number and caller’s name;
- Hospital/Facility’s name, provider number and/or NPI, address, telephone number, caller’s name.

Clinical information required for prior authorization:
- Procedure/Operation to be performed, if applicable;
- Diagnosis with supporting signs/symptoms;
- Vital signs and abnormal lab results;
- Elimination status;
- Ambulatory status;
- Hydration status;
- Co-morbidities that impact patient’s condition;
- Complications;
- Prognosis or expected length of stay;
- Current medications.

b. Skilled Nursing Facility (SNF)
All inpatient stays require prior authorization. Authorization will be issued when care and treatment are determined to be Medically Necessary and Medically Appropriate in an inpatient setting. Skilled services are services requiring the skills of qualified technical or professional health personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, and/or audiologists. Skilled services must be provided directly by or under the general supervision of technical or professional health care personnel.

Basic information needed for processing a prior authorization request:
- Member’s identification number and name;
- Patient’s name and date of birth;
- Practitioner’s name, provider number and/or NPI, address, telephone number and caller’s name;
- Hospital/Facility’s name, provider number and/or NPI, address, telephone number, caller’s name;
- Initial review, concurrent review or reconsideration request with admission date, admitting diagnosis, symptoms, treatment; and
- Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care that would influence the Medical Necessity determination.

If a covered benefit, SNF admission may be approved for Members with all the following:
- A condition requiring skilled nursing services or skilled rehabilitation services on an inpatient basis at least daily;
- A Practitioner’s order for skilled services;
- Ability and willingness to participate in ordered therapy;
- Medical Necessity for the treatment of illness or injury (this includes the treatment being consistent with the nature and severity of the illness or injury and consistent with accepted standards of medical practice); and
- Expectation for significant reportable improvement within a predictable amount of time.
Evaluation and Plan of Care

- **Evaluation of the Member** must be submitted including the following as appropriate:
  - Primary diagnosis
  - Ordering Practitioner and date of last visit
  - Date of diagnosis onset
  - Baseline status
  - Current functional abilities
  - Functional potential
  - Strength
  - Range of Motion
  - Circulation and sensation
  - Gait analysis
  - Cooperation and comprehension
  - Developmental delays (pediatric patients)
  - Other therapies or treatments
  - Patient’s goals
  - Medical compliance
  - Support system

- **Plan of care** must be submitted including the following as appropriate:
  - Short- and Long-term goals
  - Discharge goals
  - Measurable objectives
  - Functional objectives
  - Home program
  - Proposed admission date
  - Frequency of treatment
  - Specific modalities, therapy, exercise
  - Safety and preventive education
  - Community resources

**Therapy Services**

Therapy services appropriate for skilled nursing facilities include occupational therapy, physical therapy and speech therapy not possible on an outpatient basis. Specific therapy services that may be appropriate for a SNF include, but are not limited to the following:

- Complex wound care requiring hydrotherapy; and
- Gait evaluation and training to restore function in a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality.

**Nursing Services**

Nursing services appropriate for skilled nursing facilities include skilled nursing services not possible on an outpatient basis. Specific nursing services that may be appropriate for a SNF include, but are not limited to the following:

- Intramuscular injections or intravenous injections or infusions;
- Initiation of and training for care of newly placed
  - Tracheostomy
  - Pain Management
  - In-dwelling catheter with sterile irrigation and replacement
  - Colostomy
  - Gastrostomy tube and feedings
- Complex wound care involving medication application and sterile technique
- Ulcer treatment with any Stage 3 or 4 pressure ulcer

**Nursing and Therapy Services Not Requiring SNF Placement**

Skilled nursing facility placement is not necessary for the services listed below. This list is not all-inclusive.

- Administration of routine oral, intradermal or transdermal medications, eye drops, and ointments;
- Custodial services, e.g., non-infected postoperative or chronic conditions;
- Activities or programs primarily social or diversional in nature;
- General supervision of exercises in paralyzed extremities, not related to a specific loss of function;

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• Routine care of colostomy or ileostomy;
• Routine services to maintain functioning of in-dwelling catheters;
• Routine care of incontinent patients;
• Routine care in connection with braces and similar devices;
• Prophylactic and palliative skin care (i.e., bathing, application of creams, or treatment of minor skin problems);
• Duplicative services - Physical therapy services that are duplicative of Occupational Therapy services being provided or vice versa;
• Invasive procedures (i.e., iontophoresis involving needle);
• General supervision of aquatic exercise or water-based ambulation;
• Heat modalities (hot packs, diathermy or ultrasound) for pulmonary conditions or wound treatment, or as a palliative or comfort measure only (whirlpool and hydrocollator);
• Hot and cold packs applied in the absence of associated modalities;
• Diagnostic procedures performed by a Physical Therapist (i.e., nerve conduction studies); and
• Electrical stimulation for strokes when there is no potential for restoration of functional improvement. Nerve supply to the muscle must be intact.

Extension of Services
Extension of services requires the following documentation:
• Clinical progress in meeting goals
• Updated goals
• Compliance & participation with any ordered therapy
• Discharge plans & target date

C. Rehabilitation Facility
All inpatient stays require prior authorization. Authorization will be issued when care and treatment are determined to be Medically Necessary and Medically Appropriate in an inpatient setting. Inpatient Rehabilitation provides multidisciplinary, structured, intensive therapy for Members both requiring and able to participate in a minimum of 3 hours of daily therapy for 5 days. Rehabilitation goals are to prevent further disability, to maintain existing ability, and to restore maximum levels of functioning within the limits of the Member’s impairment.

Potential inpatient rehabilitation admissions include Members with recent CVA, head trauma, multiple trauma, or spinal cord injury.

Basic information needed for processing a prior authorization request:
• Member’s identification number and name;
• Patient’s name and date of birth;
• Practitioner’s name, provider number and/or NPI, address, telephone number and caller’s name;
• Hospital/Facility’s name, provider number and/or NPI, address, telephone number, caller’s name;
• Initial review, concurrent review or reconsideration request with admission date, admitting diagnosis, symptoms, treatment, frequency of therapies, Member’s ability to participate in treatment;
• Member is ventilator dependent or not; and
• Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care that would influence the Medical Necessity determination.

If a Covered Service, inpatient rehabilitation admission may be approved for Members with all the following:
Rehabilitative potential, to include assessment and/or Functional Independence Measure Score (FIMS) of impairment from illness or injury and premorbid condition;
Ability and willingness to actively participate in a minimum of 3 hours of daily therapy, 5-days-per-week;
A condition requiring 24-hour rehabilitation nursing and 24-hour availability of a Practitioner with special training in the field of rehabilitation;
A requirement for at least 2 therapies and a multidisciplinary team approach;
Medical Necessity for the treatment of illness or injury (this includes the treatment being consistent with the nature and severity of the illness or injury, and consistent with accepted standards of medical practice);
Acute medical condition stabilized;
Reasonable and reportable goals in a written plan of care submitted with the request for admission; and
Documented family commitment to the rehabilitation program (where family involvement will eventually be required).

In addition, a request for an additional inpatient rehabilitation admission for a Member previously admitted to inpatient rehabilitation for essentially the same condition needs to be carefully assessed. The date and length of previous rehabilitation, along with the improvement attained, need to be carefully considered. Alternatives in these cases may be outpatient rehabilitation, home therapy or therapies, or skilled nursing facility (SNF) placement.

Evaluation and Plan of Care

➢ Evaluation of the Member must be submitted including the following as appropriate:

- Ordering Practitioner and date of last visit
- Primary diagnosis
- Date of diagnosis onset
- Baseline status
- Current functional abilities
- Functional potential
- Strength
- Range of Motion
- Gait analysis
- Circulation and sensation
- Cooperation and comprehension
- Developmental delays (pediatric patients)
- Other therapies or treatments
- Patient’s goals
- Medical compliance
- Support system

➢ Plan of care must be submitted including the following as appropriate:

- Short- and Long-term goals
- Discharge goals
- Measurable objectives
- Functional objectives
- Home program
- Proposed admission date
- Frequency of treatment
- Specific modalities, therapy, exercise
- Safety and preventive education
- Community resources

Extension of Services

Extension of services requires the following documentation:
- Clinical progress in meeting goals
- Updated goals
- Compliance & participation with therapy
- Discharge plans & target date
- Team conference reports (at least every two weeks or with any significant change in the Member’s condition)

Note: A sample copy of the Skilled Nursing Facility/Inpatient Rehabilitation form is available on the BlueCross Provider page on the company website, www.bcbst.com.

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2. **Emergency Admission**

In-network Providers are responsible for contacting BlueCross BlueShield of Tennessee within 24 hours or the next business day of the inpatient admission. Although emergency procedures do not require prior authorization, benefits are subject to verification for Medical Necessity and Medical Appropriateness and eligibility of coverage.

In the event that an emergency hospital admission or emergency outpatient service occurs after normal office hours, you may submit the information via our website, [www.bcbst.com](http://www.bcbst.com), for registered users, or contact the Utilization Management Department within 24 hours or the next business day. If the Member is still admitted at that time, an admission review will be initiated. If the Member has been admitted and discharged, or has already received an emergency outpatient service, a retrospective review will be completed.

3. **Observation Stays**

Prior authorization for 23-hour observation stays through the emergency room is not required for commercial Members. Observation for elective services, direct admissions from the Physician’s office, or a transfer from another facility require prior authorization.

The goal of observation stays is to either complete treatment, e.g., hydration, or rule out need for inpatient stays; (e.g., chest pain is not caused by an acute myocardial infarction). Members in this status may advance to admission status if the clinical situation warrants. Admissions need to be reported to the Utilization Management Department before a scheduled admission, or within the next business day for emergency admissions to determine Medical Necessity and Medical Appropriateness.

**23-Hour Observation Room Services Policy**

The medical record must support the need for observation and a specific Practitioner’s order for observation must be documented. The record must also show the time and date of arrival and discharge from the facility.

4. **Non-Compliance**

Services requiring prior authorization rendered without obtaining approval are considered “non-compliant.” Emergency admissions require authorization within 24 hours or one (1) business day after services have started or within 24 hours or one (1) business day after conversion from observation to inpatient status. When prior authorization is required, Provider must obtain authorization prior to scheduled services. Non-compliance applies to initial as well as concurrent review for ongoing services beyond dates previously approved.

Failure to comply within specified authorization timeframes will result in a denial or reduced benefits due to non-compliance. BlueCross BlueShield of Tennessee Providers cannot bill Members for Covered Services denied due to non-compliance by the Provider.

If a Member does not inform the Provider that he/she has BlueCross BlueShield of Tennessee coverage and the Provider discovers that the Member **does have** BlueCross BlueShield of Tennessee coverage, the Provider should send a copy of the medical record relevant to the admission or services, along with the face sheet, to the UM Appeals Department within sixty (60) days of the denial. An appeal will only be overturned if Medical Necessity is determined and there is clear evidence that the facility was not aware that the Member had BlueCross BlueShield of Tennessee coverage at the time services were rendered.

5. **Maternity, Labor and Delivery, Newborn**

Normal deliveries do not require notification or authorization. Complication of pregnancy continues to require authorization.
Regardless of line of business, newborns require notification/prior authorization if:
- continued hospitalization is required after the mother has been discharged; or
- admitted to any level other than well-baby nursery; or
- transferred to another facility due to their fragile condition.

6. Home Health Services/Skilled Nursing Visits
Home health services may require prior authorization. Home health services are hands-on, skilled care/services, by or under the supervision of a registered nurse that are needed to maintain the Member’s health or to facilitate treatment of the Member’s illness or injury. In order for the services to be covered under BlueCross BlueShield of Tennessee, the Member must have a medical condition that makes him/her unable to perform personal care and meet Medical Necessity and Medical appropriateness criteria. Documentation must support the Member’s limitations, homebound status, and the availability of a caregiver/family and degree of caregiver/families’ participation/ability in Member's care.

Home Health Services normally covered include, but are not limited to:
- Part-time intermittent Skilled Nursing Services
- Medical Social Service
- Home Infusion Therapy
- Dietary guidance
- Rehabilitative Therapies such as physical therapy, occupational therapy, etc.

Home Health Services not normally covered include, but are not limited to:
- Non-treatment services
- Routine transportation
- Homemaker or housekeeping services
- Behavioral counseling
- Supportive environmental equipment
- Maintenance or custodial care
- Social casework
- Meal delivery
- Personal hygiene
- Convenience items
- Home Health Aides
- Private Duty Nursing

In order for an approval of Skilled Nursing/Home Health Visit services to be issued, the following criteria must be met:
- The Member requires the skills of a nurse on an intermittent basis;
- The Member has a condition that requires active skilled care;
- The services must be reasonable and necessary to the care of the condition; and
- The Member must be determined by BlueCross BlueShield of Tennessee to be homebound during the episode of care.

Documentation for prior authorization:
- Practitioner’s verbal or signed medical orders and plan of care for dates of service;
- Number of services requesting;
- Nurse’s visit and progress notes;
- Therapist’s visit and progress notes, if applicable;
- Availability of a caregiver; and
- Homebound status.

Home health visits should be for skilled nursing services. Visits for assessment and teaching should be for services beyond those one would expect to be taught in the Practitioner’s office and the request must include the frequency and duration of services, and must specify what services are to be provided. An insulin-dependent diabetic may have up to three skilled nursing visits to teach diabetic care. However, these visits should be lengthy, comprehensive and show evidence that clinical problem solving is actively used.
7. Transitional Care/Discharge Planning
BlueCross BlueShield of Tennessee acknowledges a vested interest in assuring patient care is provided in the most appropriate setting and will continue to assist Providers with discharge planning for its patients who are BlueCross BlueShield of Tennessee Members. Discharge planning should begin upon admission. BlueCross BlueShield of Tennessee transition of care/discharge planning nurses will assist Providers and Members upon admission, during the prior authorization process, or prior to admission if a scheduled admission. Authorization for the following services should be completed and Providers notified of the determination prior to anticipated discharge and service date:

- Hospital admissions, select procedures;
- Skilled nursing facility/restorative care unit admissions;
- Inpatient rehabilitation admission;
- Home health services (skilled nursing visits and home infusion therapy);
- Certain durable medical equipment;
- Speech therapy, occupational therapy, physical therapy;

8. Cosmetic Surgery
Cosmetic surgery is not a Covered Service. However, breast reconstructive and symmetry surgery following a mastectomy is a Covered Service.
- Reconstructive breast surgery, in all stages, on the diseased breast as a result of a mastectomy (not including a lumpectomy) is considered Medically Necessary.
- Surgery on the non-diseased breast, to establish symmetry between the two breasts in the manner chosen by the Member and the Practitioner is considered Medically Necessary.

9. Out-of-Network Services
Benefits may be limited, reduced or not be available in accordance with the terms of the Member’s health care benefits plan even if required prior authorization is obtained.

Emergency out-of-network services (based on admitting and discharge diagnosis filed on claim) are covered, but must be reported to BlueCross BlueShield of Tennessee within 24 hours or the next business day. BlueCross BlueShield of Tennessee may need to assist the Provider in returning the Member to the network when it is medically safe.

10. Transplant Services
Please see Section X. Case Management for transplant specifics.

11. Hospice Services
Hospice services are for terminally ill Members where life expectancy is six (6) months or less and may require prior authorization.

Hospice services normally covered include, but are not limited to:
- Part-time intermittent nursing care
- Bereavement counseling
- Home health aide services
- Medical social services
- Medications for control or palliation of the illness
- Physical or respiratory therapy for symptom control

Hospice services not normally covered include, but are not limited to:
- Homemaker or housekeeping services
- Meals
- Supportive environmental equipment
- Inpatient and outpatient care
- Private Duty Nursing
- Chemotherapy
- Routine transportation
- Radiation therapy
- Funeral or financial counseling
- Enteral and parenteral feeding
- Practitioner visits
- Home hemodialysis
- Psychiatric care
- Convenience or comfort items not related to the illness
12. Ambulatory Surgeries (Appropriateness Review), Diagnostic & Other Procedures

Some outpatient surgical/diagnostic procedures may require prior authorization. These procedures may be performed in outpatient surgical facilities, hospital outpatient departments, outpatient diagnostic centers, and in Practitioners’ offices. Providers may call Customer Service at the phone number listed on the Member’s ID card to determine prior authorization requirements. Some procedures do not require prior authorization if performed on an outpatient basis; however, if performed as 23-hour observation or on an inpatient basis, a prior authorization is required for the hospitalization. Non-emergency elective procedures should be submitted up to thirty (30) days, but not less than 24 hours prior to the scheduled procedure. Failure to obtain prior authorization will result in denial of payment for Covered Services.

Prior authorization is required for the following procedures performed in an inpatient or outpatient setting:

- Blepharoplasty
- Vein ligation
- Bariatric procedures
- Hysterectomy
- Breast Augmentation/Reduction
- Panniculectomy
- Endometrial Ablation
- Hyperbaric Treatments
- Occipital Nerve Neurostimulator Implantation
- Neurostimulator Implantation for Fecal and Urinary Incontinence
- 72-hour Glucose Monitoring
- Gender Reassignment Surgery

Covered Services that have not been authorized may not be billed to the Member if rendered by a BlueCross BlueShield of Tennessee network Provider. Denials for failure to request an authorization must be appealed within sixty (60) days of notification of denial. This does not preclude Provider responsibility for claims timely filing requirements. The Practitioner may appeal a Medical Necessity denial to BCBST within 180 days of notification of denial.

Note: Select outpatient procedures are subject to focused retrospective review.

Providers should call the BlueCross Provider Service line, 1-800-924-7141, or visit e-Health Services® at www.bcbst.com to determine prior authorization requirements.

13. Specialty Pharmacy Medications

Certain high-risk/high-cost specialty pharmacy medications administered in any setting other than inpatient hospital requires prior authorization for all lines of business. This authorization requirement applies to all Provider types including home infusion therapy Providers, hospitals providing outpatient infusions, and injections.

A complete listing of specialty pharmacy drugs can be found in the Preferred Formulary Reference Guide located online at http://www.bcbst.com/docs/providers/Preferred-Formulary-Reference-Guide-2016.pdf. Those requiring prior authorization under the Member’s medical benefits plan are identified by “PA”. Drugs that do not require a prior authorization, but require adherence to BCBST Medical Policy are noted by “MPC”.

Practitioners may contact one of our Specialty Pharmacy Network vendors to obtain a specialty drug. The specialty pharmacy will obtain the necessary information and will request prior authorization. The pharmacy will ship the drug to either the Provider’s office (for Provider-Administered drugs) or directly to the Member (for Self-Administered drugs). The specialty pharmacy will bill BlueCross for the drugs and collect any necessary copays or coinsurance from the Member. For a complete listing of BlueCross Specialty Pharmacy vendors see Section XIX. Pharmacy, in this Manual, or visit our website at http://www.bcbst.com/docs/pharmacy/Specialty-Drug-List-2016.pdf.
If the Provider is supplying a Provider-Administered drug that requires prior authorization, the Provider must call BlueCross Utilization Management department at 1-800-924-7141 for authorization.

For Self-Administered drugs requiring prior authorization, and NOT being supplied by a Specialty Pharmacy Network vendor, the Provider may call 1-877-916-2271.

In addition to the Member information, the following is required when requesting prior authorization for Provider-Administered specialty drugs:

- Provider NPI Number (more than one of your subsidiaries may share the same number)
- Tax ID Number (more than one of your subsidiaries may share the same number)
- Appropriate Taxonomy Code in Block 33b (taxonomy code should be specific for specialty pharmacy, HIT, etc.)
- HCPCS Code (J, Q or S code)
- Drug Name
- Strength of Drug
- National Drug Code (NDC)
- Number of Units being billed
- Frequency of Dosing
- Dosage
- Days’ Supply if billing an “ambulatory” drug on a medical claim (for example, when accepting Assignment of Benefits for Members who have to pay 100 percent up front)
- Clinical Information to support the request

**Note:** New drugs may be periodically added to the specialty pharmacy list and those products requiring authorization are subject to change. Changes will be communicated via BlueAlert newsletter or updates to this Manual.

The specialty medication section of the *BlueCross BlueShield of Tennessee Medical Policy Manual* includes decision support trees for Provider-Administered drugs to assist Providers considering use of these medications. Providers can select the appropriate drug from the manual at [http://www.bcbst.com/mpmanual/!SSL!/WebHelp/mpmprov.htm](http://www.bcbst.com/mpmanual/!SSL!/WebHelp/mpmprov.htm) and connect to the decision support tree in the policy.

For additional information on Specialty Pharmacy Medications, see Section XIX. Pharmacy, in this Manual.

### 14. Home Infusion Therapy

Home Infusion Therapy (HIT) is the administration of medications, nutrients or other solutions intravenously, subcutaneously, epidurally, intramuscularly or via implanted reservoir while in the Member’s private residence. A request for HIT originates with prescription from a qualified Practitioner to achieve defined therapeutic results. HIT must be provided by a licensed pharmacy. Home nursing for patient education, medication administration, training, and monitoring are handled directly by a qualified home health agency.

A complete listing of specialty pharmacy medications can be found in the *Preferred Formulary Reference Guide* located online at [http://www.bcbst.com/docs/pharmacy/Specialty-Drug-List-2016.pdf](http://www.bcbst.com/docs/pharmacy/Specialty-Drug-List-2016.pdf). Those requiring prior authorization under the Member’s medical benefits plan are identified by “PA”. Drugs that do not require a prior authorization, but require adherence to BCBST Medical Policy are noted by “MPC”.

Authorization listings are subject to change; Changes will be communicated via BlueAlert newsletter or updates to this Manual. Case Management may assist the Practitioner in arranging HIT for extraordinary cases and when Medical Necessity and Medical Appropriateness warrant close attention.
When an authorization is needed, specific information is required. Authorizations are valid for thirty (30) days; any break in service requires a new authorization. HIT Providers requesting approval of HIT services should submit the following information to the Utilization Management Department:

- Member name, address, date of birth, sex, ID number;
- Practitioner name, address, phone number;
- HIT agency name, address, phone number, HIT-related provider number and/or National Provider Number (NPI) and a contact person;
- Type of request: initial prior authorization, extension of services or change of services;
- Type of therapy (e.g., palliative, long-term therapy, short-term antibiotic therapy) should include dosage, frequency, date and length of service, including NDC number, HCPCS code and grams of protein for TPN;
- Primary and HIT diagnosis;
- Clinical documentation (e.g., lab values, cultures, X-rays) to support reason and need for HIT services; and
- A Practitioner’s verbal or signed medical order.

The administration of intramuscular (IM) drugs (Rocephin, Phenergan, Procrit, etc.) is not considered HIT and therefore, should not receive HIT benefits. If nursing is required to administer the drug and/or conduct teaching for the Member, these services may require prior authorization under Home Health guidelines. If the HIT Provider is dispensing the drug, they are required to follow the Pharmacy Benefits Manager (PBM) requirements for prior authorization. All self-administered drugs must be authorized and billed through the Member’s appropriate PBM. (See Section XIX. Pharmacy in this Manual.)

Authorization decisions will be phoned, faxed or sent electronically to the HIT Provider and a letter is mailed to the prescribing Practitioner and Member. Adverse decisions are rendered if Medical Necessity and Medical Appropriateness are not shown.

Extension of Services
When prior authorization is required and services are needed beyond the number of days authorized by BlueCross BlueShield of Tennessee, the HIT supplier must have the additional services authorized.

Changes/Termination in Services
When prior authorization is required, the HIT Provider must notify BlueCross BlueShield of Tennessee of any changes in therapies/medication, dosages, and/or an order for discontinuation by the ordering Practitioner, during the time frame authorized.

15. Rehabilitation Therapy Outpatient Services
Therapies/Rehabilitative services must be Medically Necessary and Medically Appropriate therapeutic and rehabilitative services intended to restore or improve bodily function lost as a result of illness or injury.

Prior authorization requirements for Cardiac Rehabilitation services are driven by the Member’s health care benefit plan. BlueCross BlueShield of Tennessee administers both insured and self-funded arrangements and because of differences in relationships, some prior authorization requirements may differ.

To ensure appropriate payment is made for Cardiac and Pulmonary Rehabilitation services, Providers are encouraged to verify the Member’s health care benefit plan’s prior authorization requirements by calling the Provider Services line, 1-800-924-7141 or via e-Health Services® at www.bcbst.com. For those health care benefit plans requiring prior authorization, penalties will continue to apply for non-compliance.

Therapy services normally covered include:
- Outpatient, home health or office therapeutic and rehabilitative services, which are expected to result in significant and measurable improvement in the Member's condition resulting from an
acute disease or injury. The services must be performed by, or under the direct supervision of a licensed therapist. (See medical policy regarding "Staff Supervision Requirement for Delegated Services" and "Staff Practitioner to Whom Services may be Delegated" in the BlueCross BlueShield of Tennessee Medical Policy Manual at http://www.bcbst.com/providers/mpm.shtml);

- Services must be performed in a Practitioner’s office, outpatient facility or home health setting;
- Physical Therapy;
- Speech Therapy (limited to coverage for disorders of articulation and swallowing, following an Acute illness);
- Occupational Therapy;
- Manipulative Therapy; and
- Cardiac and Pulmonary Rehabilitative services.

**Therapy services normally not covered include, but are not limited to:**

- Treatment beyond what can reasonably be expected to significantly improve health, including therapeutic treatments for ongoing maintenance or palliative care;
- Enhancement therapy which is designed to improve the Member's physical status beyond their pre-injury or pre-illness state;
- Complementary and alternative therapeutic services, which include, but are not limited to:
  - Massage therapy
  - Acupuncture
  - Craniosacral Therapy
  - Neuromuscular Reeducation
  - Vision Exercise Therapy
  - Cognitive Therapy
- Modalities that do not require the attendance of a licensed therapist:
  - Activities which are primarily social or recreational in nature
  - Simple exercise programs
  - Hot and cold packs applied in the absence of associated therapy modalities
  - Repetitive exercises or tasks which can be performed by the Member without a therapist, in a home setting
  - Routine dressing changes
  - Custodial services that can ordinarily be taught to a caregiver or the Member themselves.
  - Behavioral therapy
  - Play therapy,
  - Communication therapy
  - Therapy for self correcting language dysfunctions
  - Duplicate therapy (therapies should provide different treatments and not duplicate the same treatment).

**a. Speech Therapy Services (provided in a non-acute setting)**

In order for Speech Therapy services to be considered for benefits, the services must be Medically Necessary and Medically Appropriate to the treatment of the Member’s illness or injury. Unskilled services are not eligible for coverage.

**The following information must be included when authorization request is submitted:**

- Date of last visit
- Primary diagnosis
- Date of diagnosis onset
- Baseline status/current abilities
- Functional potential
- Prior level of functioning
- Diagnostic and assessment services used to ascertain the type, causal factors, and severity of speech and language disorders
- Support system
- Developmental delays
- Other therapies or treatments
Patient's goals
Therapy compliance
Prior speech therapy received and outcome

Treatment Plan
- Long and short-term goals
- Discharge goals
- Measurable objectives
- Functional objectives
- Home program, if applicable
- Duration of therapy
- Frequency of therapy
- Date therapy is to begin
- Specific therapy techniques

Note: BlueCross BlueShield of Tennessee utilizes MCG criteria when reviewing requests for speech therapy services provided in a non-acute setting.

b. Occupational Therapy Services (provided in a non-acute setting)
In order for occupational therapy services to be considered for benefits, the services must be Medically Necessary and Medically Appropriate to the treatment of the Member's illness or injury. Unskilled services are not eligible for coverage.

The following information must be included when authorization request is submitted:
- Date of last visit
- Primary diagnosis
- Date of diagnosis onset
- Baseline status/current abilities
- Functional potential
- Prior level of functioning
- Diagnostic and assessment services used to ascertain the type, causal factors, and severity of dysfunction or disorders
- Support system
- Developmental delays
- Other therapies or treatments
- Patient's goals
- Medical compliance
- Prior occupational therapy received and outcome

Treatment Plan
- Long and short-term goals
- Discharge goals
- Measurable objectives
- Functional objectives
- Home program
- Duration of therapy
- Frequency of therapy
- Dates of service
- Specific modalities and therapy

Note: BlueCross BlueShield of Tennessee utilizes MCG criteria when reviewing requests for occupational therapy services provided in a non-acute setting.
c. Physical Therapy Services (provided in a non-acute setting)

In order for physical therapy services to be considered for benefits, the services must be Medically Necessary and Medically Appropriate to the treatment of the Member's illness or injury. A prior authorization may be required for physical therapy based on the Member's benefit coverage. Unskilled services are not eligible for coverage.

The following information must be included when authorization request is submitted:

- Date of last visit
- Primary diagnosis
- Baseline status
- Functional potential
- Current functional abilities
- Strength
- ROM
- Circulation and sensation
- Cooperation and comprehension
- Support system
- Developmental delays/pediatrics
- Other therapies, treatments, chiropractic
- Patient's goals
- Medical compliance
- Homebound status

Treatment Plan

- Short- and Long-term goals
- Discharge goals
- Measurable objectives
- Functional objectives
- Home exercise program
- Time frame (frequency and duration)
- Date therapy is to begin
- Frequency of treatment
- Specific modalities, therapy, exercise
- Safety and preventive education
- Community resources

BlueCross BlueShield of Tennessee utilizes MCG criteria when reviewing requests for physical therapy services provided in a non-acute setting.

16. Medical Supplies (Outpatient Rehabilitation Services)

The following coverage criteria apply to medical supplies billed to BlueCross BlueShield of Tennessee:

- Records must clearly support that supplies were used during the Member's treatment.
- Must be prescribed by the Member's Practitioner.
- Must be Medically Necessary and Medically Appropriate for treating illness or injury.
- Generally recognized as therapeutically effective and primarily medical in nature.
- Must be at the level and quality required (not “luxury” in nature).
- Cannot be for environmental control, personal hygiene, comfort, or convenience.
- Cannot be reusable.
- Supplies required for use with rental items are included in the rental fee.
17. Durable Medical Equipment

Durable Medical Equipment (DME) purchases, rentals, or repairs require prior authorization for most lines of business. DME may be subject to retrospective review for Medical Necessity.

DME may be covered if it is determined to be Medically Necessary and Medically Appropriate for the Member’s condition. The following guidelines and documentation requirements apply to DME whether equipment is purchased or rented:

- The Member's diagnosis should substantiate the need and use of the equipment in the medical record.
- Documentation of the Member's capability to be trained in the appropriate use of the equipment.
- Rental equipment is generally considered equipment that requires frequent and substantial servicing and maintenance and/or estimated period of use is finite.
- Certain rented DME is purchased after the equipment has been rented for a total of ten (10) months.
- Documentation for customized equipment should specify the need for the custom equipment versus standard equipment.
- Reimbursement may be determined for a more cost-effective alternative if medical necessity and appropriateness for the equipment is not demonstrated in the documentation submitted for review.

Information that needs to be submitted with the claim and/or prior authorization (when applicable) request:

- Practitioner's order (if not submitted with the claim, it may be requested at any time and payment recouped if unavailable);
- Member's diagnosis and expected prognosis;
- Estimated duration of use;
- Limitations and capability of the Member to use the equipment;
- Itemization of the equipment components, if applicable;
- Appropriate HCPCS codes for equipment being requested; and
- The Member’s weight and/or dimensions (needed to determine coverage of manual or power wheelchairs), if available.

The following guidelines apply to reimbursement for repair of DME equipment:

- Equipment less than one (1) year old requires documentation related to the warranty coverage. Repairs that are covered by the warranty will not be reimbursed by BlueCross BlueShield of Tennessee;
- Documentation supporting need for services and/or items being billed; initial purchase date of equipment should be included, if available; and
- Prior authorization may be required for DME repairs for some BlueCross BlueShield of Tennessee lines of business.

BlueCross BlueShield of Tennessee will only provide benefits for Medically Necessary and Medically Appropriate Equipment. Requests for extraordinary items require justification.

BlueCross BlueShield of Tennessee will not provide benefits for Investigational Durable Medical Equipment.

18. Advanced Imaging/High Tech Imaging

Prior authorization* is required for select advanced imaging radiology procedures performed in an outpatient setting. Prior authorization reviews for these cases are processed by our High Tech Imaging vendor on behalf of BCBST. Prior authorization is not required for imaging procedures performed during an inpatient admission or emergency room visit.

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Procedures requiring prior authorization include, but are not limited to:

- Computed tomography (CT)
- Magnetic resonance angiography (MRA)
- Computed tomography angiography (CTA)
- Positron emission tomography (PET)
- Magnetic resonance imaging (MRI)
- Magnetic resonance spectroscopy (MRS)
- Nuclear cardiology

* Applies to Blue Networks E, M, P, and S, Members and BlueAdvantage PPO and HMO Members. This program is an optional add-on for Administrative Services Only (ASO) Members in Blue Networks M, P, and S.

To request prior authorization for any of the previously listed radiology procedures, call our High Tech Imaging vendor at 1-888-693-3211.

19. **Musculoskeletal (MSK) Management**

The Musculoskeletal Management Program applies to Fully Insured Blue Networks P and S Members, and BlueAdvantage PPO and HMO Members, and to certain self-funded plans at the employer’s request. This program is an optional add-on for Administrative Services Only (ASO) Members in Blue Networks M, P, and S. Prior authorization is required for select musculoskeletal services and procedures performed in an outpatient or pre-scheduled inpatient setting. Prior authorization is not required by the MSK vendor for musculoskeletal procedures performed during an unplanned admission or emergency room visit.

Procedures requiring prior authorization include, but are not limited to:

- Pain Management
- Spinal Surgeries Contact the MSK vendor for Commercial policies only
- Joint Surgeries (Hip, Knee and/or Shoulder)
- Physical Medicine (Contact the MSK vendor for BlueAdvantage only)
- Home Health, Physical Therapy, and Occupational Therapy (MedAdvantage only)

To request prior authorization for any of the above listed musculoskeletal procedures or services, submit information via the company website, [www.bcbst.com](http://www.bcbst.com), fax to 1-866-747-0587, or call 1-866-747-0586. If questions, call the MSK vendor at 1-866-747-0586.

Note: Medical Records required for initial authorization review.

Concurrent review requests beyond the initial authorization will require review through BlueCross BlueShield of TN’s normal process (via phone, fax, or Web).

20. **NICU/SCN through First Year Care Management**

Prior authorization is required for Blue Networks E, M, P, and S, newborns admitted to the Neonatal Intensive Care Unit or Special Care Nursery. Prior authorization reviews for these cases are processed by the NICU vendor on behalf of BCBST, and are reviewed for Medical Necessity throughout the hospitalization. The date of the next clinical review will be determined with each review. The NICU vendor will review:

- Birth inpatient admission to NICU or SCN
- All subsequent inpatient and outpatient admissions through Member’s first birthday
- Ancillary services including DME and Home Health through Member’s first birthday

To contact the NICU vendor, call 1-888-832-2006.

21. **Performance Evaluations of Delegate Vendors and Providers**

The BlueCross BlueShield of Tennessee Delegate Oversight Program provides an organized and systematic approach to ensure oversight of delegated administrative functions, which include Utilization Management, Quality Improvement, Credentialing, Independent Record Review, Case Management,
Claims, Customer Service, Complaints, Grievance and/or Appeals, Transportation, EPSDT, and Medical Records Review.
BlueCross BlueShield of Tennessee will, at a minimum, complete an annual assessment of reports and annual performance evaluations of vendors/Providers to whom activities have been delegated. The purpose of a performance evaluation is to ensure compliance with standards of all of the applicable state and federal laws and regulations, as well as those of all applicable accrediting and regulatory review agencies, including but not limited to URAC, Tennessee Department of Commerce and Insurance (TDCI), and BlueCross BlueShield of Tennessee policies and procedures.

The performance evaluation includes, but is not limited to, the following:
- Desktop and/or onsite evaluation of the vendor’s/Provider’s compliance with all applicable standards
- Documentation and file review to determine the compatibility of the organization’s goals and objectives with BlueCross BlueShield of Tennessee goals and objectives
- Criteria, methods, and process for determining Medical Necessity and Medical Appropriateness of care
- Written evaluation of the vendor’s/Provider’s capabilities to perform delegated functions, staffing capabilities, and performance record

The delegate vendor/Provider will support BlueCross BlueShield of Tennessee in meeting its requirements of annual and periodic performance evaluations by providing access to all records, policies, procedures, reports, and other documents as necessary to demonstrate compliance with the delegate program.

22. Second Surgical Opinion
BlueCross BlueShield of Tennessee will pay for any second surgical opinion requested by a Member. This includes not only major surgery, but also other procedures (e.g., pacemakers, ambulatory surgery procedures, etc.).

The following guidelines apply to Second Surgical Opinions:
- A surgeon (one who is not in the same group or practice as the Practitioner who rendered the first opinion) must render the second opinion.
- The Practitioner rendering the second surgical opinion must be in a BlueCross BlueShield of Tennessee network and proper referrals must be in place, if applicable.

D. Emergency Services
Emergency Room services for an emergency condition do not require prior authorization. BlueCross BlueShield of Tennessee communicates to its Members to go to the nearest emergency room if they are suffering from an emergency condition.

An emergency is defined as a sudden and unexpected medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect to result in: serious impairment of bodily functions; serious dysfunction of any bodily organ or part; or placing the prudent layperson’s health in serious jeopardy. These services may be provided by facility-based providers. It is understood that in those instances where a Physician makes emergency care determinations, the Physician shall use the skill and judgment of a reasonable Physician in making such determinations.

Note: Prior authorization is not required for emergency room visits.
E. Investigational Services

Investigational services are those services that do not meet BlueCross BlueShield of Tennessee’s definition of Medical Necessity. New and established technologies are researched and evaluated by BlueCross BlueShield of Tennessee’s Medical Policy Research & Development Department and are assessed using sources that rely upon evidence based studies. Input is also sought from our network Providers.

The definition of “Investigational” is based on the BlueCross BlueShield of Tennessee’s technology evaluation criteria. Any technology that fails to meet ALL of the following four (4) criteria is considered to be Investigational.

1. The technology must have final approval from the appropriate governmental regulatory bodies, as demonstrated by:
   - This criterion applies to drugs, biological products, devices and any other product or procedure that must have final approval to market from the U.S. Food and Drug Administration or any other federal governmental body with authority to regulate the use of the technology.
   - Any approval that is granted as an interim step in the U.S. Food and Drug Administration’s or any other federal governmental body’s regulatory process is not sufficient.

2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes, as demonstrated by:
   - The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence.
   - The evidence should demonstrate that the technology could measure or alter the physiological changes related to a disease, injury, illness, or condition. In addition, there should be evidence or a convincing argument based on established medical facts that such measurement or alteration affects health outcomes.

3. The technology must improve the net health outcome, as demonstrated by:
   - The technology’s beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.

4. The improvement must be attainable outside the Investigational settings, as demonstrated by:
   - In reviewing the criteria above, the Medical Policy Panel will consider Physician specialty society recommendations, the view of prudent medical Practitioners practicing in relevant clinical areas and any other relevant factors.

The Medical Director, in accordance with applicable ERISA standards, shall have discretionary authority to make a determination concerning whether a service or supply is an Investigational Service. If the Medical Director does not authorize the provision of a service or supply, it will not be a Covered Service. In making such determinations, the Medical Director shall rely upon any or all of the following, at his or her discretion:

1. Your medical records, or
2. the protocol(s) under which proposed service or supply is to be delivered, or
3. any consent document that You have executed or will be asked to execute, in order to received the proposed service or supply, or
4. the published authoritative medical or scientific literature regarding the proposed service or supply in connection with the treatment of injuries or illnesses such as those experienced by You, or
5. regulations or other official publications issued by the FDA and HHS, or
6. the opinions of any entities that contract with the Plan to assess and coordinate the treatment of Members requiring non-experimental or Investigational Services, or

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7. the findings of the BlueCross BlueShield Association Technology Evaluation Center or other similar qualified evaluation entities.

These criteria are used in making such determinations as whether a service is considered to be Investigational or Medically Necessary. Providers have access to these policies via the Medical Policy Manual in the Provider section on the company website, www.bcbst.com and are also informed of determinations via our monthly BlueAlert Newsletter.

If a BlueCross BlueShield of Tennessee Network Provider renders services that are Investigational or do not meet Medically Necessary and Appropriate criteria, the Provider must obtain a written statement from the Member, prior to the service(s) being rendered, acknowledging that the Member understands he/she will be responsible for the cost of the specific service(s). It is essential the signed statement be kept on file. It may be necessary to provide a copy of the written statement to BlueCross BlueShield of Tennessee if the Member questions the Member Liability amount reflected on his/her Explanation of Benefits (EOB). Once BlueCross BlueShield of Tennessee contacts the Provider, he/she will be asked to provide a copy of the signed written statement within two (2) business days. If the Provider is not able to supply the written statement, the claim will be adjusted to reflect Provider liability and the Member will not be responsible for those charges.

To help assist in this process, BlueCross BlueShield of Tennessee developed the Acknowledgement of Financial Responsibility for the Cost of Services form for Provider use. A sample copy of this form is located in Section V. Member Policy, in this Manual. Providers are encouraged to use this form. The form can also be found in the Provider section of the company website, www.bcbst.com. This form meets the contractual obligations of BlueCross BlueShield of Tennessee Provider Agreements.

F. Medically Necessary and Medically Appropriate Policy

BlueCross BlueShield of Tennessee covers Medically Necessary and Medically Appropriate health care services not otherwise excluded under BlueCross BlueShield of Tennessee health care benefits plans.

Medically Necessary or Medical Necessity
“Medically Necessary” refers to procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical Practitioner, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- in accordance with generally accepted standards of medical practice; and
- clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient’s illness, injury or disease; and
- not primarily for the convenience of the patient, Physician or other health care Provider; and
- not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease.

For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician specialty society recommendations, and the views of medical Practitioners practicing in relevant clinical areas and any other relevant factors.

Medically Appropriate
“Medically Appropriate” refers to services, which have been determined by BlueCross BlueShield of Tennessee in its discretion to be of value in the care of a specific Member. To be Medically Appropriate, a service must meet all of the following:

1. Be Medically Necessary.
2. Be consistent with generally accepted standards of medical practice for the Member’s medical condition.
3. Be provided in the most appropriate site and at the most appropriate level of service for the Member’s medical condition.
4. Not be provided solely to improve a Member’s condition beyond normal variation in individual development, appearance and aging.
5. Not be for the sole convenience of the Provider, Member or Member’s family.

BlueCross BlueShield of Tennessee may request medical records when the complexity of a case requires a review of the medical records in order to determine if a service is Medically Necessary and Medically Appropriate. **Note:** According To Contract, BlueCross BlueShield of Tennessee Will Not Reimburse For Photocopying Expenses.

BlueCross BlueShield of Tennessee encourages open Practitioner/patient communication regarding appropriate treatment alternatives.

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**G. Prospective and Retrospective Review**

These reviews are conducted based on MCG criteria (if applicable), BlueCross BlueShield of Tennessee adopted utilization management guidelines, BlueCross BlueShield of Tennessee Medical Policy, Physician’s CPT®, CMS Common Procedure Coding System and the Member’s health care benefits plan. The following listed services are not all-inclusive and may be subject to prospective or retrospective review:

- Endometrial Ablation for Treatment of Menorrhagia;
- Possible cosmetic services;
- Potential investigational services;
- Skilled nursing facility confinements;
- Chiropractic services;
- Outpatient therapies;
- Durable Medical Equipment (when prior authorization is not required);
- Prosthetics, orthotics, and supplies;
- Practitioner office services;
- Dental, accident related, and temporomandibular joint dysfunction;
- Pain management;
- Pre-existing;
- Unbundled codes and/or code combinations; and
- Non-participating provider or no prior authorization obtained.

Types of reviews may change based on policy or guideline changes, identification of the need for focused reviews, etc.

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**H. Provider Appeal Process**

It is the policy of BlueCross BlueShield of Tennessee to make available to treating Practitioners a peer-to-peer review to discuss, by telephone, determinations based on Medical Appropriateness. These reviews can be requested in the following situations:

1. Anytime during the hospital stay;
2. Within twenty-four (24) hours of notification of decision if already discharged; and
3. For elective services, prior to services being rendered or filing an appeal.

Providers can reach a dedicated voicemail system by calling the Provider Service line, 1-800-924-7141, Monday through Thursday, 8 a.m. to 6 p.m. (ET); Friday, 9 a.m. to 6 p.m. (ET). All messages left before
3 p.m. (ET) will be returned the same day. Messages left after 3 p.m. (ET) will be returned the next business day. The voicemail system requires two (2) specific dates and times to schedule the Physician-to-Physician review as well as other Member demographics indicated by the voicemail prompts. If the Provider is still not satisfied following a peer-to-peer discussion, the Provider should proceed to the next level of appeal (i.e., Provider Dispute Resolution).

**Utilization Management Appeals**

**Reconsideration Prior to Service**

Additional information may be submitted via the regular authorization process when an adverse determination is issued by BlueCross BlueShield of Tennessee. This information may also be submitted to BlueCross BlueShield of Tennessee from the Provider or Provider representative.

Provider office staff should only initiate a Physician-to-Physician discussion with one of our medical directors when the attending or ordering Physician requests, and is aware of the discussion.

**Expedited Appeal**

- The request for an expedited appeal must be initiated by phone and should include a request for expedited appeal along with any pertinent information not originally submitted.
- An expedited appeal may or may not require a peer-to-peer conversation.
- An expedited appeal can be requested when the Provider believes that the adverse determination:
  1. could seriously jeopardize the life or health of the Member and the ability of the Member to regain maximum function, and/or
  2. in the opinion of the Practitioner with knowledge of the Member’s medical condition would subject the Member to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case.

An expedited appeal will be completed and notification issued to the Member and Provider no later than seventy-two (72) hours after initial request of the appeal, however, the clinical circumstances will help determine the speed of the response.

Expedited appeals may be requested by calling the appropriate prior authorization number. You should verbally request the review to be labeled as an expedited appeal in order for BlueCross to assure the review is completed within the timeframe. (Refer to Section II. Quick Reference Telephone Guide in this Manual.)

**Standard Appeal**

The standard appeal process can be used if reconsideration or an expedited appeal resulted in an adverse determination. Requests for standard appeal for Medical Necessity denials must be received in writing by the Utilization Management department within 180 days of the date of the initial denial notification. This does not preclude timely filing requirements. Appeals of non-compliance denials must be submitted within sixty (60) days of the initial denial. The request should include a copy of any pertinent clinical information, face sheet, if applicable, and a statement from the Practitioner indicating the reasons for the appeal and a copy of the denial letter. A determination will be sent to the Provider and/or Member within thirty (30) days of the receipt of the request for appeal.

Exhausting the above noted process satisfies Section II. A. and B. of the Provider Dispute Resolution Procedure (PDRP) outlined in Section XIII in this Manual. If the party is still dissatisfied, he/she may appeal the adverse decision pursuant to Section II. D. of the PDRP.

**Medical record submission guidelines**

Occasionally, medical records are received at BlueCross BlueShield of Tennessee without a clear indication of who requested the information or complete member identification. Medical records may be submitted via hardcopy, fax or CD-ROM.
When submitting medical records for appeal:

1. Submit any request or notification letter from us as the first page of your medical record or the UM appeals form located at http://www.bcbst.com/providers/forms/Utilization-Management-Appeal-Form.pdf. Failure to do so may result in a delayed response to your request or your request being returned until appropriate documentation is supplied.
2. If submitting multiple records for a single patient or multiple records for multiple Members, ensure the individual records are secured with a clip or other indicator if mailed in the same envelope.
3. Medical records may be submitted through certified mail.
4. Medical records must be legible with all appropriate information pertinent to the presenting case.
5. Include all Member information in a clear, legible format. We must be able to identify the Member and the relationship to BlueCross BlueShield of Tennessee.
6. Claims must be attached behind the medical record. If attached to the front, it will be mistaken for a claim needing adjudication rather than a medical record needing review.

Fax Appeal (preferred method) to: (423) 591-9451
Or
Mail Appeal to:

BlueCross BlueShield of Tennessee
Commercial Appeals/Retrospective Claims Review
1 Cameron Hill Circle, Suite 0017
Chattanooga, TN 37402-0017

I. Medical Policy Manual

The Medical Policy Manual contains medical policies and general policies approved by BlueCross BlueShield of Tennessee. Medical policies address specific new medical technologies or pharmaceutical agents. General policies are very limited in number and exist for the purpose of listing all diagnostic and therapeutic medical policies addressing some disease states.

Medical policies are based upon evidence-based research using published studies and/or prevailing Tennessee practice. Determinations with respect to technologies are made using criteria developed by the BlueCross BlueShield Association's Technology Evaluation Center. The criteria are as follows:

1. The technology must have final approval from the appropriate governmental regulatory bodies.
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes.
3. The technology must improve the net health outcome.
4. The technology must be as beneficial as any established alternatives.
5. The improvement must be attainable outside the investigational settings.

The medical policies specifically state whether a technology is considered Medically Necessary, Not Medically Necessary, Investigational, or Cosmetic. Definitions of these terms are found within the Medical Policy Manual Glossary. Providers may view the BlueCross BlueShield of Tennessee Medical Policy Manual in its entirety on the company website at http://www.bcbst.com/providers/mpm.shtml.

Many policies also contain a Medical Appropriateness section. This section contains the criteria used in determining whether a particular technology is appropriate in a particular case (i.e., for a specific individual).
BlueCross BlueShield of Tennessee recognizes the occasional need for “Pilot Programs” for procedures and services which may not meet the Medical Necessity criteria established by BlueCross BlueShield of Tennessee Medical Policy, but for which there is recognized promise or other compelling reasons to test their usefulness. These Pilot Programs will allow testing for both medical and cost effectiveness of alternative Providers, procedures and services in order to determine the impact on BlueCross BlueShield of Tennessee and its Members.

Medical Policy Appeals

BlueCross BlueShield of Tennessee network Providers may appeal a draft or active medical policy. A medical policy appeal is a formal notice from a network Provider stating dissatisfaction with any medical policy determination. The dissatisfaction could be questioning the Investigational status of a medical policy or the Medical Appropriateness criteria contained in a medical policy. Published, peer-reviewed studies supporting the appealing Providers position must be submitted with each medical policy appeal.

The medical policy appeal process follows:

- Provider submits a written request for appeal of a medical policy, along with any supporting documentation to the Provider Appeals Department.
- Provider Appeals Coordinator sends the request to the division representative for the Medical Policy Research & Development Department.
- Medical Policy Research & Development Department reviews the appeal and supporting documentation.
- The appeal decision is returned to the Provider Appeals Department with a detailed response for the Provider.
- A written response is sent via registered mail to the network Provider.

Network Providers may submit a written medical policy appeal along with supporting documentation to:

Provider Appeals Coordinator
Provider Network Management
BlueCross BlueShield of Tennessee
1 Cameron Hill Circle, Ste 0039
Chattanooga, TN 37402, 0039

J. Directing Members to Participating Providers in Members’ Network

When a Member needs additional care outside your practice, you can assist them by directing them to participating Providers in the Member’s network. Members seeking care outside their network will have significant reductions in benefits or no benefits. An illustration of the increased Member liability for out-of-network utilization follows:

Example:
Physician charges = $300.00
BlueCross BlueShield of Tennessee maximum allowed = $180.00

Utilizing an in-network Provider
Provider network Physician discount = $120.00
BlueCross BlueShield of Tennessee payment = $150.00 (or 80% of $180 maximum allowed)
Member payment = $30.00
Utilizing an out-of-network Provider
Provider network Physician discount = $0
BlueCross BlueShield of Tennessee payment = $108.00 (or 60% of $180 maximum allowed)
Member payment = $192.00

By helping your patients utilize in-network Providers, you can help ensure they receive the highest level of benefits. An online directory of participating Providers by network-type is available on the company website, www.bcbst.com. Both Members and Providers may access the Provider directories from any page of our site by selecting “Find a Doctor!” located on the left-hand side of the screen.

BlueCross BlueShield of Tennessee has developed an Out-of-Network Provider Election Form for use by participating Providers when a Member in one of the commercial networks chooses to have an elective procedure performed at or from an out-of-network Provider. A sample copy of this form is available on the Provider page of the company website at www.bcbst.com.

K. Utilization Management Resources

The following tools are utilized in the clinical decision process:

First Tool- Member’s contract
The Member’s contract is the first tool in the clinical decision process. If the service is provided within the contract, then it may require evaluation of Medical Appropriateness.

Second Tool-Medical Policy
The Medical Policy is the second tool in the clinical decision process. The Medical Policy Manual will provide policy statements and Medical Appropriateness criteria to determine Medical Necessity.

Third Tool-Clinical Guidelines
The Utilization Management criteria are the third tool in the clinical decision process. Clinical guidelines include MCG, and BCBST Utilization Management Guidelines. If the contract addresses the service, but Medical Policy does not, the Clinical Guidelines should be applied to the request for services.
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IX. REFERRAL PROCESS

Information in this section has been removed. Effective January 1, 2004, BlueCross BlueShield of Tennessee no longer requires Blue Network S Point-of-Service (POS) members to:

- choose a Primary Care Practitioner; or
- obtain a referral when seeking in-network or out-of-network specialist care.

However, to receive maximum benefits, POS members should continue to seek health care services from providers that participate in Blue Network S. When Members utilize providers outside their network, benefits are substantially reduced.
X. CASE MANAGEMENT

The BlueCross BlueShield of Tennessee Case Management Programs promote Member empowerment regarding health care decisions, Member education on health conditions and options, as well as the tools and resources necessary to assist the Member/family when making health care decisions. The BlueCross BlueShield of Tennessee Case Management Programs also offer quality and cost effective coordination of care for Members with complicated care needs, chronic illnesses and/or catastrophic illnesses or injuries.

A. Components

- Lifestyle/Health Education Program
  - Lifestyle/Health Education is a self-directed program involving identifying Members with potential health risks and then empowering them with the tools and educational materials necessary to make the most informed decisions regarding their health.

- Catastrophic Medical Case Management
  - Catastrophic Medical Case Management is the collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual family’s comprehensive health needs through communication and available resources to promote quality cost-effective outcomes. The goal is to facilitate the delivery of appropriate individual health care services across the continuum of care in various settings for Members with complex and catastrophic conditions. The Catastrophic Medical Case Management Program monitors compliance with NCQA standards in order to maintain accreditation. Related activities to Case Management include care coordination, complex condition management, population health management through wellness, disease and chronic care management, and promoting transitions of care services.

- Transplant Case Management
  - Transplant Case Management focuses on the entire spectrum of transplant care. The care of the Member is managed from the time of the evaluation for a transplant until services are no longer needed. BlueCross BlueShield of Tennessee helps its Members in need of bone marrow or solid organ transplants receive quality care by directing them to Practitioners in the national transplant health networks. The facilities within this network and the Practitioners who practice there have been specifically selected for their expertise and quality outcomes in transplant cases.

- Population Health Management
  - Population Health Management focuses on Wellness, Care Coordination, Health Risk Management, Maternity, High-Risk Maternity, Chronic Care, and Complex Case Management.

B. Case Management Criteria and Guidelines

- MCG criteria (formerly Milliman Care Guidelines®)
- Case Management Society of America (CMSA) Practice Guidelines
- BlueCross BlueShield of Tennessee adopted guidelines
- BlueCross BlueShield of Tennessee Medical Policy

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Case Management Referral Criteria

The following list (not intended to be all-inclusive) are referral guides to recommend a Member for any of the case management programs:

Lifestyle/Health Education Referral Criteria:

If a Member could benefit from educational materials on these health conditions, please refer them to the Lifestyle/Health Education program.

Telephone 1-800-225-8698 Fax 1-888-328-0394

Lifestyle/Health Education

Allergies
Asthma
Arthritis
Cardiovascular Diseases
Diabetes
Kidney Diseases
Migraines
Pregnancy
Respiratory Diseases

Emergency Services Management

ER visits greater than (3) three within a 3-month period or (2) two within a (1) one-week period

Bariatric Surgery Management

Disease Management Referral Criteria:

Telephone 1-800-225-8698 Fax 1-888-328-0394

BlueHealth Solutions Chronic Condition Program
(Additional service purchased by employer)

Asthma
Chronic obstructive pulmonary disease (COPD)
Congestive heart failure (CHF)
Coronary artery disease (CAD)
Diabetes
Catastrophic Medical Case Management Referral Criteria:

**Telephone 1-800-225-8698**  **Fax 1-888-328-0394**

### Catastrophic Medical Case Management

- Air ambulance outside USA
- AIDS
- Severe burns (> 30% of body)
- Cancer
- Cerebral vascular accident (CVA)
- Complex home health care, continuous home infusion therapy needs, and all private duty nursing patients
- Crohn’s disease
- Cystic fibrosis
- Elevated lead levels
- End stage disease of any organ
- Hemochromatosis
- High risk infant
- Renal failure
- Sickle cell anemia
- Spinal cord injury
- Traumatic brain injury
- Ulcerative colitis
- Vent dependency
- Perinatal infections
- Neurological conditions
- Multiple Trauma

**Telephone 1-888-207-2421**  **Fax 423-535-5260**

### Transplant Case Management

- Bone marrow
- Solid organ
- Stem cell

Requests for case management should include the following information:

- Requesting Practitioner’s name and telephone number;
- BlueCross BlueShield of Tennessee Member name, BlueCross BlueShield of Tennessee ID number and telephone number;
- Diagnosis and current clinical information;
- Current treatment setting (e.g., hospital, home health, rehabilitation, etc.);
- Reason for request for case management (e.g., patient has COPD with frequent hospital admissions); and
- Level of urgency of care management need.

After receipt of request for case management, a case manager will make an initial call to the referral source within two (2) working days. **If an urgent request is needed, please specify in the phone or fax message.**

### C. Catastrophic Medical Case Management Team and Process

**Catastrophic Medical Case Management Team and Process**

The Catastrophic Case Management Team consists of registered nurses who are case managers, medical directors who are available for consultations, social workers who address psychosocial aspects and facilitate service provision for Members with barriers to care, and benefit specialists who have claims and benefit management experience. In the event of terminal illness, severe injury, major trauma, cognitive or physical disability, case managers work with a Member’s primary caregivers to coordinate the most appropriate, cost-effective treatment path based on the Member’s unique situation.

Rev 06/14
Case managers stay in regular contact with Members throughout treatment, coordinate clinical and health plan coverage issues, and help families utilize available community resources.

After obtaining Member consent for case management participation, the case manager will collaborate with the Member, Practitioner and other appropriate Providers to coordinate and facilitate an individualized plan of treatment to meet the Member’s health care needs.

The case manager will continue to evaluate the Member’s progress and health care needs and communicate findings with the Member and Practitioner. When the Member becomes clinically stable and/or the plan of treatment has met the Member’s needs, catastrophic case management services may be discontinued or referred to a less intensive case management program.

Prior to discontinuation of case management services, the case manager will communicate the following information to the Member:

- Reason for and specific future date for discontinuing case management services;
- Instructions for continuing prior authorization of continued services, if necessary;
- Explanation of transition of Member’s case to another care management program; and
- Instructions for requesting case management services if Member’s clinical condition regresses.

D. Transplant Case Management

The Transplant Case Management Team consists of registered nurses specifically trained in the areas of solid organ and bone marrow transplantation, medical directors, who are available for consultations, and benefit specialists who have claims and transplant benefit management experience.

It is critically important, to both the Practitioner and Member, that BlueCross BlueShield of Tennessee Transplant Case Management be contacted as soon as you think the Member may need an evaluation for transplant:

- If Prior authorization from Transplant Case Management is not obtained, the transplant and related services will not be covered or reimbursement will be reduced substantially.
- Most Members’ health care benefits plans encourage Members to receive transplant services at an In Transplant Network facility (see definition below).
- Transplants performed outside of the BlueCross BlueShield of Tennessee In-Transplant Network may not be covered or BlueCross BlueShield of Tennessee reimbursement will be greatly limited (depending on the Member’s health care benefits plan).
- If the Member does have access to Out-of-Transplant Network Benefits, those Benefits are subject to the Transplant Maximum Allowable Charge (TMAC). **Member’s liability beyond the TMAC may be substantial. The hospital and Practitioners will be at risk for these charges if the Member is unwilling or unable to pay.**

Not all BlueCross BlueShield of Tennessee In-Network Practitioners and hospitals (e.g., Blue Networks P and S) are in the BlueCross BlueShield of Tennessee In-Transplant Network. Seeking care outside the BlueCross BlueShield of Tennessee In-Transplant Network can reduce benefits and require substantial payment by the Member. Please check with BlueCross BlueShield of Tennessee Transplant Case Management to see which hospitals are in the BlueCross BlueShield of Tennessee In-Transplant Network before referring Members for transplant evaluation. Call the Transplant Case Management Department at 1-888-207-2421 for detailed network facility information.
BlueCross BlueShield of Tennessee In-Transplant Network

The BlueCross BlueShield of Tennessee In-Transplant Network consists of the Blue Distinction Centers for Transplant (BDCT), a national network of transplant centers. Other benefits, such as travel, may be available to some Members, when they use an In-Transplant Network facility. Benefits are based on the Member’s health care benefits plan and eligibility on the date of service.

The Blue Distinction Centers (BDCT) for Transplant

The BlueCross BlueShield Association administers and contracts with the transplant centers that make up The Blue Distinction Centers for Transplant. This national network of transplant centers offers comprehensive transplant services through a coordinated, streamlined program of transplant management. Participating centers are major clinical programs and leading research institutions located throughout the country. The BDCT currently contracts for: heart, single or bilateral lung, combination heart-bilateral lung, liver, (including living donor), pancreas, simultaneous pancreas-kidney, and bone marrow/stem cell (autologous/allogeneic). BDCT does not contract for Kidney Transplants. (For information on Kidney Transplants, see Kidney Transplants in this section). Since its creation, the BDCT network has offered several advantages to Participating BlueCross BlueShield Plans and our Members, including the following:

- Facility selection criteria are established for each type of procedure with the advice of a panel of nationally prominent transplant specialists;
- Morbidity and survival rates are monitored to measure the continued performance of the participating institutions and staff; and
- Medical and surgical benefits provided by the BlueCross BlueShield Plan through the network’s global rate include inpatient professional services and related institutional and organ procurement services for the prior authorized transplant.

Facilities are selected by BDCT based on their ability to meet defined clinical criteria that are unique for each type of transplant. Panels of nationally recognized transplant researchers and Practitioners advise the BlueCross BlueShield Association on selection criteria that are periodically updated in response to medical advances. Facilities are surveyed for information in many areas, including:

- Volume of procedures;
- Duration of the transplant program;
- Patient outcomes specific to the particular procedure;
- Transplant team training and experience;
- Staffing and facility requirements;
- Facility licensure, accreditation, and transplant program certification;
- Patient selection process;
- Patient management protocol;
- Educational plans and support programs available for patient/family;
- Quality Assurance/Improvement programs; and
- Procedures for patient follow-up for at least 12 months post-transplant.

Fulfillment of the BDCT eligibility requirements for one type of transplant does not qualify a facility for participation for other types of transplants. Each facility transplant program is evaluated independently against established criteria and is required to have an initial on-site evaluation prior to selection. Once selected for participation, facilities are re-evaluated annually and are subject to periodic on-site reviews.

For further information about becoming a BDCT facility or questions specifically regarding the BlueCross BlueShield Association or BDCT program, contact the Blue Distinction Centers for Transplant 1-800-263-7893.

Rev 09/11
Participating facilities receive a BDCT Procedure Manual from the BlueCross BlueShield Association. This manual contains detailed instructions, forms and contact lists for Participating and Referring BlueCross BlueShield Plans. BlueCross BlueShield of Tennessee is a Referring and a Participating Plan in the BDCT Network. The guidelines outlined in the BDCT Procedure Manual must be followed, in addition to those outlined in this manual, for maximum allowable reimbursement of transplants and transplant-related services.

**In-Network, but not In-Transplant Network**
These facilities (e.g., Participating Blue Networks P and S, BlueCard®/BlueCard® PPO) may receive a reduced level of reimbursement for some Members. If Member benefits are available, reimbursement will be subject to the Transplant Maximum Allowable Charge (TMAC) for the global transplant period. Member is liable for any amounts in excess of the TMAC up to contracted fee schedule amount.

**Out-of-Network**
If a facility is not contracted with BDCT; the Member’s BlueCross BlueShield of Tennessee Network (e.g., Blue Networks P and S, BlueCard®/BlueCard® PPO); or otherwise contracted with the local BlueCross BlueShield Plan, the facility is Out-of-Transplant Network. Members may have benefits at these facilities, but benefits and allowable reimbursement are subject to the TMAC. Reimbursement and benefits are reduced as compared with In-Transplant Network benefits and reimbursement. Amounts in excess of the TMAC are non-covered and may result in substantial Member liability.

**BlueCard®** The BlueCard program links participating health care Practitioners and the independent BlueCross BlueShield plans across the country and around the world. Not all Members have BlueCard coverage. Not all BlueCard facilities participate in the BlueCross BlueShield of Tennessee In-Transplant Network. Transplants for BlueCross BlueShield of Tennessee Members that occur at BlueCard® facilities, not in the BlueCross BlueShield of Tennessee In-Transplant Network, will be reimbursed in accordance with the Member’s health care benefits plan and may be subject to the TMAC. To determine eligibility and benefits of a BlueCard® Member call 1-800-676-BLUE (2583). Provide the operator with the Member’s ID, including alpha-prefix. You will be transferred to the Member's home BlueCross BlueShield Plan. For additional information regarding BlueCard®, see the BlueCard® website www.bluecard.com or Sec. XVI. in this Manual.

**Referrals, Case Management, and Prior Authorization**

**Referrals**
All transplants require prior authorization and coordination by a BlueCross BlueShield of Tennessee Transplant Case Manager in order for the Member to be eligible for coverage. It is very important that Members be referred to BlueCross BlueShield of Tennessee In-Transplant Network facilities or there will be significant reduction in benefits, including no benefits for some Members.

**Case Management**
By notifying Transplant Case Management prior to evaluation, the Practitioner and the Member can make informed decisions based on the Benefits available to the Member. The Transplant Case Manager will work with the Member and Practitioner to determine if the transplant-related service is medically appropriate as well as identify high-risk Members who will need additional assistance. The Transplant Benefits Specialists in this department can also let the Member know about other benefits, such as travel, that may be available to the Member, if they utilize the In-Transplant Network. They will also calculate the potential financial risk to both the Member and the Practitioner, if the Member chooses to go to an Out-of-Transplant Network facility or if they do not utilize Case Management. Contact Transplant Case Management at 1-888-207-2421 prior to all Member referrals for any transplant-related medical care, including evaluation to ensure that the services are covered and that the Member receives the highest level of benefits available. (See reimbursement examples at the end of this section).
Denials

Transplant cases determined by Transplant Case Management not to be Medically Necessary and Medically Appropriate may be referred for external review. The Member and the Practitioner will be given the determination of the external review in writing.

Appeals
Refer to Sec. VIII. and Sec. XIII in this Manual.

Prior Authorization
In addition to the above, the transplant facility must provide the BlueCross BlueShield of Tennessee Transplant Case Manager with the Member name, identification number(s), type of transplant, and proposed dates of service (inpatient/outpatient). The facility is required to submit clinical information to obtain prior authorization for the transplant once the Member has been evaluated. The facility must notify BlueCross BlueShield of Tennessee within one business day of a transplant services admission (inpatient/outpatient).

BDCT facilities must also notify the Referring BlueCross BlueShield Plan (if appropriate per BDCT Practitioner Procedures Manual) and the BlueCross BlueShield Association and submit the appropriate forms provided in the BDCT Practitioner Procedures Manual.

Length of Stay
The facility must notify BlueCross BlueShield of Tennessee to obtain initial authorization as well as provide clinical updates through out the transplant procedure and recovery. The BlueCross BlueShield of Tennessee Transplant Case Manager will authorize the initial admission for transplant and will outline the schedule for clinical updates required for extending the stay.

Transplant Global Period
Transplant benefits and reimbursement are calculated as a global period. TMAC charges apply to any and all inpatient and outpatient charges during the following time periods. Participating facilities, contracted to provide transplant services, may be eligible for additional reimbursement beyond the global rate, (outlier charges). To be eligible for outlier reimbursement the facility must contact BlueCross BlueShield of Tennessee for authorization of the outlier days. Prior authorized outlier days will be reimbursed in accordance with the contracted per diem rate if the Member is inpatient in excess of the following predetermined length-of-stay days:

- Bone Marrow/Stem Cell: 50 days, plus pre-transplant treatment days
- Lung: 38 days
- Liver: 39 days
- Liver/Kidney: 39 days
- Heart: 38 days
- Combination Heart-Bilateral Lung: 43 days
- Simultaneous Pancreas-Kidney: 34 days

Transitional Care/Discharge
Facilities must notify BlueCross BlueShield of Tennessee of a transplant Member’s proposed transition/discharge from care and obtain BlueCross BlueShield of Tennessee’s agreement to the proposed Member transition/discharge plan and follow-up recommendation.

Claims
Claims should be submitted to BlueCross BlueShield of Tennessee according to the facility’s contract and participation in the BlueCross BlueShield of Tennessee In-Transplant Network or other Networks as described previously in this section.
Blue Distinction Centers for Transplant (BDCT) Facilities –
The Participating BDCT Facility must submit the global transplant claim to the Member’s Home Plan as outlined in the BDCT Practitioner Procedures Manual when:

- Facility is contracted with BDCT for the transplant type;
- Member’s BlueCross BlueShield Home Plan is a Referring Plan in BDCT; and
- Transplant has been authorized.

The Participating BDCT Facility must follow these steps when submitting a global transplant claim:

1. Collect all itemized bills for transplant services included in the BDCT global rate (hospital, professional, ancillary, and procurement/harvesting charges). These bills are to be submitted in paper copy, using CMS-1450 and/or CMS-1500 claim forms. All eligible transplant services and applicable global rates are listed in the Hospital Participation Agreement (BDCT Contract).

2. Attach the completed Institutional Billing Summary Form (found in the BDCT Procedures Manual) to the bundled claims.

3. Attach a completed copy of the BDCT Referral Authorization Form (blank form available in the BDCT Procedures Manual) so that the Referring Plan’s Transplant Coordinator can identify the bundled claims as BDCT global claims.

4. Mail bundled claims and attachments, in one envelope, to the Member’s Home Plan Transplant Coordinator, designated in the Billing Section of the BDCT Referral Authorization Form submitted by the Referring Plan.

Mail BlueCross BlueShield of Tennessee Member claims to:

Transplant Benefits Specialist
BlueCross and BlueShield of Tennessee
1 Cameron Hill Circle CH 2.3
Chattanooga, TN 37402

5. Collect any applicable deductibles and coinsurance from the Member.

Note: See BDCT Procedures Manual for a complete listing of BDCT Referring BlueCross BlueShield Plans and all referenced forms. Participating BDCT Practitioners may obtain additional copies of the BDCT Procedures Manual from BDCT.

Out-of-Transplant Network Facilities (In Tennessee)
Participating BlueCross BlueShield of Tennessee facilities, not participating in BDCT for the transplant type must submit transplant claims to BlueCross BlueShield of Tennessee as outlined in the Participating Practitioner’s Institutional Agreement between the facility and BlueCross BlueShield of Tennessee. These claims should be mailed to:

Transplant Benefits Specialist
BlueCross and BlueShield of Tennessee
1 Cameron Hill Circle CH 2.3
Chattanooga, TN 37402

If the Member’s BlueCross BlueShield Home Plan is NOT a Referring Plan in BDCT, and the Member is NOT a BlueCross BlueShield of Tennessee Member, contact the Member’s BlueCross BlueShield Home Plan for billing and claims instructions.
Note: Transplants performed outside of the BlueCross BlueShield of Tennessee In-Transplant Network may not be Covered or BlueCross BlueShield of Tennessee reimbursement will be greatly limited (depending on the Member’s health care benefits plan). If the Member does have access to Out-Of-Transplant Network Benefits, those Benefits are subject to the Transplant Maximum Allowable Charge (TMAC). BlueCross BlueShield of Tennessee will pay all associated transplant-related claims during the global period (including pre-transplant stem cell transplant services such as mobilization and harvest) on a claim-by-claim basis according to when claims are filed until the benefit is exhausted.

Transplant Maximum Allowable Charge (TMAC) – The global TMAC is calculated based on data provided by Blue Distinction Centers for Transplant (BDCT). The TMAC amount is the lowest contracted BDCT global rate charged by any In-Transplant Network Facility for the specified organ/tissue type at the time of transplant. If the BDCT global rate includes pre-transplant services, the TMAC rate will also include those services. For example, contracted global rates may range from $100,000.00 at one facility to $175,000.00 for the same transplant type at another facility. In this example, the global TMAC is the lowest global rate of $100,000.00. It is important to remember that billed charges for the transplant type in this example may be over $200,000.00. The Member’s Out-of-Pocket Maximum does not apply to charges beyond the TMAC. Practitioners may determine the current TMAC by contacting Transplant Case Management at 1-888-207-2421. However, the reimbursement amount will be based on the TMAC as calculated at the time of the transplant. Member’s liability beyond the TMAC may be substantial. The hospital and Practitioner’s will be at risk for these charges if the Member is unwilling or unable to pay.

Coordination of Benefits – When BlueCross BlueShield of Tennessee will be paying secondary to other commercial insurance or other insurance will be paying secondary to BlueCross BlueShield of Tennessee, Transplant Case Management should be notified.

- If Secondary to Medicare, Transplant Case Management will not review for Medical Appropriateness. Payment will be handled according to Medicare Guidelines.
- If Secondary to Commercial Carrier, Transplant Case Management will review for medical appropriateness. Approved transplants will be paid according to the Member’s health care benefits plan. If other (primary) Commercial Insurance denies benefits, Transplant Case Management will coordinate benefits and handle as if BlueCross BlueShield of Tennessee were primary.

Single Patient Agreements – Single Patient Agreements are case-by-case contracts between the facility and BlueCross BlueShield of Tennessee. They are negotiated prior to transplant on behalf of BlueCross BlueShield of Tennessee Members in the following situations:

- Network Inadequacy – No network contracts exist for the transplant type (e.g., small bowel transplants)
- Urgent/Emergent Care – No network contracts exist and unanticipated emergency services are required where transfer to an In-Transplant network facility is not possible (e.g., medication induced liver failure)
- Continuity of Care – Determined on a case-by-case basis by Transplant Case Management. Must meet policy guidelines.

Claims should be submitted to BlueCross BlueShield of Tennessee according to the instructions outlined in the Single Patient Agreement Contract (if applicable).

Travel, Meals and Lodging
Some Members have Travel Benefits. If the Member has Travel Benefits (as defined in the
Member’s health care benefits plan), these benefits are paid to the Member, not the Practitioner. Examples of travel expenses include: travel expenses for evaluation of a Member prior to a covered procedure; transportation to and from the site of a covered procedure, meals, and lodging expenses for the Member and one caregiver. Travel benefits may vary.

Transitional Care
Should the facility or Member contract change after the transplant has been medically approved, but before the transplant has occurred, Transplant Case Management will notify the Member and Practitioner of the change and how benefits and reimbursement will be affected.

Kidney Transplants
Kidney transplants are handled differently than transplants contracted by BDCT. BlueCross BlueShield of Tennessee Members may access any Kidney Transplant facility identified as participating in the Member’s Network of Acute Care Hospitals contracted to provide kidney transplants (e.g., Blue Networks P and S, BlueCard®/BlueCard® PPO). BDCT does not contract with hospitals to provide Kidney Transplants (kidney alone).

Facilities will be reimbursed according to surgical Per Diems and/or Diagnosis Related Group (DRG) Rates and/or case rates outlined in the Institutional Agreement between the facility and BlueCross BlueShield of Tennessee.

Covered Health Services
Medically Necessary and Appropriate services and supplies are covered under the Member’s health care benefits plan and provided to the Member, when he or she is the recipient of one of the following organ transplants if covered under the Member’s health care benefits:

- Bone Marrow/Stem Cell
- Heart
- Heart/Lung
- Kidney
- Lung
- Liver
- Pancreas
- Kidney/Small Bowel
- Small Bowel/Liver
- Pancreas/Kidney

Benefits may be available for other organ transplant procedures, which, in BlueCross Blue Shield of Tennessee’s sole discretion, are not Investigational and which are Medically Necessary and Medically Appropriate. Requests for authorization for other, non-organ transplants (e.g., cornea, skin) should be directed to BlueCross BlueShield of Tennessee Utilization Management.

The transplant and transplant related services will not be covered or will be reduced (depending on the Member’s benefits) if the transplant and transplant related services are not approved by Transplant Case Management.

The transplant and transplant related services will not be covered or will be reduced (depending on the Member’s health care benefits plan) if the Member does not accept Transplant Case Management.

Additional benefits, such as travel, may be available to the Member, if the In-Transplant Network is utilized. Transplant Case Management will review the Member’s health care benefits plan to determine if this or other benefits exist. If available, these benefits are reimbursed to the Member, not the Practitioner.

Donor Organ Procurement
The cost of Donor Organ Procurement is included in the total cost of the Member’s organ transplant. It is included in the global TMAC calculation or any contracted global or case rate. Donor services are covered only to the extent not covered by the health coverage of the Donor.
Covered Services for the donor are limited to those services and supplies directly related to the transplant service itself:

- Testing for the donor’s compatibility;
- Removal of the organ from the donor’s body;
- Preservation of the organ; and
- Transportation of the organ to the site of transplant.

Services not Covered for the donor include:

- Complications of donor organ procurement.
- Payment to an organ donor or the donor’s family as compensation for an organ, or payment required to obtain written consent to donate an organ; and
- Donor services including screening and assessment procedures not prior authorized by the Member’s health care benefits plan.

Conditions/Limitations

- Transplant Case Management will coordinate all transplant services, including pre-transplant evaluation.
- If Transplant Case Management is not notified, the transplant and related procedures may not be covered.
- Transplants performed outside of the BlueCross BlueShield of Tennessee In-Transplant Network may not be covered or BlueCross BlueShield of Tennessee reimbursement will be greatly limited (depending on the Member’s health care benefits plan).
- If the Member does have access to Out-of-Transplant Network Benefits, those benefits are subject to the global Transplant Maximum Allowable Charge (TMAC). Not all BlueCross BlueShield of Tennessee participating network Practitioners and hospitals (Blue Networks, P and S, BlueCard®/BlueCard® PPO) are in the BlueCross BlueShield of Tennessee In-Transplant Network. **Member’s liability beyond the TMAC may be substantial. The hospital and Practitioners will be at risk for these charges if the Member is unwilling or unable to pay.**

Exclusions

- If the Member does not receive prior authorization, the transplant and related services will not be covered or reimbursement will be reduced substantially;
- Any service specifically excluded under the Member’s health care benefits plan, except as otherwise provided in this section;
- Services or supplies not specified as Covered Services under this section;
- If the Member receives prior authorization through Transplant Case Management, but does not obtain services through the In-Transplant Network, he/she will be responsible for payment to the Practitioner and/or hospital for any additional charges not covered under the Member’s health care benefits plan. These charges may be substantial;
- Any attempted covered procedure that was not performed, except where such failure is beyond the Member’s control;
- Any non-Covered Services;
- Services which are covered under any private or public research fund, regardless of whether the Member applied for or received amounts from such fund;
- Any non-human, artificial or mechanical organ;
- Payment to an organ donor or the donor’s family as compensation for an organ, or payment required to obtain written consent to donate an organ;
- Donor services including screening and assessment procedures which have not received prior authorization from BlueCross BlueShield of Tennessee;
Exclusions (cont’d)

- Removal of an organ from a Member for the purposes of transplantation into another person, except as covered by the Donor Organ Procurement provision;
- For bone marrow transplants, any registry charges other than the one from which the bone marrow is received are not covered. All charges incurred as a result of the testing/typing are considered to be expenses of the Member to the extent that the donor has no other coverage;
- Harvest, procurement, and storage of stem cells, whether obtained from peripheral blood, cord blood, or bone marrow when reinfusion is not scheduled; and
- Other non-organ transplants (e.g. cornea, skin) are not covered under this section, but may be covered as an Inpatient Hospital Service or Outpatient Facility Service, if Medically Necessary.

Reimbursement examples follow:

- Example A – Organ Transplant (non-kidney) In-Transplant Network:

  **Member Benefits are:**
  In-Transplant Network Practitioners – 80%, after In-Network Deductibles, In-Network Out-of-Pocket Maximum applies. Once the In-Network Out-of-Pocket Maximum is met, benefits are at 100%.

  - Transplant Total Billed Charges (global): $206,000.00
  - Practitioner Write-Off Due to BDCT Agreement - $76,000.00
  - BDCT Rate with this Facility is (global): $130,000.00
  - Member’s In-Network deductible and Out-of-Pocket Maximum: - $2,000.00
  - BlueCross BlueShield of Tennessee Pays Facility: $128,000.00
  - Total Member Liability: $2,000.00

  In addition to the previously mentioned benefits the Member may have travel benefits.

- Example B – Organ Transplant (non-kidney) Out-of-Transplant Network, but in BlueCross BlueShield of Tennessee Network (e.g., Blue Networks P and S, BlueCard®/BlueCard® PPO):

  **PPO Member Benefits are:**
  In-Network, but not In-Transplant Network – 80% of Transplant Maximum Allowable Charge (TMAC), after In-Network Deductible, In-Network Out-of-Pocket Maximum applies. Amounts over TMAC do not apply to the Out-of Pocket and are not covered. Once the In-Network Out-of-Pocket Maximum is met, the facility is eligible for 100% of the global TMAC. (see following grid)

  - Transplant Total Billed Charges: $206,000.00
  - Practitioner Write Off Due to Network/BlueCard PPO
  - Normal Network Priced Amount Using any Applicable Fee Schedules (e.g., Blue Network P, BlueCard PPO*): $170,000.00

  **Allowed/Covered Amount Calculation:**
  - Normal Network Priced Amount: $170,000.00
  - Transplant Maximum Allowable Charge: - $100,000.00
  - Amount in excess of the TMAC, but less than Network Pricing (non-covered): $70,000.00

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Reimbursement/Member Benefit Calculation:
Transplant Maximum Allowable Charge: $100,000.00
Member's Deductible and Out-of-Pocket Maximum: - 2,000.00

* If host plan allows use of network pricing in addition to TMAC. Insurance Benefit Covers 80% of TMAC. However, once the Out-of-Pocket Maximum is met, the facility and associated Practitioners are eligible for 100% of the remaining TMAC**:
Member owes Hospital or other Transplant Practitioners:
Deductible and Out-of-Pocket Maximum: $ 2,000.00
Amount in excess of the TMAC, but less than Network Pricing (non-covered): $ 70,000.00
TOTAL MEMBER LIABILITY TO TRANSPLANT PRACTITIONERS $ 72,000.00

Example C – Organ Transplant (non-kidney) Out-of-Transplant Network and not participating in the Member’s BlueCross BlueShield of Tennessee Network:

Member Benefits are:
Out-of-Network Practitioners – 60% of Transplant Maximum Allowable Charge (TMAC), after Out-of-Network Deductible, Out-of-Network Out-of-Pocket Maximum applies, amounts over TMAC do not apply to the Out-of Pocket and are not covered. Once the Out-of-Network Out-of-Pocket Maximum is met, the facility is eligible for 100% of the global TMAC. (see following grid)

Transplant Total Billed Charges are: $ 206,000.00
Practitioner Write Off: 0
Transplant Maximum Allowable Charge: 100,000.00

Member Benefit Calculation:
Transplant Total Billed Charges: $ 206,000.00
Transplant Maximum Allowable Charge: - 100,000.00
Amount in excess of the TMAC (non-covered): $ 106,000.00

Reimbursement Calculation:
Allowed/Covered Amount (TMAC): $100,000.00
Member’s Out-of-Network Deductible and Out-of-Pocket Maximum:
Insurance Benefit Covers 60% of TMAC. However, once the Out-of-Network, Out-of-Pocket Maximum is met, the facility and associated Practitioners are eligible for 100% of the remaining TMAC**:
$ 94,000.00

Member owes Hospital or other Transplant Practitioners: $ 6,000.00
Out-of-Network Deductible and Out-of-Pocket Maximum:
Amount in excess of the TMAC (non-covered): $ 106,000.00
TOTAL MEMBER LIABILITY TO TRANSPLANT PRACTITIONERS $ 112,000.00

No Travel Benefits are available. Travel, meals and lodging are at the expense of the Member.

**BlueCross BlueShield of Tennessee pays for all associated claims during the transplant global period on a claim-by-claim basis according to when claims are filed until the benefit is exhausted.
E. Ancillary Care Management

1. Precious Cargo® (PC) Maternity Management Program
(There is an eligibility requirement for this program.)
BlueCross Blue Shield of Tennessee’s PC Program is a maternity-specific program offered to its Administrative Services Only (ASO) accounts. The PC Program is a prenatal education program armed with valuable information that complements a Practitioner’s care. PC links mothers-to-be with important pregnancy-related health care information needed to make healthy choices during pregnancy. This program also helps identify certain health conditions and risk factors early in the pregnancy. If the pregnancy is high risk, the PC nurse refers the Member to BlueCross BlueShield of Tennessee’s Catastrophic Case Management Program where a nurse will work with the Member and the Practitioners to develop a specific plan of care, coordinate services, and monitor the Member throughout the pregnancy. The Precious Cargo® Maternity Management Program is designed to increase the number of healthy births, while reducing Neonatal Care Unit stays and their associated high costs.

When Members enroll in the Precious Cargo® Program, they receive:
- Three confidential pregnancy health risk assessments performed by obstetrical nurses;
- A copy of Your Journey Through Pregnancy, a reference book containing information outlining the nine months of pregnancy; and
- Access to BabyLine, a toll-free, 24-hour information service staffed by registered obstetrical nurses.

BlueCross BlueShield of Tennessee requests that Practitioners encourage their eligible Members to enroll in the Precious Cargo® Maternity Management program as soon as pregnancy is diagnosed. Members may self-refer into the program by calling 1-855-467-BABY or 1-855-467-2229.

2. Behavioral Health Care Management
Behavioral Health Care Management involves trained behavioral health clinicians working with medical case managers to determine the most appropriate care settings and the Practitioners best suited to treat each unique situation. The program identifies high-risk Members for assessment opportunities to manage a Member’s total care for improved treatment outcomes.

- All care for Members is fully integrated with other programs such as Medical Case Management, Disease Management, Behavioral Health Disease Management, Disability Benefits, EAPs, Medication Assisted Treatment, and others per employer group’s request.
- Behavioral Health Case Managers:
  - help Members by identifying the most appropriate treatment and Provider for the condition(s); and
  - are physically located with BlueCross BlueShield of Tennessee Medical Case Managers, increasing referral, coordination, and consultation, thus resulting in better Member outcomes due to a higher degree of integration.
- Cases are reviewed by Behavioral Health Medical Directors, Pharmacists, and/or BlueCross BlueShield of Tennessee Medical Directors, as needed.
- Members with frequent visits to emergency rooms are reviewed for case management support.
3. **BlueHealth Solutions Disease Management Program**  
(There is an eligibility requirement for this program.)  
BlueCross Blue Shield of Tennessee’s comprehensive disease management services are  
available to Commercial insured Blue Networks P, S, and E Members. The program is an  
optional add-on for its Administrative Services Only (ASO) accounts.  

This comprehensive disease management program is for Members with Coronary Artery  
Disease (CAD), Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure  
(CHF), Diabetes, and/or Asthma. Members with these conditions, and for which BCBST is  
the primary carrier, receive telephone and mail outreach. The BlueHealth Solutions Disease  
Management Program takes a whole person approach recognizing that Members face a wide  
variety of health care issues and concerns. Registered Nurses provide support across a  
broad spectrum of health conditions and needs in order to actively engage Members in better  
managing their overall care.  

Registered Nurses provide whole-person support using evidence-based, unbiased  
information, including tools and resources that help your patients to:  

- understand their diagnoses  
- become motivated to actively manage their health  
- learn important self-care skills  
- increase their compliance with physician treatment plans  

This information does not replace Practitioner care. Rather, it prepares Members to make  
health care decisions in partnership with their Practitioner.  

The BlueHealth Solutions Disease Management Program also includes an integrated 24/7  
Nurseline available to all eligible Members. Each Covered household receives a welcome  
letter and magnet. Members are encouraged to call the 24/7 Nurseline to speak with a  
Registered Nurse about any symptoms, medical conditions, and other health information.  

4. **BlueHealth Solutions Nurseline**  
(There is an eligibility requirement for this program.)  
BlueCross Blue Shield of Tennessee’s BlueHealth Solutions Nurseline is a 24/7 Nurseline  
service offered to its Administrative Services Only (ASO) accounts. Members are encouraged  
to call the 24/7 Nurseline to speak with a Registered Nurse about symptoms, medical  
conditions, or for other health information.  

5. **NICU Care Management by ProgenyHealth (Progeny)**  
BlueCross Blue Shield of Tennessee’s NICU Care Management Program is available to  
Commercial insured and Administrative Services Only (ASO) Blue Networks P, S, E, and M  
Members. Progeny provides comprehensive care coordination of all Intensive Care Nursery  
admissions from birth through discharge from the hospital by a team of NICU experienced  
nurses and board-certified neonatologists and pediatricians.  

Enrollment begins when the Facility, Practitioner, or BCBST notifies Progeny of a delivery  
and admission to the NICU. Focus is on early implementation of discharge planning services  
to help ensure that all necessary DME and health care services are in place prior to the  
infant’s anticipated discharge date.  

Utilization and Case Management is provided for all NICU babies during their hospital stay  
and continuing throughout the first year of life. Families work with dedicated case managers  
who provide education support and care coordination services. Secure 24/7 web-based  
application “BabyTrax” is available for families and Providers. An electronic breast pump gift  
is offered to all mothers of enrolled babies who agree to breast milk feed.  

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Progeny works collaboratively with NICU Providers to promote effective and efficient utilization of resources while promoting an evidence-based approach to care. Progeny works with Providers to decrease unnecessary readmissions and ER visits through family education and intervention of its dedicated case management staff.

F. Evaluation of Care Management Programs

The Care Management programs are evaluated on an annual basis and revised as needed. The programs are reviewed to add or modify activities necessitating the quality improvement of effective and efficient service to BlueCross BlueShield of Tennessee Members. Member satisfaction data is collected and reviewed to add or modify activities necessitating the quality improvement of effective and efficient service to BlueCross BlueShield of Tennessee Members.
XI. PREVENTIVE CARE

Preventive care benefits vary according to the Member’s health care benefits plan. Providers can verify Member benefits by calling the Provider Service line, 1-800-924-7141, the BlueCross BlueShield of Tennessee Customer Service number listed on the front of the Member’s ID card, or via BlueAccess, the secure area on the company website, www.bcbst.com.

Providers may also review preventive health guidelines and other preventive services information on the company website, www.bcbst.com or by visiting www.bcbst.com/providers/preventive-services.shtml. Paper copies of these guidelines are available upon request by calling 423-535-6705.
XII. QUALITY IMPROVEMENT PROGRAM (QIP)

A. Introduction

BlueCross BlueShield of Tennessee, Inc. is committed to improving the quality and safety of care and service to its Members. BlueCross BlueShield of Tennessee demonstrates this commitment through the implementation of a comprehensive Quality Improvement Program (QIP), which provides the structure that supports quality improvement activities.

The purpose of the QIP is to assess and improve the quality and safety of clinical care and service received by our Members. This is achieved by planning and implementing quality improvement activities that are integrated and coordinated across departmental lines. This purpose is accomplished by creating an infrastructure and a set of business processes that support the achievement of high quality outcomes in care and service as an integral part of the way we do business.

The QIP includes a written program description, work plan, program evaluation and a committee structure that supports the program. The QIP reflects goals that support the mission and objectives of BlueCross BlueShield of Tennessee. The QIP is integrated throughout the organization with each department sharing the responsibility for improving care or service to Members. Additionally, the QIP is compliant with all relevant federal and state regulations and complies with accrediting agency standards. Continuous Quality Improvement (CQI) processes are incorporated into the entire health care delivery system of BlueCross BlueShield of Tennessee.

B. Scope

The scope of the population served by the QIP includes all Members. Participation in QIP activities include, but are not limited to:

- Primary Care Practitioners and Specialty Providers
- Institutional Settings (hospital, skilled nursing facilities, home health agencies, pharmacies, long term care facilities, and rehabilitation facilities)
- Non-institutional Settings (free-standing surgical centers, urgent care centers, emergency departments and physical therapy)
- Internal Operations

C. Authority and Structure

Authority and Responsibility
The BlueCross BlueShield of Tennessee Board of Directors (BOD) has the ultimate responsibility and accountability for the quality and safety of care and services rendered, and for the QIP. The BOD reviews and approves the QIP annually. The BOD has formally delegated the oversight of the QIP and associated quality improvement activities to the Enterprise Quality Oversight Committee. This Committee meets at least quarterly and is responsible for, but not limited to, the review and approval of the QIP. A complete committee structure is in place to support the QI Program's clinical and service quality activities and oversee the development and implementation of the QIP. Additionally, designated regional Physicians are also involved in Quality Improvement (QI) activities and responsible for the implementation of the QIP. Network Practitioners are actively

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involved in the QIP through their participation in appropriate committees, development of clinical policies, adoption of clinical practice guidelines, peer review, review of Utilization Management (UM) criteria modifications and medical policy review.

Confidentiality
Any employee or participating Practitioner engaging in Continuous Quality Improvement (CQI) activities must uphold the established principles of Member and Practitioner confidentiality. Employees, Contractors and Practitioners will sign an affidavit of confidentiality. CQI data and reports are only accessible to those individuals participating in the QIP and those agencies responsible for ascertaining the existence of an ongoing and effective program. Summary results may be released through marketing requests for information. Any request for information from attorneys or consumers must be submitted in writing to the Legal Department indicating the purpose of the request.

Conflict of Interest
No person may participate in the review and evaluation of any case or issue in which he or she has been personally or professionally involved or where a conflict of interest may exist, which potentially compromises objective evaluation. A Practitioner serving on any committee or subcommittee, acting as a Physician advisor, or serving as peer reviewer will disqualify themselves from evaluating or reviewing a case in which he/she or his/her immediate associates have been personally or professionally involved, or if a direct personal or economic interest exists.

Quality Improvement Activities
A defined methodology ensures a systematic approach to the collection of objective, statistically valid data, in order to evaluate and improve quality of care and the services offered to Members and Practitioners. The collected data also provides an opportunity to assess structure, processes and outcomes for improvement opportunities.

BlueCross BlueShield of Tennessee focuses on clinical and service objectives and issues that are relevant for a significant portion of our Members. Reviewing the results of population assessments identifies important aspects of clinical care that significantly impact Members and Providers. Some of these activities may include but are not limited to:

- Fostering a supportive environment to help Practitioners and Providers improve the safety of practices.
- Evaluating and acting on opportunities to improve the quality of clinical and non-clinical aspects of care and service, including the availability, accessibility, coordination and continuity of care.
- Developing and promoting health, disease and risk management activities that identify and evaluate medical and behavioral health risks and implementation of actions to control or eliminate those risks.

Program Evaluation and Workplan
The overall effectiveness of the QIP is evaluated at least annually and documented in a written QI Program Evaluation. The evaluation addresses:

- Progress and status of annual goals
- Completed and ongoing QI activities
- Trending of clinical, service and other performance measurements
- Analysis of results for demonstrated improvements in quality
- Opportunities for improvement
- Overall effectiveness of the QIP
- Goals and recommendation for the workplan for the following year

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Based on the annual program evaluation, the QIP is revised and a QI workplan is developed. The purpose of the annual workplan is to focus on the QIP goals, objectives and planned projects/activities for the forthcoming year. The annual workplan also identifies responsible party(ies)/person(s), timeframes for achievement of activities, and committee reporting. The workplan is utilized as an action plan to document the status of activities and achievement of goals throughout the year.

Information about the QIP, the organization’s progress toward goals and the organization’s performance data will be made available to Members, health plan staff and Providers/Practitioners annually. For more information about the Quality Improvement Program, please call 423-535-6705.

Clinical Practice Guidelines

BlueCross BlueShield of Tennessee adopts and disseminates clinical practice guidelines that are relevant to its membership for the provision of preventive and nonpreventive health, acute and chronic medical and behavioral health services. These guidelines are intended to assist Practitioners in making appropriate health care decisions for specific clinical circumstances.

BlueCross BlueShield of Tennessee policy and procedure directs that nationally recognized guidelines be utilized when available. All clinical practice guidelines are reviewed at least annually, with more frequent review being initiated if new national standards are published prior to the review date.

Adopted Clinical Practice Guidelines can be viewed online via direct links found in the Health Care Practice Recommendations (HCPR) Manual located on the company Web site at http://www.bcbst.com/providers/hcpr.

Paper copies of these guidelines are available upon request by calling 423-535-6705.

D. Medical Management Corrective Action Plan

PURPOSE: This procedure statement outlines how BlueCross BlueShield of Tennessee, Inc., and its affiliated companies, ("the Plan") may initiate corrective actions if a participating Provider fails to comply with applicable medical management requirements set forth in section I, below. This statement also outlines how the Plan will process denials of initial applications. The Plan’s medical management programs include Provider credentialing, utilization review, quality management and Member grievance resolution activities that are overseen by professional review committees. The Plan's Board of Directors has designated the Enterprise Quality Oversight Committee and its subcommittees (the "Committees") as the professional review committees responsible for performing peer review activities in accordance with the Federal Health Care Quality Improvement Act (the "HCQIA"), TCA section 63-1-150 and other applicable laws governing the organization and operation of professional peer review or medical review committees (the "Peer Review Laws").

The Plan's staff has been authorized to provide necessary support services to the Committees. Members of the Board, Committee Members, staff Members and anyone providing information to those Committees are intended to be protected against liability to the fullest extent permitted by the Peer Review Laws. The terms of this Procedure statement have been incorporated by reference into the Plan’s Provider participation applications and agreements. As partial consideration for being permitted to apply to become a participating Provider and, if applicable, selected to participate in the Plan, participating Providers agree that they shall not seek to hold the Plan or such individuals liable for acts taken in good faith in accordance with this Procedure statement.

This procedure only applies to matters that involve Committee actions. Matters that do not involve Committee actions include: the non-acceptance of a participation application because the Provider fails to satisfy the Plan’s pre-credentialing application standards (e.g. failure to provide evidence of licensure.
or insurance), the termination of a Provider’s participation other than by reason of that Provider’s failure to comply with applicable participation requirements (e.g. the participation agreement is terminated without cause); and disputes related to claims payment or authorization decisions. Such matters must be resolved in accordance with the Plan’s Provider Dispute Resolution Procedure statement.

Records or information concerning the activities of the Committees shall be treated and maintained as privileged and confidential peer review records to the fullest extent permitted by the Peer Review Laws. Reports to the Committees, the Board of Directors or regulatory agencies concerning actions taken pursuant to this procedure statement shall not alter the status of such records or information as privileged and confidential information.

I. PARTICIPATION REQUIREMENTS

The Plan's Chief Medical Officer or his designee (the "Chief Medical Officer") will monitor participating Providers' performance to ensure that they comply with the Plan's participation requirements. The following is intended to provide a non-exclusive summary of those participation requirements:

A. Participating Providers shall cooperate, in good faith, to facilitate the Plan's medical management activities. Such cooperation includes returning telephone calls, responding to written inquiries or requests from the Plan, providing information and documents requested by the Plan and cooperating with Plan staff Members as they perform their medical management activities.

B. Participating Providers shall render or order Medically Necessary and Appropriate services for Member-patients.

C. Participating Providers shall obtain prior authorization of services in accordance with applicable Plan medical management program policies and procedures.

D. Participating Providers shall comply with accepted professional standards of care, conduct and competence.

E. Participating Providers shall continue to satisfy the Plan's credentialing requirements as set forth in the Plan’s Credential Process, including, without limitation:

1. The Provider’s licenses or certifications must be in good standing.
2. The Provider’s liability insurance coverage must remain in full force and effect.
3. There have been no unreported material changes in the Provider’s status such that the credentialing information submitted to the Plan is no longer accurate.

II. CORRECTIVE ACTIONS

A. INVESTIGATION

The Plan's staff will investigate and report any apparent non-compliance with the participation requirements to the Chief Medical Officer or his designee, after making a reasonable effort to obtain material facts concerning that matter. Providers must submit requested information and fully cooperate with those staff members as a condition of their continued participation in the Plan. Staff members or the Chief Medical Officer may, at their discretion:

1. Consult with the Provider;
2. Review material documents, including Members' medical records; or
3. Contact other Providers or persons who have knowledge concerning the matter being investigated.

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B. BASIS OF ACTIONS

The Chief Medical Officer or a Committee may initiate a corrective action if a participating Provider does not comply with applicable participation requirements, and:

1. There is a reasonable belief that the action will promote the objectives of the Plan's medical management program.
2. There has been a reasonable effort to obtain the facts concerning the Provider's alleged non-compliance.
3. The proposed action is reasonably warranted by the facts known after the investigation has been completed.

C. ACTIONS BY THE CHIEF MEDICAL OFFICER

Upon determining that a participating Provider has not complied with the Plan's participation requirements, the Chief Medical Officer may initiate corrective actions including, without limitation:

1. Counseling the Provider concerning specific actions that should be taken to address identified problems. A summary of the counseling session and the plan of corrective action will be included in the Provider's credentialing file.
2. Submitting information regarding the Provider's conduct to the appropriate Committee for further consideration and action.
3. Imposing corrective actions, following the issuance of a "notice of corrective action" including without limitation:
   a. Imposing practice restrictions, such as, focused review, mandatory prior authorizations for specified treatments or services, mandatory consultation, preceptorship, continuing medical education, closure of the Provider's practice to new Members, and/or imposition of a practice improvement plan.
   b. Terminating the Provider's participation.
   c. Imposing financial penalties such as an increased withhold, a one-time financial penalty (e.g. the cost of services incurred as a consequence of the Provider's non-compliance) or the denial of fees for inappropriate or unauthorized services.
4. Imposing a summary suspension. The Chief Medical Officer shall notify the Provider, by certified mail, of the summary suspension of the Provider's participation, if such action is necessary to protect Members' health and welfare or to protect the Plan's reputation or operations.
   a. If the Chief Medical Officer or a Committee requires additional time to investigate allegations concerning a Provider's conduct, competence, practices or reputation, the summary suspension shall remain in effect pending the completion of that investigation. Such investigation must be completed within fourteen (14) days after the imposition of the summary suspension.
   b. If, after such investigation, it is determined that the Provider's conduct, competence, practices or reputation may result in an imminent danger to Members' health or welfare, or impair the Plan's reputation or operations, the suspension shall continue in effect unless the Provider's participation is reinstated following a hearing conducted in accordance with section III, below.
   c. The Chief Medical Officer shall make appropriate arrangements to have other Providers render services to Members who are under the care of the suspended Provider. The suspended Provider shall cooperate in referring Members to such other Providers in accordance with this Corrective Action Plan and the terms of his or her participation agreement.

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d. If a Provider is a Member of a medical group or IPA, the Medical Director of that group or IPA shall be notified, in writing, of the imposition of corrective actions pursuant to this section.

D. ACTIONS BY THE COMMITTEE

1. Committee Meetings

If the Chief Medical Officer refers the matter to a Committee, that Committee shall consider information submitted to it concerning a Provider's non-compliance with the Plan's participation requirements during its next regularly scheduled meeting or at a special meeting called by the Chief Medical Officer to consider that matter. Members of the Committee may participate in such meetings in person or by telephone conference call and may take actions by consent. Any meeting of a Committee concerning a Provider's alleged non-compliance shall be conducted in confidence and any information concerning such meetings shall be maintained as privileged and confidential information to the fullest extent permitted by applicable Peer Review Laws.

2. Committee Investigations

A Committee may direct the Chief Medical Officer or his designee to further investigate and submit additional information concerning a Provider's alleged non-compliance. The Committee may also request that the Provider submit specified information or attend a meeting to respond to questions concerning such alleged non-compliance. The Provider otherwise has no right to participate in Committee proceedings.

3. Corrective Actions

The Committee may request the Chief Medical Officer to take any of the corrective actions described in section II.C, above. In addition, the Committee may take any of the Corrective Actions described in section II. C. above except for II.C.4. (imposing a summary suspension). The Credentialing Committee may deny or revoke a Provider's Credentials.

E. NOTICE OF CORRECTIVE ACTION

The Chief Medical Officer or the Chairperson of the Committee shall immediately notify the Provider, by certified or overnight mail, of the imposition of a corrective action. If the Provider is a member of an IPA or medical group, a copy of that notice shall also be sent to the Medical Director of that IPA or medical group. That corrective action shall become effective as of the date of that letter, unless the Chief Medical Officer or Committee elect to defer the effective date of that action.

The notice letter shall include:

1. A description of the corrective action,
2. A general description of the basis of that action,
3. A statement explaining how to request an appeal to the imposition of that action (to the extent that action is subject to appeal), specifying that such an appeal must be requested within thirty (30) days after the date of that notice letter.
4. If applicable, a statement that the action may be reported to the State licensing board or other entities as mandated by law if the Provider doesn't request an appeal or if that action is affirmed following exhaustion of the appeal process.
III. APPEAL PROCEDURES

A. APPEAL OF NON-REPORTABLE ACTION BY A PARTICIPATING PROVIDER

1. Written Appeal
   a. The Provider may appeal by submitting a written statement of his position within thirty (30) days of receipt of the notice of imposition of the corrective action. The written appeal will be reviewed by the Committee or Chief Medical Officer imposing the corrective action. A written response will be sent to the Provider within sixty (60) days of our receipt of the written appeal.
   b. The Provider must comply with the terms and conditions of the corrective action while the appeal is pending, unless specifically directed otherwise by the Committee or Chief Medical Officer.

2. Informal Subcommittee Meeting
   a. The Committee, in its sole discretion, may offer an informal subcommittee meeting to the Provider. The subcommittee will consist of individuals from the Committee and its purpose is to have an informal and open discussion with the Provider. The Provider has the option of accepting this offer for an informal subcommittee meeting, or may proceed to the next level of appeal as defined in this Section. The Provider does not waive any appeal rights by participating in the subcommittee meeting and may proceed with any appeals should the Committee uphold its decision after the subcommittee meeting.
   b. If an informal subcommittee is granted, the Provider may not be represented by an attorney and the meeting shall not be tape recorded or recorded by a court reporter.
   c. After the conclusion of the meeting, the subcommittee will make a recommendation to the appropriate Committee or the Chief Medical Officer concerning continued imposition of the corrective action. The subcommittee’s recommendation will be considered at the next regularly scheduled Committee meeting unless the Chief Medical Officer calls a special meeting to consider that report. The Committee may accept, modify or reverse the subcommittee's recommendation, at its discretion. The Provider shall not have the right to appeal or to otherwise participate in the Committee's deliberations concerning the subcommittee's recommendation. The Committee shall notify the Provider of its decision within ten (10) working days after the date of that meeting.

3. Binding Arbitration
   a. After the final decision by BCBST, all parties agree to take any dispute to binding arbitration. The Provider shall make a written demand that the adverse action be submitted to binding arbitration pursuant to the Commercial Arbitration Rules of the American Arbitration Association (current ed.). Either party may make a written demand for binding arbitration within thirty (30) days after it receives the Plan’s response. The venue for the arbitration shall be in Chattanooga, TN unless otherwise agreed. The arbitration shall be conducted by a panel of three (3) qualified arbitrators, unless the parties otherwise agree. The arbitrators may sanction a party, including ruling in favor of the other party, if appropriate, if a party fails to comply with applicable procedures or deadlines established by those Arbitration Rules.
   b. The claimant shall pay the applicable filing fee established by the American Arbitration Association, but the filing fee may be reallocated or reassessed as part of an arbitration award either, in whole or in part, at the discretion of the arbitrator/arbitration panel if the claimant prevails upon the merits. If the claimant withdraws its demand for arbitration, then claimant forfeits its filing fee and it may not be assessed against BCBST.
c. Each party shall be responsible for one-half of the arbitration agency’s administrative fee, the arbitrators’ fees and other expenses directly related to conducting that arbitration. Each party shall otherwise be solely responsible for any other expenses incurred in preparing for or participating in the arbitration process, including that party’s attorney’s fees.

d. The arbitrators: shall be required to issue a reasoned written decision explaining the basis of their decision and the manner of calculating any award; shall limit review to whether or not the Plan’s action was arbitrary and capricious; may not award punitive or exemplary damages; may not vary or disregard the terms of the Provider’s participation agreement, the certificate of coverage and other agreements, if applicable; and shall be bound by controlling law; when issuing a decision concerning the matter at issue. Emergency relief such as injunctive relief may be awarded by an arbitrator/arbitration panel. A party shall make application for any such relief pursuant to the Optional Rules for Emergency Measures of Protection of the American Arbitration Association (most recent edition). The arbitrators’ award, order or judgment shall be final and binding upon the parties. That decision may be entered and enforced in any state or federal court of competent jurisdiction. The arbitration award may only be modified, corrected or vacated for the reasons set forth in the United States Arbitration Act (9 USC § 1).

e. This arbitration provision supersedes any prior arbitration clause or provision contained in any other document. This arbitration clause may be modified or amended by BCBST and the Provider will receive notice of any modifications through updates to the Provider Manual.

B. APPEAL OF NON-REPORTABLE ACTION BY AN APPLICANT

1. Written Appeal

   a. The Provider may appeal by submitting a written statement of his position within thirty (30) days of receipt of the notice of the denial of application. The written appeal will be reviewed by the Committee or Chief Medical Officer. A written response will be sent to the Provider within sixty (60) days of our receipt of the written appeal.

2. Binding Arbitration

   a. If the Provider is still not satisfied with the Committee’s decision, he may make a written request that the matter be submitted to binding arbitration in accordance with the procedure set forth in section III.A.3 above.

C. APPEAL OF A POTENTIALLY REPORTABLE ACTION BY PARTICIPATING PROVIDERS OR APPLICANTS

1. Informal Subcommittee Meeting

   a. The Committee, in its sole discretion, may offer an informal subcommittee meeting to the Provider. The subcommittee will consist of individuals from the Committee and its purpose is to have an informal and open discussion with the Provider. The Provider has the option of accepting this offer for an informal subcommittee meeting, or may proceed to the next level of appeal as defined in this Section. The Provider does not waive any appeal rights by participating in the subcommittee meeting and may proceed with any appeals should the Committee uphold its decision after the subcommittee meeting.

   b. If there is an informal subcommittee meeting, the Provider may not be represented by an attorney and the meeting shall not be tape recorded or recorded by a court reporter.

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After the conclusion of the meeting, the subcommittee will make a recommendation to the appropriate Committee or the Chief Medical Officer concerning continued imposition of the corrective action. The subcommittee’s recommendation will be considered at the next regularly scheduled Committee meeting unless the Chief Medical Officer calls a special meeting to consider that report. The Committee may accept, modify or reverse the subcommittee’s recommendation, at its discretion. The Provider shall not have the right to appeal or to otherwise participate in the Committee’s deliberations concerning the subcommittee’s recommendation. The Committee shall notify the Provider of its decision within ten (10) working days after the date of that meeting.

2. Hearing

a. Appointment of the Hearing Officer

The Provider may request a hearing regardless of whether or not there was an informal subcommittee meeting. In that event, the Chief Medical Officer shall appoint a qualified designee to serve as the Hearing Officer within thirty (30) working days after receiving that request. The Hearing Officer:

1. Shall not receive a financial benefit from the outcome of the hearing and shall not act as a prosecutor or advocate for the Plan.
2. May not be in direct economic competition with the Provider requesting the hearing.
4. Shall be acting as member of the Committee while performing his or her duties.

b. Notice of Hearing

The Hearing Officer will contact the Provider to establish a mutually acceptable date, time, and place for the hearing; which shall be conducted not less than thirty (30) days after that date. The formal hearing shall be conducted within 120 days of appointment of the Hearing Officer unless both parties agree to extend this time limit. If the parties are unable to agree, the Hearing Officer shall schedule the hearing. The Hearing Officer shall then issue a written notice of hearing to the Provider summarizing: 1) the scheduled time, date and place where the hearing will be conducted; 2) the applicable hearing procedure; 3) a detailed description of the basis of the corrective action, including any acts or omissions which the Provider is alleged to have committed (the "Allegations"); and 4) a statement concerning whether that action may be reportable to the State licensing agency or other entities as mandated by law in accordance with applicable Peer Review Laws.

c. Hearing Procedure

The hearing will be an informal proceeding. Formal rules of evidence or legal procedure will not be applicable during the hearing. The Hearing Officer may reschedule or continue the hearing at his or her discretion or upon reasonable request of the parties. The Provider may forfeit the right to a hearing; however, if he or she fails to appear at the hearing without good cause, the right to schedule another hearing is also forfeited. In addition to any procedure adopted by the Hearing Officer:
1. The Provider has the right to be represented by an attorney or other representative. If the Provider elects to be represented, such representation shall be at his or her own expense.

2. The hearing will be recorded by a court reporter.

3. The Provider and the Plan must provide the other party with a list of witnesses expected to testify on its behalf during the hearing and any documentary evidence that it expects to present during the hearing, as soon as possible following issuance of the notice of hearing. Either party may amend that list at any time not less than ten (10) working days before the date of the hearing.

4. Each party has the right to inspect and copy any documentary information that the other party intends to present during the hearing, at the inspecting party's expense, upon reasonable advance notice, at the location where such records are maintained.

5. During the hearing, each party has the right to:
   i. call witnesses,
   ii. cross-examine opposing witnesses, and
   iii. submit a written statement at the close of the hearings.

6. Following the hearing, each party may obtain copies of the record of the hearing, upon payment of the charges for that record. Each party shall also receive a copy of the Hearing Officer’s report and recommendation.

d. Hearing Officer’s Report

The Hearing Officer will issue a written report and recommendation within thirty (30) days after the conclusion of the hearing. That written report will set forth the Hearing Officer's recommendation concerning the imposition of the corrective action, if any, and the basis for that recommendation.

e. Action by the Committee

The Hearing Officer’s report will be submitted to the appropriate Committee for consideration during its next regularly scheduled meeting, unless the Chief Medical Officer calls a special meeting to consider that report. The Committee may accept, modify or reverse the Hearing Officer's recommendation, at its discretion. The Provider shall not have the right to appeal or to otherwise participate in the Committee's deliberations concerning the Hearing Officer's report. The Committee shall notify the Provider of its decision within ten (10) working days after the date of that meeting. The committee’s decision is the final internal action by BCBST. In the event the decision is an adverse decision as defined by applicable federal and/or state laws, BCBST will report to the appropriate agencies or Boards as required by the applicable federal or state laws.

f. Appeal of Decision

Any action based upon or related to the Committee’s decision must be submitted to binding arbitration in accordance with paragraph III.A.3 above.
IV. REPORTING CORRECTIVE ACTIONS

A. REPORTING TO REGULATORY AGENCIES

Certain actions must be reported in accordance with both state and federal law, including without limitation, the National Practitioner Data Bank (NPDB). The Chief Medical Officer will consult with the Plan's General Counsel prior to initiating any corrective action, if there is a question concerning whether it will be a reportable action.

1. The following actions must generally be reported:
   a. All professional review actions adversely affecting a Provider's participation in the Plan for longer than thirty (30) days based upon the Provider's professional conduct or competence.
   b. A summary suspension that remains in effect for longer than fourteen (14) days.

2. Reports required by federal or state law, including without limitation the NPDB, must include:
   a. the name of the Provider,
   b. a description of the facts and circumstances that form the basis for that action, and
   c. any other relevant information requested by that licensing board.

3. The following actions are generally not reportable:
   a. Actions that do not adversely affect the Provider's participation for longer than thirty (30) days.
   b. Actions based upon the Provider's failure to comply with participation requirements that are not directly related to the Provider's professional conduct or competence.

B. INTERNAL REPORTING REQUIREMENTS

All corrective actions whether reportable to a licensing board or not, must be reported to the following persons:

1. The involved Provider.
2. The Plan's General Counsel.
3. The Plan's Provider Networks and Contracting Department.
4. The Medical Director of each participating Medical Group or IPA if the Provider is a member of that entity.
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XIII. PROVIDER DISPUTE RESOLUTION PROCEDURE

PURPOSE: To address and resolve any and all matters causing participating providers ("Providers") or BlueCross BlueShield of Tennessee or its affiliated companies ("BCBST") to be dissatisfied with any aspect of their relationship with the other party (a "Dispute"). Providers are encouraged to contact a representative of BCBST’s Provider Network Management Division if they have any questions about this procedure statement or concerns related to their network participation.

I. INTRODUCTION.

A. This Procedure describes the exclusive method of resolving any Disputes related to a Provider’s participation in BCBST's network(s). It is incorporated by reference into the participation agreement between the parties (the "Participation Agreement") and shall survive the termination of that Agreement.

B. This Procedure shall only be applicable to resolve Disputes that are subject to BCBST’s or the Provider’s control, such as claims, administrative or certification issues. It shall not be applicable to issues involving third parties that are not within a party’s control (e.g. determinations made by a customer purchasing administrative services only (“ASO Customers”) from BCBST).

C. This Procedure shall not be applicable to actions that may be reportable pursuant to the Federal Health Care Quality Improvement Act. Matters involving peer review evaluation of an applicant’s professional qualifications, conduct or competence must be resolved pursuant to BCBST’s “Medical Management Corrective Action Plan” (Section XII. D in this Manual).

D. The initiation of a Dispute shall not require a party to delay or forgo taking any action that is otherwise permitted by the Participation Agreement.

E. This Procedure statement establishes specific time periods for parties to respond to inquiries and requests for reconsideration. If it is not reasonably possible to provide a final response within those time periods, the responding party may, in good faith, advise the other party that it needs additional time to respond to that matter. In such cases, the responding party shall advise the other party of the status of that matter at least once every thirty (30) days until it submits a final response to the other party.

F. A party must commence an action to resolve a Dispute pursuant to this Dispute Resolution Procedure within eighteen (18) months of the date of the event causing that Dispute occurred (e.g. the date of the letter informing the Provider of a determination) or, with respect to a Provider request for reimbursement of unpaid or underpaid claims, within eighteen (18) months of the date the Provider received payment or, in the event of an unpaid claim, the date the Provider received notice that the claim was denied. This provision shall not extend the period during which a Participating Provider must submit a claim to BCBST pursuant to applicable provisions of the provider's agreement(s) with
BCBST, although the Provider may commence a dispute related to the denial of a claim that was not filed in a timely manner within eighteen (18) months after receiving notice of the denial of that claim. If BCBST discovers a matter creating a Dispute with a Participating Provider during an audit, which is in progress at the end of the eighteen (18) month period referenced in this paragraph, it shall have one hundred twenty days (120) from the conclusion of that audit to initiate a Dispute concerning that matter. The failure to initiate a Dispute within that period specified in this subsection shall bar any type of action related to the event causing that Dispute, unless the parties agree to extend the time period for initiating an action to resolve that Dispute pursuant to this procedure statement.

G. ALL DISPUTES WILL BE SUBJECT TO BINDING ARBITRATION IF THEY CAN NOT BE RESOLVED TO THE PARTIES’ SATISFACTION PURSUANT TO SECTIONS II (A-B) OF THIS PROCEDURE STATEMENT.

II. DESCRIPTION OF THE DISPUTE RESOLUTION PROCEDURE.

A. INQUIRY/RECONSIDERATION

Providers should contact a representative of the BCBST division or department that is directly involved in any matter that may cause a Dispute between the parties. (e.g. the Claims Service Department if there is a question concerning a claims related issue). If Providers do not know whom to contact, they may contact a representative of the Provider Network Management Division for assistance in directing their inquiries to the appropriate BCBST representative. BCBST may initiate an inquiry by contacting the Provider or the person that the Provider designates to respond to such inquiries (e.g. an office manager). If a party cannot respond immediately to the other party’s inquiry, it shall make a good faith effort to investigate and respond to that inquiry within thirty (30) days.

B. APPEAL.

If not satisfied, a party may submit a written appeal within 30 days after receiving the other party’s response to its inquiry/reconsideration. That request shall state the basis of the Dispute, why the response to its inquiry/reconsideration is not satisfactory, and the proposed method of resolving the Dispute. The receiving party will make a good faith effort to respond, in writing, within sixty (60) days after receiving that appeal.

C. BINDING ARBITRATION.

If the parties do not resolve their Dispute, the next and final step is binding arbitration. If a party is not satisfied with an adverse decision, then it shall make a written demand that the Dispute be submitted to binding arbitration pursuant to the Commercial Arbitration Rules of the American Arbitration Association (current ed.). Either party may make a written demand for binding arbitration within thirty (30) days after it receives a response to its appeal. The venue for the arbitration shall be Chattanooga, TN unless otherwise agreed. The arbitration shall be conducted by a panel of three (3) qualified arbitrators, unless the parties otherwise agree. The arbitrators may sanction a party, including ruling in favor of the other party, if appropriate, if a party fails to comply with applicable procedures or deadlines established by those Arbitration Rules.

Each party shall be responsible for one-half of the arbitration agency’s administrative fee, the arbitrators’ fees and other expenses directly related to conducting that arbitration. Each party shall otherwise be solely responsible for any other expenses incurred in preparing for or participating in the arbitration process, including that party’s attorney’s fees.
The claimant shall pay the applicable filing fee established by the American Arbitration Association, but the filing fee may be reallocated or reassessed as part of an arbitration award either, in whole or in part, at the discretion of the arbitrator/arbitration panel if the claimant prevails upon the merits. If the claimant withdraws its demand for arbitration, then the claimant forfeits its filing fee and it may not be assessed against BCBST.

The arbitrators: shall consider each claimant’s demand individually and shall not certify or consider multiple claimants’ demands as part of a class action; shall be required to issue a reasoned written decision explaining the basis of their decision and the manner of calculating any award; shall limit review to whether or not the Plan’s action was arbitrary or capricious; may not award punitive, extra-contractual, treble or exemplary damages; may not vary or disregard the terms of the Provider's participation agreement, the certificate of coverage and other agreements, if applicable; and shall be bound by controlling law; when issuing a decision concerning the Dispute. Emergency relief such as injunctive relief may be awarded by an arbitrator/arbitration panel. A party shall make application for any such relief pursuant to the Optional Rules for Emergency Measures of Protection of the American Arbitration Association (most recent edition). The arbitrators’ award, order or judgment shall be final and binding upon the parties. That decision may be entered and enforced in any state or federal court of competent jurisdiction. That arbitration award may only be modified, corrected vacated for the reasons set forth in the United States Arbitration Act (9 USC § 1).

This arbitration provision supersedes any prior arbitration clause or provision contained in any other document. This arbitration clause may be modified or amended by BCBST and the Provider will receive notice of any modifications through updates to the Provider Manual.

D. EFFECTIVE DATE.

This procedure statement was adopted by BCBST on June 1, 1997.

Last date of revision, October 13, 2015

A sample copy of the formal Provider Dispute Form follows:
## Provider Dispute Form

BlueCross BlueShield of Tennessee
1 Cameron Hill Circle, Suite 0039
Chattanooga, Tennessee 37402-0039

<table>
<thead>
<tr>
<th>Date</th>
<th>Provider Name</th>
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<tbody>
<tr>
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<tr>
<td>Provider No./NPI</td>
<td>Patient Name</td>
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<tr>
<td>Provider Contact</td>
<td>Member ID No.</td>
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<td></td>
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<tr>
<td>Provider Fax No.</td>
<td>Date of Service</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Provider Telephone No.</td>
<td>Claim No/Decision/Issue Disputed</td>
</tr>
</tbody>
</table>

When submitting a Dispute in accordance with the Inquiry or Appeal Level of the Procedure, please indicate a detailed reason for Dispute. If applicable, please include all pertinent information including prior correspondence, medical records, and all documentation you wish to have considered in the final determination of the dispute. (You may use the back of this form as necessary.)

Indication of Provider Appeal below verifies you have submitted the dispute under the Reconsideration Level of the Procedure and are dissatisfied with the response. (Please attach a copy of the response received from the applicable BCBST Customer Service Department.)

### Commercial Member

- Level I – Reconsideration
- Level II – Appeal

### BlueAdvantage Member

- Level I Reconsideration (Attrn: Customer Service for administrative disputes)
- Level I Reopening (Attrn: Utilization Management for medical necessity disputes)
- Level II – Appeal

### BlueCard

Tennessee providers and BCBST contracted providers in contiguous counties should submit disputes for all BlueCross BlueShield members to BCBST.

- Level I – Reconsideration
- Level II – Appeal

Out-of-State providers (not in contiguous counties) should submit disputes for all BlueCross BlueShield members to their local BCBS Plan. Failure to do so may result in a delayed response to your request.

Notes/Comments:

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**GO-553 (1.13)** (You may use the back of this form as necessary.)

BlueCross BlueShield of Tennessee, Inc., an Independent License of the BlueCross BlueShield Association

Rev 06/13
Provider Dispute Form *(Continued)*

<table>
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<th>Member ID No.</th>
<th>Patient Name</th>
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Notes/Comments *(Continued)*:
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XIV. CREDENTIALING

A. Introduction

The BlueCross BlueShield of Tennessee (BCBST) Credentialing Program was established August 1, 1995. The Credentialing Program is designed around goals that reflect the BlueCross BlueShield of Tennessee mission, as well as regulatory and accrediting requirements.

In order to establish consistent standards for network participation, and to meet regulatory requirements, BlueCross BlueShield of Tennessee developed Network Participation Criteria. Practitioners applying for network admission are asked to complete an application through the Council for Affordable Quality Healthcare (CAQH) for individual professionals. BCBST partners with CAQH Solutions, which offers Providers a single point of entry for application information. Organizational Providers will utilize the BCBST Facility application information. Utilizing the CAQH application or Organizational Provider application, BlueCross BlueShield of Tennessee conducts a preliminary evaluation for network participation. Practitioners must complete the application in its entirety, submit the required documentation, and complete the credentialing process prior to network participation.

Verifying credentials of Practitioners and other Health Care Professionals/Providers is an essential component of an integrated health care system. The Credentialing process incorporates an ongoing assessment of the quality-of-care services provided by those Practitioners and other Health Care Professionals/Providers who wish to participate in the BCBST network. Major components of the credentialing program include:

- Credentialing Committee
- Policies and Procedures
- Initial Credentialing Process
- Recredentialing Process
- Delegated Credentialing Activities

The BCBST Credentialing Committee (the Committee) is a peer review committee and is subject to the rights and privileges set forth in TCA Section 63-1-150. The Committee shall conduct peer review of those cases meeting the Exception Criteria of the Credentialing and Recredentialing of Practitioners policy (CR.0255) (and other situations that involve peer review functions) and will evaluate each case individually.

The Committee may, in its discretion, allow credentialing or continued credentialing of certain Practitioners or Organizations who fall within the exception criteria and deny credentialing or terminate credentials of other Practitioners or Organizations who also fall within the exception criteria. It shall be within the Committee’s discretion to assess and evaluate the facts of each individual case and determine whether it is in the best interest of BCBST’s Members and BCBST for a Practitioner or Organizations to be credentialed or credentialing continued. In its discretion, the Committee may deny all Practitioners or Organizations who fall within a certain exception criteria if the Committee determines that the health and welfare of BCBST Members could be jeopardized by credentialing such Practitioners or Organizations or continuing their credentialing. (Policy CR.0277 Credentialing Committee Discretion Policy)

Practitioners or Organizational Providers have the right to review information (received from outside sources excluding peer review protected information) submitted with their application; correct erroneous information within thirty (30) days of receipt of completed application by contacting us at the address, phone number and/or email address listed below; or be informed of the status of their credentialing/recredentialing application upon request. Inquiries regarding the Credentialing process and/or Credentialing applications should be addressed to the following:
Mailing Address: BlueCross BlueShield of Tennessee
Attn: Credentialing Department
1 Cameron Hill Circle, Ste 0007
Chattanooga, TN 37402-0007

Telephone Inquiries:
(Toll Free) 1-800-357-0395
(Fax) 1-423-535-8357
(Fax) 1-423-535-6711

E-mail: Credentials@bcbst.com

**Note:** For denial/appeal process refer to the Medical Management Corrective Action Plan in Section XI. Quality Improvement Program in this Manual for detailed description of appeal rights.

### B. Credentialing Application

Credentialing applications are used to uniformly identify and gather specific information for all Practitioners and Organizational Providers that wish to participate with BlueCross BlueShield of Tennessee. The BlueCross BlueShield of Tennessee Credentialing standards apply to all licensed independent Practitioners or Practitioner groups who have an independent relationship with BlueCross BlueShield of Tennessee. The BlueCross BlueShield of Tennessee Credentialing Program determines whether Practitioners and other Health Care Professionals, licensed by the State and under contract to BlueCross BlueShield of Tennessee, are qualified to perform their services and meet the minimum requirements defined by National Committee for Quality Assurance (NCQA), the Centers for Medicare & Medicaid Services (CMS), and the TennCare Risk Agreement. Verification of all required credentials is imperative.

Once Practitioners and Organizational Providers have completed the credentialing process, they will receive written notification within ten (10) days from BlueCross BlueShield of Tennessee’s Credentialing Department. **Note:** This notification does not guarantee acceptance in BlueCross BlueShield of Tennessee networks; Practitioners and Organizational Providers are not considered participating in BlueCross BlueShield of Tennessee networks until they receive an acceptance letter from BlueCross BlueShield of Tennessee’s Contracting Department. Our goal is to complete credentialing and contracting a Provider within thirty (30) days of receiving a completed application.

**CAQH APPLICATIONS SHOULD REFLECT THE FOLLOWING, ALONG WITH THEIR STANDARD REQUIREMENTS TO BE CONSIDERED COMPLETE:**

- Detailed Explanation of any malpractice suit within the last five (5) years
- Detailed Explanation of any question(s) answered, “Yes” on the application
- Letter of agreement signed by admitting Physician when Practitioner does not have current Hospital Privileges (If applicable)
- Copy of Certificate from Nationally Recognized Accrediting Body – NP & PA (ANCC, AANP, if applicable)
- Ownership and Disclosure of Interest Statement
- Group Grid
- Other Supporting Documentation sent to Provider from BCBST

**Letter for NPs and PAs must include:**

- The name and address of supervisory Physician;
- Verification the Physician is responsible for the care and treatment rendered;
- Verification interaction physically occurs at office where treatment is being rendered (NP/once a month; PA/once a week); and
- Verification that protocol exists as required by state law.
- APN License (NP only)
Electronic Funds Transfer (EFT):
- Providers are required to enroll in the EFT process. For enrollment information, Enrollment information is available on the CAQH Solutions website at https://solutions.caqh.org.
- If you completed the Electronic Funds Transfer Information under Section V—Payment Information of the Credentialing Application, please include a VOIRED check with the appropriate account number when returning your application.

The applying Provider will receive notification from BCBST when all documents have been received and the review process has begun. If all necessary documentation is not received within thirty (30) days of the documentation request date, the application will be closed as incomplete. The Provider has the right to correct erroneous information within thirty (30) days of receipt as well as check the status of application at any time during the credentialing/credenrical process.

If you have any questions or need assistance contact Provider Service line at 1-800-924-7141 and say “Provider Network Services” when prompted.

C. Credentialing Policies

BlueCross BlueShield of Tennessee has written policies and procedures for both the initial and recredentialing process of Practitioners and Organizational Providers. The following policies are subject to change and should only be referenced as a guideline. Final determination of credentialing status is a decision of the BlueCross BlueShield of Tennessee Corporate Credentialing Committee. For specific assistance, please contact your Provider Relations Consultant (see Section I for region-specific telephone number) or call the BlueCross BlueShield of Tennessee Credentialing Department at 1-800-357-0395.

Note: Primary Care Practitioner and OB/GYN office site visits are performed by BlueCross BlueShield of Tennessee within six (6) months of the credentialing event.

1. Credentialing Process for Practitioner:

   The following information is required and/or must be verified for Practitioners:
   - A current, valid, full, unrestricted license to practice in the state of jurisdiction.
   - History of, or current license probation will be subject to peer review.
   - Current, valid, unrestricted Prescriptive Authority (ability to prescribe medication in accordance with State law) within the scope of the Practitioner’s practice, if applicable.
   - Work history for the last five years with documented gaps in employment over 90 days.
   - Malpractice coverage in amounts of not less than $1,000,000 per occurrence and $3,000,000 aggregate (exceptions made for State Employees).
   - Clinical privileges in good standing at a licensed facility designated by the Practitioner as the primary admitting facility. (Any exceptions to this will be determined by the BCBST Credentialing Committee).
   - National Practitioner Data Bank (NPDB) report
   - Healthcare Integrity and Protection Data Bank (HIPDB) report
   - Board certification verification if the practitioner indicates certified on application
   - BlueCross BlueShield of Tennessee recognizes the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), American Academy of Pediatrics (AAP), American Dental Association (ADA), and the American Board of Podiatric Surgery (ABPS) for recognized specialty designation.
   - Absence of history of federal and/or state sanctions (Medicare, Medicaid, or TennCare).
   - Verification of a current, valid, unrestricted state license is sufficient for a Practitioner's degree. Verification of board certification or highest level of education is necessary for specialty designation.
• History of, or criminal conviction or indictment will be subject to peer review.
• Current Clinical Laboratory Improvement Amendments (CLIA) Certificate, if applicable.
• Twenty-four (24) hour, seven (7)-day-a-week call coverage or arrangements with a BlueCross BlueShield of Tennessee credentialed Practitioner.
• Statement from applicant regarding:
  * Current physical or mental problems that may affect ability to provide health care;
  * Current or past substance use disorder;
  * History of loss of license and or felony convictions;
  * History of loss or limitation of privileges or disciplinary activity; and
  * An attestation to correctness/completeness of the application.
• Office site visit to each potential Primary Care Practitioner and OB/GYN’s office including documentation of a structured review of the site and medical record maintenance process. (See Credentialing XVII.D Practice Site Evaluations/Medical Record Practices.)
• Verification that Practitioner is at office where treatment is rendered and interacts with Nurse Practitioner/Physician Assistant conforming to state regulations.
• Verification that protocol exists and is located at the premises where Nurse Practitioner/Physician Assistant practices as required by state law.

Specific requirements for specialties listed:

**Audiologist/Speech Therapist/Physical Therapist/Occupational Therapist:**
• Current Licensure in State of Tennessee in Specialty will verify education.
• If not practicing in Tennessee, education may be verified by certificate from:
  * American Occupational Therapy Certification Board;
  * American Speech-Language-Hearing Association;
  * Physical Therapist Certificate of Fitness, if applicable; or
  * Verification of highest level of education in specialty requested.
• No call coverage required.
• Clinical privileges not required.
• DEA certificate not required.

**Chiropractor:**
• Clinical privileges not required.
• DEA certificate not required.

**CRNA:**
If credentialing is required, call coverage and hospital privileges are required.

**Dentist:**
Minimum and exception criteria apply with the exception of:
• Clinical privileges not required.

**Dietician/Nutritionist:**
Minimum and exception criteria apply with the exception of:
• Licensed as a Dietician/Nutritionist.
• Minimum of a BA degree from an accredited U.S. college or university, with course approved by the American Dietetic Association’s Commission for a Didactic Program in Dietetics.
• Must undergo a 6- to 12-month practice program or internship at a healthcare facility, community agency, or food service corporation, or do the equivalent in combination with their undergraduate course work.
• Completion of a Commission on Accreditation of Dietetics Education (CADE) accredited Didactic Program in Dietetics and pass the national board examination administered by the Commission on Dietetic Registration (CDR).
• Clinical privileges not required.
• Call coverage not required.
• DEA certificate not required.
**Genetic Counselor**
Minimum and exception criteria with the exception of:
- Licensed as a Genetic Counselor.
- Clinical privileges not required.
- Call coverage not required.
- DEA certificate not required.
- Certificate from National Society of Genetic Counselors (NSGC).
- Education must be from one of the 30 accredited universities that offer Genetic Counseling.

**Health Department Practitioner**
- Minimum and exception criteria apply.

**Hospital Based (if practicing outside the hospital setting):**
- Must be credentialed and all Minimum and Exception Criteria applies.
- Any hospital-based Practitioner with additional practice sites are then evaluated and credentialed to that site’s highest standard according to the type of practice (i.e., Primary Care).

**Lactation Specialist**
Minimum and exception criteria apply with the exception of:
- Licensed as a Registered Nurse at a minimum.
- Certification with IBCLC: Global Certification for Lactation Consultant.
- Clinical privileges not required.
- Call coverage not required.
- DEA certificate not required.

**Neuropsychologist (Ph.D):**
Minimum and Exception criteria apply in addition to:
- Clinical privileges not required.
- License must specify “Health Services Provider”.
- Ph. D. degree required.

**Nurse Practitioners or Nurse Mid-Wife:**
Minimum and Exception criteria apply in addition to:
- RN License.
- Advanced Practice Nurse (APN) certificate in TN and applicable prescriptive authority for contiguous states.
- Certificate of Fitness required for Nurse Practitioners (NP), if applicable.
- If Prescriptive Authority includes a DEA certificate, all schedules must be verified.
- Certification most applicable to the nurse specialty from one of the following bodies:
  * American Nurses Credentialing Center;
  * American Academy of Nurse Practitioners;
  * American College of Nurse-Midwives Certification Council;
  * National Certification Corporation of Obstetric and Neonatal Nursing Specialties; or
  * National Certification Board of Pediatric Nurse Practitioners and Nurses.
- Written statement from the BlueCross BlueShield of Tennessee credentialed Practitioner that has a valid oversight specialty who supervises the health care professional. Such statement must include:
  * The name and address of the supervising Practitioner;
  * Verification the Practitioner is responsible for the care and treatment rendered by the NP;
  * Verification once a month the Practitioner is physically at the offices where treatment is being rendered and is interacting and overseeing the NP; and
Verification that a protocol exists and is located at the premises where the NP
practices as required by state law.
* If practicing in a setting other than Family Medicine or OB/GYN, must provide a
detailed scope of practice. Application will be considered adverse.

**Exclusion:**
- Clinical privileges not required (must have an arrangement with a credentialed
  Practitioner who has clinical privileges at a credentialed hospital facility).
- DEA certificate not required, however if applicant has DEA certificate it must be
  verified.

**Optometrist:**
Minimum and Exception criteria apply in addition to:
- State license must contain Therapeutic Certification.
- Hospital privileges are not required.

**Pathologist**
If credentialing is required, call coverage and hospital privileges are required.

**Physical Therapist/Occupational Therapist**
Minimum and Exception criteria apply in addition to:
- Current Licensure in State of Tennessee in Specialty will verify education. If not
  practicing in Tennessee, education may be verified by certificate from: American
  Occupational Therapy Certification Board, Physician Therapist Certificate of Fitness,
  if applicable or Verification of highest level of education in specialty requested.

**Exclusion:**
- No call coverage required
- Clinical privileges not required
- DEA certificate not required, however, if application has DEA certificate, all
  schedules must be verified.

**Physician Assistant:**
Minimum and Exception criteria apply in addition to:
- Certificate from the National Commission on Certification of Physician Assistants
  (NCCPA), if applicable.
- Written Statement from the BlueCross BlueShield of Tennessee credentialed
  Practitioner that has a valid PCP specialty who supervises the health care
  professional. Such statement shall include:
  * The name and address of the supervising Practitioner;
  * Verification that the Practitioner is responsible for the care and treatment
    rendered by Physician Assistant (PA);
  * Verification that once a week the Practitioner is physically practicing at the office
    where treatment is being rendered and is interacting and overseeing the PA; and
  * Verification that a protocol exists and is located at the premises where the PA
    practices as required by state law.
  * If practicing in a setting other than Family Medicine or OB/GYN, must provide a
detailed scope of practice. Application will be considered adverse.

**Exclusion:**
- Clinical privileges not required (must have an arrangement with a credentialed
  Practitioner who has clinical privileges at a credentialed hospital facility).
- DEA certificate not required, however, if applicant has DEA certificate, all schedules
  must be verified.
Physician Assistants-Surgical Assist:
- PA must be licensed, meet all other general provider requirements
- Supervising Surgeon must be credentialed with BCBST in a surgical specialty. (General, Urology, Neurology, Orthopedic, etc)
- PA must meet all State practice protocol requirements as verified with attestation.
- PA's Hospital and ASF privilege criteria must be verified.
- PA must provide proof of graduation from an accredited PA program.

PA must maintain ongoing certification by the NCCPA (which will include satisfactory completion of the NCCPA examination and all other ongoing certification requirements) and completion of NCCPA examination/certification.

Pharmacist
Minimum and Exception criteria apply in addition to:
- Copy of certification for successful completion of accredited disease specific management program(s), if applicable.
- Clinical privileges not required.
- Call coverage not required.

Podiatrist
Minimum and Exception criteria apply in addition to:
- Clinical privileges not required unless, current privileges are indicated, they will be verified.

Radiologist
If credentialing is required, call coverage and hospital privileges are required.

Sleep Medicine
This specialty is designated only for Medical Doctors and Doctors of Osteopathy.

Speech Language Pathologist
Minimum and Exception criteria apply in addition to:
- Certificate of Clinical Competence – Speech Language Pathology (CCC-SLP) from American Speech-Language-Hearing Association (ASHA) – Not Required. However, if applicant has ASHA Certificate, it must be verified. If certificate has expired, certificate must be verified by previous certificate verification.

Urgent Care Physician
All Minimum and Exception Criteria apply unless, acting as PCP, with exception of:
- Clinical privileges.
- Call Coverage.
- Site Visit.

2. Credentialing Process for Behavioral Health Practitioner/Provider
The following information is the minimum criteria required and/or must be verified for Behavioral Health Practitioners:

- Current, valid, unrestricted state license within the scope of the Practitioner’s practice.
- Current, valid, unrestricted Prescriptive Authority (ability to prescribe medication in accordance with State law) within the scope of the Practitioner’s practice, if applicable.
- Work history for last five (5) years for initial credentialing: Last three (3) years’ work history for recredentialing. Explanation for all lapses of employment exceeding ninety (90) days.
- Proof of malpractice coverage in amounts of not less than $1,000,000 per case and $3,000,000 aggregate.
2. Credentialing Process for Behavioral Health Practitioner/Provider (cont’d)

The following information is the minimum criteria required and/or must be verified for Behavioral Health Practitioners:

- National Practitioner Data Bank or Claims History Report from all malpractice carriers for the last five (5) years.
- Clinical privileges in good standing at a facility designated by the Practitioner as the primary admitting facility. If Practitioner does not have clinical privileges, Practitioner must have a coverage arrangement with a BCBST credentialed Practitioner/Provider, if applicable to scope of practice.
- Twenty-four (24)-hours-a-day, seven (7)-days-a-week call coverage
- Completed Education or Board certification in all practice specialties.

Specific requirements for specialties listed:

**Psychiatrist**
- Minimum and exception criteria

**Addictionologist (non–Psychiatrist)**
- Minimum and Exception criteria apply in addition to:
  - Certified by the American Society of Addiction Medicine (ASAM) as an addiction specialist.

**Addictionologist (Buprenorphine – Based Therapy for medication assisted treatment of substance use disorder)**
- Minimum and Exception criteria apply in addition to:
  - DEA certificate with additional buprenorphine waiver.
  - Certified by the American Society of Addiction Medicine (ASAM) as an addiction specialist.
  - Certified in buprenorphine therapy in the state where practice is to occur.

**Psychologist or Psychoanalyst**
- Minimum and Exception criteria apply in addition to:
  - DEA certificate not required, verify if applicable.
  - Doctoral degree (PhD, EdD, PsyD) in clinical psychology or counseling psychology from an accredited college or university and meet one of the following:
    1. Doctorate degree received from a college or university program on the American Psychological Association (APA) accredited list of counseling psychology or clinical psychology programs, or
    2. Completion of a pre-doctoral APA approved clinical internship at the time of graduation, or
    3. Listed in the National Register of Health Services Providers in Psychology, or
    4. Diplomate of the American Board of Professional Psychology (ABPP) under the clinical psychology or counseling psychology categories.

**Licensed Clinical Social Worker (LCSW)**
- Minimum and Exception criteria apply in addition to:
  - Master’s degree or higher from a graduate school or social work accredited by the Council on Social Work Education (CSWE).
Professional Counselors/ Mental Health Counselors/ Licensed Substance Use Disorder Treatment Professionals

- Minimum and Exception criteria apply in addition to:
  - Master’s degree or higher in mental health discipline.
  - State licensed or certified at the highest level of independent practice in the state where practice is to occur.
  - In states without licensure or certification, provider applicant must be a Certified Clinical Mental Health Counselor (CCMHC) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) OR meet all requirements to become a CCMHC (documentation of eligibility from NBCC required).

Marriage & Family Therapist

- Minimum and Exception criteria apply in addition to:
  - Master’s degree or higher in a mental health discipline.
  - State licensed or certified at the highest level of independent practice in the state where practice is to occur, OR certified as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT) OR proof of eligibility for full clinical membership in AAMFT (documentation from AAMFT required).

Pastoral Counselors

- Minimum and Exception criteria apply in addition to:
  - Master’s degree or higher in mental health discipline.
  - Must be licensed as a pastoral counselor and have certificate by the American Association of Pastoral Counselors.

Licensed Senior Psychological Examiner (SPE)

- Minimum and Exception criteria apply in addition to:
  - Master’s degree in Mental Health Counseling.

Employee Assistance Professional (EAP) Counselor

- Minimum and Exception criteria apply in addition to:
  - Certified as a Certified Employee Assistance Professional (CEAP).

Assistant Behavior Analyst (ABA)

- Minimum and Exception criteria apply in addition to:
  - Certified as an Assistant Behavior Analyst (BCaBA) by the Behavioral Analyst Certification Board.
  - Minimum of a Bachelor’s Degree from an accredited university.

  **Note:** Additional TennCare Requirements:
  - Degree must be for a BACB approved institution of higher education having the BACB required coursework and practice experience.
  - Board Certification in all practice specialties (This is not a BACB or TennCare requirement.)
Certified Behavior Analyst (CBA)

- **Minimum and Exception criteria apply in addition to:**
  - Certified as Board Certified Behavior Analyst (BCBA) or Board Certified Behavior Analyst – Doctoral (BCBA D) by Behavior Analyst Certification Board (BCBA).
  - **Note:** Acceptable TennCare equivalents:
    1. Currently licensed in the state of Tennessee for the independent practice of psychology, or
    2. Currently a Qualified Mental Health Professional licensed in the state of Tennessee with the scope of practice to include behavior analysis; and Credential verification by the Managed Care Organization.
  - Master’s or Doctorate degree from an accredited university that must be conferred in behavior analysis, education, or psychology, or in a degree program in which the candidate completed a (BACB) approved course sequence.
  - Board Certification in all practice specialties (This is not a BACB or TennCare requirement).

The following information is required and/or must be verified for Behavioral Health Organizational Providers:

- Licensed in the state of TN.
- Professional liability coverage of $1,000,000 per case/ $3,000,000 aggregate.
- Malpractice claims history for past five (5) years.
- Accreditation by: The Joint Commission, CARF, Council of Accreditation (COA), AOA, HFAP, AAAHC, Det Norske Veritas (DNV GL), CHAP. If not accredited, a site visit review or copy of state site visit.
- Certification from Medicare, Medicaid, TRICARE or state agencies if applicable.
- DEA certificate, if applicable.
- Staff roster for outpatient mental health and/or substance abuse clinics.

**Inpatient Detoxification/Inpatient Substance Use Disorder Rehabilitation**

- **Minimum criteria with the exception of:**
  - Must have 24 hours/7-days-week skilled nursing staff.
  - Oversight from a Medical Director.
  - Must have an Addictionologist either on staff or contracted or Medical Director must have three (3) years’ experience treating patients with substance use disorder.

**Inpatient Psychiatric/ Residential Psychiatric or Substance Use Disorder**

- **Minimum criteria with the exception of:**
  - 24 hour/7-days-a-week skilled nursing staff.
  - Oversight from a Medical Director.

**Crisis Stabilization Unit**

- **Minimum criteria with the exception of:**
  - Program must be part of a TJC accredited hospital or health care organization that provides psychiatric services or accredited by AOA, TRICARE, CARF or COA.
  - Formal written agreement with TJC accredited provider for emergency psychiatric, substance use disorder, or medical care if not available on site.

**Partial Hospitalization (Psychiatric or Substance Use Disorder)**

- **Minimum criteria with the exception of:**
  - Must operate 3-5 days per week and at least 4-6 hours per day.
  - Oversight from a Medical Director or licensed Program Director.
  - Must be under the supervision of a Physician.
**Intensive Outpatient (Psychiatric or Substance Use Disorder)**
- Minimum criteria with the exception of:
  - Must have the supervision of a licensed clinician.
  - Must provide services at least three (3) hours per day, 2-4 days per week.

**Outpatient Mental Health and/or Substance Use Disorder Clinic**
- Minimum criteria with the exception of:
  - Must have a governing body and an organized professional staff.
  - Must have, or have a formal contract with, a multi-disciplinary staff that includes at least one licensed psychiatrist, one licensed psychologist (psychologist must also be licensed to perform psychological testing), and at least one licensed masters- or doctoral-level mental health clinician.
  - Must have written credentialing criteria for all clinical staff.
  - All non-licensed staff must have direct clinical supervision by licensed staff; non-licensed staff may not provide the predominant portion of any major intervention modality, other than educational services.
  - Must receive oversight from a licensed behavioral health professional.

**Applied Behavior Analysis (ABA)**

**NOTE:** Services will be provided at an Outpatient Mental Health Clinic level of intensity.
- Minimum criteria with the exception of:
  - Must receive oversight from a licensed behavioral health or BACB (Behavior Analyst Certification Board) certified professional.
  - All non-licensed/ non-BACB certified staff must have direct clinical supervision by qualified licensed staff with an Autism Spectrum Disorder (ASD) specialty or BACB certification in accordance with BACB recommended clinically appropriate supervision (i.e., a minimum of 1.5 hours for every 10 hours of direct service).
  - BCaBA® (Board Certified Assistant Behavior Analyst®) staff must be supervised by BCBA® (Board Certified Behavior Analyst®) or BCBA-D® (Board Certified Behavior Analyst-Doctoral®) supervisors in accordance with BACB requirements.
  - All non-licensed staff (paraprofessionals/tutors/therapists) must have completed criminal background checks, drug screening (including random testing), and confirmation of required ABA specific training.

**Crisis Stabilization Unit**
- Minimum criteria with the exception of:
  - Program must be part of a Joint Commission accredited hospital or health care organization that provides psychiatric services or Program is part of a facility accredited by AOA, TRICARE, or CARF or COA accredits the program itself, as an observation/holding bed program that provides psychiatric services.
  - Program must meet state licensure/certification and Medicaid requirements (as applicable).
  - Program must meet all applicable federal, state and local laws and regulations.
  - Program must attest to a formal written agreement with Joint Commission accredited Provider for emergency psychiatric, substance abuse, and/or medical care if such care is not available on site.
  - Combination of licensed mental health professional, mental health workers, and other appropriate paraprofessional staff.

**Community Mental Health Center**
- Minimum criteria with the exception of:
  - Licensed as a Mental Health Outpatient Facility.
  - Formal CMS designation.
Community Mental Health Center (cont’d)
Behavioral Health Organizational providers (facilities and programs) must be evaluated at credentialing and recredentialing. Those who are accredited by an accrediting body accepted by BlueCross BlueShield of Tennessee must have their accreditation status verified. In addition, non-accredited organizational providers must undergo a structured site visit to confirm that they meet BlueCross BlueShield of Tennessee standards. Standing with state and federal authorities and programs will be verified.

3. Recredentialing Process
All Practitioners/Providers will be recredentialed at a minimum of every three years. The date of recredentialing will be based on the date of initial credentialing.

In addition to the information that will be verified by primary or secondary sources, BlueCross BlueShield of Tennessee will include and consider collected information regarding the participating Practitioner’s performance within the health plan, including information collected through the health plan’s quality management program.

Recredentialing will begin approximately three (3) to six (6) months prior to the expiration of the credentialing cycle. Providers are sent a letter stating their file will be placed in a recredentialing status and BCBST will retrieve their application from CAQH to begin the recredentialing process. To help ensure the recredentialing process is handled expediently with no interruptions in network participation we encourage the Practitioner to visit the CAQH ProView™ website, https://proview.caqh.org, to update their information.

Failure to comply with the request may result in immediate disenrollment from the Provider network. Credentialing information that is subject to change must be re-verified from primary sources during the recredentialing process. The Provider must attest to any limits on his/her ability to perform essential functions of the position and attest to absence of current illegal drug use.

4. BlueCross BlueShield of Tennessee Approved Specialties
BlueCross BlueShield of Tennessee recognizes and maintains the current list of specialties of the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), American Academy of Pediatrics (AAP), the American Board of Podiatric Surgery (ABPS), and the American Dental Association (ADA) Boards or others as deemed necessary by peer review to support business needs.

Practitioners must designate a specialty on the credentialing application. To be listed in any BlueCross BlueShield of Tennessee Provider directory in the specialty requested, the Practitioner must meet one of the following requirements:
- Recognized Board Certification, or
- Practitioners: Successful completion of residency or fellowship in the applied specialty as recognized by one of the listed Boards.
- Other Health Care Professionals: Licensure and additional certification, if applicable in the field of specialty.

American Board of Medical Specialties (ABMS)
I. American Board of Allergy and Immunology
   A. Allergy and Immunology
   B. Clinical and Laboratory Immunology

II. American Board of Anesthesiology
   A. Anesthesiology
   B. Critical Care Medicine
   C. Pain Management

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III. American Board of Colon and Rectal Surgery
   A. Colon and Rectal Surgery

IV. American Board of Dermatology
   A. Clinical and Laboratory Dermatological Immunology
   B. Dermatology
   C. Dermatopathology
   D. Pediatric Dermatology

V. American Board of Emergency Medicine
   A. Emergency Medicine
   B. Medical Toxicology
   C. Pediatric Emergency Medicine
   D. Sports Medicine
   E. Undersea-Hyperbaric Medicine

VI. American Board of Family Practice
   A. Family Practice
   B. Geriatric Medicine
   C. Sports Medicine

VII. American Board of Internal Medicine
   A. Internal Medicine
   B. Cardiovascular Disease
   C. Endocrinology, Diabetes, and Metabolism
   D. Gastroenterology
   E. Hematology
   F. Infectious Disease
   G. Medical Oncology
   H. Nephrology
   I. Pulmonary Disease
   J. Rheumatology
   K. Adolescent Medicine
   L. Clinical & Laboratory Immunology
   M. Clinical Cardiac Electrophysiology
   N. Critical Care Medicine
   O. Geriatric Medicine
   P. Interventional Cardiology
   Q. Sports Medicine

VIII. American Board of Medical Genetics, Inc.
   A. Clinical Biochemical Genetics
   B. Clinical Cytogenetics
   C. Clinical Genetics
   D. Clinical Molecular Genetics
   E. Molecular Genetic Pathology
   F. PHD Medical Genetics

IX. American Board of Neurological Surgery
   A. Neurological Surgery

X. American Board of Nuclear Medicine
   A. Nuclear Medicine

XI. American Board of Obstetrics and Gynecology
   A. Critical Care Medicine
   B. Gynecologic Oncology
   C. Gynecology
   D. Maternal and Fetal Medicine
   E. Obstetrics
   F. Obstetrics and Gynecology
   G. Reproductive Endocrinology
XII. American Board of Ophthalmology  
  A. Ophthalmology

XIII. American Board of Orthopedic Surgery  
  A. Hand Surgery  
  B. Orthopedic Surgery

XIV. American Board of Otolaryngology  
  A. Otolaryngology  
  B. Otology/Neurotology  
  C. Pediatric Otolaryngology  
  D. Plastic Surgery within the head and neck

XV. American Board of Pathology  
  A. Anatomic & Clinical Pathology  
  B. Anatomic Pathology  
  C. Blood Banking Transfusion Medicine  
  D. Chemical Pathology  
  E. Clinical Pathology  
  F. Cytopathology  
  G. Dermatopathology  
  H. Forensic Pathology  
  I. Hematology  
  J. Medical Microbiology  
  K. Molecular Genetic Pathology  
  L. Neuropathology  
  M. Pediatric Pathology

XVI. American Board of Pediatrics  
  A. Adolescent medicine  
  B. Clinical & laboratory immunology  
  C. Developmental-behavioral pediatrics  
  D. Medical toxicology  
  E. Neonatal-Perinatal medicine  
  F. Neurodevelopmental disabilities  
  G. Pediatric cardiology  
  H. Pediatric critical care medicine  
  I. Pediatric emergency medicine  
  J. Pediatric endocrinology  
  K. Pediatric gastroenterology  
  L. Pediatric hematology-oncology  
  M. Pediatric infectious disease  
  N. Pediatric nephrology  
  O. Pediatric pulmonology  
  P. Pediatric rheumatology  
  Q. Pediatrics  
  R. Sports medicine

XVII. American Board of Physical Medicine and Rehabilitation  
  A. Pain Management  
  B. Pediatric Rehabilitation Medicine  
  C. Physical Medicine and Rehabilitation  
  D. Spinal Cord Injury Medicine

XVIII. American Board of Plastic Surgery, Inc.  
  A. Hand Surgery  
  B. Plastic Surgery  
  C. Plastic Surgery within the head and neck

XIX. American Board of Preventive Medicine  
  A. Aerospace Medicine  
  B. Medical Toxicology  
  C. Occupational Medicine  
  D. Preventive Medicine  
  E. Undersea and Hyperbaric Medicine

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XX. American Board of Psychiatry and Neurology
   A. Addiction Psychiatry
   B. Child And Adolescent Psychiatry
   C. Clinical Neurophysiology
   D. Forensic Psychiatry
   E. Geriatric Psychiatry
   F. Neurodevelopmental Disabilities
   G. Neurology
   H. Neurology with special qualification in Child Neurology
   I. Pain Management
   J. Pediatric Neurology
   K. Psychiatry

XXI. American Board of Radiology
   A. Diagnostic Radiology
   B. Neuroradiology
   C. Nuclear Radiology
   D. Pediatric Radiology
   E. Radiation Oncology
   F. Radiological Physics
   G. Radiology
   H. Vascular & Interventional Radiology

XXII. American Board of Surgery
   A. Hand Surgery
   B. Pediatric Surgery
   C. Surgery
   D. Surgical Critical Care
   E. Vascular Surgery

XXIII. American Board of Thoracic Surgery
   A. Thoracic Surgery

XXIV. American Board of Urology, Inc.
   A. Urology

American Osteopathic Association Boards (AOA)
I. American Osteopathic Board of Anesthesiology
   A. Addiction Medicine
   B. Anesthesiology
   C. Critical Care Medicine
   D. Pain Management

II. American Osteopathic Board of Dermatology
   A. Dermatology
   B. Dermatopathology
   C. MOHS-Micrographic Surgery

III. American Osteopathic Board of Emergency Medicine
   A. Emergency Medical Services
   B. Emergency Medicine
   C. Medical Toxicology
   D. Sports Medicine

IV. American Osteopathic Board of Family Practice
   A. Addiction Medicine
   B. Adolescent and Young Adult Medicine
   C. Family Practice
   D. Geriatric Medicine
   E. Sports Medicine
V. American Osteopathic Board of Internal Medicine
   A. Addiction Medicine
   B. Allergy/Immunology
   C. Cardiology
   D. Clinical Cardiac Electrophysiology
   E. Critical Care Medicine
   F. Endocrinology
   G. Gastroenterology
   H. Geriatric Medicine
   I. Hematology
   J. Hematology/Oncology
   K. Infectious Disease
   L. Internal Medicine
   M. Medical Oncology
   N. Nephrology
   O. Oncology
   P. Pulmonary Disease
   Q. Rheumatology
   R. Sports Medicine

VI. American Osteopathic Board of Neurology and Psychiatry
   A. Addiction Medicine
   B. Child and Adolescent Neurology
   C. Child and Adolescent Psychiatry
   D. Neurology
   E. Neurology/Psychiatry
   F. Psychiatry
   G. Sports Medicine

VII. American Osteopathic Board of Neuromusculoskeletal Medicine
   A. Neuromusculoskeletal Medicine
   B. Osteopathic Manipulative Medicine
   C. Sports Medicine

VIII. American Osteopathic Board of Nuclear Medicine
   A. In Vivo and In Vitro Nuclear Medicine
   B. Nuclear Cardiology
   C. Nuclear Imaging and Therapy
   D. Nuclear Medicine

IX. American Osteopathic Board of Obstetrics and Gynecology
   A. Gynecologic Oncology
   B. Gynecology
   C. Maternal and Fetal Medicine
   D. Obstetrics
   E. Obstetrics and Gynecologic Surgery
   F. Obstetrics and Gynecology
   G. Reproductive Endocrinology

X. American Osteopathic Board of Ophthalmology and Otorhinolaryngology
   A. Facial Plastic Surgery
   B. Ophthalmology
   C. Otorhinolaryngology
   D. Otorhinolaryngology and Facial Plastic Surgery

XI. American Osteopathic Board of Orthopedic Surgery
   A. Orthopedic Surgery

XII. American Osteopathic Board of Pathology
   A. Anatomic Pathology
   B. Anatomic Pathology and Laboratory Medicine
   C. Blood Banking Transfusion Medicine
   D. Chemical Pathology
   E. Cytopathology
   F. Dermatopathology
XII. American Osteopathic Board of Pathology (cont’d)
   G. Forensic Pathology
   H. Hematology
   I. Laboratory Medicine
   J. Medical Microbiology
   K. Neuropathology

XIII. American Osteopathic Board of Pediatrics
   A. Adolescent and Young Adult Medicine
   B. Neonatology
   C. Pediatric Allergy and Immunology
   D. Pediatric Cardiology
   E. Pediatric Endocrinology
   F. Pediatric Hematology/Oncology
   G. Pediatric Infectious Disease
   H. Pediatric Intensive Care
   I. Pediatric Nephrology
   J. Pediatric Pulmonary Medicine
   K. Pediatrics
   L. Sports Medicine

XIV. American Osteopathic Board of Preventive Medicine
   A. Occupational Medicine
   B. Preventive Medicine/Aerospace Medicine
   C. Preventive Medicine/Occupational-Environmental Medicine
   D. Public Health/General Preventive Medicine

XV. American Osteopathic Board of Proctology
   A. Proctology

XVI. American Osteopathic Board of Radiology
   A. Angioplasty and Interventional Radiology
   B. Body Imaging
   C. Diagnostic Radiology
   D. Diagnostic Ultrasound
   E. Neuroradiology
   F. Nuclear Radiology
   G. Pediatric Radiology
   H. Radiation Oncology
   I. Radiation Therapy
   J. Radiology

XVII. American Osteopathic Board of Rehabilitation Medicine
   A. Rehabilitation Medicine
   B. Sports Medicine

XVIII. American Osteopathic Board of Surgery
   I. General Vascular Surgery
   II. Neurological Surgery

XVIII. American Osteopathic Board of Surgery (cont’d)
   III. Plastic and Reconstructive Surgery
   IV. Surgery
   V. Surgical Critical Care
   VI. Thoracic Cardiovascular Surgery
   VII. Urological Surgery

American Board of Dental Sleep Medicine
   A. Dental Sleep Medicine
American Academy of Pediatrics (AAP)
   A. Pediatric Heart Surgery
   B. Pediatric Neurosurgery
   C. Pediatric Orthopedics
   D. Pediatric Urology

American Board of Oral and Maxillofacial Pathology
   A. Oral Pathology

American Board of Oral and Maxillofacial Surgery

American Board of Orthodontics
   A. Orthodontics

American Board of Pain Management
   A. Pain Management

American Board of Pediatric Dentistry
   A. Pediatric Dentistry

American Board of Periodontology
   A. Periodontology

American Board of Podiatric Orthopedics & Primary Podiatric
   A. Podiatry (DPM)

American Board of Podiatric Surgery (ABPS)
   A. Podiatry (DPM)

American Board of Prosthodontics
   A. Prosthodontics

American Chiropractic Neurology Board, Inc.
   A. Chiropractic neurology

Other Health Care Professionals:
   II. Audiology
   III. Addictionologist (Non Psychiatrist)
   IV. Associate Behavior Analyst
   V. Certified Behavior Analyst
   VI. Certified Registered Nurse Anesthetist (CRNA)
   VII. Chiropractor (DC)
   VIII. Chiropractor Neurologist
   IX. Dietitian
   X. Employee Assistance Professional Counselor
   XI. Endodontist
   XII. Family Practice with Obstetrical Fellowship
   XIII. General Dentistry
   XIV. General Practice
   XV. Licensed Clinical social Worker (LCSW)
   XVI. Licensed Professional Counselor
   XVII. Licensed Senior Psychological Examiner (LSPE)
   XVIII. Marriage and Family Therapist
   XIX. Mental Health Counselor/Licensed Substance Abuse Treatment Professionals
   XX. Midwife (CNM)
XXI. Neurophychology (Ph.D.)
XXII. Nurse (RN)
XXIII. Nurse Clinician
XXIV. Nurse Practitioner
XXV. Nurse Practitioner, Acute Care
XXVI. Nurse Practitioner, Adult Health
XXVII. Nurse Practitioner, Family Practice
XXVIII. Nurse Practitioner, Gerontology and Adult Health
XXIX. Nurse Practitioner, Neonatal
XXX. Nurse Practitioner, Oncology
XXXI. Nurse Practitioner, Pediatrics
XXXII. Nurse Practitioner, Psychological/Mental Health
XXXIII. Nurse Practitioner, Women's Health
XXXIV. Nutrition
XXXV. Occupational Therapy (OT)
XXXVI. Optometry
XXXVII. Pastoral Counselor
XXXVIII. Pediatric Anesthesiology
XXXIX. Pediatric Genetics
XXXIX. Pediatric Ophthalmology
XXXIX. Pediatric Plastic Surgery
XL. Pharmacist
XLI. Pharmacist – Asthma Disease Management
XLII. Pharmacist – Diabetes Disease Management
XLIII. Pharmacist – Immunization Disease Management
XLIV. Physical Therapy (PT)
XLV. Physician Assistant – Surgical Assist
XLVI. Physician Assistant (PA)
XLVII. Professional Counselor
XLVIII. Prosthetist/Orthotist
XLIX. Psychiatrist
L. Psychologist or Psycholoanalyst
LI. Psychology (Ph.D.)
LII. Speech Pathology/Speech Therapy (ST)
LIII. Therapeutic Optometry
LIV. Urgent Care

5. Credentialing Process for Organizational Providers

Obtaining valid/current copies of the following information as submitted with the credentialing application, is essential to ensure that decisions are based on the most accurate, current information available.

The following types of Organizational Providers require verification of specific requirements to be considered by the Credentialing Committee. The following lists these requirements:
<table>
<thead>
<tr>
<th>Organizational Type</th>
<th>Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute Care Facility</strong></td>
<td>1) <strong>TN: Licensed as Acute Care Facility</strong> &lt;br&gt;Other States: Licensed in accordance with that state’s licensing laws &lt;br&gt;2) $1 million/$3 million Malpractice and claims history, NPDB reports, or self-reported &lt;br&gt;3) DEA certificate, if applicable &lt;br&gt;4) CLIA certificate, if applicable &lt;br&gt;5) Medicare Part A (new facilities which have not obtained subject to Committee exception) &lt;br&gt;6) TJC or AOA or CHAP or AAAHC &lt;br&gt;7) If not accredited, copy of State Site Survey required &lt;br&gt;8) Leapfrog Compliance, if available &lt;br&gt;9) General Liability Insurance &lt;br&gt;10) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare) &lt;br&gt;11) An attestation to the correctness and completeness of the application</td>
</tr>
<tr>
<td><strong>Ambulatory Infusion Center (AIC)</strong></td>
<td>1) <strong>TN: Licensed as Ambulatory Surgery Facility</strong> &lt;br&gt;Other States: Licensed in accordance with that state’s licensing laws &lt;br&gt;2. $1 million/$3 million Malpractice and claims history, NPDB reports, or self-reported &lt;br&gt;3. Medicare certificate &lt;br&gt;4. Accredited by a BCBST approved accrediting body as an AIC &lt;br&gt;5. Medical Director credentialed by BCBST &lt;br&gt;6. General Liability Insurance &lt;br&gt;7. History of federal or state sanctions (Medicare or TennCare) &lt;br&gt;8. An Attestation to the correctness and completeness of application</td>
</tr>
<tr>
<td><strong>Ambulatory Surgery Facility</strong></td>
<td>1) <strong>TN: Licensed as Ambulatory Surgery Facility</strong> &lt;br&gt;Other States: Licensed in accordance with that state’s licensing laws &lt;br&gt;2) $1 million/$3 million Malpractice and claims history, NPDB reports, or self-reported &lt;br&gt;3) CLIA certificate, if applicable &lt;br&gt;4) TJC or AOA or CHAP or AAAHC or AAAASF and Medicare Part B with copy of site audit &lt;br&gt;5) General Liability Insurance &lt;br&gt;6) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare) &lt;br&gt;7) An attestation to the correctness and completeness of the application</td>
</tr>
<tr>
<td><strong>Birthing Centers</strong></td>
<td>1) <strong>TN: Licensed as Birthing Center</strong> &lt;br&gt;Other States: Licensed in accordance with that state’s licensing laws &lt;br&gt;2) $1 million/$3 million Malpractice and claims history, NPDB reports, or self-reported &lt;br&gt;3) CLIA certificate, if applicable &lt;br&gt;4) TJC or AOA or CHAP or AAAHC or Medicare Part B &lt;br&gt;5) General Liability Insurance &lt;br&gt;6) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare) &lt;br&gt;7) An attestation to the correctness and completeness of the application</td>
</tr>
<tr>
<td><strong>Dialysis Facility</strong></td>
<td>1) <strong>State of Tennessee End Stage Renal Disease (ESRD) Facility License</strong> &lt;br&gt;Other States: Licensed in accordance with that state’s licensing laws &lt;br&gt;2) Not currently sanctioned by Medicare/Medicaid &lt;br&gt;3) $1 million/$3 million Malpractice and claims history, NPDB reports, or self-reported &lt;br&gt;4) Medicare Part A Certification &lt;br&gt;5) CLIA certificate &lt;br&gt;6) General Liability Insurance &lt;br&gt;7) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare) &lt;br&gt;8) An attestation to the correctness and completeness of the application</td>
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### Organizational Type

<table>
<thead>
<tr>
<th>Type</th>
<th>Requirements</th>
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<tbody>
<tr>
<td><strong>DME Providers</strong></td>
<td>1) <em>TN: Licensed as a DME Provider</em></td>
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<tr>
<td></td>
<td>Other States:Licensed in accordance with that state's licensing laws</td>
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<tr>
<td></td>
<td>2) Not currently sanctioned by Medicare/Medicaid</td>
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<tr>
<td></td>
<td>3) $1 million/$3 million Malpractice and claims history, NPDB reports, or self-reported</td>
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<td></td>
<td>4) Medicare Part B required</td>
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<tr>
<td></td>
<td>5) DEA certificate, if applicable</td>
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<tr>
<td></td>
<td>6) Pharmacy License, if applicable</td>
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<td></td>
<td>7) TJC or CHAP or AAAHC or ACHC or BOC or The Compliance Team or ABC or NBAOS or CARF or HQAA required</td>
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<td></td>
<td>8) General Liability Insurance</td>
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<td></td>
<td>9) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</td>
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<tr>
<td></td>
<td>10) An attestation to the correctness and completeness of the application</td>
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<tr>
<td><strong>Health Department</strong></td>
<td>1) State Tort Insurance</td>
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<tr>
<td></td>
<td>2) CLIA certificate</td>
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<tr>
<td><strong>Home Infusion Therapy Providers</strong></td>
<td>1) <em>TN: Licensed as a Home Infusion Therapy Provider (Pharmacy License)</em></td>
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<tr>
<td></td>
<td>Other States:Licensed in accordance with that state's licensing laws</td>
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<tr>
<td></td>
<td>2) Not currently sanctioned by Medicare/Medicaid</td>
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<tr>
<td></td>
<td>3) $1 million/$3 million Malpractice and claims history, NPDB reports, or self-reported</td>
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<td></td>
<td>4) Medicare Part B</td>
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<tr>
<td></td>
<td>5) DEA certificate, if applicable</td>
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<tr>
<td></td>
<td>6) TJC or CHAP or AAAHC, collect but not required</td>
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<tr>
<td></td>
<td>7) General Liability Insurance</td>
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<td>8) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</td>
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<td></td>
<td>9) An attestation to the correctness and completeness of the application</td>
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<tr>
<td><strong>Home Health Providers:</strong></td>
<td>1) <em>TN: Licensed as a Home Health Provider</em></td>
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<tr>
<td></td>
<td>Other States:Licensed in accordance with that state’s licensing laws</td>
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<tr>
<td></td>
<td>2) Not currently sanctioned by Medicare/Medicaid</td>
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<tr>
<td></td>
<td>3) $1 million/$3 million Malpractice and claims history, NPDB reports, or self-reported</td>
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<td></td>
<td>4) Medicare Part A</td>
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<tr>
<td></td>
<td>5) CLIA certificate, if applicable</td>
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<tr>
<td></td>
<td>6) TJC or CHAP or AAAHC, collect but not required</td>
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<td></td>
<td>7) If not accredited, copy of state or CMS site audit</td>
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<tr>
<td></td>
<td>8) General Liability Insurance</td>
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<td>9) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</td>
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<tr>
<td></td>
<td>10) An attestation to the correctness and completeness of the application</td>
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<tr>
<td><strong>Hospice Provider</strong></td>
<td>1) <em>TN: Licensed as a Hospice Provider</em></td>
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<tr>
<td></td>
<td>Other States:Licensed in accordance with that state’s licensing laws</td>
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<td></td>
<td>2) Not currently sanctioned by Medicare/Medicaid</td>
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<tr>
<td></td>
<td>3) $1 million/$3 million Malpractice and claims history, NPDB reports, or self-reported</td>
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<tr>
<td></td>
<td>4) Medicare Part A</td>
</tr>
<tr>
<td></td>
<td>5) CLIA certificate, if applicable</td>
</tr>
<tr>
<td></td>
<td>6) TJC or AOA or CHAP or AAAHC, collect but not required</td>
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<tr>
<td></td>
<td>7) General Liability Insurance</td>
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<td>8) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)</td>
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<td></td>
<td>9) An attestation to the correctness and completeness of the application</td>
</tr>
</tbody>
</table>
Organizational Type  | Requirements
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Independent Lab  | 1) **TN: Licensed as a Laboratory**
Other States: Licensed in accordance with that state’s licensing laws
2) Not currently sanctioned by Medicare/Medicaid
3) $1 million/$3 million Malpractice and claims history, NPDB reports, or self-reported
4) History of Professional liability claims that resulted in settlements or judgments
5) Medicare Part B
6) TJC or CAP, collect if applicable but not required
7) CLIA certificate, Draw station – CLIA not required
8) General Liability Insurance
9) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)
10) An attestation to the correctness and completeness of the application

Inpatient Rehabilitation Facility  | 1) **TN: Licensed as an Inpatient Rehabilitation Facility**
Other States: Licensed in accordance with that state’s licensing laws
2) Not currently sanctioned by Medicare/Medicaid
3) $1 million/$3 million Malpractice and claims history, NPDB reports, or self-reported
4) Medicare Part A
5) CLIA certificate, if applicable
6) DEA certificate, if applicable
7) TJC or CARF or AOA accreditation (no exception)
8) General Liability Insurance
9) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)
10) An attestation to the correctness and completeness of the application

Non-Licensed DME Providers (Non-motorized equipment only e.g. walker; canes; crutches)  | 1) Not currently sanctioned by Medicare/Medicaid
2) $1 million/$3 million Malpractice and claims history, NPDB reports, or self-reported
3) History of Professional liability claims that resulted in settlements or judgments
4) Medicare Part B
5) TJC or CHAP or AAAHC, if applicable but not required
6) General Liability Insurance
7) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)
8) An attestation to the correctness and completeness of the application

Orthotic/Prosthetic Supplier  | 1) **American Board for Certification in Orthotics and Prosthetics Accreditation OR Medicare B Certification**
2) General Liability Insurance
3) $1 million/$3 million Malpractice (exception for Breast Prosthetic suppliers ONLY to have product liability coverage $500 thousand) and claims history, NPDB reports, or self-reported
4) History of Professional liability claims that resulted in settlements or judgments
5) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)
6) An attestation to the correctness and completeness of the application

Outpatient Diagnostic  | 1) $1 million/$3 million Malpractice and claims history, NPDB reports, or self-reported
1) History of Professional liability claims that resulted in settlements or judgments
2) Medicare Part B Certification
3) General Liability Insurance
4) CLIA certification, if applicable
5) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)
6) An attestation to the correctness and completeness of the application

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<table>
<thead>
<tr>
<th>Organizational Type</th>
<th>Requirements</th>
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</table>
| Outpatient Mental Health Providers | 1) Licensed by the State of Tennessee Department of Health and Retardation.  
2) $1 million/$3 million Malpractice and claims history, NPDB reports, or self-reported  
3) General Liability Insurance  
4) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
Medicare Certification, not required  
5) An attestation to the correctness and completeness of the application |
| Outpatient Rehabilitation Facility | 1) Not currently sanctioned by Medicare/Medicaid  
2) $1 million/$3 million Malpractice and claims history, NPDB reports, or self-reported  
3) History of Professional liability claims that resulted in settlements or judgments  
4) Medicare Part A *(If Provider is licensed under the Tennessee Department of Mental Health and Developmental Disabilities and provides services to pediatric patients, evidence of the State License site audit)*  
5) TJC or CORF, collect but not required.  
6) CLIA certificate required if onsite laboratory.  
7) General Liability Insurance  
8) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
9) An attestation to the correctness and completeness of the application |
| Pain Management Center      | 1) **TN: Licensed as an Ambulatory Surgical Facility**  
Other States: Licensed in accordance with that state’s licensing laws  
2) $1 million/$3 million Malpractice and claims history, NPDB reports, or self-reported  
3) DEA certificate, if applicable  
4) CARF accreditation or American Academy of Pain Management accreditation  
5) General Liability Insurance  
6) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
7) An attestation to the correctness and completeness of the application |
| Professional Support Services Licensure (PSSL) | 1) **TN: Licensed as a Professional Support Service**  
Other States: Licensed in accordance with that state’s licensing laws  
2) $1 million/$2 million Malpractice and claims history, NPDB reports, or self-reported  
3) Medicare certificate  
4) Member of DIDS (Division of Intellectual Disability Services)  
5) History of Medicare/Medicaid sanction – no prior history  
6) General Liability  
7) An attestation to the correctness and completeness of the application |
| Skilled Nursing Facility (No Swing Beds) | 1) **TN: Licensed as a Skilled Nursing Facility**  
Other States: Licensed in accordance with that state’s licensing laws  
2) Not currently sanctioned by Medicare/Medicaid  
3) $1 million/$3 million Malpractice and claims history, NPDB reports, or self-reported  
4) Medicare Part A  
5) CLIA certificate, if applicable  
6) DEA certificate, if applicable  
7) TJC or CHAP or AAAHC or AOA, collect but not required  
8) If not accredited, copy of state or CMS site audit  
9) General Liability Insurance  
10) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
11) An attestation to the correctness and completeness of the application |
Organizational Type | Requirements
--- | ---
**Urgent Care Centers** | 1) State Business License  
2) Oversight by a Medical Director that is currently credentialed by BCBST  
3) Accreditation by Urgent Care Association of America (UCAOA) or a certificate from Certified Urgent Care (CUC) Program  
4) $1 million to $3 million in Malpractice Insurance and claims history, NPDB reports, or self-reported  
5) History of federal and/or state sanctions (Medicare, Medicaid or TennCare)  
6) General Liability Insurance  
7) An attestation to the correctness and completeness of the application
**Sleep Labs** | 1) $1 million/$3 million Malpractice and claims history, NPDB reports, or self-reported  
2) Medicare Certification Part B  
3) Accreditation by American Academy of Sleep Medicine (AASM) or JC  
4) General Liability Insurance  
5) History of any professional liability claims that resulted in settlements or judgments  
6) Medical Director who is a Diplomat of the ABSM  
7) History of federal and/or state sanctions (Medicare, Medicaid, or TennCare)  
8) An attestation to the correctness and completeness of the application

Organizational Providers must be recredentialed every 3 years to meet federal and state regulatory guidelines. During the recredentialing process the initial credentialing information must be resubmitted.

6. **BlueCross BlueShield of Tennessee Recognized Accrediting Bodies**

BlueCross BlueShield of Tennessee recognizes the following accrediting bodies:

- Accreditation Association for Ambulatory Health Care (AAAHC)
- Accreditation Commission for Health Care, Inc. (ACHC)
- American Academy of Nurse Practitioners (AANP)
- American Academy of Pain Management (AAPM)
- American Academy of Sleep Medicine (AASM)
- American Accreditation HealthCare Commission/URAC (AAHCC/URAC)
- American Association for Accreditation of Ambulatory Surgery Facilities (AAAASF)
- American Association for Marriage and Family Therapy (AAMFT)
- American Board of Genetic Counseling
- American Board of Medical Specialties (ABMS)
- American Board of Certification in Orthotics, Prosthetics, and Pedorthics (ABC)
- American Board of Dental Sleep Medicine
- American Board of Professional Psychology (ABPP)
- American College of Nurse – Midwives Certification Council
- American College of Radiology (ACR)
- American Medical Association (AMA)
- American Nurse Credentialing Center (ANCC)
- American Osteopathic Association (AOA)
- American Psychological Association (APA)
- American Society of Addiction Medicine (ASAM)
- American Speech-Language-Hearing Association (ASHA)
- Board for Orthotist/Prosthetist Certification (BOC)
- Certified Clinical Mental Health Counselor (CCMHC)
- Board of Certification (BOC)
- (COLA) formerly known as the Commission on Office Laboratory Accreditation
- College of American Pathologists (CAP)

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BlueCross BlueShield of Tennessee recognizes the following accrediting bodies (cont’d):

- Commission for the Accreditation of Birth Centers (CABC)
- Commission on Accreditation of Rehabilitation Facilities (CARF)
- Continuing Care Accreditation Commission (CCAC)
- Community Health Accreditation Program (CHAP)
- Comprehensive Outpatient Rehabilitation Facilities (CORF)
- Council on Accreditation (COA)
- Council on Social Work Education (CSWE)
- Det Norske Veritas Germanischer Lloyd (DNV GL)
- Food and Drug Administration (FDA)
- Health Care Financing Agency (HCFA) or Centers for Medicare & Medicaid Services (CMS)
- HealthCare Quality Association on Accreditation (HQAA)
- National Board for Certified Counselors (NBCC)
- National Certification Corporation for the Obstetric, Gynecologic, and Neonatal Nursing Specialties (NCC)
- National Commission on Certification of Physician Assistants (NCCPA)
- National Committee for Quality Assurance (NCQA)
- Pediatric Nursing Certification Board
- The Compliance Team, Inc.
- The Joint Commission (TJC)
- The Medical Quality Commission (TMQC)
- The National Board of Accreditation for Orthotic Suppliers (NBAOS)
- Tricare

D. Practice Site Evaluation/Medical Record Practices

Practice Site Standards

BlueCross BlueShield of Tennessee has adopted practice site standards for all credentialed Practitioners that provide ambulatory care to Members. These standards were developed to assure Members have access to care in a clean, safe, organized and physically accessible environment.

Clinical Risk Management (CRM) monitors Member complaints received regarding the quality of office sites. Practitioners will be advised in writing of specific complaints received about the quality of the office site. Credentialed Practitioners with two (2) office quality complaints within a six (6) month period, that include but is not limited to complaints about physical accessibility, adequacy of waiting area and cleanliness of site, will be referred to Clinical Quality Assurance Department to request an onsite review for compliance with the standards listed below within sixty (60) days of 2nd Member complaint. CRM will investigate the severity of all complaints received. BCBST may act on one complaint if it is determined necessary.

Primary Care Practitioner (PCP) practice sites and OB/GYN sites not previously reviewed and currently occupied by a network Practitioner will be evaluated prior to, or within sixty (60) days of initial credentialing. Practitioners will receive site review results with suggestions for improvement, if applicable, at the conclusion of the audit. Non-compliant sites will be reported to Clinical Risk Management Committee and re-audited within six (6) months.

Sites non-compliant on re-audit will be reviewed by Clinical Risk Management for placement on a Performance Improvement Plan and a 2nd re-audit planned within six (6) months.

Current established site review standards listed below have been adopted by BCBST. Compliance with all required elements noted with an asterisk (*), and an overall score of 80 percent achieved is required to meet these site review standards. These standards are subject to change and revisions will be posted in quarterly updates.
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<tbody>
<tr>
<td>1.</td>
<td>The office is to be handicap accessible.</td>
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<tr>
<td>2.</td>
<td>The office is to be clean, and organized, with adequate examining room and waiting room space.</td>
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<tr>
<td>3.</td>
<td>The office should have adequate lighting in waiting room and treatment area.</td>
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<tr>
<td>4.</td>
<td>Examining rooms should be designed for patient privacy.</td>
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<tr>
<td>5.</td>
<td>There should be evidence of compliance with BlueCross BlueShield of Tennessee appointment availability standards for routine and urgent care.</td>
</tr>
<tr>
<td>6.</td>
<td>Appropriate procedures should be in place for after-hours coverage. Voice mail messaging/answering machines should include instructions for reaching the Practitioner on call.</td>
</tr>
<tr>
<td>7.</td>
<td>There should be an individual medical record for each patient.</td>
</tr>
<tr>
<td>8.</td>
<td>Current medical records should be available at the site where services are provided and readily accessible.</td>
</tr>
<tr>
<td>9.</td>
<td>Medical records should be kept in a secure location. Sites with Electronic Medical Records should provide evidence of a secure off site record retention/recovery process.</td>
</tr>
<tr>
<td>10.</td>
<td>There should be evidence of a medical record confidentiality plan/policy that includes Protected Health Information (PHI).</td>
</tr>
<tr>
<td>11.</td>
<td>Medical records should be legible and maintained in detail consistent with good medical/professional practice, which permits effective internal/external review and/or medical audit and facilitates follow up treatment.</td>
</tr>
<tr>
<td>12.</td>
<td>Practice sites that do not use Electronic Medical Records should provide evidence that medical record documentation includes a comprehensive medical history and routine preventive care appropriate for age, gender and risk factors.</td>
</tr>
<tr>
<td>13.</td>
<td>There should be evidence of a fire safety/emergency action plan with evidence of staff education. This plan must be written at locations with 10 or more employees. Pathways to doors should be clear and well marked.</td>
</tr>
<tr>
<td>14.</td>
<td>Emergency Supplies and procedures should be available for scope of practice. Minimum requirements include: Epinephrine and O₂ for PCP sites Delivery kit for OB/GYN Crash cart and O₂ at sites that perform stress test or services that require sedation.</td>
</tr>
<tr>
<td>15.</td>
<td>The office should have infection control procedures that include appropriate disposal of bio-hazardous material. Hand washing facilities should be in/near treatment rooms and OSHA standards and MSDS/SDS information should be available to staff.</td>
</tr>
<tr>
<td>16.</td>
<td>There should be a process for the appropriate disposal of needles and other sharps.</td>
</tr>
<tr>
<td>17.</td>
<td>There should be a process for inventory control of all stock and sample medications.</td>
</tr>
<tr>
<td>18.</td>
<td>There should be evidence of an inventory control process for dispensing controlled substances and disposal of expired or unused portions of drugs.</td>
</tr>
<tr>
<td>19.</td>
<td>Controlled substances must be maintained in a locked area.</td>
</tr>
<tr>
<td>20.</td>
<td>Evidence of CLIA registration with site-specific address is required for any practice location where lab is performed.</td>
</tr>
<tr>
<td>21.</td>
<td>If radiology services are provided, a current state inspection compliance notice should be posted with the date of the last inspection.</td>
</tr>
<tr>
<td>22.</td>
<td>Radiology technique should be posted near the radiology equipment if not generated by radiology equipment.</td>
</tr>
<tr>
<td>23.</td>
<td>For Physician Extenders, there should be a protocol on site and evidence of supervising Physician oversight, as required by practice type and state regulations.</td>
</tr>
<tr>
<td>24.</td>
<td>There should be a sign posted that Physician Extenders may provide care, where applicable.</td>
</tr>
<tr>
<td>25.</td>
<td>Professional staff should be licensed appropriately with evidence of licensure on file.</td>
</tr>
<tr>
<td>26.</td>
<td>Member rights and responsibilities should be posted or otherwise made available to Members.</td>
</tr>
</tbody>
</table>
Comprehensive Medical Record Standards

Network Practitioners are expected to maintain medical records in detail consistent with good medical/professional practice, which permits effective internal/external review and/or medical audit and facilitates appropriate care and treatment by any health care practitioner.

Practitioner performance will be evaluated against the standards listed below through random solicitation of records for review, and evaluation of records obtained as part of routine health plan operations and quality of care reporting processes.

Clinical staff will schedule onsite medical record reviews for no less than five (5) percent of credentialed Primary Care Practitioners annually to evaluate against published standards. Suggestions for improvement will be documented and shared with Practitioner or Practitioner representative if applicable. In addition, medical record reviews will be performed during the annual HEDIS® project and analysis performed to identify Practitioners with educational needs.

Random comprehensive medical record reviews may also be performed for any credentialed Practitioner upon request of the Clinical Risk Management Department.

Practitioners with illegible records and those with appropriateness of care or potential utilization of care concerns noted during review will be referred to the Clinical Risk Management Department for further review.

Medical record data is utilized to evaluate potential coordination of care concerns and to provide supplemental data for internal/external quality reports.

Medical Record Keeping Practices

1. Medical records should be legible.
2. Member identification is to be on each page of the record.
3. Each recorded chart entry is to be dated and identified by the author. Stamped signatures are not acceptable.
4. The medical records should be readily accessible to the Practitioner during normal office hours.

Documentation

5. All medical records are to contain a current Member problem list, which addresses chronic and significant recurrent/acute conditions.
6. All medication allergies, absence of allergies, and/or adverse reactions are to be consistently documented and prominently displayed in all medical records.
7. An initial history and physical examination should be documented for new patients within 12 months of Member first seeking care or within 3 visits, whichever occurs first. Past medical history that includes behavioral health history, serious accidents, illnesses and surgeries, and gestational and birth history for pediatric patients under age 6 should be documented.
8. Each medical record is to contain an updated list of medications the Member is taking, or documentation that the Member is presently not taking any medications.
9. Each medical record is to contain tobacco, alcohol, and/or substance use history (for Members 12 years and over and seen three (3) or more times).
10. The medical record of all Members age 18 years and over should contain documentation of whether a medical advance directive has been executed for Medicaid/Medicare Members.
11. If the Member has executed an advance directive, a copy should be on file within the office.
Appropriateness of Care

12. Each visit should include documentation of Member’s chief complaint or purpose for visit. Clinical assessment and physical examination should be documented and correspond to Member’s stated complaint or visit purpose and/or ongoing care for chronic illnesses.

13. Working diagnosis or medical impressions that logically follow from the clinical assessment and physical examination should be recorded.

14. Rationale for treatment decisions should appear Medically Appropriate and be substantiated by documentation in the record, with laboratory tests performed at appropriate intervals.

15. Records should substantiate the Member’s clinical problems and treatment in a manner such that another Practitioner can determine the Member’s overall clinical course under the reviewed Practitioner’s management.

Continuity and Coordination of Care

16. There should be documentation of unresolved problems from past visits, and abnormal consults or diagnostic tests through follow-up phone call or return office visit.

17. Medical records should contain documentation of appropriate use of consultants, which includes Behavioral Health Providers, and documentation of medical services performed by a referral specialist/Practitioner.

18. If diagnostic and/or therapeutic ancillary services were performed, there should be a copy of the written report of the service in the record.

Education and Preventive Care

19. Each medical record should contain evidence that age/sex appropriate preventive screenings/immunizations are offered in accordance with Clinician’s Handbook of Preventive Services or the American Academy of Pediatrics, as applicable.

20. Care for high-risk conditions should be documented in accordance with BlueCross BlueShield of Tennessee’s Health Care Practice Recommendations.

21. There should be documentation of Member education/instructions.

Facility Site Standards

Non-accredited facilities applying for Initial Credentialing with BlueCross BlueShield of Tennessee networks must meet and maintain compliance with the site standards listed below.

Non-compliant sites for currently credentialed Providers will be referred to the BlueCross BlueShield of Tennessee Clinical Risk Management Committee for review. The credentialing process will be halted for all non-credentialed Providers until BlueCross BlueShield of Tennessee facility site standards are met.

Physical Assessment

1. The facility is to be handicap accessible.
2. The facility should be clean and organized with adequate lighting and work space in treatment rooms to conduct patient exams effectively.

After Hours Coverage

3. Appropriate procedures should be in place for after-hours coverage, where applicable.

Medical Record Keeping

4. There should be an individual medical record for each Member.
5. Medical records should be kept in a secure location.
6. There should be evidence of a medical record confidentiality plan/policy that includes Protected Health Information (PHI).
7. Medical records should be legible and maintained in detail consistent with good medical/professional practice, which permits effective internal/external review and/or medical audit and facilitate follow-up treatment.

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Safety
8. Emergency supplies and procedures should be available for the scope of practice.
9. Policy and procedures should be available and reviewed annually regarding administrative, operational, safety, disaster management and infection control.
10. There should be evidence of staff education to include safety, disaster management and infection control.
11. There should be infection control measures consistent with OSHA guidelines.
12. There should be a Quality Improvement plan monitoring all aspects of performance of care/services with evidence of staff review.
13. Evidence of CLIA registration is required if lab is performed in the facility.
14. If radiology services are provided, a current state inspection compliance notice should be posted with the date of the last inspection.
15. Radiological technique should be posted near the radiology equipment.
16. There should be a process for inventory control of all stock and sample medications and medical supplies.
17. There should be evidence of an inventory control process for dispensing controlled substances and disposal of expired or unused portions of drugs.
18. Controlled substances must be maintained in a locked area.
19. The facility should maintain equipment in a safe manner consistent with the manufacturer’s recommendations.
20. Professional staff should be licensed appropriately with evidence of licensure on file.
21. Member Rights and Responsibilities should be posted, or available in the facility.
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XV. Provider Networks

Participation in BlueCross BlueShield of Tennessee Provider Networks requires satisfaction of applicable network participation and credentialing requirements.

Providers interested in expanding their participation in BlueCross BlueShield of Tennessee Provider Networks, or needing to communicate any changes in their practice may call their local Provider Relations Consultant. (See Section II. BlueCross BlueShield of Tennessee Quick Reference Guide, for specific contact numbers.)

Providers may initiate a request for a copy of their own contract by calling the BCBST Provider Service line, 1-800-924-7141. Just say “Network Contracting” when prompted or select Option 4. Written requests should be mailed to:

BlueCross BlueShield of Tennessee
1 Cameron Hill Cr, Ste 0007
Chattanooga, TN  37402-0007

A. Network Participation Criteria

BlueCross BlueShield of Tennessee has established Network Participation Criteria detailing the terms and conditions for participation in BlueCross BlueShield of Tennessee Provider Networks. These Terms and Conditions will be consistently applied to all Providers regardless of participation status. These Terms and Conditions will apply to any Provider who:

- is a Network Provider;
- is recruited by the Plan;
- requests participation or re-applies for participation;
- re-applies following voluntary or involuntary termination of Provider’s participation;
- has a significant change in practice, or other intervening event or activity, which initiates a re-application and/or reconsideration of the Provider’s current participation status.

B. Changes in Practice

Certain federal and state regulations may require BlueCross BlueShield of Tennessee contracted Providers to timely notify us of any changes to their street address, telephone numbers, office hours, and any other changes that impact availability.

If you have moved, acquired an additional location, changed your status for accepting patients, or made other changes to your practice:

- Call the BlueCross Provider Service line, 1-800-924-7141, Monday through Thursday, 8 a.m. to 6 p.m. (ET); Friday, 9 a.m. to 6 p.m. (ET). Choose the “touchtone” option or just say “Network Contracts or Credentialing” when prompted, to easily update your information: and

Taking these steps will confirm that all information for contracting and credentialing is correct and help ensure Provider directories utilized by Members contain the most current and correct information about their practice.

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The following may require reconsideration for continued participation of a currently contracted Provider, immediate termination of a contracted Provider, review of the initial application by a non-contracted Provider, or re-application for participation by a non-contracted Provider.

The following changes may require reconsideration and/or re-application for participation in a BlueCross BlueShield of Tennessee Network. BlueCross BlueShield of Tennessee reserves the right to interpret and apply these criteria in its sole discretion and judgment. Any Provider adversely affected by BlueCross BlueShield of Tennessee’s application of these criteria will be entitled to the appropriate appeals procedure set forth in the Provider Dispute Resolution Procedure or set forth in this Manual.

### Practitioner

Including but not limited to:
- Change in practice locations;
- Change in practice specialty;
- Change in ownership;
- Entering into or exiting from a group practice;
- Change in hospital privileges;
- Change in insurance coverage;
- Disciplinary or corrective action by licensing agency, federal agency (DEA, Medicare, Medicaid, etc.) or peer review committee;
- Malpractice claim(s) and/or judgment(s);
- Indictment, arrest, conviction or moral turpitude allegation;
- Adverse or adversarial relationship with BlueCross BlueShield of Tennessee;
- Any material change, which affects the Practitioner’s ability to perform its obligations to Members and/or BlueCross BlueShield of Tennessee;
- Any material change in the information submitted on the pre-application or application.

### Institutional or Ancillary Providers

- Change in ownership;
- Malpractice claim(s) and/or judgment(s);
- Change in insurance coverage;
- Disciplinary or corrective action by licensing agency, federal agency (DEA, Medicare, Medicaid, etc.) or peer review committee. Disciplinary action includes (without Limitation) any change in license status, such as probation, or any extraordinary conditions or training mandated by any licensing agency, federal agency, or peer review committee beyond those normal educational requirements for all Providers to maintain a license.
- Adverse or adversarial relationship with BlueCross BlueShield of Tennessee;
- Any material change which affects the organization’s ability to perform its obligations to Member(s) and/or BlueCross BlueShield of Tennessee;
- Any material change in the information submitted on the pre-application or application.

### C. Providers Denied Participation

Providers denied participation in a BlueCross BlueShield of Tennessee Network for other than network need, may not be considered for reapplication for one (1) year from the date of denial.

This requirement may be waived by BlueCross BlueShield of Tennessee in its sole discretion.

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D. Removal of Providers from BCBST Provider Network

The Provider Participation Standards Committee (PPSC) will review and take action on all requests for removal of Providers from BCBST Provider Networks including, but not limited to, Providers that have (1) been arrested or indicted (2) been convicted of a crime (3) committed fraud or (4) been accused or convicted of any offense involving moral turpitude in any jurisdiction, in addition to the other reasons set forth in the Provider’s Agreement. If PPSC determines a Provider falls within any of these termination reasons, a Provider may be immediately terminated from the BCBST Networks or BCBST may refuse participation in any BCBST Networks.

PPSC may also address any contractual breach of contracts that can lead to terminating a network Provider. In either event, Provider shall not be considered, at the discretion of BCBST, for participation for two (2) years after the date of the resolution of the offense or allegation, except as otherwise provided by applicable laws. Provider’s initial or continued participation shall not be considered, at the discretion of BCBST, unless the charges are dismissed or otherwise resolved in the Provider’s favor. When appropriate, review and action by PPSC may occur electronically.

The Provider Participation Standards Committee has delegated the responsibility for initiating administrative terminations to the Provider Administration Department. If the Provider Administration staff confirms all BCBST policies and procedures were followed related to such administrative terminations, notice of termination may be sent without committee review. If the Provider Administration staff determines there are unique circumstances that warrant a committee level review, the termination action will be brought to PPSC. A list of the reasons for administrative termination of a provider’s participation include, without limitation:

- Loss of License
- Medicare/Medicaid or SCHIP Sanctions
- Loss of BCBST Credentials or failure to complete the BCBST Credentialing or Recredentialing process
- Lack of Network Specific Admitting Privileges
- Lack of Network Specific 24 Hour Coverage
- Retired/Deceased/Moved out of State
- Excluded from participation in the Medicare/Medicaid and/or SCHIP programs pursuant to Sections 1128 or 1156 of the Social Security Act or who are otherwise not in good standing with the TennCare program
- Advocacy revoked by the Tennessee Medical Foundation
- Lack of Electronic Funds Transfer
- Lack of Paperless Claims Filing
- No Claims Activity Within 18 Consecutive Months

A quarterly report will be submitted to PPSC reflecting administrative terminations for that quarter.

Providers that are removed from a BCBST Participating Network may reapply in accordance with the Network Participation Criteria.

In those cases where a Provider is removed from all BCBST Credentialed Networks, credentials will be suspended the effective date of contract termination. Upon exhaustion of the contract termination appeal process, credentials will be discontinued.
E. Provider Termination Appeal Process

Providers, whose network participation has been terminated for cause through the Committee, shall be entitled to due process in accordance with the procedural remedies set forth below:

- All Provider Network Management contract termination for cause notices are communicated to the Provider via certified mail to the last known address, located in the BlueCross BlueShield of Tennessee (BCBST) Providers’ file.
- Termination notices sent to Providers will include instructions on appealing the termination decision.

Providers whose network participation has been terminated without cause through the Committee, shall not be entitled to a written appeal, but will proceed straight to binding arbitration.

1. APPEAL OF NON-REPORTABLE ACTION BY A PARTICIPATING PROVIDER
   a. Written Appeal
      i. The Provider may appeal by submitting a written statement of their position within thirty (30) days of the date of the letter of notice to the Provider. The written appeal will be reviewed by the Committee and a written response will be sent to the Provider within sixty (60) days of our receipt of the written appeal.
   b. Binding Arbitration
      i. After the final decision by BCBST, all parties agree to take any dispute to binding arbitration. The Provider shall make a written demand that the adverse action be submitted to binding arbitration pursuant to the Commercial Arbitration Rules of the American Arbitration Association (current ed.). Either party may make a written demand for binding arbitration within thirty (30) days after it receives the Plan’s response. The venue for the arbitration shall be in Chattanooga, TN unless otherwise agreed. The arbitration shall be conducted by a panel of three (3) qualified arbitrators, unless the parties otherwise agree. The arbitrators may sanction a party, including ruling in favor of the other party, if appropriate, if a party fails to comply with applicable procedures or deadlines established by those Arbitration Rules.
      ii. The claimant shall pay the applicable filing fee established by the American Arbitration Association, but the filing fee may be reallocated or reassessed as part of an arbitration award either, in whole or in part, at the discretion of the arbitrator/arbitration panel if the claimant prevails upon the merits. If the claimant withdraws its demand for arbitration, the claimant forfeits its filing fee and it may not be assessed against BCBST.
      iii. Each party shall be responsible for on-half of the arbitration agency’s administrative fee, the arbitrators’ fees and other expenses directly related to conducting that arbitration. Each party shall otherwise be solely responsible for any other expenses incurred in preparing for or participating in the arbitration process, including that party’s attorney’s fees.
      iv. The arbitrators: shall be required to issue a reasoned written decision explaining the basis of their decision and the manner of calculating any award; shall limit review to whether or not the Plan’s action was arbitrary and capricious; may not award punitive or exemplary damages; may not vary or disregard the terms of the Provider’s participation agreement, the certificate of coverage and other agreements, if applicable; and shall be bound by controlling law; when issuing a decision concerning the matter at issue.
Emergency relief such as injunctive relief may be awarded by an arbitrator/arbitration panel. A party shall make application for any such relief pursuant to the Optional Rules for Emergency Measures of Protection of the American Arbitration Association (most recent edition). The arbitrators’ award, order or judgment shall be final and binding upon the parties. That decision may be entered and enforced in any state or federal court of competent jurisdiction. The arbitration award may only be modified, corrected or vacated for the reasons set forth in the United States Arbitration Act (9 USC § 1).

v. This arbitration provision supersedes any prior arbitration clause or provision contained in any other document. This arbitration clause may be modified or amended by BCBST and the Provider will receive notice of any modification through updates to the Provider Manual.

2. APPEAL OF NON-REPORTABLE ACTION BY AN APPLICANT
   a. Written Appeal
      i. A Provider may appeal by submitting a written statement of his position within thirty (30) days of receipt of the notice of the denial of application. The written appeal will be reviewed by the Committee. A written response will be sent to the Provider within sixty (60) days of our receipt of the written appeal.

   b. Binding Arbitration
      i. If the Provider is still not satisfied with the Committee’s decision, they may make a written request that the matter be submitted to binding arbitration in accordance with the procedure set forth in section 1.b above.

3. APPEAL OF A POTENTIALLY REPORTABLE ACTION BY PARTICIPATING PROVIDERS OR APPLICANTS
   a. Hearing
      i. Appointment of the Hearing Officer
         The Provider may request a hearing. In that event, the Chairperson of the Committee shall appoint a qualified designee to serve as the Hearing Officer within thirty (30) working days after receiving that request. The Hearing Officer:
         1. Shall not receive a financial benefit from the outcome of the hearing and shall not act as a prosecutor or advocate for the Plan.
         2. May not be in direct economic competition with the Provider requesting the hearing.
         3. Must be qualified to evaluate the issues likely to be presented during the hearing.
         4. Shall be acting as member of the Committee while performing his or her duties.

      ii. Notice of Hearing
         The Hearing Officer will contact the Provider to establish a mutually acceptable date, time, and place for the hearing; which shall be conducted not less than thirty (30) days after that date. The formal hearing shall be conducted within 120 days of appointment of the Hearing Officer unless both parties agree to extend this time limit. If the parties are unable to agree, the Hearing Officer shall schedule the hearing. The Hearing Officer shall then issue a written notice of hearing to the Provider summarizing: 1) the scheduled time, date and place where the hearing will be conducted; 2) the applicable hearing procedure; 3) a description of the basis for the Hearing, including any acts or omissions which the Provider is alleged to have committed (the “Allegations”); and 4) a statement concerning whether that action may be reportable to the State licensing agency or other entities as mandated by law.

      iii. Hearing Procedure
         The hearing will be an informal proceeding. Formal rules of evidence or legal procedure will not be applicable during the hearing. The Hearing Officer may
reschedule or continue the hearing at his or her discretion or upon reasonable request of the parties. The Provider may forfeit the right to a hearing; however, if he or she fails to appear at the hearing without good cause, the right to schedule another hearing is also forfeited. In addition to any procedure adopted by the Hearing Officer:

1. The Provider has the right to be represented by an attorney or other representative. If the Provider elects to be represented, such representation shall be at his or her own expense.

2. The hearing will be recorded by a court reporter.

3. The Provider and the Plan must provide the other party with a list of witnesses expected to testify on its behalf during the hearing and any documentary evidence that it expects to present during the hearing, as soon as possible following issuance of the notice of hearing. Either party may amend that list at any time not less than ten (10) working days before the date of the hearing.

4. Each party has the right to inspect and copy any documentary information that the other party intends to present during the hearing, at the inspecting party’s expense, upon reasonable advance notice, at the location where such records are maintained.

5. During the hearing, each party has the right to:
   a. Call witnesses
   b. Cross-examine opposing witnesses
   c. Submit a written statement at the close of the hearings

6. Following the hearing, each party may obtain copies of the record of the hearing, upon payment of the charges for that record. Each party shall also receive a copy of the Hearing Officer’s report and recommendation.

iv. Hearing Officer’s Report
The Hearing Officer will issue a written report and recommendation within thirty (30) days after the conclusion of the hearing. That written report will set forth the Hearing Officer’s recommendation, and the basis for that recommendation.

v. Action by the Committee
The Hearing Officer’s report will be submitted to the appropriate Committee for consideration during its next regularly scheduled meeting, unless a special meeting is called to consider that report. The Committee may accept, modify or reverse the Hearing Officer’s recommendation, at its discretion. The Provider shall not have the right to appeal or to otherwise participate in the Committee’s deliberations concerning the Hearing Officer’s report. The Committee shall notify the Provider of its decision within ten (10) working days after the date of that meeting. The committee’s decision is the final internal action by BCBST. In the event the decision is an adverse decision as defined by applicable federal and/or state laws, BCBST will report to the appropriate agencies or Boards as required by the applicable federal or state laws. This is the final action of BCBST and the Committee will take the appropriate action at the Conclusion of the Committee decision.

vi. Dispute regarding the Decision
Any action based upon or related to the Committee’s decision must be submitted to binding arbitration in accordance with paragraph 1.b above.

F. Participation in BCBST Networks

BlueCross BlueShield of Tennessee Provider Network Management participation criterion for 1) Practitioners; 2) Institutional Providers; and 3) Ancillary Providers in BlueCross BlueShield of Tennessee Networks follow:
1. **Minimum Practitioner Network Participation Criteria**

Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCross BlueShield of Tennessee, Inc. and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.

<table>
<thead>
<tr>
<th>Network Attribute</th>
<th>PPO Blue Network P (Preferred)/BlueAdvantage</th>
<th>PPO Blue Network S (Select)</th>
<th>Preferred Dental/FEP Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Tennessee/Contiguous Counties</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>II. State License</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. License to practice is Current and Valid</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>2. License to practice is Unrestricted as to services performed</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>3. If the Provider’s medical license has been revoked, suspended or not renewed (a license &quot;revocation&quot;) by any jurisdiction, for cause, or the Provider has surrendered or agreed to surrender license to avoid such a revocation, Provider shall not be considered for participation until not less than 1 year after the date that Provider’s license was re-instated, except as otherwise provided by applicable laws. If such a license revocation action is pending or initiated against a Provider, Provider’s participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider maintains licensure.</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>III. Malpractice Insurance</td>
<td>$1 million/$3 million unless State employee</td>
<td>$1 million/$3 million unless State employee</td>
<td>$1 million/$3 million unless State employee</td>
</tr>
<tr>
<td>IV. Accept Terms of Contract</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>V. Board Certified/Eligible</td>
<td>Required</td>
<td>Required</td>
<td>Required for Specialists</td>
</tr>
</tbody>
</table>
Minimum Practitioner Network Participation Criteria (cont’d)
Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCross BlueShield of Tennessee, Inc. and its affiliates (“BCBST”) will consider Provider for participation in one or more of its Networks at its sole discretion.

<table>
<thead>
<tr>
<th>Network Attribute</th>
<th>PPO Blue Network P (Preferred)/BlueAdvantage</th>
<th>PPO Blue Network S (Select)</th>
<th>Preferred Dental/ FEP Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>VI. Must be able to meet Credentialing and Recredentialing Requirements</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>VII. Successful Site Evaluation</td>
<td>Required for Primary Care and High Volume Specialists</td>
<td>Required for Primary Care and High Volume Specialists</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Factors reviewed at site visit are:
Accessibility/appearance, Risk Management Policies/Procedures, access/availability of medical services, medical records administration, and valid certification for regulated services and personnel.

VIII. Admitting Privileges
Maintain admitting privileges (or provision for coverage by a BCBST participating Provider) with a BCBST network hospital*

<table>
<thead>
<tr>
<th></th>
<th>Required</th>
<th>Required</th>
<th>Required if hospital services are performed</th>
</tr>
</thead>
</table>

*Any exceptions must be approved by BCBST

IX. Availability Standards
Network participation is dependent on the business needs of BlueCross BlueShield of Tennessee, Inc. and its affiliates

<table>
<thead>
<tr>
<th>1. Primary Care</th>
<th>No limits to size. Must meet Network Availability Standards</th>
<th>Limited Network. Must meet Network Availability Standards</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Hospital Based</td>
<td>Affiliated with Participating Hospital</td>
<td>Affiliated with Participating Hospital</td>
<td>N/A</td>
</tr>
<tr>
<td>Anesthesiology (includes CRNAs)</td>
<td>Fee Schedule</td>
<td>Fee Schedule</td>
<td>N/A</td>
</tr>
<tr>
<td>Pathology</td>
<td>Fee Schedule</td>
<td>Fee Schedule</td>
<td>N/A</td>
</tr>
<tr>
<td>Radiology</td>
<td>Fee Schedule</td>
<td>Fee Schedule</td>
<td>N/A</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>Fee Schedule</td>
<td>Fee Schedule</td>
<td>N/A</td>
</tr>
<tr>
<td>Hospital required to deliver</td>
<td>Yes</td>
<td>Yes</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Rev 03/16
Minimum Practitioner Network Participation Criteria (cont’d)
Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCross BlueShield of Tennessee, Inc. and its affiliates (‘BCBST’) will consider Provider for participation in one or more of its Networks at its sole discretion.

<table>
<thead>
<tr>
<th>Network Attribute</th>
<th>PPO Blue Network P (Preferred)/ BlueAdvantage</th>
<th>PPO Blue Network S (Select)</th>
<th>Preferred Dental/ FEP Dental</th>
</tr>
</thead>
</table>

X. Member Access Standards

1. Agrees to provide care to members within BCBST standards

<table>
<thead>
<tr>
<th></th>
<th>Required</th>
<th>Required</th>
<th>Required</th>
</tr>
</thead>
</table>

2. Demonstrates a practice history, which BCBST deems consistent and comparable with Providers’ ability to comply with these standards.

<table>
<thead>
<tr>
<th></th>
<th>Required</th>
<th>Required</th>
<th>Required</th>
</tr>
</thead>
</table>

2.1 Regular: Routine Examination, TENNderCARE, Preventive Care, Physical Exam

<table>
<thead>
<tr>
<th></th>
<th>Required</th>
<th>Required</th>
<th>Required</th>
</tr>
</thead>
</table>

2.2 Prenatal Care:

   |                      | To be seen in the first trimester, ≤ 6 weeks of woman's questioning pregnancy | To be seen in the first trimester, ≤ 6 weeks of woman's questioning pregnancy | N/A |

Rev 12/14
Minimum Practitioner Network Participation Criteria (cont'd)
Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCross BlueShield of Tennessee, Inc. and its affiliates ("BCBST") will consider Provider for participation in one or more of its Networks at its sole discretion.

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</tr>
</thead>
<tbody>
<tr>
<td>Second Trimester</td>
<td>If the first appointment is beyond the 1st trimester, ≤ 15 days</td>
<td>If the first appointment is beyond the 1st trimester, ≤ 15 days</td>
<td>N/A</td>
</tr>
<tr>
<td>2.3 Urgent Care (Adult &amp; Child)</td>
<td>&lt; 48 hours</td>
<td>&lt; 48 hours</td>
<td>N/A</td>
</tr>
<tr>
<td>2.4 Emergency Care (Adult &amp; Child)</td>
<td>Immediate - refer to facility-based providers</td>
<td>Immediate - refer to facility-based providers</td>
<td>N/A</td>
</tr>
<tr>
<td>2.5 Specialty Care (Adult &amp; Child)</td>
<td>As practitioner deems appropriate for condition or follow-up</td>
<td>As practitioner deems appropriate for condition or follow-up</td>
<td>N/A</td>
</tr>
<tr>
<td>2.6 Wait Times</td>
<td>1) Office Wait Time (including lab and X-ray)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>&lt; 45 minutes</td>
<td>&lt; 45 minutes</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>2) Member Telephone Call (during office hours):</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Urgent</td>
<td>&lt; 15 minutes</td>
<td>&lt; 15 minutes</td>
</tr>
<tr>
<td></td>
<td>Routine</td>
<td>24 hours</td>
<td>24 hours</td>
</tr>
<tr>
<td></td>
<td>3) Member Telephone Call (after office hours):</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>Urgent</td>
<td>&lt; 30 minutes</td>
<td>&lt; 30 minutes</td>
</tr>
<tr>
<td></td>
<td>Routine</td>
<td>&lt; 90 minutes</td>
<td>&lt; 90 minutes</td>
</tr>
<tr>
<td>2.7 7Day/24 Hour Coverage through Par Providers</td>
<td>Required</td>
<td>Required</td>
<td>N/A</td>
</tr>
<tr>
<td>3. Open Practice</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
</tr>
<tr>
<td>4. Service Area Definition</td>
<td>TN &amp; Contiguous Counties</td>
<td>TN &amp; Contiguous Counties</td>
<td>TN &amp; Contiguous Counties</td>
</tr>
</tbody>
</table>

Rev 12/14
Minimum Practitioner Network Participation Criteria (cont'd)

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</thead>
<tbody>
<tr>
<td>XI. Reimbursement</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Agrees to the price and reimbursement schedule for the Network</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>2. Agrees to the reimbursement methodology:</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>3. Agrees not to balance bill member</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>4. Delegation</td>
<td>Subject to minimum criteria and approval by Delegated Oversight Committee</td>
<td>Subject to minimum criteria and approval by Delegated Oversight Committee</td>
<td>Subject to minimum criteria and approval by Delegated Oversight Committee</td>
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<tr>
<td>5. Administrative Services Only (ASO) Available</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>6. Acceptance of Electronic Funds Transfer (EFT)</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>7. Electronic Claims Submission</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
</tbody>
</table>

XII. Quality Improvement/Utilization Review/Medical Management Program

<table>
<thead>
<tr>
<th>Quality Improvement/Utilization Review/Medical Management Program</th>
<th>PPO Blue Network P (Preferred)/BlueAdvantage</th>
<th>PPO Blue Network S (Select)</th>
<th>Preferred Dental/FEP Dental</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Cooperate with BCBST QI &amp; UM Programs</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>2. Maintain a QI/UM Plan</td>
<td>Required</td>
<td>Required</td>
<td>N/A</td>
</tr>
<tr>
<td>3. Demonstrate practice style and history, which BCBST deems consistent and comparable with BCBST quality management program standards and practices.</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>4. Meet BCBST acceptable practice pattern analysis performance parameters related to quality of care, patient satisfaction and cost efficiency.</td>
<td>Required</td>
<td>Required</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Minimum Practitioner Network Participation Criteria (cont’d)
Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCross BlueShield of Tennessee, Inc. and its affiliates (‘BCBST’) will consider Provider for participation in one or more of its Networks at its sole discretion.

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<tbody>
<tr>
<td><strong>XIII. General Provisions</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Meet member satisfaction standards - Based on member complaints, grievances, and satisfaction survey</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>2. Demonstrate willingness to cooperate with other Providers, hospitals and health care facilities</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>3. Agree to participate in exclusive arrangements</td>
<td>Required/Negotiated</td>
<td>Required/Negotiated</td>
<td>N/A</td>
</tr>
<tr>
<td>4. Satisfactory record on fraud and abuse and billing practices</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>5. Practice style which is consistent with current standards of medical delivery</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>6. Prescribing pattern, which is consistent with BCBST’s quality management program.</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>7. If the Provider’s Drug Enforcement Administration Certificate, Controlled Dangerous Substances Certificate, or any schedules thereof have been revoked, suspended or not renewed (a “revocation”) by any jurisdiction, for cause, or surrendered to avoid imposition of such revocation Provider shall not be considered for participation until not less than 1 year after the date that Provider was re-issued a certificate or schedule except as otherwise provided by applicable laws. If such a certificate or schedule revocation action is pending or initiated against a Provider, Provider’s participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider retains certification or schedules.</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
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Minimum Practitioner Network Participation Criteria (cont'd)

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<tr>
<td>8. If the Provider has: (1) been arrested or indicted; (2) been convicted of a crime; (3) committed fraud; or (4) been accused or convicted of any offense involving moral turpitude by any jurisdiction, Provider may be immediately terminated from the BCBST Networks or BCBST may refuse participation in any BCBST Networks. In either event, Provider shall not be considered, at the discretion of BCBST for participation for 2 years after the date of the resolution of the offense or allegations except as otherwise provided by applicable laws. Provider’s initial or continued participation shall not be considered, at the discretion of BCBST, unless the charges are dismissed or otherwise resolved in the Provider’s favor.</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>9. Not currently excluded from Medicare, Medicaid or Federal Procurement and NonProcurement Program(s), or SCHIP.</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>10. Term of Contract</td>
<td>Minimum 180 Day Termination</td>
<td>Minimum 1 year; 180 Day Termination; Maximum 3 years</td>
<td>30 day clause</td>
</tr>
<tr>
<td>11. Abide by Terms of BCBST Provider Dispute Resolution Procedure</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>12. Exclusivity Allowed</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>13. Defined Service Area</td>
<td>Statewide</td>
<td>Statewide</td>
<td>Statewide</td>
</tr>
</tbody>
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Minimum Practitioner Network Participation Criteria (cont'd)

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</thead>
<tbody>
<tr>
<td>14. If Provider has established an adversarial relationship with BCBST, members or participating Providers that might reasonably prevent the Provider from acting in good faith and in accordance with applicable laws or the requirements of BCBST's agreements with that Provider, other Providers, members or other parties. Provider may not be considered for initial or continued participation in BCBST Networks. As examples, such adversarial relationships include, but are not limited to: credible evidence of making defamatory statements about BCBST; initiating legal or administrative actions against BCBST in bad faith; BCBST's prior or pending termination of the Provider's participation agreement for cause; or prior or pending collection actions against members in violation of an applicable hold harmless requirement. This participation criteria is not intended to prevent the Provider from fully and fairly discussing all aspects of a patient's medical condition, treatment or coverage (i.e. to &quot;gag&quot; the Provider from discussing relevant matters with members). Involving Members or third parties in disputes with BCBST prior to receiving a final determination of that dispute in accordance with BCBST's Provider Dispute Resolution Procedure may be deemed, however, to constitute an adversarial relationship with BCBST.</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>15. Provider's network participation agreement has not been terminated, for other than administrative reasons, within the past year. Examples of administrative terminations are failure to complete the credentialing process or failure to maintain hospital privileges at a network hospital. For administrative terminations, Provider may reapply upon cure of the deficiency.</td>
<td>Required</td>
<td>Required</td>
<td>Required</td>
</tr>
</tbody>
</table>
### 2. Minimum Institutional Provider Network Participation Criteria

Acute Care Hospitals, Ambulatory Surgical Facilities, Birthing Centers, Dialysis Centers, Inpatient Rehabilitation, Outpatient Rehabilitation, Skilled Nursing Facilities, Mobile X-ray Labs, and Sleep Centers. Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BCBST and its affiliates (“BCBST”) will consider Provider for participation in one or more of its Networks at its sole discretion.

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<th>PPO Blue Network S (Select)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. Tennessee/Contiguous Counties</strong></td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td><strong>II. State License</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. License is Current and Valid.</td>
<td>Required, as applicable (see Exhibit B-1)</td>
<td>Required, as applicable (see Exhibit B-1)</td>
</tr>
<tr>
<td>2. License is Unrestricted as to services performed.</td>
<td>Required, as applicable (see Exhibit B-1)</td>
<td>Required, as applicable (see Exhibit B-1)</td>
</tr>
<tr>
<td>3. If the Provider's license has been revoked, suspended or not renewed (a license &quot;revocation&quot;) by any jurisdiction, for cause, or if the Provider has surrendered license or agreed to surrender license to avoid such a revocation, the Provider shall not be considered for participation until not less than 1 year after the date that license was re-issued, except as otherwise provided by applicable laws. If such a license revocation action is pending or initiated against a Provider, the Provider's participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider retains license.</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td><strong>III. Malpractice Insurance</strong></td>
<td>$1 million/$3 million unless State employee</td>
<td>$1 million/$3 million unless State employee</td>
</tr>
<tr>
<td><strong>IV. Medicare Certification Requirements</strong></td>
<td>Required, as applicable (see Exhibit B-1)</td>
<td>Required, as applicable (see Exhibit B-1)</td>
</tr>
</tbody>
</table>
BlueCross BlueShield of Tennessee Commercial Provider Administration Manual

Minimum Institutional Provider Network Participation Criteria (Cont’d)

Acute Care Hospitals, Ambulatory Surgical Facilities, Birthing Centers, Dialysis Centers, Inpatient Rehabilitation, Outpatient Rehabilitation, Skilled Nursing Facilities, Mobile X-ray Labs, and Sleep Centers. Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BCBST and its affiliates (“BCBST”) will consider Provider for participation in one or more of its Networks at its sole discretion.

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<th>PPO Blue Network S (Select)</th>
</tr>
</thead>
<tbody>
<tr>
<td>V. Accreditation Requirements</td>
<td>Required, as applicable (see Exhibit B-1)</td>
<td>Required, as applicable (see Exhibit B-1)</td>
</tr>
<tr>
<td>VI. Accept Terms of Contract</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>VII. Meet Credentialing and Recredentialing Requirements</td>
<td>Required</td>
<td>Required</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VIII. Availability Standards</th>
<th>Network participation is dependent on the business needs of BlueCross BlueShield of Tennessee, Inc. and its affiliates</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>IX. Member Access Standards</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Agrees to provide care to members within BCBST standards</td>
<td>Required</td>
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<tr>
<td>2. Demonstrates a medical delivery history, which BCBST deems consistent and comparable with Providers ability to comply with these standards.</td>
<td>Required</td>
</tr>
<tr>
<td>3. Service Area Definition</td>
<td>TN &amp; Contiguous Counties</td>
</tr>
<tr>
<td>4. Hospitals that are contracted in out-of-state counties which are contiguous to Tennessee must meet the minimum criteria to justify commercial network participation. Minimum criteria includes but is not limited to satisfaction of minimum claim volume and membership thresholds as well as market impact analysis</td>
<td>Required</td>
</tr>
</tbody>
</table>

Rev 12/14
Minimum Institutional Provider Network Participation Criteria (cont’d)

Acute Care Hospitals, Ambulatory Surgical Facilities, Birthing Centers, Dialysis Centers, Inpatient Rehabilitation, Outpatient Rehabilitation, Skilled Nursing Facilities, Mobile X-ray Labs, and Sleep Centers. Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BCBST and its affiliates (“BCBST”) will consider Provider for participation in one or more of its Networks at its sole discretion.

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<tbody>
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<td>X. Reimbursement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Agrees to the price and reimbursement schedule for the Network</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>2. Agrees to the reimbursement methodology:</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>3. Agrees not to balance bill member</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>4. Delegation</td>
<td>Subject to minimum criteria and approval by Delegated Oversight Committee</td>
<td>Subject to minimum criteria and approval by Delegated Oversight Committee</td>
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<tr>
<td>5. Administrative Services Only (ASO) Available</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>6. Acceptance of Electronic Funds Transfer (EFT)</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>7. Electronic Claims Submission</td>
<td>Required</td>
<td>Required</td>
</tr>
</tbody>
</table>

XI. Quality Improvement/Utilization Review/Medical Management Program

| 1. Cooperate with BCBST QI & UM Programs | Required | Required |
| 2. Maintain a QI/UM Plan | Required | Required |
| 3. Demonstrate medical delivery style and history, which BCBST deems consistent and comparable with BCBST quality management program standards and practices. | Required | Required |

XII. General Provisions

| 1. Meet Member satisfaction standards – Based on member complaints, grievances, and satisfaction survey | Required | Required |
| 2. Demonstrate willingness to cooperate with other Providers, hospitals and health care facilities | Required | Required |
| 3. Agree to participate in exclusive arrangements | Required/Negotiated | Required/Negotiated |
| 4. Satisfactory record on fraud and abuse and billing practices | Required | Required |
Minimum Institutional Provider Network Participation Criteria (cont’d)

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<th>PPO Blue Network S (Select)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5. Medical Delivery style which is consistent with current standards of medical delivery</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>6. Claims filing method</td>
<td>CMS-1450</td>
<td>CMS-1450</td>
</tr>
<tr>
<td>7. If any person who has an ownership interest of the Provider has: (1) been arrested or indicted (2) been convicted of a crime (3) committed fraud or (4) been accused or convicted of any offense involving moral turpitude in any jurisdiction, Provider may be immediately terminated from the BCBST Networks or BCBST may refuse participation in any BCBST Networks. In either event provider shall not be considered, at the discretion of BCBST, for participation for 2 years after the date of the resolution of the offense or allegation, except as otherwise provided by applicable laws. Provider's initial or continued participation shall not be considered, at the discretion of BCBST, unless the charges are dismissed or otherwise resolved in the Provider's favor.</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>8. Not currently excluded from Medicare, Medicaid or Federal Procurement and NonProcurement Program(s) or SCHIP.</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>9. Term of Contract</td>
<td>See Exhibit B-1</td>
<td>See Exhibit B-1</td>
</tr>
<tr>
<td>10. Abide by Terms of BCBST Provider Dispute Resolution Procedure</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>11. Exclusivity Allowed</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>12. Defined Service Area</td>
<td>Statewide</td>
<td>Statewide</td>
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Rev 12/14
Minimum Institutional Provider Network Participation Criteria (cont’d)

Acute Care Hospitals, Ambulatory Surgical Facilities, Birthing Centers, Dialysis Centers, Inpatient Rehabilitation, Outpatient Rehabilitation, Skilled Nursing Facilities, Mobile X-ray Labs, and Sleep Centers. Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BCBST and its affiliates (“BCBST”) will consider Provider for participation in one or more of its Networks at its sole discretion.

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<tr>
<td>13. Provider has not established an adversarial relationship with BCBST or its affiliates, members or participating Providers that might reasonably prevent the Provider from acting in good faith and in accordance with applicable laws or the requirements of BCBST’s agreements with that Provider, other Providers, members or other parties. As examples, such adversarial relationships include, but are not limited to: creditable evidence of making defamatory statements about BCBST; initiating legal or administrative actions against BCBST in bad faith; BCBST’s prior or pending termination of the Provider’s participation agreement for cause; or prior or pending collection actions against members in violation of an applicable hold harmless requirement. This participation criteria is not intended to prevent the Provider from fully and fairly discussing all aspects of a patient’s medical condition, treatment or coverage (i.e. to “gag” the Provider from discussing relevant matters with members). Involving Members or third parties in disputes with BCBST prior to receiving a final determination of that dispute in accordance with BCBST’s Provider Dispute Resolution Procedure may be deemed, however, to constitute an adversarial relationship with BCBST.</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>14. Provider’s network participation agreement has not been terminated, for other than administrative reasons, within the past year. Examples of administrative terminations are failure to complete the credentialing process. For administrative terminations, Provider may reapply upon cure of the deficiency.</td>
<td>Required</td>
<td>Required</td>
</tr>
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Rev 12/14
### Exhibit B-1
Minimum Institutional Provider Network Participation Criteria

<table>
<thead>
<tr>
<th>Network Attribute</th>
<th>PPO Blue Network P (Preferred)/BlueAdvantage</th>
<th>PPO Blue Network S (Select)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State License Requirements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Care Hospitals</td>
<td>TN: Licensed as an Acute Care Facility</td>
<td>TN: Licensed as an Acute Care Facility</td>
</tr>
<tr>
<td></td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Ambulatory Surgical Facility (ASF)</td>
<td>TN: Licensed as an Ambulatory Surgery Facility</td>
<td>TN: Licensed as an Ambulatory Surgery Facility</td>
</tr>
<tr>
<td></td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Ambulatory Surgical Facility, Birthing Center</td>
<td>TN: Licensed as a Birthing Center</td>
<td>TN: Licensed as a Birthing Center</td>
</tr>
<tr>
<td></td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Dialysis Center</td>
<td>TN: Licensed as a Dialysis Center</td>
<td>TN: Licensed as a Dialysis Center</td>
</tr>
<tr>
<td></td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Inpatient Rehabilitation</td>
<td>TN: Licensed as an Inpatient Rehabilitation Facility</td>
<td>TN: Licensed as an Inpatient Rehabilitation Facility</td>
</tr>
<tr>
<td></td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Outpatient Rehabilitation</td>
<td>TN: Does not license Outpatient Rehabilitation Facilities</td>
<td>TN: Does not license Outpatient Rehabilitation Facilities</td>
</tr>
<tr>
<td></td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td>TN: Licensed as a Skilled Nursing Facility</td>
<td>TN: Licensed as a Skilled Nursing Facility</td>
</tr>
<tr>
<td></td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Sleep Labs/Centers</td>
<td>TN: Does not license Sleep Centers</td>
<td>TN: Does not license Sleep Centers</td>
</tr>
<tr>
<td></td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Mobile X-ray Lab</td>
<td>TN: Does not license Mobile X-ray Labs</td>
<td>TN: Does not license Mobile X-ray Labs</td>
</tr>
<tr>
<td></td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Pain Management Centers</td>
<td>TN: Licensed as an Ambulatory Surgery Facility</td>
<td>TN: Licensed as an Ambulatory Surgery Facility</td>
</tr>
<tr>
<td></td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
<td>Contiguous: Licensed in accordance with that state’s licensing laws</td>
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</tbody>
</table>
## Exhibit B-1 (Cont’d)
### Minimum Institutional Provider Network Participation Criteria

<table>
<thead>
<tr>
<th>Network Attribute</th>
<th>PPO Blue Network P (Preferred)/ BlueAdvantage</th>
<th>PPO Blue Network S (Select)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Accreditation and/or Certification Requirements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute Care Hospital</td>
<td>JC, AOA, CHAP or ACHC and Medicare A or State Site Survey</td>
<td>JC, AOA, CHAP or ACHC and Medicare A or State Site Survey</td>
</tr>
<tr>
<td>Ambulatory Surgical Facility (ASF)</td>
<td>JC, AOA, AAAHC, or AAAAAF, and Medicare B</td>
<td>JC, AOA, AAAHC, or AAAAAF, and Medicare B</td>
</tr>
<tr>
<td>Ambulatory Surgical Facility, Birthing Center</td>
<td>JC, AOA, CHAP, ACHC or Medicare B</td>
<td>JC, AOA, CHAP, ACHC or Medicare B</td>
</tr>
<tr>
<td>Dialysis Center</td>
<td>Medicare A</td>
<td>Medicare A</td>
</tr>
<tr>
<td>Inpatient Rehabilitation</td>
<td>JC, CARF or AOA and Medicare A</td>
<td>JC, CARF or AOA and Medicare A</td>
</tr>
<tr>
<td>Outpatient Rehabilitation</td>
<td>Medicare A or Mental Health License</td>
<td>Medicare A or Mental Health License</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>Medicare A</td>
<td>Medicare A</td>
</tr>
<tr>
<td>Sleep Labs/Centers</td>
<td>AASM and Medicare B</td>
<td>AASM and Medicare B</td>
</tr>
<tr>
<td>Mobile X-ray Lab</td>
<td>Medicare Part B</td>
<td>Medicare Part B</td>
</tr>
<tr>
<td>Pain Management Centers</td>
<td>CARF or American Academy of Pain Management</td>
<td>CARF or American Academy of Pain Management</td>
</tr>
</tbody>
</table>

### Term of Contract

<table>
<thead>
<tr>
<th>Network Attribute</th>
<th>PPO Blue Network P (Preferred)/ BlueAdvantage</th>
<th>PPO Blue Network S (Select)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Hospital</td>
<td>3 years initially; annually thereafter, 120 day notification prior to expiration of 3 year term</td>
<td>3 years initially; annually thereafter, 120 day notification prior to expiration of 3 year term</td>
</tr>
<tr>
<td>Ambulatory Surgical Facility (ASF)</td>
<td>Annual; 120 days prior to anniversary of effective date</td>
<td>Annual; 120 days prior to anniversary of effective date</td>
</tr>
<tr>
<td>Ambulatory Surgical Facility, Birthing Center</td>
<td>Annual; 120 days prior to anniversary of effective date</td>
<td>Annual; 120 days prior to anniversary of effective date</td>
</tr>
<tr>
<td>Dialysis Center</td>
<td>Annual; 180 day clause</td>
<td>Annual; 180 day clause</td>
</tr>
<tr>
<td>Inpatient Rehabilitation</td>
<td>Annual; 180 day clause</td>
<td>Annual; 180 day clause</td>
</tr>
<tr>
<td>Outpatient Rehabilitation</td>
<td>Annual; 180 day clause</td>
<td>Annual; 180 day clause</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF)</td>
<td>Annual; 180 day clause</td>
<td>Annual; 180 day clause</td>
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<tr>
<td>Sleep Labs/Centers</td>
<td>Annual; 180 day clause</td>
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</tr>
<tr>
<td>Mobile X-ray Lab</td>
<td>Annual; 180 day clause</td>
<td>Annual; 180 day clause</td>
</tr>
<tr>
<td>Pain Management Centers</td>
<td>Annual, 120 days prior to anniversary of effective date</td>
<td>Annual, 120 days prior to anniversary of effective date</td>
</tr>
</tbody>
</table>
### 3. Minimum Ancillary Provider Network Participation Criteria

Home Health, Home Infusion, Durable Medical Equipment (includes Specialty DME and Prosthetic/Orthotic DME), Hospice and Independent Laboratory

Satisfaction of any minimum participation criteria set forth below does not guarantee initial or continued network participation. BlueCross BlueShield of Tennessee, Inc. and its affiliates (“BCBST”) will consider Provider for participation in one or more of its Networks at its sole discretion.

<table>
<thead>
<tr>
<th>Network Attribute</th>
<th>PPO Blue Network P (Preferred)/BlueAdvantage</th>
<th>PPO Blue Network S (Select)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>I. Tennessee/Contiguous Counties</strong></td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td><strong>II. State License</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. License to practice is Current and Valid</td>
<td>Required, as applicable (see Exhibit B-1)</td>
<td>Required, as applicable (see Exhibit B-1)</td>
</tr>
<tr>
<td>2. License to practice is Unrestricted as to services performed.</td>
<td>Required, as applicable (see Exhibit B-1)</td>
<td>Required, as applicable (see Exhibit B-1)</td>
</tr>
<tr>
<td>3. If the Provider’s license has been revoked or not renewed (a license “revocation”) by any jurisdiction, for cause, or surrendered license to avoid such a revocation, Provider shall not be considered for participation until not less than 1 year after the date that license was re-issued, except as otherwise provided by applicable laws. If such a license revocation action is pending or initiated against a Provider, the Provider’s participation shall not be considered unless the charges are dismissed or otherwise resolved such that the Provider retains license.</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td><strong>III. Minimum Insurance Requirements</strong></td>
<td>Required, as applicable (see Exhibit B-1)</td>
<td>Required, as applicable (see Exhibit B-1)</td>
</tr>
<tr>
<td><strong>IV. Medicare Certification Requirements</strong></td>
<td>Required, as applicable (see Exhibit B-1)</td>
<td>Required, as applicable (see Exhibit B-1)</td>
</tr>
</tbody>
</table>
Minimum Ancillary Provider Network Participation Criteria (cont’d)

Home Health, Home Infusion, Durable Medical Equipment (includes Specialty DME and Prosthetic/Orthotic DME), Hospice and Independent Laboratory

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</tr>
</thead>
<tbody>
<tr>
<td>V. Accreditation Requirements</td>
<td>Required, as applicable (See Exhibit B-1)</td>
<td>Required, as applicable (See Exhibit B-1)</td>
</tr>
<tr>
<td>VI. Accept Terms of Contract</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>VII. Meet Credentialing and Recredentialing Requirements</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>VIII. Availability Standards</td>
<td>Required, as applicable (See Exhibit B-1)</td>
<td>Required, as applicable (See Exhibit B-1)</td>
</tr>
</tbody>
</table>

Network participation is dependent on the business needs of BlueCross BlueShield of Tennessee, Inc. and its affiliates.

1. Ancillary Providers
   - Limited Network. Must meet Network Availability Standards.
   - Limited Network. Must meet Network Availability Standards.

IX. Member Access Standards

1. Agrees to provide care to members within BCBST standards
   - Required
   - Required

2. Demonstrates a medical delivery history, which BCBST deems consistent and comparable with Providers’ ability to comply with these standards.
   - Required
   - Required

3. Service Area Definition
   - TN & Contiguous Counties
   - TN & Contiguous Counties
Minimum Ancillary Provider Network Participation Criteria (cont’d)

Home Health, Home Infusion, Durable Medical Equipment (includes Specialty DME and Prosthetic/Orthotic DME), Hospice and Independent Laboratory

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</tr>
</thead>
<tbody>
<tr>
<td>X. Reimbursement</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Agrees to the price and reimbursement schedule for the Network</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>2. Agrees to the reimbursement methodology</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>3. Agrees not to balance bill member</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>4. Delegation</td>
<td>Subject to minimum criteria and approval by Delegated Oversight Committee</td>
<td>Subject to minimum criteria and approval by Delegated Oversight Committee</td>
</tr>
<tr>
<td>5. ASO Available</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>6. Acceptance of Electronic Funds Transfer (EFT)</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>7. Electronic Claims Submission</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>XI. Quality Improvement/Utilization Review/Medical Management Program</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Cooperate with BCBST QI &amp; UM Programs</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>2. Maintain a QI/UM Plan</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>3. Demonstrate medical delivery style and history, which BCBST deems consistent and comparable with BCBST quality management program standards and practices.</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>4. Agrees to Rapid Response Requirement</td>
<td>Required, as applicable (See Exhibit B-1)</td>
<td>Required, as applicable (See Exhibit B-1)</td>
</tr>
<tr>
<td>XII. General Provisions</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Meet Member satisfaction standards – Based on member complaints, grievances, and satisfaction survey</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>2. Demonstrate willingness to cooperate with other Providers, hospitals and health care facilities.</td>
<td>Required</td>
<td>Required</td>
</tr>
</tbody>
</table>
Minimum Ancillary Provider Network Participation Criteria (cont'd)

Home Health, Home Infusion, Durable Medical Equipment (includes Specialty DME and Prosthetic/Orthotic DME), Hospice and Independent Laboratory

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<th>PPO Blue Network S (Select)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Agree to participate in exclusive arrangements</td>
<td>Required/Negotiated</td>
<td>Required/Negotiated</td>
</tr>
<tr>
<td>4. Satisfactory record on fraud and abuse and billing practices</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>5. Medical Delivery style which is consistent with current standards of medical delivery</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>6. Claims filing method</td>
<td>Required, as applicable (See Exhibit B-1)</td>
<td>Required, as applicable (See Exhibit B-1)</td>
</tr>
<tr>
<td>7. Must provide all services</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>8. Services must be available in all counties of a CSA (subcontracting permitted)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>9. CLIA Certificate</td>
<td>Required for Independent Labs only</td>
<td>Required for Independent Labs only</td>
</tr>
<tr>
<td>10. Valid contract with CAREMARK®</td>
<td>Required for Home Infusion only</td>
<td>Required for Home Infusion only</td>
</tr>
<tr>
<td>11. If any person who has an ownership interest of the Provider has: (1) been arrested or indicted (2) been convicted of a crime (3) committed fraud or (4) been accused or convicted of any offense involving moral turpitude in any jurisdiction, Provider may be immediately terminated from the BCBST Networks or BCBST may refuse participation in any BCBST Networks. In either event provider shall not be considered, at the discretion of BCBST, for participation for 2 years after the date of the resolution of the offense or allegation, except as otherwise provided by applicable laws. Provider's initial or continued participation shall not be considered, at the discretion of BCBST, unless the charges are dismissed or otherwise resolved in the Provider's favor.</td>
<td>Required</td>
<td>Required</td>
</tr>
</tbody>
</table>

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Minimum Ancillary Provider Network Participation Criteria (Cont’d)

Home Health, Home Infusion, Durable Medical Equipment (includes Specialty DME and Prosthetic/Orthotic DME), Hospice and Independent Laboratory

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<th>PPO BlueNetwork S (Select)</th>
</tr>
</thead>
<tbody>
<tr>
<td>12. Not currently excluded from Medicare, Medicaid or Federal Procurement and NonProcurement Program(s), or SCHIP.</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>13. Term of Contract</td>
<td>See Exhibit B-1</td>
<td>See Exhibit B-1</td>
</tr>
<tr>
<td>14. Abide by Terms of BCBST Provider Dispute Resolution Procedure</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>15. Exclusivity Allowed</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>16. Defined Service Area</td>
<td>Statewide</td>
<td>Statewide</td>
</tr>
<tr>
<td>17. Provider has not established an adversarial relationship with BCBST, members or participating Providers that might reasonably prevent the Provider from acting in good faith and in accordance with applicable laws or the requirements of BCBST’s agreements with that Provider, other Providers, members or other parties. As examples, such adversarial relationships include, but are not limited to: credible evidence of making defamatory statements about BCBST; initiating legal or administrative actions against BCBST in bad faith; BCBST’s prior or pending termination of the Provider’s participation agreement for cause; or prior or pending collection actions against members in violation of an applicable hold harmless requirement. This participation criteria is not intended to prevent the Provider from fully and fairly discussing all aspects of a patient’s medical condition, treatment or coverage (i.e. to “gag” the Provider from discussing relevant matters with members). Involving Members or third parties in disputes with BCBST prior to receiving a final determination of that dispute in accordance with BCBST’s Provider Dispute Resolution Procedure may be deemed, however, to constitute an adversarial relationship with BCBST.</td>
<td>Required</td>
<td>Required</td>
</tr>
<tr>
<td>18. Provider’s network participation agreement has not been terminated, for other than administrative reasons, within the past year. Examples of administrative terminations are failure to complete the credentialing process. For administrative terminations, Provider may reapply upon cure of the deficiency.</td>
<td>Required</td>
<td>Required</td>
</tr>
</tbody>
</table>

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### Exhibit B-1
**Minimum Ancillary Provider Network Participation Criteria**

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<tr>
<td><strong>State License Requirements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health</td>
<td>TN: Licensed as a Home Health Provider</td>
<td>TN: Licensed as a Home Health Provider</td>
</tr>
<tr>
<td></td>
<td><strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
<td><strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>TN: Licensed as a Home Health Provider</td>
<td>TN: Licensed as a Home Infusion Therapy Provider</td>
</tr>
<tr>
<td></td>
<td><strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
<td><strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>TN: Licensed as a Home Infusion Therapy Provider</td>
<td>TN: Licensed as a Durable Medical Equipment Supplier</td>
</tr>
<tr>
<td></td>
<td><strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
<td><strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
<td>TN: does not license Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
<td>TN: does not license Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
</tr>
<tr>
<td></td>
<td><strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
<td><strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Specialty Durable Medical Equipment Suppliers (Non-Licensed offering non-motorized equipment only, e.g. walker, canes)</td>
<td>TN: does not license Specialty Durable Medical Equipment Suppliers</td>
<td>TN: does not license Specialty Durable Medical Equipment Suppliers</td>
</tr>
<tr>
<td></td>
<td><strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
<td><strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Medical Supply Durable Medical Equipment Suppliers (Soft goods only, e.g., ostomy supplies)</td>
<td>TN: does not license Specialty Durable Medical Equipment Suppliers</td>
<td>TN: does not license Specialty Durable Medical Equipment Suppliers</td>
</tr>
<tr>
<td></td>
<td><strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
<td><strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td>Hospice</td>
<td>TN: Licensed as a Hospice Provider</td>
<td>TN: Licensed as a Hospice Provider</td>
</tr>
<tr>
<td></td>
<td><strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
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<tr>
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<td></td>
<td></td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td><strong>TN</strong>: Licensed as a Medical Laboratory</td>
<td><strong>TN</strong>: Licensed as a Medical Laboratory</td>
</tr>
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<td></td>
<td><strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
<td><strong>Contiguous</strong>: Licensed in accordance with that state’s licensing laws</td>
</tr>
<tr>
<td><strong>Minimum Insurance Requirements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malpractice Insurance</td>
<td>$1 million/$3 million unless State employee</td>
<td>$1 million/$3 million unless State employee</td>
</tr>
<tr>
<td>Comprehensive Insurance (DME Only)</td>
<td>$1 million/$3 million unless State employee</td>
<td>$1 million/$3 million unless State employee</td>
</tr>
<tr>
<td>Product Liability (Breast Prosthesis Only)</td>
<td>$500,000</td>
<td>$500,000</td>
</tr>
<tr>
<td><strong>Medicare Certification Requirements</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health</td>
<td>Medicare Part A</td>
<td>Medicare Part A</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>Medicare Part B</td>
<td>Medicare Part B</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Medicare Part B</td>
<td>Medicare Part B</td>
</tr>
<tr>
<td>Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
<td>Medicare Part B</td>
<td>Medicare Part B</td>
</tr>
<tr>
<td>Specialty Durable Medical Equipment Suppliers (Non-Licensed offering non-motorized equipment only, e.g. walker, canes)</td>
<td>Medicare Part B</td>
<td>Medicare Part B</td>
</tr>
<tr>
<td>Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)</td>
<td>Medicare Part B</td>
<td>Medicare Part B</td>
</tr>
<tr>
<td>Hospice</td>
<td>Medicare Part A</td>
<td>Medicare Part A</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>Medicare Part B</td>
<td>Medicare Part B</td>
</tr>
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<td><strong>Accreditation Requirements</strong></td>
<td></td>
<td></td>
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<tr>
<td>Home Health</td>
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<td>N/A</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>JC or CHAP or AAAHC, BOC, The Compliance Team, ABC, NBAOS, CARF, HQAA, ACHC</td>
<td>JC or CHAP or AAAHC, BOC, The Compliance Team, ABC, NBAOS, CARF, HQAA, ACHC</td>
</tr>
<tr>
<td>Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
<td>N/A</td>
<td>N/A</td>
</tr>
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### Exhibit B-1 (cont’d)
Minimum Ancillary Provider Network Participation Criteria

<table>
<thead>
<tr>
<th>Network Attribute</th>
<th>PPO Blue Network P (Preferred)/ BlueAdvantage</th>
<th>PPO Blue Network S (Select)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Durable Medical Equipment Suppliers (Non-Licensed offering non-motorized equipment only, e.g. walker, canes)</td>
<td>JC or CHAP or AAAHC, if applicable</td>
<td>JC or CHAP or AAAHC, if applicable</td>
</tr>
<tr>
<td>Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)</td>
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<td>N/A</td>
</tr>
<tr>
<td>Hospice</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Independent Laboratory</td>
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<td>N/A</td>
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**Agrees to Rapid Response Requirement**

<table>
<thead>
<tr>
<th>Service</th>
<th>PPO Blue Network P (Preferred)/ BlueAdvantage</th>
<th>PPO Blue Network S (Select)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Specialty Durable Medical Equipment Suppliers (Non-Licensed offering non-motorized equipment only, e.g. walker, canes)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Hospice</td>
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<td>N/A</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>N/A</td>
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</tr>
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</table>

**Claims Filing Method**

<table>
<thead>
<tr>
<th>Service</th>
<th>PPO Blue Network P (Preferred)/ BlueAdvantage</th>
<th>PPO Blue Network S (Select)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health</td>
<td>CMS-1450</td>
<td>CMS-1450</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>CMS-1500</td>
<td>CMS-1500</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>CMS-1500</td>
<td>CMS-1500</td>
</tr>
<tr>
<td>Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
<td>CMS-1500</td>
<td>CMS-1500</td>
</tr>
<tr>
<td>Specialty Durable Medical Equipment Suppliers (Non-Licensed offering non-motorized equipment only, e.g. walker, canes)</td>
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Exhibit B-1 (cont’d)
Minimum Ancillary Provider Network Participation Criteria

<table>
<thead>
<tr>
<th>Network Attribute</th>
<th>PPO Blue Network P (Preferred)/ BlueAdvantage</th>
<th>PPO Blue Network S (Select)</th>
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</thead>
<tbody>
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<td>CMS-1500</td>
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<tr>
<td>Hospice</td>
<td>CMS-1450</td>
<td>CMS-1450</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>CMS-1500</td>
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</table>

**Must Provide all Services**

<table>
<thead>
<tr>
<th>Service</th>
<th>PPO Blue Network P (Preferred)/ BlueAdvantage</th>
<th>PPO Blue Network S (Select)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
<td>N/A</td>
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</tr>
<tr>
<td>Specialty Durable Medical Equipment Suppliers (Non-Licensed offering non-motorized equipment only, e.g. walker, canes)</td>
<td>N/A</td>
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</tr>
<tr>
<td>Medical Supply Durable Medical Equipment Suppliers (Soft good supplies only, e.g., ostomy supplies)</td>
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<td>N/A</td>
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<tr>
<td>Hospice</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>N/A</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Services must be available in all counties of a CSA (subcontracting permitted)**

<table>
<thead>
<tr>
<th>Service</th>
<th>PPO Blue Network P (Preferred)/ BlueAdvantage</th>
<th>PPO Blue Network S (Select)</th>
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</thead>
<tbody>
<tr>
<td>Home Health</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Home Infusion Therapy</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
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<td>Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
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### Exhibit B-1 (cont’d)
Minimum Ancillary Provider Network Participation Criteria

<table>
<thead>
<tr>
<th>Network Attribute</th>
<th>PPO Blue Network P (Preferred)/BlueAdvantage</th>
<th>PPO Blue Network S (Select)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialty Durable Medical Equipment Suppliers <em>(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)</em></td>
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<td>N/A</td>
</tr>
<tr>
<td>Medical Supply Durable Medical Equipment Suppliers <em>(Soft good supplies only, e.g., ostomy supplies)</em></td>
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<td>N/A</td>
</tr>
<tr>
<td>Hospice</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>Independent Laboratory</td>
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</table>

### Term of Contract

<table>
<thead>
<tr>
<th>Service Type</th>
<th>PPO Blue Network P (Preferred)/BlueAdvantage</th>
<th>PPO Blue Network S (Select)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health</td>
<td>180 days</td>
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</tr>
<tr>
<td>Home Infusion Therapy</td>
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<td>180 days</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>180 days</td>
<td>180 days</td>
</tr>
<tr>
<td>Prosthetic/Orthotic Durable Medical Equipment Suppliers</td>
<td>180 days</td>
<td>180 days</td>
</tr>
<tr>
<td>Specialty Durable Medical Equipment Suppliers <em>(Non-Licensed offering non-motorized equipment only, e.g. walker, canes)</em></td>
<td>180 days</td>
<td>180 days</td>
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<tr>
<td>Medical Supply Durable Medical Equipment Suppliers <em>(Soft good supplies only, e.g., ostomy supplies)</em></td>
<td>180 days</td>
<td>180 days</td>
</tr>
<tr>
<td>Hospice</td>
<td>180 days</td>
<td>180 days</td>
</tr>
<tr>
<td>Independent Laboratory</td>
<td>60 days</td>
<td>60 days</td>
</tr>
</tbody>
</table>

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**XV-31**
G. Provider Identification Number Process

Before submitting claims to BlueCross BlueShield of Tennessee, a Provider must request and be assigned an individual provider identification number or contact us to register their National Provider Identifier (NPI). The purpose of this number is to identify the Provider and ensure accurate distribution of payments, remittance advices (Explanation of Payments (EOPs)), and 1099 forms. **The assigned provider number or NPI in no way signifies that the Provider participates in any or all BlueCross BlueShield of Tennessee networks.**

Inquiries regarding the need for a new provider number or to register their NPI should be directed to:

- BlueCross BlueShield of Tennessee Provider Service line, 1-800-924-7141, and just say "Network contracting" when prompted.
XVI. BLUECARD® PROGRAM

The BlueCard Program links participating health care providers and the independent BlueCross and/or BlueShield plans across the country and around the world through a single electronic network for claims processing and reimbursement.

The BlueCard Program also allows Members who are away from (traveling or living) their Home Plan’s service area to receive medical care from participating Providers wherever services may be required and in many instances, to receive the same level of benefits they would receive if the services were rendered in their Home Plan’s service area.

The program allows Providers to submit claims for BlueCross and/or BlueShield plan Members from other BlueCross and BlueShield plans, including international BlueCross and BlueShield plans, directly to the Provider’s local plan (Host Plan*). That plan will be the Provider’s contact for claims filing, claims payment, adjustments, inquiries, and problem resolution.

*Home Plan is the plan that “owns” the Member’s coverage  
**Host Plan is the Practitioner’s local BlueCross BlueShield Plan – for Tennessee Practitioner’s treating Members of other Blue Plans, it is BlueCross BlueShield of Tennessee.

A. How the Program Works

1. A BlueCross and/or BlueShield Member is outside his/her Home Plan’s service area and needs health care services.
2. The Member locates a participating Provider* by calling the BlueCard Provider Finder at 1-800-810-BLUE (2583) or by accessing the BlueCard Provider Finder website at www.bcbs.com/healthtravel/finder.html.
3. The Member presents his/her BlueCross and/or BlueShield ID card. The Member’s identification number should begin with a three-character alpha prefix.
4. The Provider should verify the Member’s eligibility and benefits by calling BlueCard Eligibility at 1-800-676-BLUE (2583), the customer service number on the back of the Member’s ID card, or online via the secure BlueAccess link on the company website, www.bcbst.com. (See subsection B. “How to Identify a BlueCard Member” to determine the Member’s BlueCross BlueShield Plan.) Note: A BlueCard Member’s coverage and utilization management requirements may differ from those of BlueCross BlueShield of Tennessee. The facility is responsible for obtaining any necessary inpatient prior authorizations; however, the Practitioner may elect to confirm a prior authorization has been obtained. See subsection L. “Prior Authorization Requirements”).
5. The Provider should submit claims to BlueCross BlueShield of Tennessee.
6. BlueCross BlueShield of Tennessee will electronically forward the claim to the Member’s Home Plan with the Provider’s network participation status and the maximum allowable based on the Provider’s agreement with BlueCross BlueShield of Tennessee.
7. The Member’s Home Plan will determine the benefits to be provided based on the Member’s eligibility, contract provisions, the Provider’s network status, and the maximum allowable. The Home Plan will transmit back to BlueCross BlueShield of Tennessee the finalized adjudication information (e.g., reason for denial, amount applied to deductible, amount paid, etc.).
8. BlueCross BlueShield of Tennessee will notify the Provider via the Explanation of Payment (EOP) of the final adjudication results.
9. The Member’s Home Plan will notify the Member of his/her benefits via an Explanation of Benefits (EOB).

*If the Member receives services from a non-participating Provider, the Member is responsible for:
• paying the charges at the time the services are rendered;
• submitting the claim to BlueCross BlueShield of Tennessee; and
• any amounts not paid by his/her benefit plan, including amounts exceeding the maximum allowable.

B. How to Identify a BlueCard Member

BlueCard Members will carry BlueCross and/or BlueShield identification cards that include one or more of the following identifiers:

- Subscriber identification number begins with an alpha-prefix
- Suitcase logo (empty or PPO inside)
- Member’s Plan name other than BlueCross BlueShield of Tennessee reflected on back of ID card

Sample copies of the BlueCard ID cards follow:

BlueCard Traditional ID Card

BlueCard PPO ID Card

C. BlueCard Traditional

- BlueCard Traditional Members have identification cards with either no suitcase or with an “empty” suitcase logo.
- BlueCard Traditional Members are often required to use a participating Provider within their Home Plan’s service area. Therefore, Providers should verify the level of benefits (in-network vs. out-of-network) they will receive for services provided these Members.
- For dates of service prior to 1/1/09, the maximum allowable was based on Blue Network C. Effective for dates of service 1/1/09, and after, the maximum allowable is based on Blue Network P.
D. BlueCard PPO

- BlueCard PPO Members have identification cards with a “PPO” inside a suitcase logo.
- Benefits are provided at the in-network level if the Provider is participating in the local BlueCross and/or BlueShield Plan’s BlueCard PPO Network.
- The maximum allowable is based on Blue Network P.

E. BlueCard Alternative PPO Network

- Alternative PPO Network Members have identification cards that include the local BlueCross and/or BlueShield’s alternative PPO Network name listed.
- Benefits are provided at the in-network level if the Provider is participating in the local BlueCross and/or BlueShield’s designated Alternative PPO Network.
- Alternative PPO Network Members do not have access to a Wrap Network.
- The maximum allowable is based on Blue Network S.

F. Medicare Advantage Private-Fee-for-Service (PFFS)

A Medicare PFFS plan is a plan offered by an organization that pays Physicians and Providers on a fee-for-service basis. This is no specific network that Providers sign up for to service PFFS Members. Members can obtain services from any licensed Physician or Provider in the United States who is qualified to be paid by Medicare and accepts the plan’s terms of payment.

The maximum allowable for Covered Services will be equivalent to the current Medicare payment amount.

Please refer to the Member identification card for instructions on how to access terms and conditions. Providers may also locate this information on our website at http://www.bcbst.com/providers/BenefitHighlights.shtml.

G. Medicare Advantage PPO

Beginning 1/1/2010, Medicare Advantage PPO network sharing is available in all the Centers for Medicare & Medicaid Services (CMS)-approved Medicare Advantage (MA) PPO BlueCross and/or BlueShield Plans local service areas.

This network sharing allows MA PPO Members from Blue Plans to obtain in-network benefits when traveling or living in the service areas of the other two Plans if the Member receives care from a contracted MA PPO Provider.

The maximum allowable is based on the Blue Advantage PPO Network. If you are not a contracted Blue Advantage PPO Network Provider and you provide services for any Blue Medicare Advantage out-of-area Member, the maximum allowable will be based on the Medicare allowed amount for Covered Services.

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H. BlueCard Claim Filing

Claims for the following services should be submitted to BlueCross BlueShield of Tennessee unless the Provider contracts directly with the Member’s Home Plan:

- Medical services (including secondary claims)
- Routine hearing
- Routine vision

Claims for the following services should be submitted directly to the Member’s Home Plan:

- Stand-alone Dental
- Prescription Drugs

Effective 10/14/2012, all Blue Plans implemented new claims filing procedures for Ancillary Providers. It is very important that ALL Providers understand the impact of this change.

File the claim accordingly for the Ancillary Provider as outlined below:

- **Independent Clinical Lab** – Lab Providers should file claims to the Blue Plan in whose state the specimen was drawn, which will be determined by which state the referring Provider is located.

- **Durable Medical Equipment (DME)/Home Medical Equipment (HME)** – DME/HME Providers should file claims to the Blue Plan in whose state the equipment was shipped to, or purchased at a retail store.

- **Specialty Pharmacy** – Specialty pharmacies should file the claim to the Blue Plan in whose state the ordering Physician is located.

**Note:** If the Provider contracts with more than one Blue Plan in a state for the same product type (i.e., PPO or Traditional), the Provider may file the claim with either Plan.

**Note:** Contiguous County Providers should file claims according to these guidelines regardless of Network status.

Providers utilizing outside vendors to provide services (example: sending blood specimen for special analysis that cannot be done by the lab where the specimen was drawn) should utilize in-network participating Ancillary Providers to reduce the possibility of additional Member liability for Covered benefits. A list of in-network participating Providers may be obtained by contacting their Provider Network Manager (See Section II. BlueCross BlueShield of Tennessee Quick Reference Guide in this Manual) or call BlueCard at 1-800-705-0391.

Claims should be filed with the identification number as it appears on the Member’s ID card omitting any dashes or spaces within the identification number. Additionally, Ancillary Provider claims must include the name of the referring Physician or the claim will be rejected.

When submitting electronically, follow the guidelines found in this Manual (Section VI. Billing and Reimbursement – Filing Electronic Claims). Providers needing additional information regarding electronic claims filing can call BlueCross BlueShield of Tennessee eBusiness Solutions at 423-535-5717.

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When submitting paper claims, mail to:
BlueCross BlueShield of Tennessee
Claims Service Center
1 Cameron Hill Circle, Ste 0002
Chattanooga, TN 37401-0002

When submitting paper claims for secondary benefits (secondary to a commercial carrier or to Medicare), please include the primary carrier’s Explanation of Payment.

I. BlueCard and Medicare Crossover Claims

Each BlueCross and/or BlueShield Plan independently contracts with the Centers for Medicare and Medicaid Services (CMS) for crossover claims.

Since the CMS Coordination of Benefits Agreement allows insurance carriers to select which claims cross over automatically, Providers may see some variation in crossover processes; i.e., type of bill, Provider location state, Medicare Administrative Contractor for Jurisdiction C (DME MAC), and Medicare payment versus Beneficiary liability among the BlueCross and/or BlueShield Plans.

Providers are encouraged to review their Medicare Summary Notice (MSN) to determine if Medicare crossed over a specific claim to the Member’s Home Plan. If the MSN indicates the claim was crossed over, the Member’s Home Plan will process the claim directly. If the MSN does not indicate the claim crossed over, the Provider should submit a paper claim with a copy of Medicare’s MSN to:

BlueCross BlueShield of Tennessee
Claim Service Center
1 Cameron Hill Circle, Ste 0002
Chattanooga, TN 37401-0002

Providers may request status for Medicare crossover claims online via the secure BlueAccess link on the company website, www.bcbst.com.

J. BlueCard Program Reimbursement

BlueCross BlueShield of Tennessee will reimburse Providers for BlueCard Program claims submitted according to BlueCross BlueShield of Tennessee claims filing guidelines when:

- The Member is eligible for benefits
- The services are covered under the Member’s plan*
- The Provider has not already been paid for the services

*The Home Plan determines what services are considered eligible under the Member’s plan including all medical policy determinations (e.g., Medical Necessity, Investigational; routine, etc.).
K. Medical Records

BlueCross BlueShield of Tennessee will forward requests for medical information and/or copies of records as requested by the Member’s Home Plan. The medical information and/or records should be returned to BlueCross BlueShield of Tennessee as quickly as possible to reduce any delays in claims processing. Because we are interested in servicing you in the most efficient manner possible, Providers are encouraged to submit medical records using the following guidelines:

- Submit any request letters from us as the first page of your medical record.
- Providers are encouraged to fax the requested information to the number listed on the request letter. This allows for direct storage into our image repository.
- Submit only the requested information.
- Claim copies are not necessary when submitting requested medical records. Any claim copies submitted must be behind the medical record. If attached to the front, it will be mistaken for a claim needing adjudication rather than a medical record needing review.

Note: Medical record requests are based on the Home Plan’s medical policies and may differ from those of BlueCross BlueShield of Tennessee.

L. Prior Authorization Requirements

Each BlueCross and/or BlueShield Plan determines its medical policies related to prior authorization requirements. Home Plans may require prior authorization based on the type of service or location of service. The services requiring prior authorization may vary from those determined by BlueCross BlueShield of Tennessee.

Providers may elect to verify any prior authorization requirements via telephone or by utilizing BlueAccess, BlueCross BlueShield of Tennessee’s secure area on its website, www.bcbs.com.

M. Inquiries

The following grid lists examples of specific inquiries and provides direction to the appropriate contact:

<table>
<thead>
<tr>
<th>Inquiry</th>
<th>Contact</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verification of eligibility/benefits</td>
<td>Home Plan</td>
<td>1-800-676-BLUE or by accessing BlueCard within BlueAccess</td>
</tr>
<tr>
<td>Prior Authorizations</td>
<td>Home Plan</td>
<td>See back of Member’s ID card</td>
</tr>
<tr>
<td>Electronic claims submissions</td>
<td>Host Plan (BCBST)</td>
<td>BCBST eBusiness Solutions 423-535-5717</td>
</tr>
<tr>
<td>General questions</td>
<td>Host Plan (BCBST)</td>
<td>BlueCard Host Service 1-800-705-0391</td>
</tr>
<tr>
<td>Processed claims</td>
<td>Host Plan (BCBST)</td>
<td>BlueCard Host Service 1-800-705-0391</td>
</tr>
<tr>
<td>Inquiry</td>
<td>Contact</td>
<td>Description</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>----------------------------------------------</td>
<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Status requests</td>
<td>Host Plan (BCBST)</td>
<td>BlueCard Host Service 1-800-705-0391 or by accessing BlueCard within BlueAccess</td>
</tr>
<tr>
<td>Claim rejected “Home Plan will handle direct”</td>
<td>Home Plan</td>
<td>Customer Service Number located on back of Member’s ID card</td>
</tr>
<tr>
<td>Claim rejected “Additional information needed”</td>
<td>Host Plan (BCBST)</td>
<td>BlueCard Host Service 1-800-705-0391</td>
</tr>
<tr>
<td>Overpayments</td>
<td>Host Plan (BCBST)</td>
<td>BlueCard Host Service 1-800-705-0391</td>
</tr>
<tr>
<td>Appeals Host</td>
<td>Plan (BCBST)</td>
<td>Follow guidelines found in this Manual (Section XIII. Provider Dispute Resolution Procedure)</td>
</tr>
</tbody>
</table>

Providers interested in more information regarding the BlueCard Program can call BlueCross BlueShield of Tennessee’s BlueCard Service Department at 1-800-705-0391.
XVII. VISION CARE

A. BCBST Employee Group 44 Plan


*Claims for services due to illness or injury to the eye are Covered under Members’ medical plan. These claims should continue to be filed to BCBST for reimbursement.

Providers not contracted with EyeMed will continue to receive the same reimbursement by submitting an out-of-network claim form to EyeMed on behalf of the Member or by collecting from the Member and having the Member submit the claim to EyeMed for reimbursement. The EyeMed out-of-network claim form is available on the company website at http://www.bcbst.com/members/vision/OON+Claim+Form++8.2008.pdf. Contact EyeMed at 1-888-581-3648 for more information on becoming a contracted Provider.

BCBST employees with vision benefits through EyeMed can be identified by group number 109844 reflected on the Member ID card.

The following ID card identifies BlueCross BlueShield of Tennessee Group 44 Members:

Note: This change affects BCBST employee Group 44 plan only.
B. VisionBlue – Network-based vision coverage plan

VisionBlue is a network-based routine vision care program offered by BlueCross BlueShield of Tennessee in partnership with EyeMed VisionCare.

Benefits for services due to illness or injury are covered under the Member’s medical plan.

The following ID card identifies BlueCross BlueShield of Tennessee Members also subscribing to VisionBlue:

![VisionBlue ID Card Image]

Providers holding a contract with EyeMed provide services at the in-network benefit level and file claims directly with EyeMed. Members who seek services from out-of-network Providers (those not having a contract with EyeMed) must file their claim directly to EyeMed to receive the out-of-network benefits.

The following list reflects standard VisionBlue benefits offered by BlueCross BlueShield of Tennessee. However, benefits vary Plan by Plan; Therefore, Providers should always check eligibility and benefits prior to rendering services.
# VisionBlue Summary of Benefits

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network Member Cost</th>
<th>Out-of-Network Reimbursement</th>
<th>Benefit Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>VISION EXAMINATION</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comprehensive Eye Examination</td>
<td>$10 or $20 copay</td>
<td>up to $35</td>
<td>One exam within a 12-month period For each Member covered under the plan</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plans with materials coverage also include benefits listed below</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Contact Lenses Fit And Follow-Up</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard</td>
<td>$55 copay</td>
<td>up to $0</td>
<td>One exam within a 12-month period For each Member covered under the plan</td>
</tr>
<tr>
<td>Premium</td>
<td>10% off retail</td>
<td>up to $0</td>
<td></td>
</tr>
<tr>
<td><strong>VISION MATERIALS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Standard Plastic Lenses</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single Vision</td>
<td>$10 or $25 copay</td>
<td>up to $30</td>
<td></td>
</tr>
<tr>
<td>Bifocal</td>
<td>$10 or $25 copay</td>
<td>up to $45</td>
<td></td>
</tr>
<tr>
<td>Trifocal</td>
<td>$10 or $25 copay</td>
<td>up to $60</td>
<td></td>
</tr>
<tr>
<td><strong>Frames</strong></td>
<td>$0 copay up to ($100, $120, $150) allowance, 20% off balance over allowance</td>
<td>Up to ($50, $60, $75)</td>
<td>One pair of frames within a 12- or 24-month period for each member covered under the plan</td>
</tr>
<tr>
<td><strong>Contacts</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Conventional</td>
<td>$0 copay up to ($100, $120, $150) allowance, 15% off balance over allowance</td>
<td>Out of network up to ($80, $96, $120)</td>
<td></td>
</tr>
<tr>
<td>Disposable</td>
<td>$0 copay up to ($100, $120, $150) allowance</td>
<td>Out of network up to ($80, $96, $120)</td>
<td></td>
</tr>
<tr>
<td>Medically Necessary</td>
<td>Paid in Full</td>
<td>Up to $200</td>
<td></td>
</tr>
<tr>
<td><strong>Lens Options</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Polycarbonate</td>
<td>$40 copay</td>
<td>Up to $0</td>
<td></td>
</tr>
<tr>
<td>Standard Polycarbonate (For covered Dependent children under 19 years of age)</td>
<td>$0 copay</td>
<td>Up to $5</td>
<td></td>
</tr>
<tr>
<td>UV Treatment</td>
<td>$15 copay</td>
<td>Up to $0</td>
<td></td>
</tr>
<tr>
<td>Tint</td>
<td>$15 copay</td>
<td>Up to $0</td>
<td></td>
</tr>
</tbody>
</table>
**VisionBlue Summary of Benefits (cont’d)**

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network</th>
<th>Out-of-Network</th>
<th>Benefit Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Plastic Scratch Coating</td>
<td>$15 copay</td>
<td>Up to $0</td>
<td></td>
</tr>
<tr>
<td>Standard Progressive Lenses (add on to Bifocal)</td>
<td>$65 copay</td>
<td>Up to $45</td>
<td></td>
</tr>
<tr>
<td>Premium Progressive Lenses (add on to Bifocal)</td>
<td>$65 copay, 20% off retail price less $120 allowance</td>
<td>Up to $45</td>
<td></td>
</tr>
<tr>
<td>Standard Anti-Reflective Coating</td>
<td>$45 copay</td>
<td>Up to $0</td>
<td></td>
</tr>
</tbody>
</table>

**Note:**
- This document serves as a summary of the benefits that are detailed in the Member’s Evidence of Coverage. These benefits are subject to the Covered Services and Limitations on Covered Services, Exclusions from Covered Services, and Schedule of Benefits sections of the Member’s Evidence of Coverage.
- When applicable benefits are paid after the copay amounts listed above and to the allowance listed. Members are responsible for amounts above the allowance.
- Members may see any vision care Provider. However, contracted Providers in the BCBST network have agreed to limit certain charges and provide additional discounts once the allowance has been reached. Members are responsible for all charges that exceed the out-of-network reimbursement.

**VisionBlue Frequently Asked Questions**

**Why was EyeMed Vision Care chosen to administer the new VisionBlue product?**
- By choosing EyeMed, BlueCross BlueShield of Tennessee is able to allow Members a variety of private Practitioners as well as retail outlets.

**Will I submit VisionBlue claims to BCBST or EyeMed?**
- To determine if claims should be submitted to BCBST or EyeMed, simply flip the Member’s card over. If it is a VisionBlue Member, the back of the card will read “Vision: EYEMED 1-877-342-0737”. All other vision claims should be sent to BCBST. In addition, if a claim is sent to BCBST in error, it will be returned to the Provider with instructions to resubmit to EyeMed.

**How can I contact EyeMed directly?**
- EyeMed has dedicated an entire customer service line for BCBST Members and Providers. The number to call is 1-877-342-0737.

**Who do I contact to verify eligibility and check claim status for Members that have routine benefits provided through EyeMed?**
- You would need to contact EyeMed Customer Service at 1-877-342-0737.
VisionBlue Frequently Asked Questions (Cont’d)

If the services rendered are medical in nature and not considered routine, where should I submit the claim?

- Claims of medical services should be filed directly to the Member’s medical insurance carrier.

I am interested in becoming a provider with EyeMed. Who should I contact?

- Please contact EyeMed directly by calling 1-877-342-0737.

Will my current patients with BCBST vision be changing to this new product?

- No, not at this time. The only exception would be if an employer group chose to add or change to this product.
C. Essential Health Benefits (EHB) Medical Plan

New Health Care Reform Plans from BCBST have Pediatric vision benefits built into the medical plan. The Affordable Care Act (ACA) mandates that certain additional services be covered, to include, but not limited to pediatric vision care services for Members under 19 years of age.

A sample copy of the BlueCross BlueShield of Tennessee EHB ID card follows:

Adults are not covered for vision services under the EHB medical plan. Adult coverage is available as a separate vision supplemental plan providing coverage to individuals 19 years and older. Benefits vary; therefore, Providers should always check eligibility and benefits prior to rendering services.

A sample copy of a Vision Supplemental Plan ID card follows:

VisionBlue plan benefits may be checked by calling the VisionBlue EyeMed phone number listed on the back of the Member ID card.
Essential Health Benefits Medically Necessary and Appropriate Routine Vision Care Services

Covered Services

1. Routine vision services, including services and supplies to detect or correct refractive errors of the eyes.

Limitations

1. Vision Examinations are covered once every Annual Benefit Period.
2. Eyeglass frames are covered once every Annual Benefit Period.
3. Eyeglass lenses or contact lenses are covered once every Annual Benefit Period.
4. Prescription Sunglasses will be handled as any other lens.
5. Benefits are not available more frequently than as specified in Attachment C: Schedule of Benefits.
6. Discounts do not apply for benefits provided by other group benefit plans or promotional offers.

Exclusions:

1. Medical and/or surgical treatment of the eye, eyes, or supporting structure, including surgeries to detect or correct refractive errors of the eyes.
2. Eye exercises and/or therapy.
3. Orthoptic or vision training, subnormal vision aids and any associated supplemental testing; Aniseikonic lenses.
4. Medical and/or surgical treatment of the eye, eyes or supporting structures.
5. Charges for lenses and frames ordered while insured but not delivered within 60 days after Coverage is terminated, or vision testing examinations that occur after the date of termination.
6. Charges for non-prescription sunglasses, photosensitive, anti-reflective or other optional charges when the charge exceeds the amount allowable for regular lenses.
7. Charges filed for procedures determined by the Plan to be special or unusual, (i.e. orthoptics, vision training, subnormal vision aids, aniseikonic lenses, tonography, corneal refractive therapy, etc.)
8. Charges for lenses that do not meet the Z80.1 or Z80.2 standards of the American National Standards Institute.
9. Charges in excess of the Covered benefit as established by the Plan.
11. Corrected eyewear required by an employer as a condition of employment, and safety eyewear unless specifically Covered under the plan.
12. Non-prescription lenses and frames, and non-prescription sunglasses (except for 20% discount).
13. Services or materials provided by any other group benefit providing vision care.
14. Two pairs of glasses in lieu of bifocals.
15. Charges for replacement of broken, lost, or stolen lenses, contact lenses, or frames.
16. Charges for services or materials from an Ophthalmologist, Optometrist or Optician acting outside the scope of his or her license.
17. Charges for any additional service required outside basic vision analyses for contact lenses, except fitting fees.

The BlueCross BlueShield of Tennessee EHB Summary of Benefits follows:
# EHB Summary of Benefits

## EHB Pediatric Vision

<table>
<thead>
<tr>
<th>Benefit</th>
<th>EyeMed Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam with Dilation as Necessary</td>
<td>$0 Copayment</td>
<td>60% of Maximum Allowable Charge</td>
</tr>
</tbody>
</table>

## Contact Lens Fit and Follow-Up:

(Contact lens fit and two follow-up visits are available once a comprehensive eye exam has been completed.)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>EyeMed Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Contact Lens Fit and Follow-Up:</td>
<td>$0 Copayment</td>
<td>60% of Maximum Allowable Charge</td>
</tr>
<tr>
<td>Premium Contact Lens Fit and Follow-Up:</td>
<td>$0 Copayment</td>
<td>60% of Maximum Allowable Charge</td>
</tr>
</tbody>
</table>

## Frames:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>EyeMed Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Designated available frame at provider location</td>
<td>100% Coverage for Provider designated frames</td>
<td>60% of Maximum Allowable Charge</td>
</tr>
</tbody>
</table>

## Standard Lenses (Glass or Plastic):

<table>
<thead>
<tr>
<th>Benefit</th>
<th>EyeMed Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single Vision</td>
<td>$0 Copayment</td>
<td>60% of Maximum Allowable Charge</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$0 Copayment</td>
<td>60% of Maximum Allowable Charge</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$0 Copayment</td>
<td>60% of Maximum Allowable Charge</td>
</tr>
<tr>
<td>Lenticular</td>
<td>$0 Copayment</td>
<td>60% of Maximum Allowable Charge</td>
</tr>
<tr>
<td>Standard Progressive Lens</td>
<td>$0 Copayment</td>
<td>60% of Maximum Allowable Charge</td>
</tr>
</tbody>
</table>

## Lens Options:

<table>
<thead>
<tr>
<th>Benefit</th>
<th>EyeMed Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>UV Treatment</td>
<td>$0 Copayment</td>
<td>60% of Maximum Allowable Charge</td>
</tr>
<tr>
<td>Tint (Fashion &amp; Gradient &amp; Glass-Grey)</td>
<td>$0 Copayment</td>
<td>60% of Maximum Allowable Charge</td>
</tr>
<tr>
<td>Standard Plastic Scratch Coating</td>
<td>$0 Copayment</td>
<td>60% of Maximum Allowable Charge</td>
</tr>
<tr>
<td>Standard Polycarbonate</td>
<td>$0 Copayment</td>
<td>60% of Maximum Allowable Charge</td>
</tr>
<tr>
<td>Photocromatic / Transitions Plastic</td>
<td>$0 Copayment</td>
<td>60% of Maximum Allowable Charge</td>
</tr>
</tbody>
</table>

## Contact Lenses:

(Contact lens includes materials only)

<table>
<thead>
<tr>
<th>Benefit</th>
<th>EyeMed Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extended Wear and Extended Wear Disposables</td>
<td>Up to 6 months supply of monthly or 2 week disposable, single vision spherical or toric contact lenses</td>
<td>60% of Maximum Allowable Charge</td>
</tr>
<tr>
<td>Daily Wear / Disposables</td>
<td>Up to 3 months supply of daily disposable, single vision spherical contact lenses</td>
<td>60% of Maximum Allowable Charge</td>
</tr>
</tbody>
</table>
A. Standard DentalBlue Covered Services and Limitations

The standard DentalBlue Program provides a wide range of benefits to cover most services associated with dental care.

If more than one procedure or course of treatment can be used to accomplish the same treatment goal, meets generally accepted standards of professional dental care, and offers a favorable prognosis for the patient's condition, then benefits may be based on the lowest cost procedure or treatment. This will be at our sole discretion.

If a Member transfers from the care of one Dentist to another during the course of treatment, or if more than one Dentist renders services for one dental procedure, benefits will not exceed those that would have been provided had one Dentist rendered the service. Benefits will also not be paid for incomplete treatment.

Examinations

Covered: Standard exams including comprehensive, periodic, detailed/extensive and periodontal oral evaluations (exams). Emergency exams, including limited oral evaluations (exams).

Limitations: No more than one standard exam in any 6-month period. No more than one emergency exam in any 12-month period. No more than one detailed/extensive or periodontal exam in any 36-month period. An additional comprehensive exam (D0150) will be considered for each participating Provider once in a 36-month period, assuming the same Provider has not performed a detailed/extensive or periodontal exam within the same 36-month period.

Exclusions: Re-evaluations and consultations.

X-rays

Covered: Full mouth series, intraoral and bitewing radiographs (X-rays).

Limitations: No more than one full mouth set of X-rays in any 36-month period. A full mouth set of X-rays is defined as either an intraoral complete series or panoramic X-ray. Benefits provided for either include benefits for all necessary intraoral and bitewing films taken on the same day. No more than four bitewing films in any 12-month period. Bitewing films must be taken on the same date of service.

Exclusions: Extraoral, skull and bone survey, sialography, TMJ, and tomographic survey X-ray films, cephalometric films and diagnostic photographs. Cephalometric films and diagnostic photographs may be covered as orthodontic benefits under Coverage D.

Cleanings, Fluoride Treatment

Covered: Adult and child prophylaxis (cleaning). Child and adult (subject to age limitations) fluoride treatments, performed with or without a prophylaxis.

Limitations: No more than one of any prophylaxis or periodontal maintenance procedure in any 6-month period. Periodontal maintenance procedures are subject to additional limitations listed under Basic Periodontics later in this section, and may be subject to a different Coverage level under the terms of the Member's Contract. No more than one fluoride treatment in any 12-month period, for Members under age 19. Fluoride must be applied separately from prophylaxis paste.
Sealants, Space Maintainers  
**Covered:** Other Preventive Services, including sealants, preventive resins, and space maintainers.  

**Limitations:** No more than one sealant or preventive resin per first or second molar tooth per lifetime, for Dependents under age 16. Space maintainers for Dependents under age 14. No more than one recementation in any 12-month period.  

**Exclusions:** Nutritional and tobacco counseling, oral hygiene instructions.

Basic Restorative Services  
**Covered:** Basic restorative services, including amalgam restorations (silver fillings), resin composite restorations (tooth colored fillings), stainless steel crowns. Palliative emergency treatment for the relief of pain. Other restorative services, including repair of full and partial dentures.  

**Limitations:** No more than one amalgam or resin restoration per tooth surface in any 12-month period. Replacement of existing amalgam and resin composite restorations covered only after 12 months from the date of initial restoration. Replacement of stainless steel crowns covered only after 36 months from the date of initial restoration. No more than one repair per denture per 24 months.  

**Exclusions:** Gold foil restorations.

Major Restorative Services  
**Covered:** Single tooth restorations, including crowns (resin, porcelain, ¾ cast, and full cast), inlays and onlays (metallic, resin and porcelain), and veneers.  

**Limitations:** Only for the treatment of severe carious lesions or severe fracture on permanent teeth, and only when teeth cannot be adequately restored with an amalgam or resin composite restoration (filling). For permanent teeth only. For Dependents under age 12, benefits will not be provided for cast crowns or laminate veneers. Replacement of single tooth or fixed partial denture restorations Covered only after 60 months from the date of initial placement.  

**Exclusions:** Temporary and provisional crowns.

Prosthodontic Services - Fixed Bridges  
**Covered:** Fixed partial dentures (bridges), including pontics, retainers, and abutment crowns, inlays, and onlays (resin, porcelain, ¾ and full cast).  

**Limitations:** Only for treatment where a missing tooth or teeth cannot be adequately restored with a removable partial denture. For permanent teeth only, no benefits for Dependents under age 16. Replacement of fixed partial dentures or single tooth restoration Covered only after 60 months from the date of initial placement. Prosthodontic Services - Removable Dentures  
**Covered:** Complete, immediate and partial dentures.  

**Limitations:** If, in the construction of a denture, the Member and the Dentist decide on a personalized restoration or to employ special rather than standard techniques or materials, benefits provided shall be limited to those that would otherwise be provided for the standard procedures or materials (as determined by the Plan). Benefits are not provided for Dependents under age 16. Replacement of removable dentures Covered only after 60 months from the date of initial placement.  

**Exclusions:** Interim (temporary) dentures.
Other Major Restorative & Prosthodontic Services

Covered: Crown and bridge services including core buildups, post and core, recementation, and repair. Denture services including adjustment, relining, rebasing and tissue conditioning.

Limitations: The benefits provided for crown and bridge restorations include benefits for the services of crown preparation, temporary or prefabricated crowns, impressions and cementation. Benefits will not be provided for a core build-up separate from those provided for crown construction, except in those circumstances where benefits are provided for a crown because of severe carious lesions or fracture is so extensive that retention of the crown would not be possible. Post and core services are covered only when performed in conjunction with a Covered crown or bridge. Crown and bridge repair and re-cementation are covered separately only after 12 months from the date of initial placement. Denture adjustments are covered separately from the denture only after 6 months from the date of initial placement. No more than one denture reline or rebase in any 36-month period.

Exclusions: Other major restorative services including protective restoration and coping. Other prosthodontic services including overdenture, precision attachments, connector bars, stress breakers and coping metal. Interim pontic and retainer crowns.

Basic Endodontics

Covered: Pulpotomy, pulpal therapy.

Limitations: For primary teeth only. Not covered when performed in conjunction with major endodontic treatment. The benefits for basic endodontic treatment include benefits for X-rays, pulp vitality tests, and protective restoration provided in conjunction with basic endodontic treatment. However, pulp vitality tests and protective restorations are not Covered when billed separately from other endodontic services.

Exclusions: Pulpal debridement.

Major Endodontics

Covered: Root canal treatment and re-treatment, apexification, pulpal regeneration, apicoectomy services, root amputation, retrograde filling, hemisection, pulp cap.

Limitations: No more than one root canal treatment, re-treatment pulpal regeneration, or apexification per tooth in 60-month period. No more than one apicoectomy per root per lifetime. The benefits for major endodontic treatment include benefits for x-rays, pulp vitality tests, pulpotomy, pulpectomy and sedative fillings and temporary filling material provided in conjunction with major endodontic treatment. However, pulp vitality tests and protective restorations are not Covered when billed separately from other endodontic services.

Exclusions: Implantation, canal preparation, and incomplete endodontic therapy.

Basic Periodontics

Covered: Non-surgical periodontics, including periodontal scaling and root planing, full mouth debridement and periodontal maintenance procedure.

Limitations: No more than one periodontal scaling and root planing per quadrant in any 24-month period. No more than one full mouth debridement per lifetime. No more than one of any prophylaxis (cleanings) or periodontal maintenance procedure in any 6-month period. Cleanings are subject to additional limitations listed under Preventive Services, and may be subject to a different Coverage level under the terms of the Member’s Contract. Benefits for periodontal maintenance are provided only after active periodontal treatment (surgical or non-surgical), and no sooner than 90 days after completion of such treatment. Benefits for periodontal scaling and root planing, full mouth debridement, periodontal maintenance and prophylaxis are not provided when more than one of these procedures is performed on the same day.

Exclusions: Provisional splinting, scaling in the presence of gingival inflammation, antimicrobial medication and dressing changes.
Major Periodontics

Covered: Surgical periodontics including gingivectomy, gingivoplasty, gingival flap procedure, crown lengthening, osseous surgery and bone and tissue grafting.

Limitations: No more than one major periodontal surgical procedure in any 36-month period. Benefits provided for major periodontics include benefits for services related to 90 days of postoperative care.

Exclusions: Tissue regeneration and apically positioned flap procedure.

Basic Oral Surgery

Covered: Non-surgical or simple extractions.

Limitations: Benefits provided for basic oral surgery include benefits or suturing and postoperative care.

Exclusions: Benefits for general anesthesia or intravenous sedation when performed in conjunction with basic oral surgery.

Major Oral Surgery

Covered: Surgical extractions (including removal of impacted teeth and wisdom teeth), coronectomy, and other oral surgical procedures typically not Covered under a medical plan.

Limitations: Benefits provided for major oral surgery include benefits for local anesthesia, suturing and postoperative care. Benefits for general anesthesia or intravenous (IV) sedation are provided only in connection with major oral surgery procedures, and only when provided by a Dentist licensed to administer such agents.

Exclusions: Any related oral surgery typically Covered under a medical plan, but not limited to, excision of lesions and bone tissue, treatment of fractures, suturing, wound and other repair procedures, TMJ and related procedures. Orthognathic surgery and treatment for congenital malformations. Harvesting of bone for use in autogenous grafting.

Orthodontics Services

Covered: Exams, photographic images, diagnostic casts, cephalometric X-rays, installation and adjustment of orthodontic appliances and treatment to reduce or eliminate an existing malocclusion.

Limitations: The need for orthodontic services must be diagnosed, identifying a handicapping malocclusion that is both abnormal and correctable, and a Treatment Plan must be submitted to and approved by the Plan. The Plan reserves the right to review the Member’s dental records, including necessary X-rays, photographs, and models to determine whether orthodontic treatment is Covered. Orthodontic services may be limited to Dependents under a specified age limit, as defined under the terms of the Member’s Contract: Orthodontic services may be limited by a Maximum Allowable Charge, Calendar Year Deductible and lifetime maximum as defined under the terms of the Member’s Contract. Multiple occurrences of orthodontic treatment may be allowed subject to the lifetime maximum. All orthodontic services shall be deemed to be concluded on the last date treatment performed during Member’s Coverage, even if a prior approved Treatment Plan has not been completed.

Exclusions: Replacement or repair of any lost, stolen and damaged appliance furnished under the Treatment Plan. Surgical procedures to aid in orthodontic treatment.
B. Other General Exclusions

BlueCross BlueShield of Tennessee’s dental plan does not provide benefits for the following services, supplies or charges to include, but not limited to:

1. Dental services received from a dental or medical department maintained by or on behalf of an Employer, mutual benefit association, labor union, trustee or similar person or group.

2. Charges for services performed by the Member or Member’s spouse, or Member’s or Member’s spouse’s parent, sister, brother or child.

3. Services rendered by a Dentist beyond the scope of his/her license.

4. Dental services which are free, or for which the Member is not required or legally obligated to pay or for which no charge would be made if the Member had no dental Coverage.

5. Dental services to the extent that charges for such services exceed the charge that would have been made and collected if no Coverage existed hereunder.

6. Dental services covered by any medical insurance coverage, or by any other non-dental contract or certificate issued by Blue Cross Blue Shield of Tennessee or any other insurance company, carrier, or plan. For example, removal of impacted teeth, tumors of lip and gum, accidental injuries to the teeth, etc.

7. Any court-ordered treatment of a Member unless benefits are otherwise payable.

8. Courses of treatment undertaken before the Member became Covered under this program.

9. Any services performed after the Member ceased to be eligible for Coverage.

10. Dental care or treatment not specifically listed under the terms of the Member’s Contract.

11. Any treatment or service that the Plan determines is not Necessary Dental Care that does not offer a favorable prognosis that does not meet generally accepted standards of professional dental care, or that is experimental in nature.

12. Services or supplies for the treatment of work related illness or injury, regardless of the presence or absence of Workers’ Compensation coverage. This exclusion does not apply to injuries or illnesses of an employee who is (1) a sole-proprietor of the Group; (2) a partner of the Group; or (3) a corporate officer of the Group, provided the officer filed an election not to accept Workers’ Compensation with the appropriate government department.

13. Charges for any hospital or other surgical or treatment facility and any additional fees charged by a Dentist for treatment in any such facility.

14. Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes. This does not exclude those services provided under Orthodontic benefits (if applicable).

15. Replacement of tooth structure lost from wear or attrition.

16. Dental services resulting from loss or theft of a denture, crown, bridge or removable orthodontic appliance.
17. Diagnosis for, or fabrication of, adjustment or maintenance and cleaning of maxillofacial prosthesis, appliances or restorations necessary to correct bite problems or restore the occlusion or correct temporomandibular joint dysfunction (TMJ) or associated muscles.

18. Diagnostic dental services such as diagnostic tests and oral pathology services.

19. Adjunctive dental services including all local and general anesthesia, sedation, and analgesia (except as provided under major oral surgery).

20. Charges for the treatment of desensitizing medicaments, drugs, occlusal guards and adjustments, mouthguards, microabrasion, behavior management, and bleaching.

21. Charges for the treatment of professional visits outside the dental office or after regularly scheduled hours or for observation.

22. Charges for the inhalation of nitrous oxide/analgesia, anxiolysis.

C. Clinical Criteria Requirements

The following criteria are based on procedure codes as defined in the American Dental Association’s (ADA) Current Dental Terminology CDT 2005 manual.

These criteria were formulated from information gathered from practicing dentists, dental schools, ADA clinical articles and guidelines, insurance companies, as well as other dental related organizations. They are designed as guidelines for consideration of payment and payment decisions and are not intended to be all-inclusive or absolute.

Requests for information regarding treatment using these codes, such as radiographs, periodontal charting, or descriptive narratives, are determined by generally accepted dental standards for consideration of payment. Additional narrative information is appreciated when there may be a special situation.

Unspecified codes (e.g., D0999, D2999, D3999, D4999, D5899 D5999, D6999, D7999, D8999, D9999) will be clinically reviewed and considered for payment if a narrative and/or appropriate radiographs are included with the claim. In some instances, the State legislature will define the requirements for dental procedures.

The following grid lists CDT codes and the required documentation that should accompany claims to BlueCross BlueShield of Tennessee for review. Only attach the required documentation for the codes listed; Attaching documentation to claims for procedures NOT listed will result in claims processing delays.
<table>
<thead>
<tr>
<th>CDT Code</th>
<th>Description</th>
<th>Documentation Required with Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>D2510; D2520;</td>
<td>Inlays</td>
<td>Preoperative radiographs</td>
</tr>
<tr>
<td>D2530</td>
<td></td>
<td>Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.</td>
</tr>
<tr>
<td>D2542 – D2544</td>
<td>Onlays</td>
<td>Preoperative radiographs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.</td>
</tr>
<tr>
<td>D2610; D2620;</td>
<td>Inlays</td>
<td>Preoperative radiographs</td>
</tr>
<tr>
<td>D2630</td>
<td></td>
<td>Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.</td>
</tr>
<tr>
<td>D2642 – D2644</td>
<td>Onlays</td>
<td>Preoperative radiographs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.</td>
</tr>
<tr>
<td>D2650 – D2652</td>
<td>Inlays</td>
<td>Preoperative radiographs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.</td>
</tr>
<tr>
<td>D2662 – D2664</td>
<td>Onlays</td>
<td>Preoperative radiographs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.</td>
</tr>
<tr>
<td>D2710; D2712;</td>
<td>Crowns</td>
<td>Preoperative radiographs^</td>
</tr>
<tr>
<td>D2720 – D2722;</td>
<td></td>
<td>Teeth #7 - #10 and #23 - #26</td>
</tr>
<tr>
<td>D2740; D2750 –</td>
<td></td>
<td>Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio;</td>
</tr>
<tr>
<td>D2752; D2780 –</td>
<td></td>
<td>whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.</td>
</tr>
<tr>
<td>D2783; D2790 –</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2792; D2794</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D2960 – D2962</td>
<td>Veneers</td>
<td>Preoperative radiographs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.</td>
</tr>
<tr>
<td>D6600 – D6615;</td>
<td>Inlays/Onlays</td>
<td>Preoperative radiographs and Perio Charting</td>
</tr>
<tr>
<td>D6624; D6634</td>
<td></td>
<td>Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.</td>
</tr>
<tr>
<td>D0999 – D9999</td>
<td>Unspecified Procedures</td>
<td>Preoperative radiographs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Extensive decay or fracture; periodontal and endodontic prognosis; clinical crown/root ratio;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>whether performed for cosmetics, attrition, vertical dimension, special construction, splinting.</td>
</tr>
</tbody>
</table>

^ Radiographs required when filing more than one specific procedure.

**Note:** To help ensure claims process timely, please do not attach radiographs or perio charting unless submitting a claim for one of the above listed procedures. Effective 1/1/2008, BlueCross BlueShield of Tennessee will no longer return X-rays to the Provider. Because X-rays are considered part of the patient’s clinical record, the dentist office should retain the original image and only submit a copy of the X-ray with the claim.

BCBST accepts electronic attachments, such as X-rays or perio charts through National Electronic Attachment (NEA). Currently BCBST is not able to accept Explanation of Benefits (EOBs) from other insurance carriers electronically. For more information, please call NEA at 1-800-782-5150, ext. 2.

Rev 12/12
D. Essential Health Benefits (EHB) Medical Plan

New Health Care Reform plans from BCBST have Pediatric dental benefits built into the medical plan. The Affordable Care Act (ACA) mandates that certain additional services be covered, including, but not limited to pediatric oral care services for Members under 19 years of age.

A sample copy of the BlueCross BlueShield of Tennessee EHB ID card follows:

Adults are not covered for dental services under the EHB medical plan. Adult coverage is available as a separate dental supplemental plan providing coverage to individuals 19 years and older. Benefits vary; therefore, Providers should always check eligibility and benefits prior to rendering services.

A sample copy of a Dental Supplemental Plan ID card follows:

The following grid lists pediatric dental benefits included in the BlueCross BlueShield of Tennessee Essential Health Benefits plan:

Rev 12/13
Pediatric Dental Benefits included in the BCBST EHB Medical Plan

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Network Dentist</th>
<th>Out-of-Network Dentist</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coverage A</strong> Diagnostic and Preventive Services; Exams; Cleanings; X-rays</td>
<td>100%</td>
<td>100% of the Maximum Allowable Charge after Deductible</td>
</tr>
<tr>
<td><strong>Coverage B</strong> Basic and Restorative Services; Basic Restorative; Basic Endodontics; Oral Surgery; Basic Periodontics</td>
<td>80%</td>
<td>80% of the Maximum Allowable Charge after Deductible</td>
</tr>
<tr>
<td><strong>Coverage C</strong> Major Restorative and Prosthodontic Services; Major Restorative; Major Endodontics; Major Periodontics; Implants</td>
<td>50%</td>
<td>50% of the Maximum Allowable Charge after Deductible</td>
</tr>
<tr>
<td><strong>Coverage D</strong> Medically Necessary Orthodontia for Members under age 19. Prior Authorization is required.</td>
<td>50% after Deductible*</td>
<td>50% of the Maximum Allowable Charge after Deductible*</td>
</tr>
</tbody>
</table>

*Percent may vary by medical plan

**Dental Services – Pediatric Dental**

The Essential Health Benefits plan provides a wide range of benefits to Cover most services associated with dental care for dependents under age 19.

If a Member transfers from the care of one Dentist to another during the course of treatment, or if more than one Dentist renders services for one dental procedure, benefits will not exceed those that would have been provided had one Dentist rendered the service.

When more than one treatment alternative exists, meets generally accepted standards of professional dental care, and offers a favorable prognosis for the individual's condition, BCBST reserves the right to provide payment for the least expensive Covered Service alternative.

**Diagnostic Services**

A. Exams
   1. Covered
      a. Standard exams including comprehensive, periodic, detailed/extensive limited and periodontal oral evaluations (exams).
   2. Limitations
      a. No more than one standard exam in any 6 month period.
   3. Exclusions
      a. Re-evaluations and consultations.

B. X-rays
   1. Covered
      a. Full mouth series, intraoral and bitewing radiographs (x-rays).
2. Limitations  
   a. No more than one full mouth set of x-rays in any 60 month period. A full mouth set of 
      x-rays is defined as either an intraoral complete series or panoramic x-ray. Benefits 
      provided for either include benefits for all necessary intraoral and bitewing films taken 
      on the same day.  
   b. No more than four bitewing films in any 6 month period. Bitewing films must be taken 
      on the same date of service.  
3. Exclusions  
   a. Extraoral, skull and bone survey, sialography, and tomographic survey x-ray films, 
      cephalometric films and diagnostic photographs. 

Preventive Services  
A. Prophylaxis (Cleanings)  
   1. Covered  
      a. Child prophylaxis (cleaning) for primary and permanent teeth.  
   2. Limitations  
      a. No more than one of any prophylaxis or periodontal maintenance procedure in any 6 
         month period.  
      b. Periodontal maintenance procedures are subject to additional limitations listed below 
         under Basic Periodontics, and may be subject to a different Coverage level under 
         Attachment C: Schedule of Benefits.  
B. Fluoride Treatment  
   1. Covered  
      a. Topical fluoride treatments, performed with or without a prophylaxis.  
   2. Limitations  
      a. No more than one fluoride treatment in any 6 month period.  
      b. Fluoride must be applied separately from prophylaxis paste.  
C. Other Preventive Services  
   1. Covered  
      a. Sealants, preventive resin restorations, space maintainers.  
      b. Palliative (emergency) treatment for the relief of pain.  
   2. Limitations  
      a. No more than 1 sealant, preventive resin restoration, or resin infiltration per first or 
         second molar tooth per 36 months. Resin infiltrations are subject to a different 
         Coverage level under Attachment C: Schedule of Benefits.  
      b. No more than one re-cementation in any 12 month period.  
   1. Exclusions  
      a. Nutritional and tobacco counseling, oral hygiene instructions provided by a Dentist. 

Basic Restorative Services  
A. Fillings and Stainless Steel Crowns  
   1. Covered  
      a. Amalgam restorations (silver fillings), resin composite restorations (tooth colored 
         fillings), resin infiltrations, stainless steel crowns.  
   2. Limitations  
      a. No more than one amalgam or resin restoration per tooth surface in any 12 month 
         period.  
      b. Replacement of existing amalgam and resin composite restorations Covered only 
         after 12 months from the date of initial restoration.  
      c. Replacement of stainless steel crowns Covered only after 60 months from the date of 
         initial restoration.  
      d. No more than 1 sealant, preventive resin restoration, or resin infiltration per first or 

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second molar tooth per 36 months. (Sealant/Preventive resins are subject to additional limitations listed under Preventive Services, and may be subject to a different Coverage level under Attachment C: Schedule of Benefits.)

3. Exclusions
a. Gold foil restorations.

Other Basic Restorative Services

1. Covered
   a. Repair of full and partial dentures and bridges
   b. Crown and Inlay re-cementation.
   c. Denture services including adjustments, relining, rebasing and tissue conditioning.
   d. General anesthesia and IV sedation only when administered by a properly licensed Dentist in a dental office in conjunction with covered surgery procedures or when necessary due to concurrent medical conditions.

2. Limitations
   a. No more than one repair per denture per 24 months.
   b. Denture adjustments are Covered separately from the denture only after 6 months from the date of initial placement.
   c. No more than one denture reline or rebase in any 36 month period.

Major Restorative & Prosthodontic Services

Single Tooth Restorations

1. Covered
   a. Crowns (resin, porcelain, ¾ cast, and full cast), inlays and onlays (metallic, resin and porcelain), and veneers.

2. Limitations
   a. Only for the treatment of severe carious lesions or severe fracture on permanent teeth, and only when teeth cannot be adequately restored with an amalgam or resin composite restoration (filling).
   b. For permanent teeth only.
   c. Replacement of single tooth restorations or fixed partial dentures. Covered only after 60 months from the date of initial placement.

3. Exclusions
   a. Temporary and provisional crowns.

Multiple Tooth Restorations – Bridges

1. Covered
   a. Fixed partial dentures (bridges), including pontics, retainers, and abutment crowns, inlays, and onlays (resin, porcelain, ¾ and full cast).

2. Limitations
   a. Only for treatment where a missing tooth or teeth cannot be adequately restored with a removable partial denture.
   b. For permanent teeth only.
   c. Replacement of fixed partial dentures or single tooth restorations. Covered only after 60 months from the date of initial placement.

3. Exclusions
   a. Interim pontic and retainer crowns.
Removable Prosthodontics - Dentures

1. Covered
   a. Complete, immediate and partial dentures.

2. Limitations
   a. If, in the construction of a denture, the Member and the Dentist decide on a personalized restoration or to employ special rather than standard techniques or materials, benefits provided shall be limited to those which would otherwise be provided for the standard procedures or materials (as determined by the Plan).
   b. for permanent teeth only.
   c. Replacement of removable dentures Covered only after 60 months from the date of initial placement.

3. Exclusions
   a. Interim (temporary) dentures.

Other Major Restorative & Prosthodontic Services

1. Covered
   a. Crown and bridge services including core buildups, post and core, and repair.
   b. Implants and Implant supported prosthetics, including local anesthetic.

2. Limitations
   a. The benefits provided for crown and bridge restorations include benefits for the services of crown preparation, temporary or prefabricated crowns, impressions and cementation.
   b. Benefits will not be provided for a core build-up separate from those provided for crown construction, except in those circumstances where benefits are provided for a crown because of severe carious lesions or fracture is so extensive that retention of the crown would not be possible.
   c. Post and core services are Covered only when performed in conjunction with a Covered crown or bridge.
   d. Crown, inlay, onlay, and veneer repair are Covered separately only after 12 months from the date of initial placement.
   e. Implant limited to one per tooth per 60 months.
   f. Bone graft for implant is covered if implant is covered.
   g. Implant debridement is limited to one per tooth per 60 months and is covered if implant is covered.
   h. Replacement of implant supported prosthesis is covered only after 60 months from the date of any prosthesis placement.

3. Exclusions
   a. Other major restorative services including protective restoration and coping.
   b. Other prosthodontic services including overdenture, precision attachments, connector bars, stress breakers and coping metal.
   c. Temporary and interim implant abutment.

Endodontics (treatment of the dental pulp or root canal)

Basic Endodontics

1. Covered
   a. Pulpotomy, pulpal therapy.

2. Limitations
   a. For primary teeth only.
   b. Not Covered when performed in conjunction with major endodontic treatment.
   c. The benefits for basic endodontic treatment include benefits for x-rays, pulp vitality

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tests, and protective restoration provided in conjunction with basic endodontic
treatment. However, pulp vitality tests and protective restorations are not Covered
when billed separately from other endodontic services.

3. Exclusions
   a. Pulpal debridement.

**Major Endodontics**

1. Covered Services
   a. Root canal treatment and re-treatment, apexification, pulpal regeneration,
apicoectomy services, root amputation, retrograde filling, hemisection, pulp cap.

2. Limitations
   a. The benefits for major endodontic treatment include benefits for x-rays, pulp vitality
tests, pulpotomy, pulpectomy and protective restoration and temporary filling material
provided in conjunction with major endodontic treatment. However, pulp vitality tests
and protective restorations are not Covered when billed separately from other
endodontic services.

3. Exclusions
   a. Implantation, canal preparation, and incomplete endodontic therapy.

**Periodontics**

**Basic Periodontics**

1. Covered
   a. Non-surgical periodontics, including periodontal scaling and root planing, full mouth
debridement and periodontal maintenance procedure.

2. Limitations
   a. No more than one periodontal scaling and root planing per quadrant in any 24 month
period.
   b. No more than one full mouth debridement per lifetime.
   c. No more than four of any prophylaxis (cleanings) or periodontal maintenance
procedure in any 12 month period. Cleanings are subject to additional limitations
listed under Preventive Services, and may be subject to a different Coverage level
under Attachment C: Schedule of Benefits.
   d. Benefits for periodontal maintenance are provided only after active periodontal
treatment (surgical or non-surgical), and no sooner than 90 days after completion of
such treatment.
   e. Benefits for periodontal scaling and root planing, full mouth debridement, periodontal
maintenance and prophylaxis are not provided when more than one of these
procedures is performed on the same day.

3. Exclusions
   a. Provisional splinting, scaling in the presence of gingival inflammation, antimicrobial
medication and dressing changes.

**Major Periodontics**

1. Covered
   a. Surgical periodontics including gingivectomy, gingivoplasty, gingival flap procedure,
crown lengthening, osseous surgery and bone and tissue grafting.
   b. Benefits provided for major periodontics include benefits for services related to 90
days of postoperative care.

2. Limitations
   a. No more than one major periodontal surgical procedure in any 36 month period.

3. Exclusions
   a. Tissue regeneration and apically positioned flap procedure.
Oral Surgery

Basic Oral Surgery

1. Covered
   a. Non-surgical or simple extractions.

2. Limitations
   a. Benefits provided for basic oral surgery include benefits for suturing and postoperative care.

3. Exclusions
   a. Benefits for general anesthesia or intravenous sedation when performed in conjunction with basic oral surgery.

Major Oral Surgery

1. Covered
   a. Surgical extractions (including removal of impacted teeth), coronectomy, and other oral surgical procedures typically not Covered under a medical plan.
   b. Benefits provided for major oral surgery include benefits for local anesthesia, suturing and postoperative care.

2. Limitations
   a. Benefits for general anesthesia or intravenous (IV) sedation are provided only in connection with major oral surgery procedures, and only when provided by a Dentist licensed to administer such agents.

3. Exclusion
   a. Oral surgery typically Covered under a medical plan, including but not limited to, excision of lesions and bone tissue, treatment of fractures, suturing, wound and other repair procedures and related procedures.

General Pediatric Dental Exclusions

Pediatric Dental Coverage does not provide benefits for the following services, supplies or charges:

1. Services rendered by a Dentist beyond the scope of his or her license.
2. Dental services which are free, or for which the Member is not required or legally obligated to pay or for which no charge would be made if he/she had no dental Coverage.
3. Dental services covered by any medical insurance coverage, or by any other non-dental contract or certificate issued by BlueCross BlueShield of Tennessee or any other insurance company, carrier, or plan. For example, removal of impacted teeth, tumors of lip and gum, accidental injuries to the teeth, etc.
4. Dental care or treatment not specifically listed in Attachment C: Schedule of Benefits.
5. Any treatment or service that the Plan determines is not Necessary Dental Care that does not offer a favorable prognosis that does not meet generally accepted standards of professional dental care, or that is experimental in nature.
6. Charges for any hospital or other surgical or treatment facility and any additional fees charged by a Dentist for treatment in any such facility.
7. Dental services with respect to congenital malformations or primarily for cosmetic or aesthetic purposes including cosmetic orthodontia.
8. Replacement of tooth structure lost from wear or attrition.
9. Dental services resulting from loss or theft of a denture, crown, bridge or removable orthodontic appliance.

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10. Charges for a prosthetic device that replaces one or more lost, extracted or congenitally missing teeth before the Coverage becomes effective under the Plan unless it also replaces one or more natural teeth extracted or lost after the Coverage became effective.

11. Diagnosis for, or fabrication of, adjustment or maintenance and cleaning of maxillofacial prosthesis, appliances or restorations necessary to correct bite problems or restore the occlusion.

12. Diagnostic dental services such as diagnostic tests and oral pathology services.

13. Adjunctive dental services including all local and general anesthesia, sedation, and analgesia (except as provided under a covered surgery).


15. Charges for the treatment of professional visits outside the dental office or after regularly scheduled hours or for observation.

16. Charges for the inhalation of nitrous oxide/analgesia, anxiolysis.

**Dental Services - Orthodontia - Pediatric Only**

Orthodontia when performed in conjunction with Medically Necessary and Appropriate orthognathic Surgery for Members under age 19. Prior Authorization for Medically Necessary orthodontia must be obtained from the Plan, or benefits will be reduced or denied.

1. **Covered**
   a. Medically Necessary and Appropriate non-cosmetic orthodontia when performed in conjunction with orthognathic Surgery for Members under age 19.

2. **Exclusions**
   a. Orthodontia for Members over age 19.
   b. Cosmetic orthodontia.

**Dental Supplement Plan Options**

The following grid reflects basic options for Dental Supplement Plans for Members age 19 or older that may be added to an Essential Health Benefits medical plan. These Members will have "MEDICAL/DENTAL/VISION" reflected on their ID card.
Basic options for Dental Supplement Plans
Benefits for individuals over age 18

<table>
<thead>
<tr>
<th>COINSURANCE</th>
<th>DEDUCTIBLE</th>
<th>ANNUAL MAXIMUM</th>
<th>Cosmetic ORTHO*</th>
</tr>
</thead>
<tbody>
<tr>
<td>100%/80%/50%</td>
<td>$50</td>
<td>$1,000</td>
<td>No</td>
</tr>
<tr>
<td>100%/80%/50%</td>
<td>$50</td>
<td>$1,000</td>
<td>Child (1K)*</td>
</tr>
<tr>
<td>100%/80%/50%</td>
<td>$50</td>
<td>$1,500</td>
<td>No</td>
</tr>
<tr>
<td>100%/80%/50%</td>
<td>$50</td>
<td>$1,500</td>
<td>Child (1.5K)*</td>
</tr>
<tr>
<td>100%/80%/50%</td>
<td>$50</td>
<td>$2,000</td>
<td>No</td>
</tr>
<tr>
<td>100%/80%/50%</td>
<td>$50</td>
<td>$1,000</td>
<td>Child &amp; Adult (1K)*</td>
</tr>
<tr>
<td>100%/80%/0%</td>
<td>$25</td>
<td>$1,000</td>
<td>No</td>
</tr>
<tr>
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</tr>
<tr>
<td>100%/90%/60%</td>
<td>$50</td>
<td>$1,000</td>
<td>Child (1K)*</td>
</tr>
<tr>
<td>Personal Dental Schedule Plan</td>
<td>$50</td>
<td>$1,000</td>
<td>No</td>
</tr>
</tbody>
</table>

*Cosmetic Orthodonia is also payable to those under age 19 on these plans

E. Predeterminations

The Predetermination of Benefits program allows the Dentist and the Member to know exactly what kinds of treatment are covered. If a course of treatment will exceed $200.00, the treatment plan and estimated charges should be submitted to BlueCross BlueShield of Tennessee for review before the work starts. In order to review, the predetermination must be on an ADA dental claim form and “Dentist’s Pre-Treatment Estimate” box should be checked and a description of each service and charge should be submitted along with all supporting aids such as preoperative X-rays and/or photographs. **Do not include the date(s) that the work will be started.**

BlueCross BlueShield of Tennessee will review the claim and other information submitted and notify the Member and the Provider via the Dental Pre-Determination of Benefits form of its decision and estimated dental benefits available.

Rev 03/15
F. ADA/BlueCross BlueShield of Tennessee Dental Claim Form

Dental claims must be completed on one of the three most current standard American Dental Association (ADA) claim form or BlueCross BlueShield of Tennessee claim form using the most appropriate ADA Current Dental Terminology (CDT) codes. To help avoid processing delays, claim forms should be completed with special attention given to the critical fields listed below. If the format or data inserted in these fields is not valid, the claim will be returned to the Provider for correction or resubmission.

- Member name
- Member date of birth
- BlueCross BlueShield of Tennessee subscriber ID number* (Not Social Security Number)
- Date of service
- Procedure code
- Total charges
- Tooth number (as appropriate)
- Tooth surface (as appropriate)
- Area of oral cavity (as appropriate)
- Provider tax ID number/NPI number
- Signature of treating dentist (or authorized representative for the treating dentist)

*Enter the subscriber identification number exactly as it is listed on the Member’s BlueCross BlueShield of Tennessee ID card.

BlueCross BlueShield of Tennessee began phasing in non-Social Security Number (SSN) identification numbers in 2004 to help protect Member privacy.

Some claim form fields may request the Member’s Social Security number. However, because BlueCross BlueShield of Tennessee moved to non-SSN identification numbers, it may not be able to identify the Member by the SSN. This is particularly true for new groups, which do not require Members to provide their SSN.

When submitting the subscriber ID number, do not include data in front of the ID number, such as “ID#”, “SSN” or “#”. The imaging equipment will read this extra data as part of the number, which may result in a rejection.

**Note:** The Tennessee Board of Dentistry Code of Professional Conduct Section 5; 5.B.4 states the date of completion is the treatment date. The revised ADA claim form does not take into consideration individual state laws or specific contracting agreements.

A sample copy and description of an ADA Dental Claim Form follows:
1. **ADA Claim Form Locator Field Description:**
   Note: Extended descriptions are reflected on fields commonly filed incorrectly.

**Header Information**
Field 1  Type of Transaction  
Field 2  Predetermination/Prior authorization Number

**Primary Payer Information**
Field 3  Primary Payer Name and Address

**Other Coverage Information**
Field 4  Other Dental or Medical Coverage  
Field 5  Subscriber Name  
Field 6  Subscriber Date of Birth  
Field 7  Gender M/F  
Field 8  Subscriber Social Security Number (SSN) or ID Number if the other coverage is with BlueCross BlueShield of Tennessee, we need the BlueCross BlueShield of Tennessee subscriber ID number (NOT the SSN)  
Field 9  Plan/Group Number  
Field 10  Relationship to Primary Subscriber  
Field 11  Other Carrier Name

**Primary Subscriber Information**
Field 12  Name and Address  
Field 13  Date of Birth  
Field 14  Gender  
Field 15  BlueCross BlueShield of Tennessee subscriber ID number – This can be found on the front of the Member ID card.  
Field 16  Plan/Group Number  
Field 17  Employer Name

**Patient Information**
Field 18  Relationship to Primary Subscriber  
Field 19  Student Status  
Field 20  Name and Address  
Field 21  Patient's Date of Birth (MM/DD/CCYY)  
Field 22  Gender  
Field 23  Patient ID/Account # (Assigned by Dentist)

**Record of Services Provided**
Field 24  Procedure Date  
Field 25  Area of Oral Cavity - is designated by a two-digit code shown below. Keep in mind area of oral cavity code is NOT the tooth number.

<table>
<thead>
<tr>
<th>Area of Oral Cavity Code</th>
<th>Area Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>00</td>
<td>Entire Oral Cavity</td>
</tr>
<tr>
<td>01</td>
<td>Maxillary (Upper) Arch</td>
</tr>
<tr>
<td>02</td>
<td>Mandibular (Lower) Arch</td>
</tr>
<tr>
<td>10</td>
<td>Upper Right Quadrant</td>
</tr>
<tr>
<td>20</td>
<td>Upper Left Quadrant</td>
</tr>
<tr>
<td>30</td>
<td>Lower Left Quadrant</td>
</tr>
<tr>
<td>40</td>
<td>Lower Right Quadrant</td>
</tr>
</tbody>
</table>

Field 26  Tooth System  
Field 27  Tooth Number(s) or Letter(s) (When the procedure directly involves a tooth or range of teeth, otherwise, leave this field blank. If same procedure is performed on more than a single tooth on the same date of service, report each procedure and tooth involved on separate lines on the claim form. When the procedure involves a range of teeth, the range is reported in this field. This is reflected by a “-” to separate the first and last tooth in the range, e.g., 1-4; 7-10; 22-27, or by the use of commas “,” to separate individual tooth numbers or ranges, e.g., 1, 2, 4, 4-10, 3-5, 22-27.)

Rev 06/08
Field 28  Tooth Surface – Complete this field when the procedure code performed on a tooth involves one or more tooth surfaces. The following single-letter codes are used to identify surfaces:

<table>
<thead>
<tr>
<th>Letter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Buccal</td>
</tr>
<tr>
<td>D</td>
<td>Distal</td>
</tr>
<tr>
<td>F</td>
<td>Facial (or Labial)</td>
</tr>
<tr>
<td>I</td>
<td>Incisal</td>
</tr>
<tr>
<td>L</td>
<td>Lingual</td>
</tr>
<tr>
<td>M</td>
<td>Mesial</td>
</tr>
<tr>
<td>O</td>
<td>Occlusal</td>
</tr>
</tbody>
</table>

Field 29  Procedure Code
Field 29a Diagnosis Code Pointer (2012 Claim For Only)
Field 29b Quantity (2012 Claim Form Only)
Field 30  Description
Field 31  Fee
Field 31a Other Fee(s) (2012 Claim Form Only)
Field 32  Total Fee (2012 Claim Form Only)
Field 32a Other Fee(s)
Field 33  Total Fee

Missing Teeth Information
Field 33  Identify missing tooth with an “x” (2012 Claim Form Only)
Field 34  Identify missing tooth with an “x”

Diagnosis Code Information
Field 34  Diagnosis Code List Qualifier (2012 Claim Form Only)
Field 34a Diagnosis Code(s) (2012 Claim Form Only)
Field 35  Remarks

Authorizations
Field 36  Patient/Guardian Signature
Field 37  Subscriber Signature
Field 38  Place of Treatment
Field 39  Number of Enclosures (00-99)
Field 40  Is treatment for Orthodontics?
Field 41  Date Appliance Placed
Field 42  Months of Treatment Remaining
Field 43  Replacement of Prosthesis?
Field 44  Date Prior Placement
Field 45  Treatment Resulting from (Check Applicable Box)
Field 46  Date of Accident
Field 47  Auto Accident State

Billing Dentist or Dental Entity
Field 48  Name and Address
Field 49  10-digit NPI of the Billing Dentist – Do NOT enter the billing entity’s Social Security Number or Tax ID Number (TIN) in this field.
Field 50  License Number
Field 51  SSN or TIN – This number should match the information filed on the billing entity’s W-9 form
Field 52  Phone Number
Field 52A Additional Provider ID

Treating Dentist and Treatment Location Information
Field 53  Signature (Treating Dentist)/Date
Field 54 10-digit NPI of the Billing Dentist – Do NOT enter the billing entity’s Social Security Number or Tax ID Number in this field.
Field 55 License Number
Field 56 Address, City, State, Zip Code
Field 56A Provider Specialty Code
Field 57 Phone Number
Field 58 Additional Provider ID

Note: When submitting charges on an ADA Dental Claim Form to BlueCross BlueShield of Tennessee, please include the assigned BlueCross BlueShield of Tennessee Individual Provider Identification Number and/or National Provider Identifier (NPI) number. This provider-specific number is located in the upper right hand corner of the assigned BlueCross BlueShield of Tennessee Dental Remittance Advice and may be listed on the dental claim form in Field 49 and 54. Some dental practices choose to obtain a group provider number and/or NPI for payment purposes. In these cases the remittance advice will reflect the group provider number and/or NPI. This group number is used to report payments and should not be used when submitting claims. If there is a question on the individual provider number, dentists may contact Dental Customer Service at 1-800-523-1478.

2. Tips for Completing a Dental Claim Form

Listed below are some tips that will help ensure claims are processed timely and accurately:

- Type all letters in Upper Case (capital letters)
- Use black ink (if typed) or block letters (if hand written) to reflect a clear impression.
- Enter insured’s ID number as shown on ID Card
- BlueCross BlueShield of Tennessee requests that providers use an eight-digit format for all dates (MM_DD_CCYY) Example: January 1, 2005 would be written out as 01/01/2005.
  Some paper dental forms will only allow a 2-digit year in the date of service. In these cases, use the format MMDDYY (01/01/05).
- Review each claim to ensure all required fields have been provided.
- Send only original claims and supporting documentation.
- Securely staple any attachments, receipts, etc.
- Be sure to include the BlueCross BlueShield of Tennessee designated Individual Provider Identification Number or NPI in Fields 49 and 54.
- File corrected claims hardcopy and clearly mark “Corrected Billing” in the Remarks section of the claim form; Do Not use correction tape or white out. Draw a line through the original information and list the new information above, below or beside the original information. (The original information MUST be visible).

G. Orthodontic Claims Processing Guidelines

Effective August, 1, 2011, Providers no longer need to file a claim for monthly adjustments. Instead, Providers were notified they should file one (1) claim for the total charge of the orthodontic treatment plan indicating the initial placement date.

Exception to above:
In order to initiate the automated monthly adjustment payment process, Providers may need to file a single monthly adjustment claim if the patient is currently in treatment and he/she has:

- changed insurance carrier and now has BlueCross orthodontic benefits; or
- received a new BlueCross ID/Group/or Plan Number.
The allowed amount for the initial placement is 25 percent of the total covered charge(s) for the orthodontic treatment plan. Monthly adjustments will automatically be processed each month until the Member’s orthodontic lifetime maximum is met or the Provider or Member advises BlueCross BlueShield of Tennessee that the Member is no longer in treatment. The maximum allowed amount for monthly adjustments is $200 payable to the treating dentist listed on the initial orthodontic treatment plan claim.

H. Filing a Dental Claim Form

Dental claims may be faxed or mailed to BlueCross BlueShield of Tennessee.

Billing Requirements for Faxed Paperwork (PWK) Attachments

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

BCBST will only match on the first iteration of PWK06 (ACN) from the ANSI 837 data. Ensure your first iteration at claim or line level matches the PWK06 (ACN)

<table>
<thead>
<tr>
<th>ANSI 837 Loop</th>
<th>Field Description</th>
<th>837P/I Segment</th>
</tr>
</thead>
<tbody>
<tr>
<td>2300</td>
<td>Attachment Report Type Code</td>
<td>PWK01</td>
</tr>
<tr>
<td></td>
<td>Use the values indicated in the IG to identify the type of attachment.</td>
<td></td>
</tr>
<tr>
<td>2300</td>
<td>Attachment Transmission Code</td>
<td>PWK02</td>
</tr>
<tr>
<td></td>
<td>Use the values indicated in the IG to identify how the attachment will be sent. BCBST accepts supporting documentation by fax only, the value of FX (By Fax) in this data element is the only value accepted.</td>
<td></td>
</tr>
<tr>
<td>2300</td>
<td>Identification Code Qualifier</td>
<td>PWK05</td>
</tr>
<tr>
<td></td>
<td>Use code value of AC (Attachment Control Number). This data element is required if PWK02 = FX.</td>
<td></td>
</tr>
<tr>
<td>2300</td>
<td>PWK06 Attachment Control Number</td>
<td>PWK06</td>
</tr>
<tr>
<td></td>
<td>This is a value assigned by the provider to uniquely identify the attachment. This number must also be included on the “Attachment Fax Sheet”.</td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

Mail dental claims to: BlueCross BlueShield of Tennessee
Claims Service Center
1 Cameron Hill Cr, Ste 0002
Chattanooga, TN 37402-0002

Rev 06/15
I. Dental Professional Remittance Advice

The Dental Professional Remittance Advice is an explanation of payments and deductions. It is necessary for the Provider’s office staff to understand the Remittance Advice thoroughly in order to make all billing adjustments accurately. A sample copy of the Dental Professional Remittance Advice can be found on the company website at http://www.bcbst.com/providers/Sample-Copies-of-Remittance-Advices.page.

The following instructs Providers how to read a BlueCross BlueShield of Tennessee dental remittance advice when overpayment recovery activity is reflected.

Credit Balance Activity

BlueCross BlueShield of Tennessee utilizes the Credit Balance Process (Automatic Payment Recovery) to recover overpayment of charges. Credit balances are the result of a credit (amount to be taken back) which exceeds actual payments on a given Dental Remittance Advice (RA). A credit balance will carry forward and be applied against future Remittance Advices. Depending on the amount of the credit balance, it may take more than one future RA to deplete the entire balance.

A credit balance carried forward and applied against a subsequent RA should be applied to the Member’s account where the original overpayment occurred. The following steps should be taken to resolve a credit balance:

Step 1
Locate the prior Remittance Advice and identify where the credit balance originally occurred.

Step 2
Determine whether this credit balance is the result of an Online Adjustment or a Manual Credit Adjustment.

➤ Online Adjustment
This type of adjustment occurs when a Provider or Eligible Member initiates an adjustment request. The adjustment will appear on Page one (1) of the Remittance Advice in the claim detail section and is identified by a negative (-) indicator in the “Amount Paid” column. Page two (2) of the Remittance Advice reflects the credit balance due to BlueCross BlueShield of Tennessee, the Remittance total amount, the credit amount applied to this check, and, the check amount (the final dollar amount printed on the check). At the bottom of this page, the Adjustment Reference No., the current balance due to BlueCross BlueShield of Tennessee and the specific claim numbers involved in the Online Adjustment are listed.

➤ Manual Adjustment
This type of adjustment is initiated by BlueCross BlueShield of Tennessee via a Refund Request letter to the Provider outlining specific claims-overpayment information. Once the Provider returns the overpaid amount to BlueCross BlueShield of Tennessee, the amount returned by the provider will be entered manually and the overpaid claim adjusted.

Step 3
Post Claim Payment and/or Credit Adjustment (amount BlueCross BlueShield of Tennessee took back) to the individual Member’s account.
J. Provider Overpayments

If a Provider identifies that a payment made by BCBST results in an overpayment, it is the responsibility of the Provider to reimburse BCBST the overpaid amount. The Provider should return the overpayment with a copy of the Remittance Advice (RA) and a cover letter explaining why the payment is being refunded.

Mail to: BlueCross BlueShield of Tennessee
   Receipts Department
   1 Cameron Hill Circle
   Chattanooga, TN 37402

In the event that a Provider receives a BCBST overpayment notification, no action is required unless records conflict with the findings. BCBST will recover the overpayment through an offset to the remittance advice within 45 days from the date of the notification. Please do not send a check for the overpayment.

Overpayment Notifications
An overpayment notification is sent on all overpayments that are identified on claims submitted by Physicians, non-participating facilities and par facilities requiring notification.

K. Electronic Funds Transfer

Beginning January 1, 2015, BCBST began executing the July 2013 electronic claims filing requirement pursuant to the BCBST Minimum Practitioner Network Participation Criteria, which requires all network Providers to enroll in the Electronic Funds Transfer (EFT) process. EFT is a free service that sends payments directly to the Provider’s financial institution and increases the speed at which they receive payment.

Key advantages to receiving payments electronically are:
- Earlier payments;
- More secure payment process;
- Reduced administrative costs; and
- Less paper storage.

BCBST accepts electronic funds transfer (EFT) enrollment through CAQH Solutions, who offers a universal enrollment tool for providers that provides a single point of entry for adopting EFT and ERA. The CAQH process facilitates compliance with the 2014 EFT/ERA Administrative Simplification mandate under the Affordable Care Act, eliminates administrative redundancies and creates significant time and cost savings. Enrollment information is available on the CAQH Solutions website at https://solutions.caqh.org.

To view/print a copy of your remittance advices, ensure you have access to BlueAccess, BCBST’s secure area on its websites, www.bcbst.com and http://bluecare.bcbst.com. To register, just click on the “Register Now” link located in the BlueAccess section on the website and follow the simple instructions to obtain a user ID and password.

For more information regarding the EFT Program Process, or for assistance with BlueAccess, please call eBusiness Service at 423-535-5717, Option 2, Monday through Thursday, 8 a.m. to 6 p.m., Friday 9 a.m. to 6 p.m. (ET), or e-mail eBusiness_Service@bcbst.com.
EnrollHub™ is the new name for the CAQH EFT and ERA enrollment tool.
**Phone:** 1-844-815-9763 available Monday through Thursday 7 a.m. to 9 p.m. (ET), Friday 7 a.m. to 7 p.m. (ET)
**e-mail:** eftenrollhub@caqh.org
**Website:** http://www.caqh.org/eft_enrollment.php

CAQH ProView™ is now the provider data collection tool formerly the Universal Provider Datasource®.
**Phone:** 1-844-259-5347 available Monday through Thursday 7 a.m. to 9 p.m. (ET), Friday 7 a.m. to 7 p.m. (ET)
**e-mail:** proview@caqh.org
**Website:** https://proview.caqh.org

**Note:** Vendor and BCBST shall be bound by the National Automated Clearing House Association rules relating to corporate trade payment entries (the "Rules") in the administration of these ACH Credits.

### L. Balance Billing

DentalBlue Providers agree to accept reimbursement made in accordance with the terms of their Provider Contract with BlueCross BlueShield of Tennessee (BCBST), plus any applicable Member copayment/deductible, and coinsurance amounts as the maximum amount payable to the Provider for Covered Services rendered to Members.

DentalBlue Providers **may not** seek payment from a BCBST Member when:

- The Provider failed to comply with BCBST medical management policies and procedures or provided a service which does not meet BCBST standards for Medical Necessity or does not comply with BCBST medical policy;
- The Provider failed to submit or resubmit claims for payment within the time periods required by BCBST (timely filing guidelines); or Services rendered are considered Investigational by BCBST and are therefore non-reimbursable, unless **prior** to rendering such services to the Member, Provider has entered into a **procedure-specific** written agreement with the Member, which advised Member of his/her payment responsibilities.

DentalBlue Providers **may** bill the BCBST Member for:

- Non-Covered Services*;
- Any applicable Deductible/Copay Amounts; and
- Any applicable Co-Insurance Amounts.

When seeking payment from a BCBST Member, please refer to the **Patient Owes** column on your Provider Remittance Advice. This column includes the **Non-covered total**, **Deductible/Copay** total, and **Coinsurance** total. It may also reflect the **Other Insurance** total, which is the amount paid by the patient’s other insurance carrier.

Before billing the Member, check both the **Deductible/Copay** and the **Other Insurance** columns to ensure any applicable copayment or other insurance payments have not been received.

*When billing a member for non-covered services due to benefit limitations, i.e. dollar maximums, network Providers **may only** bill the Member the difference between the maximum dollar limit amount and the allowed amount. The difference between the billed amount and the allowed amount is considered a Provider write-off.

Rev 03/15
**Example: Dollar Limit**

The Member has a $1,000 annual maximum. The Member has already used $800 of his/her annual maximum. This leaves a remaining benefit of $200.

Claim Billed amount of $450 and all services would be a Covered Service
Claim Allowed amount of $325
Remaining annual maximum benefit $200

Since this claim meets the member’s annual maximum and all services were eligible for benefits, the Member would receive the benefit of the discounted amount on the entire claim. The Member liability would be $125 (difference between allowed amount on the claim and remaining benefit. Provider write-off $125 (difference between billed amount and allowed amount)

However, on any subsequent claims after the Member has met his/her annual maximum, the DentalBlue Provider does not have to take a Provider write-off for the remainder of the benefit period/calendar year.

**M. Financial Responsibility for the Cost of Dental Services**

If a BlueCross BlueShield of Tennessee DentalBlue Network Provider renders a service which is Investigational or does not meet Medically Necessary and Appropriate criteria, the Provider must obtain a written statement from the Member, prior to the service(s) being rendered, acknowledging that the Member understands he/she may be responsible for the cost of the specific service(s) and any related services. Providers may also utilize this form in the event a Member requests non-emergency, cosmetic or elective services that are specifically excluded under the Member’s health benefits plan. It is essential the signed statement be kept on file, as it may be necessary to provide a copy of the signed statement to BlueCross BlueShield of Tennessee verifying the Member’s agreement to the financial responsibility.

To help assist in this process, BlueCross BlueShield of Tennessee developed the *Acknowledgement of Financial Responsibility for the Cost of Dental Services* form for Provider use. This form meets the contractual obligations of BlueCross BlueShield of Tennessee DentalBlue Provider Agreements. Providers are strongly encouraged to use this form.

Providers using their own form should insure their form includes the following:

1. The name of the specific service/procedure the Provider will perform;
2. The reason why the Provider believes that BlueCross BlueShield of Tennessee will not provide benefits for the service/procedure; i.e., BlueCross BlueShield of Tennessee considers the service/procedure to be Investigational, Cosmetic or not Medically Necessary and Appropriate;
3. The approximate cost of the service/procedure and associated costs;
4. A statement acknowledging the Member understands that BlueCross BlueShield of Tennessee will not provide benefits for the service/procedure;
5. A statement acknowledging the Member has been advised why BlueCross BlueShield of Tennessee will not cover the service/procedure and that he/she understands and agrees that he/she will be responsible for all the costs and any associated costs;
6. A statement indicating the form is only valid for one (1) service/procedure; and
7. A specific expiration date.

A sample copy of the *Acknowledgement of Financial Responsibility for the Cost of Dental Services* form follows:
BlueCross BlueShield of Tennessee
Acknowledgement of Financial Responsibility for the Cost of Dental Services
(For use with DentalBlue)

To: __________________;

Re: (Identification of Prescribed Service)

I have been informed that my dental health care benefits insurer or administrator, BlueCross BlueShield of Tennessee, may determine that the above referenced dental service(s) may be an Investigational Service, Cosmetic, may not be a Covered Service or may not be Medically Necessary or Medically Appropriate as those terms are defined in my Member dental health care benefits plan from BlueCross BlueShield of Tennessee. Therefore, the dental service would be excluded from coverage by my dental health care benefits plan. My Dentist has also informed me about alternative treatments, if any, that may be covered by BlueCross BlueShield of Tennessee.

I understand that my Dentist may request that BlueCross BlueShield of Tennessee reconsider that determination by presenting evidence that the referenced dental service(s) is not an Investigational Service, is a Covered Service or the dental service is considered to be Medically Necessary or Medically Appropriate. I also understand that I have the right to request reconsideration of that determination, as described in the Member grievance section of my dental health care benefits plan, either before or after receiving the service(s).

I have been informed that the potential costs of the referenced dental service(s) will be approximately $_________. I understand that, if I elect to receive the dental service(s) and BlueCross BlueShield of Tennessee determines that the dental service(s) is an Investigational Service, is not a Covered Service or the service is not considered to be Medically Necessary or Medically Appropriate, I will be responsible to pay for all costs associated with the dental service(s), including, but not limited to, practitioner costs, facility costs, ancillary charges and any other related expenses. I acknowledge that BlueCross BlueShield of Tennessee may not pay for the dental service(s).

In the event of multiple dental procedures, this form is valid only for one (1) unit of the prescribed dental service(s), unless specifically provided for otherwise.

This form will expire and will no longer be valid six (6) months from the date of execution.

Signature of Patient or Responsible Person

___________________________________

Date: ______________________________

Rev 12/09
N. Disclaimer

Each BlueCross BlueShield of Tennessee Member has his/her own group-specific benefits. To ensure correct benefits, please contact BlueCross BlueShield of Tennessee Customer Service at 1-800-523-1478 to determine specific Member benefits prior to performing services. Or visit us on the company website, www.bcbst.com.
BlueCross BlueShield of Tennessee commercial pharmacy benefits currently cover most legend drugs for The Food and Drug Administration (FDA) indicated use. Non-FDA approved drugs are considered experimental and are not covered. Appropriate “off-label” utilization of FDA-approved medications may be approved if they are recognized in standard compendia and/or there is supporting evidence listed in a peer-reviewed journal.

Practitioners prescribing controlled substances to BlueCross Members are expected to comply with all existing federal and state laws governing this activity, including checking a patient’s drug utilization in the State’s Controlled Drug Database. The “Controlled Substance Prescribing Documentation Standards” may be monitored through Practitioner site reviews and medical record audits of Members receiving controlled substances upon request from the Clinical Risk Management Department. These adopted standards can be viewed on the company website at www.bcbst.com/pharmacy/pdf_documents/Controlled-Substance-Prescribing.pdf.

Practitioners who are non-compliant with these documentation standards are monitored by the Pharmacy and Therapeutics Committee and may be referred to the Clinical Risk Management Committee (CRMC) for further review and action.

The BlueCross Corporate Pharmacy Directors (CPD) conduct personal visits with prescribing Practitioners to supply information designed to assist the Practitioner in the provision of quality, cost-effective health care to BlueCross Members. Timely clinical information is presented around specific high incidence medical conditions and is intended to inform the Practitioner of potential gaps in care, compliance and adherence issues as well as opportunities for cost-effective therapeutic options. Data is presented as an aid in the overall management of our Members.

A Member’s particular health care plan may exclude certain drug classes or individual drugs (e.g., oral contraceptives, products for hair loss, drugs considered for cosmetic purposes, et al.). A Provider or Member may check with a customer service representative for assistance in determining covered benefits. The customer service phone number is listed on the back of the Member’s identification card, or sign into BlueAccess®, the company’s secure page on its website, www.bcbst.com for more information on drugs excluded on their health care plan.

There are many varieties of co-pay/co-insurance structures for BlueCross Members. These may range from 10 or 20 percent co-insurance to a two-tiered drug card co-pay of $10/$20 (or other variations) to a three-tiered co-pay of perhaps $10/$35/$50 (or other variations). Generic drugs are in the first tier; preferred brand name products are in the second tier; and for the three-tiered plan, non-preferred brands are in the third tier. For two tiered plans, all brand name products are in the second tier. Co-pays for medications on the specialty pharmacy list may have a multiplier (2X), which requires a higher co-pay for the specialty drug. Select plans require co-pay (usually $100) for Provider-administered specialty drugs obtained at a Physician’s office.
D. Pharmacy Network

The majority of Tennessee pharmacies are in the pharmacy network. Members can locate their plan’s pharmacy network information on their health care insurance ID card. These pharmacies are listed in the BlueCross BlueShield of Tennessee Referral Directory of Network Providers, which can be accessed on the company website, www.bcbst.com. Additionally, BlueCross uses a national network, which allows Members to obtain prescriptions outside of Tennessee.

E. Claims Submission

Claims for Provider-administered drugs administered in a Practitioner’s office should be submitted electronically on a CMS-1500 claim form using the most appropriate CPT® or HCPCS code and the specific drug’s National Drug Code (NDC) number, which is printed on the drug container. The strength of the drug and the number of units administered also must be submitted. Claims for self-administered drugs (Oral, Topical and self-administered injectables) should be electronically submitted through a network pharmacy to the Member’s pharmacy benefits manager (PBM). Claims for self-administered drugs will not process through the BlueCross medical claims system.

F. Preferred Drug List (PDL)

The PDL is a list of the top therapeutic classes of drugs, which are therapeutically sound and offer a cost advantage for the Member and the Member’s sponsoring plan. The PDL is updated quarterly and can be accessed on the company website at http://www.bcbst.com/docs/providers/Preferred-Formulary-Reference-Guide-2016.pdf.

G. Limited Formulary

Limited Formulary

- Contains every aspect of the standard formulary excluding certain drug classes that are available over-the-counter;
- Customized, generic-based with alternative therapies;
- Expanded tools, i.e., Step Therapy; and
- Control utilization and costs.


H. Prior Authorization

Certain drugs with special indications require authorization by the pharmacy benefits manager (PBM) prior to dispensing by a pharmacy. The prescribing Practitioner is responsible for obtaining the necessary authorization from the PBM. The Prior Authorization (PA) List can be found in the standard Member Handbook, the Preferred Formulary Reference Guide on the Provider page on the company website at http://www.bcbst.com/manage-my-plan/pharmacies-and-prescriptions/drug-lists.page, and is also available through your Provider Relations Consultant. (See Section II. Quick Reference Telephone Guide in this Manual for appropriate phone numbers.) For BlueCross commercial health benefits plans, Express Scripts® (ESI) serves as the pharmacy benefits manager. Requests for prior authorization can be made by calling ESI at 1-877-916-2271 or by faxing the request to 1-880-837-0959.
Reconsideration for denied requests should be faxed directly to the BlueCross BlueShield of Tennessee Pharmacy Management Department at 1-888-343-4232. Often, additional supportive clinical information is necessary for approval of a request for a PA drug.

I. Appeals

If a prior authorization request has been denied, a prescribing Physician may file an Appeal by faxing a brief written statement giving medical justification supporting the request. Appeals may be faxed to 1-888-343-4232. If following the appeal process the prior authorization continues to be denied, the Member may pursue the request through the normal grievance process outlined in the Member Handbook.

J. Quantity Limits or Maximum Drug Limitation

Some medications have a quantity limit for a given time period. All specialty drugs are limited to a one-month supply. A list of these products can be found in the standard Member Handbook, the Preferred Formulary Reference Guide on the Provider page on the company website at http://www.bcbst.com/docs/providers/Limited-Formulary-Reference-Guide-2016.pdf and is also available through your Provider Relations Consultant. Requests for exceptions to these limits may be faxed to 1-888-343-4232.

K. Pharmacy and Therapeutics Committee

All policies and procedures affecting the pharmacy programs are reviewed and approved by the Pharmacy and Therapeutics Committee, which is a panel of pharmacists and Physicians, some of whom are community Practitioners. Any comments or suggestions regarding the commercial pharmacy program may be directed to:

BlueCross BlueShield of Tennessee
Pharmacy Programs – CH 2.3
1 Cameron Hill Circle
Chattanooga, TN 37402

L. Specialty Pharmacy Program

BlueCross BlueShield of Tennessee’s Specialty Pharmacy Program is available for commercial Members who utilize certain high-cost/high-risk drugs for serious, chronic conditions. Specialty pharmacy medications require complex care, including special handling, patient education and continuous monitoring.

BlueCross has a network of specialty pharmacy vendors for Members and Providers to call to obtain specialty medications. A listing of the specialty pharmacy vendors follows:
The specialty pharmacy vendor will call the Member to collect the required copayment or coinsurance. This amount is typically paid by credit card. The medication is shipped directly to the Member’s home or other designated location. After shipping, the specialty pharmacy vendor will call the Member to verify the medication was received and to answer any questions the Member may have concerning the medication or its administration.

The specialty pharmacy vendor may contact the prescribing Practitioner for specific medication orders, or the Practitioner may contact the specialty pharmacy vendor with drug orders. With the added pharmacy support services available through each vendor, Members have access to:

- Patient care coordinators;
- Pharmacists and nurses;
- Optimize drugs usage, and
- Monitor and manage complex drug regimens.

Certain specialty pharmacy medications administered in any setting other than inpatient hospital may require prior authorization by either the Member’s medical benefits plan or his/her pharmacy benefits plan.


See Section VIII: Utilization Management Program in this Manual for prior authorization requirements for specialty pharmacy medications covered under the Member’s medical benefits plan.

---

<table>
<thead>
<tr>
<th>Specialty Pharmacy Vendor</th>
<th>Phone</th>
<th>Fax</th>
<th>Phone</th>
<th>Fax</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accredo Health Group</td>
<td>1-877-792-7684</td>
<td>1-866-892-3223</td>
<td>1-888-315-3395</td>
<td>1-866-387-1003</td>
<td>1-888-315-3270</td>
<td></td>
</tr>
<tr>
<td>Axium Healthcare Pharmacy</td>
<td>1-888-292-0744</td>
<td>1-800-239-0725</td>
<td>1-866-387-1003</td>
<td>1-844-612-9057</td>
<td>1-800-269-5493</td>
<td></td>
</tr>
<tr>
<td>Barnes Healthcare Services</td>
<td>1-352-333-2525</td>
<td>1-888-276-7948</td>
<td>1-844-842-7722</td>
<td>1-888-239-0725</td>
<td>1-866-387-1003</td>
<td>1-844-612-9057</td>
</tr>
<tr>
<td>Benevure Pharmacy</td>
<td>1-800-323-2445</td>
<td>1-888-276-7948</td>
<td>1-888-239-0725</td>
<td>1-866-387-1003</td>
<td>1-800-269-5493</td>
<td></td>
</tr>
<tr>
<td>BriovaRx</td>
<td>1-866-791-8679</td>
<td>1-888-791-7666</td>
<td>1-800-237-2767</td>
<td>1-800-323-2445</td>
<td>1-855-394-2930</td>
<td>1-901-367-4814</td>
</tr>
<tr>
<td>Caremark Specialty Pharmacy</td>
<td>1-800-323-2445</td>
<td>1-888-791-7666</td>
<td>1-800-237-2767</td>
<td>1-800-323-2445</td>
<td>1-901-367-4814</td>
<td></td>
</tr>
<tr>
<td>Eiris Health Services</td>
<td>1-844-588-5560</td>
<td>1-888-791-7666</td>
<td>1-800-237-2767</td>
<td>1-800-323-2445</td>
<td>1-901-367-4814</td>
<td></td>
</tr>
<tr>
<td>EntrustRX</td>
<td>1-855-778-2229</td>
<td>1-877-792-7684</td>
<td>1-888-239-0725</td>
<td>1-866-387-1003</td>
<td>1-800-906-7798</td>
<td>1-844-612-9057</td>
</tr>
<tr>
<td>HPC Specialty Pharmacy</td>
<td>1-855-813-0583</td>
<td>1-888-791-7666</td>
<td>1-800-237-2767</td>
<td>1-800-323-2445</td>
<td>1-901-367-4814</td>
<td></td>
</tr>
<tr>
<td>Long’s Drugs</td>
<td>1-866-655-7421</td>
<td>1-888-791-7666</td>
<td>1-800-237-2767</td>
<td>1-800-323-2445</td>
<td>1-901-367-4814</td>
<td></td>
</tr>
</tbody>
</table>

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To obtain a prior authorization for a self-administered medication being billed under the Member’s pharmacy benefits plan and filed through a pharmacy, the network Practitioner should call Express Scripts® Prior Authorization Desk at 1-877-916-2271. Specialty Pharmacy vendors may also call this number on behalf of the Practitioner to obtain prior authorization.

To obtain a prior authorization for a Provider-administered drug being billed as a medical claim, the Provider should call BlueCross Utilization Management Department at 1-800-924-7141.

Note:
- Claims for self-administered injectables must be electronically submitted through a network pharmacy to the Member’s pharmacy benefits manager.
- Claims for provider-administered medications should be electronically submitted as a medical claim.
- Claims for self-administered medications taken “on assignment” by the specialty vendor should be faxed to the BlueCross claims department at 423-535-3741.

The patient prescription form can be used for any BlueCross Specialty Pharmacy vendors. This form and additional program information can also be accessed from the Provider page on the company website at www.bcbst.com/providers/pharmacy/specialty-pharm-detail.shtml.

A sample copy of the Specialty Pharmacy Program Patient Prescription Form follows:
Patient Prescription Form
Specialty Pharmacy Program - CONFIDENTIAL -

Please complete and fax to one of the following pharmacies:

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>Phone</th>
<th>Fax</th>
</tr>
</thead>
<tbody>
<tr>
<td>AcerisHealth, Inc.</td>
<td>1-855-405-6823</td>
<td></td>
</tr>
<tr>
<td>Accredo Health Group</td>
<td>1-888-238-0725</td>
<td>1-866-397-1003</td>
</tr>
<tr>
<td>Acro Pharmaceuticals</td>
<td>1-800-505-7786</td>
<td>1-844-612-9567</td>
</tr>
<tr>
<td>Ameris, Inc.</td>
<td>1-855-776-2229</td>
<td>1-877-801-1540</td>
</tr>
<tr>
<td>Avella of Deer Valley Inc.</td>
<td>1-877-782-7664</td>
<td>1-866-752-7684</td>
</tr>
<tr>
<td>Axia Healthcare Pharmacy</td>
<td>1-888-315-3335</td>
<td></td>
</tr>
<tr>
<td>Barnes Healthcare Services</td>
<td>1-888-333-2525</td>
<td>1-888-275-7541</td>
</tr>
<tr>
<td>Benvenuto Pharmacy</td>
<td>1-844-772-7722</td>
<td></td>
</tr>
<tr>
<td>BioPlus Specialty Pharmacy</td>
<td>1-800-292-0744</td>
<td></td>
</tr>
<tr>
<td>BrioRx</td>
<td>1-866-791-8676</td>
<td></td>
</tr>
<tr>
<td>Caremark Specialty Pharmacy  Services</td>
<td>Phone: 1-800-237-2767</td>
<td>Fax: 1-800-323-2445</td>
</tr>
<tr>
<td>Eis Health Services</td>
<td>1-855-294-2030</td>
<td>1-901-387-4811</td>
</tr>
<tr>
<td>EntrustRx</td>
<td>1-855-273-3024</td>
<td>1-855-273-3025</td>
</tr>
<tr>
<td>HPC Specialty Pharmacy</td>
<td>1-800-757-1912</td>
<td>1-855-813-0982</td>
</tr>
<tr>
<td>Long's Drugs</td>
<td>1-866-437-6177</td>
<td>1-866-556-7421</td>
</tr>
<tr>
<td>NPS Pharmacy</td>
<td>1-855-535-6265</td>
<td></td>
</tr>
<tr>
<td>OceoRx</td>
<td>1-888-662-8623</td>
<td>1-877-682-6585</td>
</tr>
<tr>
<td>PANTHER Specialty Pharmacy</td>
<td>1-855-726-8479</td>
<td>1-855-246-3398</td>
</tr>
<tr>
<td>Reise Rx, Inc.</td>
<td>1-877-388-5607</td>
<td>1-901-388-5607</td>
</tr>
<tr>
<td>Transccept Pharmacy, Inc.</td>
<td>1-866-426-0441</td>
<td>1-866-426-0441</td>
</tr>
</tbody>
</table>

Physician Information

Physician’s Name:  
Address:  
City:  
State:  
Zip:  
Office Contact:  
Telephone:  
Fax:  
NPI #:  
State License #:  
DEA #:  

Patient Information

Patient’s Name:  
Address:  
City:  
State:  
Zip:  
Date of Birth:  
Sex:  
Social Security #:  
Daytime Telephone #:  
Evening Telephone #:  
Height:  
Weight:  
Allergies:  

Primary Insurance Information

Insured’s Name:  
Relationship:  
ID #:  
Policy #:  
Carrier/Group #:  

Other Insurance Information

Insurance Company:  
Policy #:  
Insured’s Name:  
Relationship:  
Social Security #:  
Date of Birth:  

Clinical Information

Diagnosis Code:  

Prescription Medications | Strength | Directions (Dose/Routes/Frequency) | Quantity/Length |
---|---|---|---|
1 | | |
2 | | |
3 | | |
4 | | |

# of Refills:  
Physician’s Signature:  
Date:  
DAW:  

Delivery Instructions

Ship to:  
☐ Physician’s Office  
☐ Patient’s Home  
☐ Other  

Delivery Date:  
Refill Date:  

If other, please supply:  
Address:  
City:  
State:  
Zip:  

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XX. BEHAVIORAL HEALTH SERVICES

A. Introduction

BlueCross BlueShield of Tennessee is committed to providing safe and effective treatment at the most clinically appropriate and least restrictive level of care necessary to meet a Member’s care needs. Our commitment begins with providing a credentialed network of behavioral health Providers to meet the access and availability requirements of its Members.

B. Prior Authorization Guidelines

Prior authorization is required for the following behavioral health levels of care:

- inpatient acute care and inpatient substance use detox
- residential
- partial hospitalization
- intensive outpatient programs
- inpatient and outpatient electroconvulsive therapy (ECT)
- psychological testing
- transcranial magnetic stimulation (TMS)

Note: Always check Member benefits for final determination on authorization requirements as these may vary per Plan. Depending on the specific Member health care plan, benefits for non-prior authorized care may be reduced or may not be available.

Behavioral health utilization reviews for emergency services are available 24-hours-a-day, 7-days-a-week. Emergency behavioral health services should be authorized at the time of admission.

C. Access to Services

Telephone Access for Referral and Authorization

Members can directly access emergency behavioral health services 24-hours-a-day, 7-days-a-week. Licensed Clinical Care Managers with at least three (3) years’ clinical experience are available to assist Members and Providers with their questions.

BlueCross BlueShield of Tennessee Members can call 1-800-888-3773 during normal business hours to arrange routine behavioral health services. Medical or Behavioral Health Providers or their office staff can also use this number to assist Members in setting up appointments for required behavioral health evaluations or treatment.

Treatment Access to Facilities and Professionals

BlueCross BlueShield of Tennessee maintains standards to provide access to licensed and approved psychiatric and substance use disorder facilities and treatment programs, as well as licensed behavioral health care professionals.
Facilities must be licensed by the State and may require accreditation by the Joint Commission or the Commission Accreditation of Rehabilitation Facilities, or other recognized accrediting body to be approved for network participation.

Behavioral health care professionals must be state-licensed as one of the following:
- Advanced Practice Nurse (APN)
- Clinical Nurse Specialist/Psychiatric (RN, CNS)
- Licensed Clinical Social Worker (LCSW)
- Licensed Marriage and Family Therapist (LMFT)
- Licensed Professional Counselor (LPC)
- Licensed Senior Psychological Examiner (LSPE)
- Psychiatrist (MD, DO)
- Psychologist (Ph.D, Psy.D., Ed.D with MHSP qualification)

Additional details regarding network eligibility requirements can be found in Section XIV. Credentialing, in this Manual.

D. Behavioral Health Specific Billing Guidelines

The following information will assist you when billing behavioral health professional and facility claims. For general claims filing instructions, please refer to Section VI. Billing and Reimbursement, in this Manual.

1. Health and Behavior Assessment/Intervention

Performance of a health and behavior assessment may include a health-focused clinical interview, behavioral observations, psychophysiological monitoring, use of health-oriented questionnaires, and interpretation of assessment data. Elements of a health and behavior intervention may include cognitive, behavioral, social, and psychophysiological procedures that are designed to improve the patient’s health, ameliorate specific disease-related problems, and improve overall well-being.

The following CPT® codes should be billed with a medical diagnosis: (Please refer to the current International Classification of Diseases [ICD] Codes manual for the most appropriate diagnosis code in effect for the date of service.)

<table>
<thead>
<tr>
<th>CPT® Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>96150</td>
<td>Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires, each 15 minutes face-to-face with the patient; initial assessment.</td>
</tr>
<tr>
<td>96151</td>
<td>Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psychophysiological monitoring, health-oriented questionnaires, each 15 minutes face-to-face with the patient; re-assessment.</td>
</tr>
<tr>
<td>96152</td>
<td>Health and behavior intervention, each 15 minutes, face-to-face; individual.</td>
</tr>
<tr>
<td>96153</td>
<td>Health and behavior intervention, each 15 minutes, face-to-face; group (2 or more patients).</td>
</tr>
<tr>
<td>96154</td>
<td>Health and behavior intervention, each 15 minutes, face-to-face; family (with the patient present).</td>
</tr>
<tr>
<td>96155</td>
<td>Health and behavior intervention, each 15 minutes, face-to-face; family (without the patient present).</td>
</tr>
</tbody>
</table>
2. Psychiatric Consultation Guidelines in a Medical Setting
When psychiatric consultation services are required, Providers should call BlueCross BlueShield of Tennessee to verify Member eligibility and benefits. The following guidelines apply:

<table>
<thead>
<tr>
<th>If consultation is in:</th>
<th>service may be:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Room</td>
<td>performed only by psychiatrist and billed according to contract fee schedule</td>
</tr>
<tr>
<td>Hospital Bed</td>
<td>performed by psychiatrist and/or psychologist and billed according to contract fee schedule</td>
</tr>
<tr>
<td>Nursing Home</td>
<td>performed by all behavioral health professionals and billed according to contract fee schedule</td>
</tr>
</tbody>
</table>

Psychiatric consultation services must be billed with the appropriate Place of Service code for the medical treatment setting and the CPT® code provided at the time the service was authorized. Claims must be billed on a CMS-1500 claim form or ANSI-837P transaction.

3. Facility and Program Services Revenue Codes
As a result of the code set requirements under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), behavioral health facility claims must be filed with the appropriate Revenue Codes. A listing and contract descriptions follow:

<table>
<thead>
<tr>
<th>Revenue Code</th>
<th>Contract Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0114, 0124, 0134, 0144, 0154, 0204, 0116, 0126, 0136, 0146, 0156, 0118, 0128, 0138, 0148, 0158</td>
<td>Hospitalization for Psychiatric and Substance Use Disorders</td>
</tr>
<tr>
<td>0762</td>
<td>Observation, up to 23 hours</td>
</tr>
</tbody>
</table>
| 1001 | • Non-Acute, Residential Treatment, Psychiatric  
• Non-Acute, Residential Treatment, Eating Disorder |
| 1002 | Non-Acute, Residential Treatment, Substance Use Disorder |
| 0901 | ECT Inpatient and Outpatient |
| 0905 | • Intensive Outpatient, Psychiatric  
• Intensive Outpatient, Eating Disorder |
| 0906 | Intensive Outpatient, Substance Use Disorder |
| 0912, 0913 | • Partial Hospital, Psychiatric  
• Partial Hospital, Substance Use Disorder  
• Partial Hospital, Eating Disorder |
| 0944, 0945 | Ambulatory Detox |
| 0944, 0529 | Methadone Maintenance (not a covered service in all plans) |
| 0513 | Ambulatory Follow-up/bridge to outpatient services |
E. Provider/Member Complaints/Grievances

Providers and Members can register complaints or grievances by calling the behavioral health services number or the BlueCross BlueShield of Tennessee Customer Service number, which are listed on the Member ID card.

F. Covered Behavioral Health Services

Benefits are available for clinical assessment, diagnosis, referral, as well as inpatient and outpatient services for treatment of Behavioral Health Disorders (mental health and substance use).

Behavioral health services are covered when received from a contracted Provider or a non-contracted Provider depending upon the Member’s health care benefits plan. Members should consult their health care benefits plan or call the Customer Service number listed on their ID card for prior authorization requirements, benefit coverage, and information about the Mental Health Parity and Addiction Equity Act of 2008.

Program Services

Program services are covered when received in a licensed behavioral health facility program, or unit for mental health disorders or substance use disorders and when prior authorized by the Member’s health care benefits plan. Utilization review services are available 24-hours-a-day, 7-days-a-week for acute care services. Program services include acute care, residential care, partial hospitalization, intensive outpatient programs, and inpatient and outpatient electroconvulsive therapy (ECT) defined as follows:

- **Acute Care**
  Acute care is provided in a hospital licensed by a state to provide treatment for psychiatric or substance disorders and is accredited by an acceptable accrediting body. Acute care includes 24-hour psychiatric and substance use care for adults, adolescents and children with distinct criteria for each service. It may also include detoxification, co-occurring disorders, eating disorder, and other services targeted to treat specific behavioral health disorders.

- **Residential**
  Residential care includes psychiatric and substance use treatment in an accredited program. Residential care is 24-hour-a-day care.

- **Partial Hospitalization and Intensive Outpatient Programs**
  Partial hospitalization and intensive outpatient programs must be provided in licensed facilities that have been accredited by an acceptable accrediting body and/or have passed a structured site visit.

- **Inpatient and Outpatient Electroconvulsive Therapy**
  Electroconvulsive therapy (ECT) is covered when performed in a hospital setting. For most Plans, both inpatient and outpatient ECT requires review and prior authorization.

- **Transcranial Magnetic Stimulation**
  Transcranial magnetic stimulation (TMS) has been approved as a treatment for major depressive disorder for all BCBST lines of business. TMS is a non-invasive method of delivering electrical stimulation to the brain. TMS is not approved for treatment of other diagnoses or conditions.

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The therapy is administered in an inpatient, outpatient, or office setting. If needed, a treatment course may be repeated after a 3-month cessation period. All TMS services must be performed by a qualified and trained psychiatrist.

TMS is not allowed for pregnant women or for children under age 18.

Services provided in an outpatient setting must be preauthorized and requests must include a Physician’s order.

The following CPT® codes are used for billing TMS services:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90867</td>
<td>Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; initial, including cortical mapping, motor threshold determination, delivery and management</td>
</tr>
<tr>
<td>90868</td>
<td>Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent delivery and management, per session</td>
</tr>
<tr>
<td>90869</td>
<td>Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management</td>
</tr>
</tbody>
</table>

**Note:** Use revenue codes 0510, 0513, and 0920 in conjunction with appropriate CPT® codes when services are initiated in an inpatient setting. Please note that charges for TMS filed by a facility during inpatient care are included in the inpatient reimbursement and are **not** paid separately.

**Psychological Testing**

All providers are required to submit a psychological testing request in order to obtain prior authorization for this service. Testing request should include:
- General information about the member
- Reported difficulties the member is experiencing
- History of treatment and assessment
- Impact testing will have on the diagnosis and treatment of the member
- Specific types of tests should be listed, with only the most common test acronyms used
- Specific number of hours the provider anticipates administration of the individual tests will require

Providers should be aware that educational testing is considered an excluded benefit under BCBST. Educational testing is to be provided by the school system under federal Mandate PL 94-142. (According to the Child Find mandate of the Individuals with Disabilities Education Act, schools are required to locate, identify, and evaluate all children with disabilities from birth through age 21. (20 U.S.C. 1412(a)(3)).) There are also restrictions regarding the use of testing for vocational and legal purposes.

Generally, in depth psychological testing will not be considered medically necessary if the diagnostic questions can be addressed through medical, neurological, or psychiatric examination.

**Traditional Outpatient Services**

Traditional outpatient medication management and therapy services are covered when provided in an office setting, or within facility-based outpatient settings. Professionals delivering these services must be licensed at the independent practice level in the state in which the services are provided and meet other requirements as formulated by State of Tennessee law, BlueCross BlueShield of Tennessee, and the behavioral health services covered under the Member’s health care benefits plan.
XXI. bcbst.com

The company website, www.bcbst.com, is an award-winning, easy-to-use service that enables Providers and Members having Internet capabilities to link to a compilation of informative health care information.

1. BlueAccess

BlueAccess includes e-Health Services® (benefits and claims information and a number of online authorizations), Primary Care Practitioner Member rosters, quarterly Commercial Practice Pattern Analysis (PPA) and User Guide, Patient Review of Physicians, an online Blue Members review system, and Providers’ remittance advice.

If you are already registered, look for the “BlueAccess” login box located in the top right-hand corner of the Web page. Simply enter your user ID and password to view information in a secure environment, just as it appears right now in our computer system. First time users can click on “Register Now” (see above), and follow registration instructions.

e-Health Services®
e-Health Services is a quick, convenient way to answer many of your health insurance questions 24-hours-a-day, 7-days-a-week.

On this site, you can:

- verify benefits, including eligibility and coverage details
- check medical, behavioral health and dental claim status (excludes prescription drug claims)
- look up prior authorization status
- submit prior authorization requests and receive online approvals if specific criteria are met; and much, much more……
Practice Pattern Analysis (PPA)

BlueCross BlueShield of Tennessee periodically performs a Practice Pattern Analysis (PPA), which is a quality management study designed to provide Practitioners with important information about their utilization practices and quality of care.

PPAs are not intended to prescribe what constitutes appropriate individual care, but rather are designed to reveal patterns of care that are outside the normal range of practice for a Practitioner’s specialty. PPAs provide useful information to assist Practitioners in evaluating the appropriateness of care and give them an opportunity to compare their overall practice patterns to those of their peers.

National Consumer Cost Tool

Effective 7/1/2013, Providers can view their cost data in the National Consumer Cost Tool (NCCT) on BlueAccess prior to the information being made available to Members. This information is available for a 60-day review period.

The National Consumer Cost Tool presents an opportunity for Blues Plans to offer a secure, interactive environment where consumers can evaluate cost-related information, become knowledgeable about the estimated costs of future procedures, and participate more effectively in their health care decisions.

More information on how to access the NCCT data is located on the Provider page on the company website, www.bcbst.com under the “Accessing NCCT Data via BlueAccess” link. Or e-mail us at NCCTquestions@bcbst.com.

Patient Review of Physicians

Patient Review of Physicians is an online review system that Blue Members nationwide can use as part of their decision-making when they are selecting a Physician or other professional Provider. BlueCross BlueShield of Tennessee delivers information about Members’ actual experiences with their Providers through an easy-to-use, nationally consistent, online survey and aggregated results display.

The Blue Cross Blue Shield Association implemented a rigorous process that authenticates, verifies, and moderates reviews prior to posting online. This process helps assure only authenticated Blue Members who verify they have seen the Physician can contribute reviews.

Providers can logon to BlueAccess, navigate to the “Transparency Review” section and choose “Provider Ratings Review” to access a summary of all Provider reviews and perform a number of Provider-specific actions, such as:

- sign up for e-mail or fax alerts when new reviews are received;
- hide up to two (2) reviews; and
- post a response to a review.

Not only is patient review a valuable tool for providing insights into your patient’s experiences, it can also attract new patients. While patient reviews are just one of many factors to consider when patients choose a health care Provider, research shows that online patient reviews are one of the most sought after pieces of information for consumers. Approximately 85-90 percent of patient reviews are positive, and some Physicians use them as a means to promote their practice. To assure your overall score is positive, encourage your patients to contribute to your reviews.
2. Other Online Reference Materials

*Provider administration manuals, Medical Policy Manual and Health Care Practice Recommendations Manual*

A number of reference materials are also available online giving you access to current administrative processes, and medical policies.

The website contains a “find” feature making it convenient for Providers to locate specific information, (e.g., billing requirements, UM guidelines, preventive care guidelines, upcoming medical policies and much more).

Click on the manual you wish to reference; to search for a specific topic, simply:

- click on the “find” button (little binoculars);
- type in a word or number of words that most describe the topic you wish to find; and
- hit “enter” on your keyboard.

You will be taken to where the first mention of your search is located. To continue searching, just click on the “find again” button (little binoculars with forward arrow).
3. Network Directories

Referring your patients to other participating Providers is not only contractual, but will save substantial out-of-pocket costs for your patients.

The information listed in this online directory is updated daily. As is the case with any directory, the listed Providers' participation in the network is verifiable only up to the date the directory was updated. Providers join, as well as, leave the networks. It is very important to verify health care professionals' and facilities' continued participation in a network before referring a patient.

Although it is the Provider's obligation to notify his/her BlueCross BlueShield of Tennessee patients of any intent to terminate participation in a network, BCBST will also display future termination dates beside the Provider's name once notice is received. It is our intent to publish these termination dates thirty (30) days prior to the actual termination effective date.

We invite you to visit the company website often- Information and new features are added on a regular basis.
XXII. BlueCare®/TennCare Select Program Outline

This section has been removed. Information regarding BlueCare and TennCare Select can be found in the BlueCare Tennessee Provider Administration Manual located on the Provider page on the company websites www.bcbst.com and http://bluecare.bcbst.com/
XXIII. Provider Audit Guidelines

A. Overview

All claims submitted to BlueCross BlueShield of Tennessee and any of their affiliates and/or subsidiaries for reimbursement are subject to audit for the purpose of verifying the information submitted is correct, complete, in accordance with Provider contract requirements, and supported by established coding guidelines.

Claims are routinely analyzed for potential billing and coding irregularities, as well as known areas of potential fraud and abuse. Audit of specific Providers or Provider groups may also be requested by any vested party.

All records requested must be provided; claims payments involved with records not received are subject to immediate recovery as unsubstantiated by documentation.

Audits are based on recognized coding and billing guidelines such as, but not limited to the UB Coding Editor, ICD Manual and CPT® Manual as well as specific Provider contractual language.

Audit rights are defined in this Manual and any of their affiliates and/or subsidiaries Provider Agreement. Claims found with errors, both overcharges and undercharges, will be submitted for adjustment.

B. Audit Process

Audit Scheduling
All Providers are given advance notice of scheduled audit dates. Once an audit is scheduled, it should not be changed or cancelled except for extenuating circumstances. If scheduled audits are continually delayed, or denied by the Provider, payment for those claims selected for audit will be retracted until the audit is allowed.

Medical Record Request Process
When requested by BlueCross, Provider will be required to furnish in a timely manner medical records and encounter data in electronic or hardcopy format. Medical records may be submitted via our secure file transfer portal (SFTP) that is fully HIPAA compliant and requires minimal set up. All complete medical records must be provided by the beginning of the audit to help ensure a timely audit schedule. Medical records not provided at the audit start date may result in retraction of payment.

Audit Process
All claims are reviewed for correct coding and billing, contract compliance and accurate reimbursement based on applicable regulatory governing agencies and BlueCross guidelines as published in this Manual.

Facility Audit Process
Facility Audit schedules audits in advance and medical records are requested a minimum of eight (8) weeks before the scheduled audit date. This provides ample time to compile and submit medical records, I-bills and invoices, and ER tools, as applicable. Audits begin on the scheduled date and it is expected that all documentation has been received prior to the actual start date of the audit. Audit staff will be available daily during the audit to discuss audit findings and will conduct an exit interview with designated staff to provide a general overview of the audit findings (specific details are to be covered in daily discussions).
Audit Accommodations
BlueCross reserves the right to conduct on-site audits. Adequate and reasonable accommodations will be required during the audit. These accommodations include but are not limited to adequate desk space, location compatible for wireless internet service, lighting, temperature, seating, etc. A single location for the entire audit team without relocation during the audit is expected.

If auditors are expected to connect to the Provider’s system for access to medical records, Providers are responsible for ensuring connectivity, communicating instructions, and providing training on computer systems prior to the audit. E-mail communications outline the requirements for remote access given to auditors, but the testing process and validation of access is expected prior to begin date of the scheduled audit.

Audit Findings
The Provider will receive a Final Audit Report detailing the results of each audited claim at the audit conclusion, normally within thirty (30) days. The claims found in error may be submitted for adjustment and/or re-adjudication. Providers are expected to correct identified issues immediately.

Subsequent Audits
A decision may be made to expand the audit scope based on audit findings.

Additional follow-up audits may be performed to substantiate the Provider has made any necessary corrections to billing and/or documentation practices according to the billing and coding guidelines cited on a previous audit.

Vendor Audits
BlueCross, or a vendor designated by us, is allowed to perform on-site, desk, or remote audits and inspections of financial and/or medical records, and Utilization Management covering treatment of any BlueCross Member. Such audits and inspections shall be permitted without charge to us or its designated vendor, who shall be provided copies of records involving the audit or inspection without charge.

BlueCross has contracted with a claims audit vendor to perform post payment coding, utilization and Medical Necessity audits. BlueCross’s claims audit vendor follows CMS auditing procedures similar to those practiced by the Medicare claims audit vendor where Clinical Review Judgment (CRJ) is used to determine if the services provided were Medically Necessary, coded at the appropriate level and/or billed according to recognized utilization standards. CRJ is utilized on all complex audits and involves a thorough review of all submitted medical documentation in order for the reviewer to develop a complete clinical picture of the patient as part of the evaluation. In addition to the complex reviews, BlueCross’s claims audit vendor also performs automated audits utilizing proprietary algorithms to identify potential overpayments as a result of billing and coding errors.

Submission of Outpatient Claims Following an Audit
In accordance with CMS ruling 1455-R issued on March 13, 2013, BlueCross will accept outpatient claims from facilities for the outpatient services (emergency room visits, observation services, etc.) performed prior to an inpatient admission when our recovery audit vendor has determined that the inpatient admission was not Medically Necessary. BlueCross will process the outpatient claims according to our normal processing and reimbursement rules.

To prevent delays in reimbursement, hospitals should mark the outpatient claim to indicate that it is the result of a vendor audit, and submit it within 120 days of the date of our remittance advice reflecting recovery of the inpatient claim. If a facility has appealed an audit decision and received a denial, the outpatient claim should be submitted within 120 days of the date of the appeal decision. A copy of the appeal decision should also be submitted to help ensure proper handling of the claim. Additionally, hospitals must maintain documentation to support the services billed on the outpatient claim.
C. Operational Guidelines for Facility Emergency Department Claims Audit Process

**Step 1:** For all lines of business, effective April 1, 2012, BlueCross will conduct ED audits utilizing the hospital’s current designated ED claims level classification tool.

**Step 2:** The facility, within two (2) weeks notification of the audit, will send BlueCross an electronic or hardcopy version of their facility’s current ED classification tool(s), the effective dates of the tool(s), guidelines/instructions for appropriate use, and a contact for questions and answers regarding the tool(s).

**Step 3:** If the facility has changed ED tool or modified the logic in its current ED classification tool during the audit period, we reserve the option to use the hospital’s previous ED classification tool version upon an observed shift increase of 5 percent or more of ED levels 4 and/or 5.

**Step 4:** The baseline will be established by a comparison of the ED claims billed prior to ED classification tool logic modification or complete tool change against the ED claims billed using the modified version (see illustration below).

- Based upon the ED tool modification date, BlueCross will include six (6) months retrospective claims data during the analysis of the previous ED tool.

If the facility has changed ED tool or modified the logic in its current ED classification tool within three (3) months from the end of the audit period, we will perform the audit using both tools as indicated by the effective dates of the tool(s).

**Example: Determining if analysis is needed**

| Audit Date: | Apr-12 |
| Claim Data Range: | Dec-10 thru Jan-12 |
| Audit Tool Modified: | Jun-11 |

**Comparison**

| Dec-10 thru May-11 | Audit period using previous ED tool (6 months) |
| Jun-11 thru Jan-12 | Audit period using modified ED tool (3 months or greater) |

**Example: Analysis in determining 5% increase**

<table>
<thead>
<tr>
<th>ED Levels</th>
<th>Claims billed December thru May</th>
<th>% of each level to total billed</th>
<th>Claims billed June thru January</th>
<th>% of each level to total billed</th>
<th>% Shift +/-</th>
</tr>
</thead>
<tbody>
<tr>
<td>L1</td>
<td>200</td>
<td>20%</td>
<td>100</td>
<td>10%</td>
<td>-10%</td>
</tr>
<tr>
<td>L2</td>
<td>200</td>
<td>20%</td>
<td>200</td>
<td>10%</td>
<td>-10%</td>
</tr>
<tr>
<td>L3</td>
<td>300</td>
<td>30%</td>
<td>300</td>
<td>20%</td>
<td>-20%</td>
</tr>
<tr>
<td>L4</td>
<td>300</td>
<td>10%</td>
<td>300</td>
<td>20%</td>
<td>-20%</td>
</tr>
<tr>
<td>L5</td>
<td>100</td>
<td>10%</td>
<td>800</td>
<td>20%</td>
<td>10%</td>
</tr>
<tr>
<td>Total</td>
<td>1000</td>
<td>100%</td>
<td>1000</td>
<td>100%</td>
<td></td>
</tr>
</tbody>
</table>

Results indicate >5% increase in levels 4 and/or 5. Outcome: BCBS would audit using previous tool

**Step 5:** BlueCross will notify the facility of the observed shift increase of five (5) percent or more of ED levels 4 and/or 5 and the intent to audit with previous classification tool for all ED claims in the audit OR the intent to audit using two (2) tools as indicated by the effective dates of the tool(s).

**Step 6:** BlueCross will perform the audit and communicate findings as usual. Any facility that outsources ED coding to a 3rd party vendor is still obligated to provide an electronic or hardcopy version of their facility’s current ED classification tool(s), the effective dates of the tool(s), guidelines/instructions for appropriate use, and a contact for questions and answers regarding the tool(s). In the event the facility or 3rd party vendor does not provide the above-referenced information with the timeframe established by Step 2.

BlueCross reserves the right to conduct ED audits utilizing the following Emergency Room Level Determination audit tool:
# Emergency Room Level Determination

**Instructions:** Circle the documented interventions in each level.
Assign the highest level that meets the criteria listed

**Diagnosis:**

<table>
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<tr>
<th>Level/CPT®</th>
<th>Possible Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>99281</td>
<td>• VS x 1 – (PR and BP)</td>
</tr>
<tr>
<td></td>
<td>• A completed clinical assessment form</td>
</tr>
<tr>
<td></td>
<td>• Instructions for specimen collection</td>
</tr>
<tr>
<td></td>
<td>• OTC meds administered</td>
</tr>
<tr>
<td></td>
<td>• Uncomplicated suture removal</td>
</tr>
<tr>
<td></td>
<td>• Simple dressing change</td>
</tr>
<tr>
<td></td>
<td>• Immunization</td>
</tr>
</tbody>
</table>

1 Intervention Present

| 99282      | • VS x 1 – (PR and BP)  |
|            | • O2 Sat x 1            |
|            | • Neuro Check x 1       |
|            | • Administer prescription drug, PO, topical |
|            | • Assessment fetal heart tones |
|            | • Assisting MD with any exam |
|            | • Basic specimen testing: Accuchek, dipstick, UA clean catch |
|            | • Complicated or infected suture removal |
|            | • Enema or disimpaction |
|            | • Simple cultures (throat, skin, urine, wound) |
|            | • Simple laceration/abrasion repair (w/Dermabond, w/o sutures) |
|            | • Simple removal of FB without incision or anesthetic |
|            | • Venipuncture for lab |
|            | • Visual acuity exam |

Requires 2 or more of these Interventions

| 99283      | • VS x 2 – (PR and BP)  |
|            | • O2 Sat x 2            |
|            | • Neuro checks x 2      |
|            | • Accuchek x 2          |
|            | • Perform or assist w/ minor procedures: suturing, packing, I&D, casting, pelvic procedures beyond routine exam, Foley cath or irrig |
|            | • Control of nasal hemorrhage |
|            | • Doppler assessment |
|            | • Ear or Eye irrigation |
|            | • EKG x 1               |
|            | • IM/SQ med administered x 1 |
|            | • INT insertion         |
|            | • IV fluids w/o meds    |
|            | • IV push 1- 2          |
|            | • Nasopharyngeal suctioning |
|            | • Nebulizer treatment x 1 |
|            | • Oxygen therapy        |
|            | • Routine trach care (clean, change dressing, suction) |
|            | • Telemetry             |
|            | • X-Ray x 1             |
|            | • Access Port           |

Requires 3 or more of these Interventions

*Rev 12/15*
# Emergency Room Level Determination (cont'd)

<table>
<thead>
<tr>
<th>Code</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>99284</strong></td>
<td>Requires 3 or more of these Interventions.</td>
</tr>
<tr>
<td></td>
<td>• VS x 3 – (PR and BP)</td>
</tr>
<tr>
<td></td>
<td>• O2 Sat x 3</td>
</tr>
<tr>
<td></td>
<td>• Neuro checks x 3</td>
</tr>
<tr>
<td></td>
<td>• Accuchek x 3</td>
</tr>
<tr>
<td></td>
<td>• Blood or blood products administered x 1 unit</td>
</tr>
<tr>
<td></td>
<td>• Change trach tube</td>
</tr>
<tr>
<td></td>
<td>• Coordination for admission or observation to any facility</td>
</tr>
<tr>
<td></td>
<td>• EKG – 2 or more</td>
</tr>
<tr>
<td></td>
<td>• IM/SQ med administered x 2</td>
</tr>
<tr>
<td></td>
<td>• IV med drip</td>
</tr>
<tr>
<td></td>
<td>• IV push x 3 – 4</td>
</tr>
<tr>
<td></td>
<td>• Insertion nasal/oral airway</td>
</tr>
<tr>
<td></td>
<td>• Insertion PEG or NG tube</td>
</tr>
<tr>
<td></td>
<td>• Care of confused, combative pt or change in mental status</td>
</tr>
<tr>
<td></td>
<td>• Nebulizer treatment x 2</td>
</tr>
<tr>
<td></td>
<td>• Nonconfirmed overdose</td>
</tr>
<tr>
<td></td>
<td>• PICC insertion</td>
</tr>
<tr>
<td></td>
<td>• Use of specialized resources – SS, hearing, visual impairment, police, crisis management.</td>
</tr>
<tr>
<td></td>
<td>• Radiological testing of 2 – 3 areas</td>
</tr>
</tbody>
</table>

| **99285** | Requires 3 or more of these Interventions.                               |
|          | • VS x 4 or more – (PR and BP)                                           |
|          | • O2 Sat x 4                                                             |
|          | • Neuro cks x 4                                                           |
|          | • Accucheks x 4                                                          |
|          | • Assisting w/ major procedure: FX reduction/ relocation, endotracheal/ trach tube insertion, endoscopy, thoracentesis, paracentesis, LP, conscious sedation |
|          | • Decontamination for isolation, hazardous material                      |
|          | • IV med administered requiring intensive monitoring                      |
|          | • IV push x 5 or more                                                    |
|          | • Multiple (2 or more) IV lines infusing                                  |
|          | • Nebulizer treatment x 3                                                 |
|          | • Precipitous delivery in ER                                              |
|          | • Use of chemical or physical restraints                                 |
|          | • Radiological testing of 4 or more areas                                 |

| **99291** | Critical Care – Requires both criteria                                  |
|          | • Time 30 – 74 minutes                                                   |
|          | • Critical Condition                                                     |
|          | • Additional Notes                                                       |

| **99292** | Critical Care – Requires both criteria                                  |
|          | • Time 75 – 104 minutes                                                  |
|          | • Critical Condition                                                     |
|          | • Additional Notes                                                       |

**NOTES:**
D. Data Mining and Claims Auditing

Claims Data Analysis is performed using algorithms that analyze claims data retrospectively. Claims are evaluated, both individually and against other claims utilizing edits developed from recognized standards of coding, billing and reimbursement. Claims will be adjusted according to the results of the application of these principles. BlueCross and any of their affiliates and/or subsidiaries reserve the right to periodically evaluate and modify these edits.

E. Reconsideration Process

In the event you wish to dispute Provider Audit findings, you may submit a written request for reconsideration and state why you disagree. Additional supporting documentation and medical records applicable to your dispute should be included. Claims audited are subject to the Provider Dispute Resolution Process. See Section XII. Provider Dispute Resolution Procedure in this Manual for detailed information.
XXIV. MEDICARE ADVANTAGE

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B. Medicare Advantage Products
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   2. Benefit Highlights
   3. ID Card

C. Reimbursement Methodology

D. Risk Adjustment

E. Claims Information

F. Electronic Funds Transfer (EFT)

G. CMS Star Ratings

H. Health Management
   1. Case Management
   2. Care Management
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      d. Contact Method According to Type of Service
      e. Compliance with Prior Authorization Requirements
      f. Non-Compliance with Prior Authorization Requirements
      g. Mandated Notices
      h. Retrospective Claims and Clinical Record Review
      i. Acute Care Facility
      j. Skilled Nursing Facility (SNF)
      k. Rehabilitation Facility
      l. Home Health Services and Billing Guidelines
      m. Durable Medical Equipment (DME)
      n. Speech, Occupational and Physical Therapy, Chiropractic
         Manipulation
      o. Orthotics/Prosthetics
      p. Laboratory Services
      q. Retrospective Review
      r. Pharmacy (Part B Drugs)
      s. Organization Determinations
      t. Reconsideration Process
      u. Advanced Imaging
   3. Oxygen Authorizations
   4. Reimbursement for Oxygen Equipment
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I. Valuable Health Tools for your BlueAdvantage and BlueChoice Patients

J. Pharmacy
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   2. Prior Authorization
   3. Quantity Limits or Maximum Drug Limitation
   4. Redetermination
   5. Pharmacy Directory
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K. Provider Appeal Process

L. Website Related Links

M. Contact Us
XXIV. MEDICARE ADVANTAGE

A. Introduction

PPO
BlueCross BlueShield of Tennessee offers five Medicare Advantage Preferred Provider Organization (PPO) products: BlueAdvantage Ruby, BlueAdvantage Diamond, BlueAdvantage Sapphire, BlueAdvantage Garnet, and BlueAdvantage Plus (Group). A PPO plan is a plan having a network of contracted Providers who have agreed to treat plan Members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or non-network Providers. Member cost-sharing may be higher when plan benefits are received from non-network Providers.

BlueAdvantage Ruby, BlueAdvantage Diamond, BlueAdvantage Sapphire, BlueAdvantage Garnet, and BlueAdvantage Plus (Group) PPO products and benefits are defined in subsection B.

HMO
BlueChoice Tennessee offers two (2) Medicare Advantage Health Maintenance Organization (HMO) plans. An HMO plan has a network of contracted Providers who agree to treat plan Members for a specified payment amount. Members must use plan Providers except in emergency or urgent care situations or for out-of-area renal dialysis. Members who obtain routine care from out-of-network Providers will be responsible for the cost of the care.

PPO/HMO
For Covered Services, contracted Providers may collect no more from the BlueAdvantage or BlueChoice Member at the time of service than the applicable cost-sharing amount and, if the Provider does not accept assignment, the Medicare limiting charge. If a Provider mistakenly collects more from the Member than the designated cost-sharing amount, the Provider must refund the difference to the Member.

Reimbursement methodology is defined in subsection C.

B. Medicare Advantage Products

1. Product Descriptions

- **BlueAdvantage Ruby**
  BlueAdvantage Ruby combines the benefits of Medicare Part A and B and includes additional services not covered by Original Medicare, such as a yearly routine physical, routine vision care, and an eyewear allowance. Plus it offers Medicare Part D prescription drug coverage.

- **BlueAdvantage Diamond**
  BlueAdvantage Diamond combines the benefits of Medicare Part A and B and includes additional services not covered by Original Medicare, such as a yearly routine physical, routine vision care, and an eyewear allowance. Plus it offers Medicare Part D prescription drug coverage.

- **BlueAdvantage Sapphire**
  BlueAdvantage Sapphire combines the benefits of Medicare Part A and B and includes additional services not covered by Original Medicare, such as a yearly routine physical, routine vision care, and an eyewear allowance. Plus it offers Medicare Part D prescription drug coverage.
- **BlueAdvantage Garnet**
  BlueAdvantage Garnet combines the benefits of Medicare Part A and B and includes additional services not covered by Original Medicare, such as a yearly routine physical, routine vision care, and an eyewear allowance. Plus it offers Medicare Part D prescription drug coverage.

- **BlueAdvantage Plus (Group PPO plan)**
  BlueAdvantage Plus is a group PPO plan that combines the benefits of Medicare Part A and B and includes additional services not covered by Original Medicare, such as a yearly routine physical. Plus it offers Medicare Part D prescription drug coverage. Because this is a group product, benefits may vary by group; please verify benefits in BlueAccess®, BlueCross BlueShield of Tennessee’s secure portal on [www.bcbst.com](http://www.bcbst.com).

- **BlueChoice (HMO Plan)**
  BlueChoice combines the benefits of Medicare Part A and B and includes additional services not covered by Original Medicare, such as a yearly routine physical, routine vision care, an eyewear allowance and preventive dental benefits. Plus it offers Medicare Part D prescription drug coverage.

- **BlueChoice Plus (HMO Plan)**
  BlueChoice combines the benefits of Medicare Part A and B and includes additional services not covered by Original Medicare, such as a yearly routine physical, routine vision care, an eyewear allowance and preventive and comprehensive dental benefits. Plus it offers Medicare Part D prescription drug coverage.

**Note:** Effective 1/1/2016, all routine vision care is administered by EyeMed.

2. **Benefit Highlights**

The following grids contain highlights only for services received in network for BlueAdvantage and BlueChoice plans effective 1/1/2016.

For a complete outline of Member benefits and cost-sharing amounts, see the BlueAdvantage and BlueChoice Summary of Benefits on our company website, [http://www.bcbst.com/providers/medicare-advantage/](http://www.bcbst.com/providers/medicare-advantage/).

The following grid highlights 2016 BlueAdvantage (PPO) and BlueChoice (HMO) benefits:
## BlueCross BlueShield of Tennessee BlueAdvantage (PPO) and BlueChoice (HMO) Benefit Summary

**Effective January 1, 2016 through December 31, 2016**

### Plan Types
- **Diamond**
- **Ruby**
- **Sapphire**
- **Garnet**
- **BlueChoice**
- **BlueChoice Plus**

#### Premium

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>IN</th>
<th>OCN</th>
<th>IN</th>
<th>OCN</th>
<th>IN</th>
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<tr>
<td><strong>Premium</strong></td>
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#### DOP Maximum

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<td><strong>DOP Maximum</strong></td>
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#### Inpatient Hospital Care

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<th>Plan Type</th>
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<td><strong>Inpatient Hospital Care</strong></td>
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#### Inpatient Mental Health Care

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<th>OCN</th>
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<tr>
<td><strong>Inpatient Mental Health Care</strong></td>
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#### Skilled Nursing Facility

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<td><strong>Skilled Nursing Facility</strong></td>
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#### Home Health Care

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<tbody>
<tr>
<td><strong>Home Health Care</strong></td>
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#### Hospice

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#### Doctor Office Visits

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<th>IN</th>
<th>OCN</th>
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<tbody>
<tr>
<td><strong>Doctor Office Visits</strong></td>
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#### Other Services

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<th>OCN</th>
<th>IN</th>
<th>OCN</th>
<th>IN</th>
<th>OCN</th>
<th>IN</th>
<th>OCN</th>
</tr>
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<tbody>
<tr>
<td><strong>Other Services</strong></td>
<td></td>
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#### Diagnostic Tests, X-Rays, Lab, and Therapeutic Radiology

<table>
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<th>IN</th>
<th>OCN</th>
<th>IN</th>
<th>OCN</th>
<th>IN</th>
<th>OCN</th>
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<th>OCN</th>
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</thead>
<tbody>
<tr>
<td><strong>Diagnostic Tests, X-Rays, Lab, and Therapeutic Radiology</strong></td>
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<table>
<thead>
<tr>
<th>Plan</th>
<th>Diamond IN</th>
<th>Diamond DPN</th>
<th>Ruby IN</th>
<th>Ruby DPN</th>
<th>Sapphire IN</th>
<th>Sapphire DPN</th>
<th>Garnet IN</th>
<th>Garnet DPN</th>
<th>BlueChoice IN</th>
<th>BlueChoice DPN</th>
<th>BlueChoice Plus IN</th>
<th>BlueChoice Plus DPN</th>
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<tr>
<td>23 - Cardiac/Pulmonary Rehab</td>
<td>$25</td>
<td>$20</td>
<td>$10</td>
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<td>$10</td>
<td>$10</td>
<td>$10</td>
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<td>$0</td>
<td>$0</td>
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<td>$0</td>
</tr>
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<td>immunizations/ vaccinations</td>
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<td>$0</td>
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<td>20%</td>
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<td>20%</td>
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<td></td>
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</tr>
<tr>
<td></td>
<td>B-covered drugs (not including chemotherapy drugs)</td>
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<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
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<tr>
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<td>B-covered chemotherapy drugs</td>
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<td>27 - Dental Services Routine/ Preventive Care</td>
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<td>medicare covered</td>
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<td>$15</td>
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<td>$15</td>
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</tr>
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<td>$40</td>
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<td>$40</td>
</tr>
<tr>
<td></td>
<td>glasses/contacts (eye wear)</td>
<td>$175 allowance / every yr</td>
<td>$175 allowance / every yr</td>
<td>$75 allowance / every yr</td>
<td>$175 allowance / every yr</td>
<td>$75 allowance / every yr</td>
<td>$75 allowance / every yr</td>
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<td>$40</td>
<td>$40</td>
<td>$40</td>
<td>$40</td>
<td>$40</td>
<td>$40</td>
</tr>
</tbody>
</table>

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3. ID Card

Every BlueAdvantage and BlueChoice plan Member receives an ID card reflecting the benefit plan and product the Member is enrolled. The ID card provides the following information:

- Member name;
- Member ID number;
- Member copayment amount; and
- Drug coverage indicator

Providers can verify the Member’s plan by simply checking his/her Member ID card. When a Member presents to your office, please take a moment to look at the card to help prevent Members from being denied services incorrectly.

Sample copies of the BlueAdvantage and BlueChoice ID cards follow:

**BlueAdvantage PPO**

**BlueChoice HMO**
C. Reimbursement Methodology

When billing for services rendered to BlueAdvantage (PPO) and BlueChoice (HMO) Members, Providers should refer to the most current federal, state, or other payer instructions for specific requirements applicable to the CMS-1500 professional and CMS-1450 facility health insurance claim forms. Medical/clinical codes including modifiers should be reported in accordance with the governing coding organization. Please refer to your BlueAdvantage and/or BlueChoice contract for reimbursement specifics.

**Note:** Unless specified differently in this section, all other commercial billing guidelines apply for BlueAdvantage and BlueChoice Members (see Section VI. Billing and Reimbursement, of this Manual).

**General Provisions**

Eligible services not priced by the Centers for Medicare & Medicaid Services (CMS) will be based on a reasonable allowable fee as determined by BlueCross BlueShield of Tennessee.

BlueCross and BlueChoice Tennessee reserve the right to request documents submitted to or issued by the Medicare Fiscal Intermediary or Carrier that are necessary to determine the appropriate fee under Medicare-based reimbursement methodology.

Providers have a right to appeal reimbursement under BlueAdvantage or BlueChoice. If a Provider has information that Original Medicare would pay more for a service, documentation (e.g. copy of a remittance advice or other official notice of payment for the same service from the Medicare Fiscal Intermediary or Carrier as proof of Medicare payment) may be submitted to BlueCross BlueShield of Tennessee, Attn: BlueAdvantage, 1 Cameron Hill Circle, Ste 0002, Chattanooga, TN 37402-0005 for review, verification, and payment adjustment if appropriate. Please complete and attach a Provider Dispute Resolution form (see subsection K. Provider Appeals Process) with your submission.

Details regarding Medicare reimbursement methodologies can be found on the CMS website, [www.cms.gov](http://www.cms.gov). Links to the CMS website for specific Provider types are located in the following grid. In the event CMS changes one or more of the links, refer to CMS website, [www.cms.gov](http://www.cms.gov). If there is a conflict between the following information and information published by CMS, the information published by CMS will prevail.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>CMS Link for Detailed Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulatory Surgical Center (ASC)</td>
<td><a href="http://www.cms.gov/HospitalOutpatientPPS">http://www.cms.gov/HospitalOutpatientPPS</a></td>
</tr>
<tr>
<td>and Supplies (DMEPOS)</td>
<td></td>
</tr>
<tr>
<td>Provider Type</td>
<td>CMS Link for Detailed Information</td>
</tr>
<tr>
<td>--------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Federally Qualified Health Centers (FQHC)</td>
<td><a href="http://www.cms.gov/center/fqhc.asp">http://www.cms.gov/center/fqhc.asp</a></td>
</tr>
<tr>
<td>Home Health</td>
<td><a href="http://www.cms.gov/HomeHealthPPS/">http://www.cms.gov/HomeHealthPPS/</a></td>
</tr>
<tr>
<td>Hospice</td>
<td><a href="http://www.cms.gov/Center/Provider-Type/Hospice-Center.html">http://www.cms.gov/Center/Provider-Type/Hospice-Center.html</a></td>
</tr>
<tr>
<td>Acute Inpatient Service</td>
<td><a href="http://www.cms.gov/AcuteInpatientPPS/">http://www.cms.gov/AcuteInpatientPPS/</a></td>
</tr>
<tr>
<td>Hospital - Outpatient Services</td>
<td><a href="http://www.cms.gov/HospitalOutpatientPPS/">http://www.cms.gov/HospitalOutpatientPPS/</a></td>
</tr>
<tr>
<td>Inpatient Rehabilitation Facility</td>
<td><a href="http://www.cms.gov/InpatientRehabFacPPS/">http://www.cms.gov/InpatientRehabFacPPS/</a></td>
</tr>
<tr>
<td>Hospitals</td>
<td><a href="http://www.cms.gov/center/hospital.asp">http://www.cms.gov/center/hospital.asp</a></td>
</tr>
<tr>
<td>Inpatient Psychiatric Facility (IPF)</td>
<td><a href="http://www.cms.gov/InpatientPsychFacilPPS/">http://www.cms.gov/InpatientPsychFacilPPS/</a></td>
</tr>
<tr>
<td>Long-Term Care Hospital</td>
<td><a href="http://www.cms.gov/LongTermCareHospitalPPS">http://www.cms.gov/LongTermCareHospitalPPS</a></td>
</tr>
<tr>
<td>Skilled Nursing Facilities</td>
<td><a href="http://www.cms.gov/SNFPPS/">http://www.cms.gov/SNFPPS/</a></td>
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<tr>
<td>Part B Drugs</td>
<td><a href="http://www.cms.gov/CompetitiveAcquisforBios/">http://www.cms.gov/CompetitiveAcquisforBios/</a></td>
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<tr>
<td>Anesthesia</td>
<td><a href="http://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html">http://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html</a></td>
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<tr>
<td>Health Professional Shortage Area (HPSA)</td>
<td><a href="http://www.cms.gov/HPSAPSAPhysicianBonuses/">http://www.cms.gov/HPSAPSAPhysicianBonuses/</a></td>
</tr>
<tr>
<td>Rural Health</td>
<td><a href="http://www.cms.gov/center/rural.asp">http://www.cms.gov/center/rural.asp</a></td>
</tr>
</tbody>
</table>
Specific Provisions

1. Radiopharmaceuticals and Contrast Materials

2. Hospital Based Clinic Visits
Effective October 1, 2014, and consistent with reimbursement guidelines of other payers as well as current BlueCross and BlueCare Tennessee contracts, Medicare Advantage will no longer separately reimburse for an E&M or G0463 professional service charge under Revenue Code 510 (hospital-based clinic setting as defined in 42 CFR 410.2) when provided in conjunction with a procedural service charge on the same date of service by the same rendering practice or Provider. Only the higher weighted service will be reimbursed.

D. Risk Adjustment

Risk Adjustment is the process by which the Centers for Medicare & Medicaid Services (CMS) reimburses Medicare Advantage (MA) plans, such as BlueCross BlueShield of Tennessee, for the health status and demographic characteristics of their enrollees. CMS utilizes the Hierarchical Condition Category (HCC) payment model (the ICD Code version required by CMS at the time the service is provided) and encounter data submitted by MA plans to establish risk scores. The primary source of encounter data or ICD codes routinely submitted to CMS is extracted from claims with additional conditions being identified during retrospective chart review and protective health assessments.

CMS looks to Providers to code identified conditions accurately using the ICD coding guidelines with supporting documentation in their medical record.

The Physician’s role in risk adjustment includes:

- Accurately reporting the ICD Code version required by CMS at the time the service is provided to the highest level of specificity (critical as this determines disease severity).
- Documentation should be complete, clear, concise, consistent and legible.
- Documentation of all conditions treated or monitored at the time of the face-to-face visit in support of the reported diagnoses codes.
- Use of standard abbreviations.
- Medical records should be signed with Physician’s credentials present.
- Medical records should identify a treatment plan for conditions present.
- Notifying the Medicare Advantage plan of any erroneous data submitted and following the appropriate procedures to correct erroneous data (see Section VI. Billing and Reimbursement in this Manual for instructions on submitting a Corrected Bill*).
- Submitting claims data in a timely manner, generally within thirty (30) days of the date of service (or discharge for hospital inpatient admissions).

*When a Corrected Bill is filed, BlueCross will recover any payment previously made under the original claim submission from the Provider’s remittance advice (a refund request letter will not be sent). Any applicable new payment will be based on the services submitted on the Corrected Bill claim.

Risk Adjustment Data Validation (RADV) Audits conducted by CMS
Annually, CMS selects (both random and targeted) Medicare Advantage (MA) Organizations for a data validation audit. CMS utilizes medical records to validate the accuracy of risk adjustment diagnoses submitted by MA organizations. The medical record review process includes confirming that appropriate diagnosis codes and level of specificity were used, verifying the date of service is within the data

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collection period, and ensuring the Provider’s signature and credentials are present. If CMS identifies discrepancies and/or confirms there is not adequate documentation to support a reported diagnosis in the medical record during the data validation process, financial adjustments will be imposed.

Medical Record Documentation Tips for meeting CMS requirements for submission of encounter data and RADV audits:

Progress Note Requirements:
- Progress notes must contain patient name and DOS on each page.
- If the progress note is more than one page or two-sided, the pages must be numbered, (i.e., 1 of 2). If pages are not numbered, then the Provider must sign each page of the progress note.
- Progress notes should follow the standard S.O.A.P. format.

Provider Signature Requirements on Progress Note:
- All progress notes must be signed by the Provider rendering services.
- Provider credentials must either be pre-printed on the progress notes as a stationary or the Provider must sign all progress notes with his/her credentials as part of the signature.
- Dictated notes and consults must be signed by the Provider.
- Provider signature must be legible, i.e., “John Smith Doe, M.D.” or “JSD, MD”. If a Provider’s signature is missing or illegible, an attestation must be completed by the Physician or Physician Extender.

Provider Signature Requirements on Progress Note (cont’d):
- Stamped signatures are no longer acceptable for Provider documents as of April 28, 2008, as stated by CMS (Medicare Program Integrity Manual, Transmittal 248, Change Request 5971.5550). For risk adjustment purposes (Part C), signature stamps will no longer be acceptable on medical records with dates of service on or after January 1, 2009.
- Electronic Medical Record (EMR) progress notes must have the following wording as part of the signature line: “Electronically signed”, “Authenticated by”, “Signed by”, “Validated by”, “Approved by”, or “Sealed by”. The signed EMR record must be closed to all changes.
- Sign off on medical records should be completed timely.
- Medical records must be signed by a Medical Doctor, (MD), Physicians Assistant (PA), Nurse Practitioner (NP), or Doctor of Osteopathic Medicine (DO).

Diagnosis Documentation Requirements on Progress Note:
- Documentation should include evaluation of each diagnosis on the progress note, not just the listing of chronic conditions, i.e., DM w/Neuropathy – meds adjusted, CHF-compensated COPD – test ordered, HTN – uncontrolled, Hyperlipidemia – stable on meds. CMS considers diagnoses listed on the progress note without an evaluation or assessment as a “problem list”, which is not acceptable for risk adjustment submission.
- Use the words “history of” cancer, stroke, etc., to indicate the condition is no longer a current health concern. Avoid using “history of” for conditions the Member still has or for which they are being treated. For example, indicating a history of diabetes is not correct. While the Member has diabetes in his history, it is still a current condition.
- Each progress note must be able to “stand alone”. Do not refer to diagnoses from a preceding progress note, problem list, etc.
- Avoid documentation of diagnosis as probable, suspected, questionable, rule out, or working, rather, document or code to the highest degree certainty known for that encounter/visit, such as symptoms, signs, abnormal test results, or other reason for the visit.

Releasing Medical Records
BlueCross has the right to request medical records without charge to ensure appropriate coding and/or identify additional diagnosis for risk adjustment data submission to CMS – refer to your Medicare Advantage Provider Agreement (Section C.7) and/or the Model Terms and Conditions of Payment (Section 6). Providers may receive requests from the Risk Adjustment

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Department for medical records with specific dates of service for review. Beginning April 2016, BlueCross will use ArroHealth to request and collect medical records. Medical records can be mailed, faxed, e-mailed, or collected on site from the Provider's office.

Mail to: ArroHealth
49 Wireless Blvd. Ste 140
Hauppauge, NY 11788
Attn: MMR3 Unit - BlueCross BlueShield of Tennessee

Fax to: 1-866-790-4192

e-Mail to: auditing@arrohealth.com

Questions may be addressed to ArroHealth at 1-855-651-1885, or call your BlueCross Provider Relations Consultant (see Section II. BlueCross BlueShield of Tennessee Quick Reference Guide of this Manual for contact phone numbers).

Confidentiality and General Consent
Confidentiality of patient information is important to BlueCross. Any information disclosed by you in response to medical record requests for risk adjustment will be treated in accordance with applicable privacy laws. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 C.F.R. § 164.502, you are permitted to disclose the requested data for purpose of treatment, payment and health care operations after you have obtained the “general consent” of the patient. A general consent form should be an integral part of your patient’s medical records file.

A sample copy of the Risk Adjustment Medical Record Request letter follows:
DEAR HEALTH CARE PROVIDER OR OFFICE ADMINISTRATOR:

As a Medicare Advantage (MA) organization, BlueCross BlueShield of Tennessee is required to submit risk adjustment data to the Centers for Medicare & Medicaid Services (CMS). We are beginning our annual Medicare risk adjustment medical records data review to ensure we submit complete risk adjustment data to CMS. We need your help to collect this data. This is a medical record review and not a claims payment audit.

ArroHealth (formerly known as MedSave USA) will contact you about data collection

We are working with ArroHealth on this initiative. In the past, you may have worked with Verisk Health or MedSave USA for data collection. MedSave USA is now ArroHealth. The services performed by Verisk Health transitioned to ArroHealth. BlueCross is a Medicare Advantage organization, so you do not need patient authorization to provide medical records for this review.

We ask you provide a complete copy of the medical records for Medicare Advantage plan patients on the enclosed list for dates of service from Jan. 1, 2015 to present.

You can provide the medical records to ArroHealth by:

- Securely faxing to 1-866-790-4192
- Calling 1-855-651-1885 to have a scanner technician visit your office
- Securely Emailing to auditing@arrohealth.com
- Mailing the records directly to ArroHealth (please mark the envelope “Confidential”):
  ArroHealth
  Attn: MRR3 Unit – BlueCross BlueShield of Tennessee
  49 Wireless Blvd Suite 140
  Hauppauge, NY 11788

ArroHealth is happy to work with your copy partner to acquire medical records. However, your BlueCross provider contract stipulates the release of medical records without charge.

Our agreement with ArroHealth complies with HIPAA privacy regulations

ArroHealth works with us in a role that is defined and covered by the Health Insurance Portability and Accountability Act (HIPAA). As a business associate of BlueCross under HIPAA, ArroHealth is authorized to conduct this review. ArroHealth will maintain the confidentiality of any protected health information (PHI) they receive on our behalf.

Please respond within 14 days of receiving this request

We appreciate your assistance with this data collection. If you have questions, please call ArroHealth at 1-855-651-1885, Monday through Friday, from 8:30 a.m. to 5:30 p.m. ET. If you still have questions, please contact your BlueCross Provider Relations Consultant.

Sincerely,

J. Todd Ray
VP & GM Senior Products
BlueCross BlueShield of Tennessee
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For additional information regarding risk adjustment, visit:


**Provider Assessment Forms**

In 2017 Physicians will again be eligible to receive payments for completing and submitting a Provider Assessment Form (PAF) for their attributed BlueAdvantage and BlueChoice Members. A paper version of this form is available and an electronic one is located in the Quality Care Rewards web tool located on BlueAccess℠.

BlueCross will reimburse the service as E/M Code 99420 and the reimbursement will be tiered with the highest earning potential in the first quarter and descending reimbursement in each quarter thereafter. Reimbursement is limited to one PAF per Calendar Year per Member. If multiple Providers bill a PAF for the same Member in a Calendar Year, only the first claim will be considered for payment. Subsequent claim submissions will be disallowed.

The PAF incentive schedule is located on the Financial Summary landing page in the Quality Care Rewards web tool located in BlueAccessSM and on the Quality Care Rewards website at http://www.bcbs.com/providers/quality-initiative/Provider-Assessment-Form-Resources.page.

To receive reimbursement, you must complete the form in its entirety and submit electronically at https://www.bcbs.com/ibi_apps/bip/portal/Provider%20Quality or complete the writable pdf found at http://www.bcbs.com/providers/quality-initiatives/Provider-Assessment-Form-Resources.page. It should also be included in your patient’s chart as part of his or her permanent record.

**Chronic Kidney Disease (CKD) and End Stage Renal Disease (ESRD) Patient Registration Form**

In 2016 Physicians have access to a new case management program. This program is designed to identify when Members are in Stage 4 or Stage 5 of CKD.

Early detection of CKD and proper management to prevent or slow the progression of the disease improves the overall health and clinical outcomes of seniors while reducing health care costs. The case management program offers education and support for Members identified with CKD and End Stage Renal Disease (ESRD). It provides Members with tools and support to promote knowledge and self-management of their CKD along with other chronic conditions to resolve barriers to care.


Ensure that you have submitted the CMS-2728-U3 form into the CROWNWeb Data Management system and mail a hard copy of the form to the Social Security Administration.

Forms must be submitted within forty-five (45) days for:

- All patients who initially receive a kidney transplant instead of a course of dialysis
- Patients for whom a regular course of dialysis has been prescribed because they have reached that stage of renal impairment that a kidney transplant or regular course of dialysis is necessary to maintain life.
- Beneficiaries who have already been entitled to ESRD Medicare benefits and those benefits were terminated because their coverage stopped 3 years post-transplant but now are again applying for Medicare ESRD benefits because they returned to dialysis or received another kidney transplant.
- Beneficiaries who stopped dialysis for more than 12 months and have had their Medicare ESRD benefits terminated and now returned to dialysis or received a kidney transplant.
• A patient that has received a transplant or trained for self-care dialysis within the first 3 months of the first date of dialysis and initial form was submitted.

Please note: You must complete all the mandatory fields for your form to be considered “Complete.” Failure to do so will result in an “Incomplete” form. If your form is “Incomplete,” we will contact you to gather any missing information.

E. Claims Information

Effective July 1, 2013, all network providers are required to submit claims electronically rather than by paper format. Submitting claims electronically will ensure compliance with the terms of the Minimum Practitioner Network Participation Criteria as well as lower costs and streamline adjudication. This effort is consistent with the health care industry’s movement toward more standardized and efficient electronic processes.

Key advantages to submitting electronically are:

• Earlier payments;
• More secure submission process
• Reduced administrative costs; and
• Less paper storage.

More information regarding submitting electronic claims can be found on the company website at http://www.bcbst.com/providers/ebusiness/electronic-claims-electronic-funds-transfer.page. For assistance with BlueAccess, please contact eBusiness Service at 423-535-5717, Option 2, Monday through Thursday, 8 a.m. to 6 p.m., Friday 9 a.m. to 6 p.m. (ET), or via e-mail at eBusiness_Service@bcbst.com.

Tennessee Providers should submit claims on a CMS-1500 or CMS-1450 (UB-04) claim form for all BlueAdvantage and BlueChoice Members directly to BlueCross BlueShield of Tennessee, using their National Provider Identifier (NPI) number.

• If a Provider currently submits claims electronically to BlueCross, the Provider may submit BlueAdvantage and BlueChoice claims using the same process.

• PPO paper claims may be mailed to:

  BlueCross BlueShield of Tennessee
  Attn: BlueAdvantage
  1 Cameron Hill Cr, Ste 0002
  Chattanooga, TN 37402-0002

• HMO paper claims may be mailed to:

  BlueChoice TN HMO Operations
  1 Cameron Hill Cr, Ste 0002
  Chattanooga, TN 37402-0002

Providers outside of Tennessee should file claims to their local Blue Plan in their normal manner.

Note: Claims for all BlueAdvantage and BlueChoice products should be filed using the same Centers for Medicare & Medicaid Services (CMS) billing guidelines, forms and codes as Original Medicare.
F. Electronic Funds Transfer (EFT)

Beginning January 1, 2015, BlueCross began executing the July 2013 electronic claims filing requirement pursuant to the BlueCross BlueShield of Tennessee Minimum Practitioner Network Participation Criteria, which requires all network Providers to enroll in the Electronic Funds Transfer (EFT) process. EFT is a free service that sends payments directly to the Provider’s financial institution and increases the speed at which they receive payment.

- Key advantages to receiving payments electronically are:
  - Earlier payments;
  - More secure payment process;
  - Reduced administrative costs; and
  - Less paper storage.

BlueCross accepts electronic funds transfer (EFT) enrollment through CAQH Solutions, who offers a universal enrollment tool for providers that provides a single point of entry for adopting EFT and Electronic Remittance Advice (ERA). The CAQH process facilitates compliance with the 2014 EFT/ERA Administrative Simplification mandate under the Affordable Care Act, eliminates administrative redundancies and creates significant time and cost savings. Enrollment information is available on the CAQH Solutions website at https://solutions.caqh.org.

To view/print a copy of your remittance advices, ensure you have access to BlueAccess, BlueCross’s secure area on its website, www.bcbst.com. To register, just click on the “Register Now” link located in the BlueAccess section on the website and follow the simple instructions to obtain a user ID and password.

For more information regarding the EFT Program Process, or for assistance with BlueAccess, please call eBusiness Service at 423-535-5717, Option 2, Monday through Thursday, 8 a.m. to 6 p.m., Friday 9 a.m. to 6 p.m. (ET), or e-mail eBusiness_Service@bcbst.com.

EnrollHub™ is the new name for the CAQH EFT and ERA enrollment tool.
Phone: 1-844-815-9763 available Monday through Thursday 7 a.m. to 9 p.m. (ET)
Friday 7 a.m. to 7 p.m. (ET)
e-mail: eftenrollhub@caqh.org
Website: http://www.caqh.org/eft_enrollment.php

CAQH ProView™ is now the provider data collection tool formerly the Universal Provider Datasource®.
Phone: 1-844-259-5347 available Monday through Thursday 7 a.m. to 9 p.m. (ET)
Friday 7 a.m. to 7 p.m. (ET)
e-mail: proview@caqh.org
Website: https://proview.caqh.org

Note: Vendor and BlueCross shall be bound by the National Automated Clearing House Association rules relating to corporate trade payment entries (the "Rules") in the administration of these ACH Credits.

G. CMS Star Ratings

The Centers for Medicare & Medicaid Services (CMS) uses a five-star quality rating system to measure Medicare beneficiaries’ experience with their health plans and the health care system. This rating system applies to all Medicare Advantage (MA) lines of business: Health Maintenance Organization (HMO), Preferred Provider Organization (PPO). It also applies to Medicare Advantage plans that cover both health services and prescription drugs (MA-PD).
The program is a key component in financing health care benefits for MA and MA-PD plan enrollees. In addition, the ratings are posted on the CMS consumer website, www.medicare.gov, to give beneficiaries help in choosing among the MA and MA-PD plans offered in their area.

Physicians should understand the metrics included in the CMS rating system as some of them are part of BlueCross BlueShield of Tennessee Physician Quality program, in which you may be eligible to participate. This program is designed to promote improvement in quality and recognize primary care Providers for demonstrating an increase in performance measures over a defined period of time.

**CMS Goals for the Five-star Rating System**

- Implement provisions of the Affordable Care Act
- Clarify program requirements
- Strengthen beneficiary protections
- Strengthen CMS’ ability to distinguish stronger health plans for participation in Medicare Parts C and D and to remove consistently poor performers

**How Are Star Ratings Derived?**

A health plan’s rating is based on measures in five categories:

- Staying healthy, screenings, tests and vaccines
- Managing chronic (long-term) conditions
- Member experience with the health plan
- Member complaints, problems getting services and improvement in the health plan’s performance
- Health plan customer service

A Medicare drug plan’s rating is based on measures in four categories:

- Drug plan customer service
- Member complaints, problems getting services and improvement in the health plan’s services
- Member experience with the drug plan
- Patient safety and accuracy of drug pricing

Measures in both of these categories are used to rate MA health plans. Annually, CMS sets the thresholds for each measure.

**Benefits to Providers**

- Improved patient relations
- Improved health plan relations
- Increased awareness of patient safety issues
- Greater focus on preventive medicine and early disease detection
- Strong benefits to support chronic condition management

**Benefits to Members**

- Improved relations with their doctors
- Greater health plan focus on access to care
- Increased levels of customer satisfaction
- Greater focus on preventive services for peace of mind, early detection and health care that matches their individual needs

**BlueCross BlueShield of Tennessee’s Commitment**

BlueCross is strongly committed to providing high-quality Medicare health plans that meet or exceed all CMS quality benchmarks. The structure and operations of the CMS star rating system ensures that funding is used to protect or, in some cases, to increase benefits and to keep member premiums low.

BlueCross encourages Members to become engaged in their preventive and chronic-care management through outreach, screening opportunities, and Member rewards.
Tips for Providers

- Encourage patients to obtain preventive screenings annually or when recommended by the U.S. Preventive Services Task Force (USPSTF).
- Create office practices to identify and intervene with noncompliant patients at the time of their appointment.
- Submit complete and correct encounters/claims with appropriate codes via our Provider Quality Care Rewards web tool located in BlueAccess.
- Submit clinical data such as lab results to BlueCross.
- Communicate clearly and thoroughly; ask, "Do you have any questions?"
- Understand each measure you impact.
- Incorporate Health Outcomes Survey (HOS) questions into each visit. Find out more about HOS at http://www.hosonline.org/Content/SurveyInstruments.aspx.
- BlueCross will make the data available to you of services each patient has not yet received via the Provider Quality Care Rewards web tool located in BlueAccess. Review this information and the patient’s medical record to determine if the services have been completed or scheduled.
- If a service is not completed, flag or contact the Member to schedule the service.
- If a service is completed, submit an electronic attestation via the Provider Quality Care Rewards web tool in BlueAccess; or complete, sign and return the Paper Attestation Form to BlueCross with information and/or any exclusion(s).

Questions?
For Program-Related Support
Contact a member of our Provider Quality Team or your Provider Relations Consultant (see Section II. BlueCross BlueShield of Tennessee Quick Reference Guide in this Manual for appropriate phone numbers).

Online Resources
www.bcbst.com/providers/quality-initiatives.page

For Technical Support with BlueAccess
Contact our eBusiness team at (423) 535-5717, Option 2 or at ebusiness_services@bcbst.com

Helpful Websites
To learn more about the CMS quality rating measures, visit:

http://www.cms.gov
http://www.hosonline.org

H. Health Management

1. Case Management

The Case Management Program is managed by the Case Management Department, which provides the following services:

- Population Health Management – Chronic Care Improvement Program (CCIP)
- Discharge Care Coordination
- Care Coordination
- Complex Case Management
- Transplant Case Management
Referrals and Triage
Members, family and/or caregivers, Practitioners and Providers are encouraged to initiate referrals for any of the above listed programs. A Case Management team member, such as a registered nurse or social worker will contact the designated person upon receipt of the program referral.

Population Health Management Program
Population Health Management is designed to provide education, resources, and support to Members with chronic conditions.

The chronic conditions being managed within this program (subject to change based on analysis of “at risk” Members) are:

- Diabetes
- Congestive heart failure
- Coronary artery disease
- Chronic obstructive pulmonary disease, and
- Chronic kidney disease
- Depression

The primary goal of the Population Health Management Program is to stabilize the Member’s health condition and assist them with tools, education and care necessary for self-management. The program promotes the Member and caregiver’s active participation in management of their chronic condition resulting in an increased knowledge of the disease process, prevention and treatment.

Additionally, the Member increases his/her knowledge of healthy lifestyle changes and co-morbid management. The treating Physician’s involvement is an integral part of the program and development of an individualized plan of care and desired outcomes. The program supports the Physician by reinforcing education, monitoring and reporting. Providers identifying Members with these diagnoses are requested to contact Care Management for referral into the program.

Discharge Care Coordination
The Discharge Care Coordination Program is a post hospital discharge program. Registered nurses call Members dismissed from acute care or post-acute care facilities within 48-72 hours after discharge.

Members are called to verify:

- Understanding of discharge instructions
- Appointments have been made with the Member’s Physician for post discharge follow-up
- Transportation is available in order to get to the appointment.
- Post discharge medications have been obtained and the Member understands their prescriptions; what the medication is for, and whether or not to continue previous prescribed medications
- Understanding of dietary instructions and needs
- Available food on hand in order to meet dietary needs
- Caregiver availability
- Safety concerns or needs

If needed, an additional call will be made within one week

Care Coordination
Care Coordination services involve the full spectrum of care coordination. Care Coordination is intended to stabilize Members’ health condition/disease, promote self-management by providing tools and education to allow them to make informed decisions about their health care, encourage and provide tools for active participation in managing their condition(s), and assist with arranging for care in the most appropriate setting and care that is necessary for self-management. Providers are encouraged to make referrals to the program.
The Care Coordination team helps to identify the Member’s needs, assist them to find solutions to those needs, and to reduce barriers to health care. Care Coordination interventions can improve quality of life, make effective use of available health care and community-based resources, and improve health outcomes.

**Complex Case Management**
Case management is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet a Member’s health needs through communication and available resources to promote quality cost-effective outcomes.

Members with complex health care needs, unstable multi-disease states, and conditions where a longer period of management will be required are managed through Complex Case Management. Complex and catastrophic conditions such as multiple chronic conditions, trauma, End Stage Renal Disease, AIDS, extensive burns, Guillain-Barre’ syndrome, frequent emergency department utilization, and frequent inpatient admissions are intensively managed by continually assessing, planning, coordinating, implementing and evaluating care. By using this approach, multiple health and psychosocial needs of the Member are met.

The Case Management team works with the Member, treating Practitioners, family members, and other members of the health care team to coordinate and facilitate an individualized plan of treatment, evaluate the Member’s progress and facilitate referrals to a less intensive health management program.

**Transplant Case Management**
Transplant Management focuses on the entire spectrum of transplant care. The care of the Member is managed from the time the possibility of a transplant need is identified and can continue up to twelve (12) months post-transplant based on the Member’s status. Transplants must be performed in a Medicare approved facility. Attention is given to assisting and educating the Members about acquisition and use of needed drugs prescribed by their Physician, with special emphasis on the Part B benefit for anti-rejection drugs.

It is critically important, to both the Practitioner and Member, that Care Management be contacted as soon as the provider identifies the Member may need an evaluation for transplant.

**Contact/Referrals to Above Health Management Programs Information**

Practitioners/Providers are encouraged to initiate referrals for any of the health management programs by contacting BlueAdvantage or BlueChoice Health Management.

Phone: 1-800-611-3489
Fax: 1-800-727-0841

**Referral requests should include the following information:**
- Requesting Provider’s name and telephone number;
- Contact person and telephone number (if different from Requesting Provider);
- Member name;
- Member ID number and telephone number;
- Diagnosis and current clinical information;
- Current treatment setting (e.g., hospital, home health, rehabilitation, etc.);
- Reason for referral; and
- Level of urgency.

A Case Manager will contact the requesting Provider upon receipt of the program referral.
2. Care Management

BlueAdvantage and BlueChoice Health Management programs adhere to CMS’ Medicare Advantage rules and regulations promulgated in 42 CFR § 422 and CMS’ *Internet Only Medicare Managed Care Manual*. CMS’ requirements for Medicare Advantage vary from the requirements for Original Medicare. Chapter 13 of the *Medicare Managed Care Manual* is a significant resource utilized to implement our Care Management programs.

Care management includes services that require prior authorization, services that require notification, advance determinations and retrospective review that may be requested by a Member, Practitioner or Provider. CMS’ Medicare Advantage reconsideration process is available in cases of dissatisfaction with the review decision. Provider reimbursement appeals are handled through the CMS mandated Provider Payment Dispute Process. Additional Provider appeals are handled through the BlueCross BlueShield of Tennessee Provider Dispute Resolution Procedure. (Refer to Section XIII. in this Manual for more information about these processes).

These utilization management strategies are additional effective mechanisms for identifying Members who may benefit from Health Management programs outlined above.

Criteria Hierarchy

Medical Necessity is described in CMS’ hierarchy for determining Medical Necessity prospectively or retrospectively. Medical Necessity reviews are performed without regard to age, gender, creed, religion or race/nationality.

The hierarchy of decision is that the service must:
- be a benefit;
- not be excluded; and
- be appropriate and Medically Necessary.

The hierarchy of references includes:
1. The law (Title 18 of the SSA);
2. The Regulations (Title 42 Code of Federal Regulations (CFR) parts 422 and 476);
4. MA Benefit Policy Manual (IOM 100-02);
6. Coverage guidelines in Interpretive Manuals (Internet Only Manual (IOM), sub manuals Pub 100-04 Claims Processing, Pub 100-08 Program Integrity Manual, Pub 100-10 QIO manual, Pub 100-16 Medicare Managed Care Manual; and

Program Safeguard Contractor (PSC) local coverage determinations;
8. MCG criteria;
10. BlueCross Medical Policy; and
11. Other major payer policy and peer reviewed literature.

a. Advance Determination

A Member or Provider has the opportunity to seek a determination of coverage before receiving or providing services by requesting an Advance Determination. Providers can obtain an Advance Determination for select services from BlueCross for BlueAdvantage and BlueChoice Members. Advance Determinations are performed to render coverage, Medical Necessity and Appropriateness determinations before services are rendered rather than during claims processing. However, claims submitted for services that were not reviewed prospectively will be reviewed retrospectively for Medical Appropriateness to determine coverage and reimbursement.

Rev 06/16
Providers can obtain an Advance Determination by phone, fax, or online (see “Contact Information” at end of this section).

A reference number is issued when care and treatment are determined to be Medically Necessary and Medically Appropriate. Advance Determinations are also made available to Members when the service does not require a prior authorization.

b. Prior Authorization
Prior authorization is **required** before services are provided to BlueAdvantage PPO and BlueChoice HMO Members.

Prior authorization for coverage and Medical Necessity is required for:
- All acute care facility, skilled nursing facility, rehabilitation, and long-term acute care
- Behavioral health facility inpatient stays, partial hospitalization, psychiatric residential, electroconvulsive treatment, and transcranial magnetic stimulation
- Certain Part B Pharmacy Medications
- Chiropractic manipulation
- Durable medical equipment for purchase greater than $500
- Oxygen equipment
- Durable medical equipment that is mandated as a rental by CMS
- Orthotics and prosthetics greater than $200
- Speech therapy, occupational therapy and physical therapy (after the initial evaluation)
- Home Health Service to include all therapies, nursing visits, and psychiatric visits
  (Note: authorization is **not** required for supplies, nurses’ aides, or social worker visits.)
- Advanced Imaging

An authorization number is issued when care and treatment are determined to be Medically Necessary and Medically Appropriate. A case reference number is issued regardless of the decision (either approved or denied) and Providers will be notified via letter of the determination.

**Note:** BlueChoice HMO Members must use plan Providers except in emergency or urgent care situations or for out-of-area renal dialysis. Members who obtain routine care from out-of-network Providers will be responsible for the cost of the care. In order to receive care for services not available in the BlueChoice HMO network, a BlueCross Out-of-Network form must be completed. This form can be found on the company website at [http://www.bcbst.com/providers/forms/OON_provider_election_form.pdf](http://www.bcbst.com/providers/forms/OON_provider_election_form.pdf).

c. Inpatient DRG Day Outlier Management Program
Consistent with the criteria in MCG, BlueCross will reimburse acute inpatient hospitalization days outside of the initial DRG initial day approval as follows:

- MCG will be used relative to the concurrent information provided from the acute care facility to determine if the care and services provided are consistent with acute inpatient service provision. This review is performed by a Plan Medical Director. If criteria are not met, then the hospital day may be denied for benefit coverage as not meeting acute inpatient level of care criteria per MCG. This review will occur during the time period after which the DRG days have elapsed, and are subject to the facility providing concurrent clinical information for review as contractually required.

- If clinical information is requested three (3) times using at least two (2) different notification methods, then the days will be denied for a lack of clinical information necessary to establish Medical Necessity. In situations with a lack of clinical information, these denied days will not be eligible for reconsideration review and the facility will have to follow standard facility appeal remedies.

**Note:** The Member cannot be held liable for payment of services received when not authorized.
Readmission Reimbursement

Submitting a corrected bill or combining the services from the readmission with those of the initial admission will result in all services on the claim being disallowed. Also, billing with a “leave of absence” revenue code (018X) for the interval period and combining all the dates of service in a single claim will lead to a disallowed claim. Similarly, submitting a corrected bill or other alternate outpatient resubmission for these services is not appropriate, and services will be disallowed.

Readmission Quality Program

31-Day Similar-Cause Readmission Quality Program

Consistent with the Centers for Medicare & Medicaid Services (CMS) Readmissions Reduction Program, BlueCross will reimburse for a thirty-one (31) day readmission from an index admission as follows:

- For purposes of this program, a readmission is defined as an unplanned acute inpatient admission to the same or similar facility, or facility operating under the same contract, occurring within three (3) and thirty-one (31) days after a discharge from an acute care hospital (index admission) discharge for a complication of the original hospital stay or admission resulting from a modifiable cause relating to the index admission discharge diagnosis, as determined by a Plan Medical Director.

- In this readmission scenario, the facility will be reimbursed only for a single inpatient DRG (the higher weighted of the two (2) admissions) and all other days will be reimbursed under DRG outlier methodology and subject to concurrent inpatient medical review for Medical Necessity.

- Readmissions that occur in an observational (outpatient) setting, are exempt from this program and are reimbursed as per the facility agreement.

- If there is a second (2nd) readmission that occurs, still within thirty-one (31) days from the index admission discharge, then this will likewise bundle into the original admission, if the above parameters are met.

- Standard facility appeal remedies are still applicable.

Note: The Member cannot be held liable for payment of services received when not authorized.

48 Hour Similar-Cause Readmission Quality Program

Consistent with the Centers for Medicare & Medicaid Services (CMS) Readmissions Reduction Program, BlueCross will reimburse for a forty-eight (48) hour readmission from an index admission as follows:

- For purposes of this program, a readmission is defined as an unplanned acute inpatient admission to the same or similar facility, or facility operating under the same contract, occurring within forty-eight (48) hours after a discharge from an acute care hospital (index admission) discharge for a complication of the original hospital stay or admission resulting from a modifiable cause relating to the index admission discharge diagnosis, as determined by a Plan Medical Director.

- In this readmission scenario, the facility will not be reimbursed for the readmission regardless of the readmission length of stay. This penalty is due to the fact that CMS considers a short-term readmission for the same or similar diagnosis to generally be due to a process failure in discharge planning or due to the Member not being clinically stable for discharge at the time of the original discharge.
• Readmissions that occur in an observational (outpatient) setting, are exempt from this program and are reimbursed as per the facility agreement.

• Standard facility appeal remedies are still applicable.

Note: The Member cannot be held liable for payment of services received when not authorized.

d. Contact Method According to Type of Service

The following grid is intended to assist Providers in determining the appropriate contact method according to type of service requested:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Submit via:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Rehabilitation</td>
<td>BlueCross BlueShield of Tennessee Fax Only 1-888-535-5243</td>
</tr>
<tr>
<td>Long Term Acute Care</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facilities</td>
<td></td>
</tr>
<tr>
<td>(See Section VIII in this Manual for details)</td>
<td></td>
</tr>
<tr>
<td>Outpatient Therapies - Speech</td>
<td>BlueCross BlueShield of Tennessee Fax 1-888-535-5243</td>
</tr>
<tr>
<td>(See Section VIII in this Manual for details)</td>
<td></td>
</tr>
<tr>
<td>Outpatient Therapies - Musculoskeletal Procedures, eff. 3/1/2012 - (See Section VIII in this Manual for details)</td>
<td>Musculoskeletal Program Vendor Fax 1-866-747-0587</td>
</tr>
<tr>
<td>Inpatient (Medical)</td>
<td>BlueCross BlueShield of Tennessee Fax 1-888-535-5243</td>
</tr>
<tr>
<td>Part B Pharmacy Medications</td>
<td></td>
</tr>
<tr>
<td>Observations Conversions</td>
<td></td>
</tr>
<tr>
<td>Home Health Services (excluding Home Infusion Therapy)</td>
<td></td>
</tr>
<tr>
<td>(See Section VIII in this Manual for details)</td>
<td></td>
</tr>
<tr>
<td>Advanced Imaging</td>
<td>Advanced Imaging Vendor Fax 1-888-693-3210</td>
</tr>
<tr>
<td>(See Section VIII in this Manual for details)</td>
<td>eHealth Web submission</td>
</tr>
<tr>
<td>Behavioral Health Services</td>
<td>BlueCross BlueShield of Tennessee Fax 1-888-535-5243</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td></td>
</tr>
<tr>
<td>Orthotic/Prosthetic (O &amp; P)</td>
<td></td>
</tr>
</tbody>
</table>

e. Compliance with Prior Authorization Requirements

Prior authorization reviews can be initiated by the Member, designated Member advocate, Practitioner, or facility. However, it is ultimately the facility and Practitioner’s responsibility to contact BlueCross to request an authorization and to provide the clinical and demographic information that is required to complete the authorization. Scheduled admissions/services must be authorized up to twenty-four (24) hours prior to admission. Notification of emergency admissions (unplanned) is required within twenty-four (24) hours or next business day after services have started.

Behavioral health utilization review services are available 24-hours-a-day, 7-days-a-week. Prior authorization for all behavioral health services is required prior to admission.

When a request for an authorization of a procedure, an admission/service or a concurrent review of the days is denied, the penalty for not meeting authorization guidelines will apply to both the facility and the Practitioner rendering the care for the day(s) or service(s) that have been denied. BlueCross’s non-payment is applicable to both the facility and Practitioner rendering the care. The Member is held harmless if the Member is eligible at the time services are rendered and the Covered Services are received from a network Provider.
f. Non-Compliance with Prior Authorization Requirements

Services provided without obtaining approval are considered “non-compliant” when prior authorization is required. Provider must obtain authorization prior to scheduled services. Non-compliance applies to initial as well as concurrent review for ongoing services beyond dates previously approved. Failure to comply within specified authorization timeframes will result in a contractual denial or reduced benefits due to non-compliance. BlueCross Providers cannot bill Members for Covered Services denied due to non-compliance by the Provider.

If a Member does not inform the Provider that he/she has BlueCross coverage and the Provider discovers that the Member does have BlueCross coverage, the Provider should send a copy of the medical record relevant to the admission or services, along with the face sheet, to the Care Management Appeals Department. An appeal will only be overturned if Medical Necessity is determined and there is clear evidence that the facility was not aware that the Member had BlueCross coverage at the time services were rendered.

g. Mandated Notices

I. Important Message from Medicare (IM): Any facility providing care at an inpatient hospital level is responsible for delivering advance written notice of a Member’s rights as a hospital inpatient including discharge appeal rights to the Member or the authorized Member representative in accordance with applicable CMS regulations. CMS requires the Important Message from Medicare (IM) be distributed no later than two (2) calendar days following the Member’s admission to the hospital and follow-up notice as far in advance of discharge as possible, but no more than two (2) calendar days before discharge unless the notice is delivered within two (2) calendar days of discharge.

II. Detailed Notice of Discharge (DN): CMS requires a Detailed Notice of Discharge (DN) be distributed to a Member or authorized representative requesting an appeal of discharge from an inpatient facility or when BlueCross no longer intends to continue coverage of an authorized inpatient admission. BlueCross delegates to Providers the responsibility for developing and delivering the DN for Provider discharge determinations and for delivery of DN for BlueCross discharge determinations. CMS requires the DN to be delivered as soon as possible, but no later than noon of the day after the QIO’s notification or BlueCross’s request for delivery. Providers are required to fax a signed copy of the DN to BlueCross UM Department at 1-888-535-5243 or 1-423-535-5243. Providers must be able to demonstrate compliance with the delivery of the DN in accordance with applicable CMS regulations.

III. Notice of Medicare Non-Coverage (NOMNC): Home Health Agencies (HHA), Skilled Nursing Facilities (SNF), and Comprehensive Outpatient Rehabilitation Facilities (CORF) are responsible for delivering Notices of Non-Coverage (NOMNC) to the Member or the authorized Member representative in accordance with applicable CMS regulations. CMS requires the NOMNC be delivered at least two (2) days prior to the Member’s HHA, SNF, or CORF authorized services ending. Days will not be extended due to untimely delivery of the NOMNC by the facility. If the Member’s services are expected to be fewer than two (2) days in duration, the HHA, SNF, or CORF must provide the NOMNC to the Member at the time of admission to the Provider. The NOMNC must be faxed to BlueAdvantage no later than noon the day following receipt of the NOMNC. A model NOMNC form can be found on our website at http://www.bcbst.com/providers/medicare-advantage/forms.shtml. Providers are required to fax a signed copy of the NOMNC to BlueCross BlueShield of Tennessee Care Management Department at 1-888-535-5243 or 1-423-535-5243.

IV. Detailed Explanation of Non-Coverage (DENC): CMS requires a Detailed Explanation of Non-Coverage (DENC) be distributed to a Member or authorized representative requesting an appeal of discharge from a SNF, HHA, or CORF or when BlueCross no longer intends to continue coverage. BlueCross delegates to Providers the responsibility for developing and delivering the DENC for Provider discharge determinations and for delivery of the DENC for BlueCross discharge determinations. CMS requires the DENC to be delivered as soon as possible,
but no later than close of business the day of the QIO’s notification or BlueCross’s request for delivery. Providers are required to fax a signed copy of the DENC to BlueCross BlueShield of Tennessee Care Management Department at 1-888-535-5243 or 1-423-535-5243. Providers must be able to demonstrate compliance with the delivery of the DENC in accordance with the applicable CMS regulations. Providers are required to inform BlueCross Members that a request for denial notice must be submitted to BlueCross by the Member, in the event that the Member believes that he/she is being denied service.

h. Retrospective Claims and Clinical Record Review

Retrospective claims reviews are conducted to provide a determination of Medical Necessity, as well as verification of eligibility and benefits. Claims are targeted for review based on National Coverage Determinations, Local Coverage Determinations and BlueCross Medical Policy. Reviews are performed prior to claims payment using CMS’ processing guidelines (i.e. post acute care transfer policy, low utilization payment adjustments, outlier payments, etc.).

Retrospective clinical record reviews may be conducted to meet our CMS contractual requirements. Record review results support CMS and other regulatory agencies audits, applicable accreditation audits, quality improvement activities, Quality Improvement Organization (QIO) and Independent Review Entity (IRE) review processes, and CMS’ risk-adjusted payment processes.

Care Management Contact Information:

Phone: 1-800-836-1660
Fax: 1-800-394-3053 or (423)-591-9499

Mailing Address:

BlueCross BlueShield of Tennessee
Medicare Advantage Care Management Department
1 Cameron Hill Circle, Ste 0005
Chattanooga, TN 37402-0005

i. Acute Care Facility

In order for the services to be covered under BlueAdvantage and BlueChoice, care and treatment must be Medically Necessary and Appropriate in an inpatient setting. Scheduled inpatient stays begin on the morning of a procedure in nearly all instances.

Clinical information needed for processing an advance determination/prior authorization request:

- Procedure/Operation to be performed, if applicable;
- Diagnosis with supporting signs/symptoms;
- Treatment Plan;
- Vital signs and abnormal lab results;
- Elimination status;
- Ambulatory status;
- Hydration status;
- Comorbidities that impact patient’s condition;
- Complications;
- Prognosis or expected length of stay;
- Current medications; and
- Discharge plans*

*Discharge information should be sent daily to BlueCross to help ensure appropriate follow-up and coordination of care for Members. Discharge dates may be entered for all lines of business via BlueAccess, our secure area on the company website www.bcbst.com or faxed to 423-591-9501. Providers may fax one Member listing for all lines of business as long as each Member listed reflects the line of business the Member belongs. Provider cover sheets should include the facility name and NPI number to help ensure appropriate and efficient processing.
j. **Skilled Nursing Facility (SNF)**
In order for SNF services to be covered under BlueAdvantage and BlueChoice, care and treatment must be Medically Necessary and Appropriate in an inpatient setting. Skilled services are services requiring the skills of qualified technical or professional health personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, speech pathologists, and/or audiologists. Skilled services must be provided directly by or under the general supervision of technical or professional health care personnel. SNFs are required to follow CMS guidelines regarding delivery of the Notice of Medicare Non-coverage (NOMNC). SNF days will not be extended due to untimely delivery of the NOMNC to the Member by the facility. The NOMNC must be faxed to BlueCross Medicare Advantage no later than noon the day following receipt of the NOMNC. (See details of Notice of Medicare Non-Coverage (NOMNC) in this Manual.)

To facilitate an advance determination or prior authorization request please use the BlueCross BlueShield of Tennessee Skilled Nursing Fax form located online at [http://www.bcbst.com/providers/medicare-advantage/forms.shtml](http://www.bcbst.com/providers/medicare-advantage/forms.shtml) and fax to 1-888-535-5243. BlueAdvantage and BlueChoice have dedicated RN Care Coordinators available to assist you with necessary services for your BlueAdvantage and BlueChoice patients. Our Health Management team can be contacted at 1-800-924-7141.

Basic information needed for processing an advance determination request:
- Member’s identification number, name, and date of birth;
- Practitioner’s name, provider number, NPI, Medicare number; address, and telephone number;
- Hospital/Facility’s name, provider number and/or NPI, Medicare number, address and telephone number;
- Admission date; and
- Caller’s name.

Clinical information required for review:
- Admitting diagnosis, symptoms, and treatment plan;
- Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care that would influence the Medical Necessity determination;
- A condition requiring skilled nursing services or skilled rehabilitation services on an inpatient basis at least daily;
- A Practitioner’s order for skilled services;
- Ability and willingness to participate in ordered therapy;
  - Medical Necessity for the treatment of illness or injury (this includes the treatment being consistent with the nature and severity of the illness or injury and consistent with accepted standards of medical practice);
  - Expectation for significant reportable improvement within a predictable amount of time; and
- Discharge Plans.

**Evaluation and Plan of Care**
Evaluation of the Member must be submitted including the following as appropriate:
- Primary diagnosis;
- Circulation and sensation;
- Ordering Practitioner and date of last visit;
- Gait analysis;
- Date of diagnosis onset;
- Cooperation and comprehension;
- Baseline status;
- Developmental delays (pediatric patients);
- Prior level of functioning;
- Current functional abilities;
• Functional potential;
• Expected maximum level of functioning;
• Other therapies or treatments;
• Patient's goals;
• Strength;
• Medical compliance;
• Range of motion; and
• Support system/Caregiver.

Plan of care must be submitted including the following as appropriate:
• Short and long-term goals;
• Proposed admission date;
• Discharge goals;
• Frequency of treatment;
• Measurable objectives;
• Specific modalities, therapy, exercise;
• Functional objectives;
• Safety and preventive education;
• Home program; and
• Community resources.

Information for billing Health Insurance Prospective Payment System (HIPPS) Codes
Effective July 1, 2014, the Centers for Medicare & Medicaid Services (CMS) requires Medicare Advantage plans to bill health insurance prospective payment system (HIPPS) codes for all skilled nursing facility (SNF) claims.

Guidance:

• SNF claims received for processing with dates of service July 1, 2014, and after that do not include HIPPS coding with Revenue Code 0022 will be rejected and require re-submission with the appropriate HIPPS code;
• The HIPPS code should be billed indicating a quantity of one (1) $0.00 charge and a date of service equal to the date of the earliest billable service on the claim; and
• The claim’s “From” and “Through” dates should cover the assessment* and services.

*SNFs shall submit a HIPPS code from the admission assessment completed during the covered stay. If an assessment was not completed, refer to the following guidelines:

Stays of more than fourteen (14) days – If the admission assessment was completed prior to the covered portion of the stay, submit a HIPPS code:
• From another assessment completed during the covered portion of the stay;
• From the most recent assessment completed prior to the covered portion of the stay; or
• If no assessment was completed, submit a code from the most recent assessment.

Stays of fourteen (14) days or less – If no admission assessment was completed before discharge for a covered stay, submit a HIPPS code:
• From another assessment from the stay; or
• Use default code “AAA00”

Submit a default code ONLY if:
• Member was discharged prior to the completion of the initial assessment; or
• No other assessment was completed during the covered stay.

For additional HIPPS code information, refer to CMS Memo at http://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Downloads/encounterdatahippsmemo.pdf.
Therapy Services
Therapy services appropriate for skilled nursing facilities include occupational therapy, physical therapy and speech therapy not possible on an outpatient basis. Specific therapy services that may be appropriate for a SNF include, but are not limited to the following:

- Complex wound care requiring hydrotherapy; and
- Gait evaluation and training to restore function in a patient whose ability to walk has been impaired by neurological, muscular or skeletal abnormality.

Nursing Services
Nursing services appropriate for skilled nursing facilities include skilled nursing services not possible on an outpatient basis. Specific nursing services that may be appropriate for a SNF include, but are not limited to the following:

- Intramuscular injections or intravenous injections or infusions;
- Initiation of and training for care of newly placed:
  - Tracheostomy
  - In-dwelling catheter with sterile irrigation and replacement
  - Colostomy
  - Levin tube
  - Gastrostomy tube and feedings;
- Complex wound care involving medication application and sterile technique; and
- Treatment of Grade 3 or higher decubitus ulcers or widespread skin disorder.

Nursing and Therapy Services Not Requiring SNF Placement:
Skilled nursing facility placement is not necessary for the services listed below. This list is not all-inclusive.

- Administration of routine oral, intradermal or transdermal medications, eye drops, and ointments;
- Custodial services, e.g., non-infected postoperative or chronic conditions;
- Activities or programs primarily social or diversional in nature;
- General supervision of exercises in paralyzed extremities, not related to a specific loss of function;
- Routine care of colostomy or ileostomy;
- Routine services to maintain functioning of in-dwelling catheters;
- Routine care of incontinent patients;
- Routine care in connection with braces and similar devices;
- Prophylactic and palliative skin care (i.e., bathing, application of creams, or treatment of minor skin problems);
- Duplicative services - Physical therapy services that are duplicative of occupational Therapy services being provided or vice versa;
- Invasive procedures;
- General supervision of aquatic exercise or water-based ambulation;
- Heat modalities (hot packs, diathermy or ultrasound) for pulmonary conditions or wound treatment, or as a palliative or comfort measure only (whirlpool and hydrocollator);
- Hot and cold packs applied in the absence of associated modalities;
- Diagnostic procedures performed by a Physical Therapist (i.e., nerve conduction studies); or
- Electrical stimulation for strokes when there is no potential for restoration of functional improvement. Nerve supply to the muscle must be intact.

k. Rehabilitation Facility
In order for rehabilitation facility services to be covered under BlueAdvantage and BlueChoice, care and treatment must be Medically Necessary and Appropriate. Inpatient Rehabilitation provides multidisciplinary, structured, intensive therapy for Members both requiring and able to participate in a minimum of three (3) hours of daily rehabilitation therapy services. Rehabilitation goals are to prevent further disability, to maintain existing ability, and to restore maximum levels of functioning within the
limits of the Member’s impairment. Potential inpatient rehabilitation admissions include Members with recent CVA, head trauma, multiple trauma, spinal cord injury or recent amputation.

BlueAdvantage and BlueChoice have dedicated RN Care Coordinators available to assist you with necessary services for your BlueAdvantage and BlueChoice patients. Our Health Management team can be contacted at 1-800-924-7141.

Basic information needed for processing an advance determination or prior authorization request:

- Member’s identification number, name, and date of birth;
- Practitioner’s name, provider number, NPI, Medicare number; address, and telephone number;
- Hospital/Facility’s name, provider number, NPI, Medicare number, address, and telephone number;
- Admission date; and
- Caller’s name.

Clinical Information required for review:

- Admitting diagnosis, symptoms, treatment, frequency of therapies, Member’s ability to participate in treatment;
- Member is ventilator dependent or not; and
- Any additional medical/behavioral health/social service issue information and case management/behavioral health coordination of care that would influence the Medical Necessity determination; and
- Discharge plans.

Evaluation of the Member must be submitted including the following as appropriate:

- Ordering Practitioner and date of last visit;
- Gait analysis;
- Primary diagnosis;
- Circulation and sensation;
- Date of diagnosis onset;
- Cooperation and comprehension;
- Baseline status;
- Prior level of functioning;
- Current functional abilities;
- Functional potential;
- Expected maximum level of functioning;
- Other therapies or treatments;
- Patient’s goals;
- Strength;
- Medical compliance;
- Range of Motion; and
- Support system/Caregiver.

Plan of care must be submitted including the following as appropriate:

- Short and long-term goals;
- Proposed admission date;
- Discharge goals;
- Frequency of treatment;
- Measurable objectives;
- Specific modalities, therapy, exercise;
- Functional objectives;
- Safety and preventive education;
- Home program; and
- Community resources.
I. **Home Health Services and Billing Guidelines**

Home health services are hands-on, skilled care/services, by or under the supervision of a registered nurse that are needed to maintain the Member’s health or to facilitate treatment of the Member’s illness or injury. In order for the services to be covered under BlueAdvantage and BlueChoice, the Member must have a medical condition that makes him/her unable to perform personal care and meet Medical Necessity and Medical Appropriateness criteria. Documentation must support the Member’s limitations, homebound status, and the availability of a caregiver/family and degree of caregiver/families' participation/ability in Member’s care.

Basic information needed for processing an advance determination request:

- Member’s identification number, name, and date of birth;
- Practitioner’s name, provider number, NPI, Medicare number; address, and telephone number;
- Hospital/Facility’s name, provider number, NPI, Medicare number, address, and telephone number;
- Date of service;
- Caller’s name;
- Signed order from the ordering or treating Physician indicating primary reason for home health services; and
- Documentation supporting Certification Medical Necessity (CMN) requirements.

**Clinical information/documentation required for review.**

To help prevent any delay in care for Members needing home health services, on initial home health requests that have an MD order or request to treat and diagnose, a maximum of seven (7) visits over a thirty (30)-day timeframe will be approved as notification. This allows the Provider time to obtain all related clinical and required documentation supporting the CMN. Any request for additional visits extending past this time period will need to have all supporting documentation for Medical Necessity review.

**Note:** Please fax a copy of the Home Health form to BlueAdvantage Care Management at 1-888-535-5243 or (423) 535-5243.

Sample copies of the BlueAdvantage (PPO)™ and BlueChoice (HMO)™ Services Authorization Request fax forms follow:
BlueChoice (HMO)SM Services Authorization Request

Please type/print legibly. Upon completion of this form, please fax to 1-888-535-5243. For a faster response submit online DRG authorization requests via BlueAccessSM at www.bcbs-medicare.com 24-hours-per-day/7-days-per-week.*

Member Name: ____________________________________________
Member Date of Birth: ___________________ Member ID Number: ___________________
Sender Name: ____________________________________________
Sender Phone Number: ___________________ Sender Fax Number: ___________________
Facility Name: ____________________________________________ Facility Tax ID and/or NPI#: ___________________
Facility Address: ____________________________________________
Date of Service/Admit Date: ___________________ Type of Care (elective/emergent): ___________________
Diagnosis Code(s): ___________________ Number of Units Requested: ___________________
Procedure with CPT®/HCPCS(s) Codes: ___________________
Ordering/Admitting Physician Name: ___________________ Provider ID and/or NPI#: ___________________
Physician Address: ____________________________________________

Service Type: (Select appropriate service type and include a list of all pertinent information such as)
☐ Initial DRG ☐ Conversion to DRG ☐ SNF ☐ SNF Concurrent ☐ Inpatient Rehabilitation ☐ LTAC
1st and 2nd day of clinical for the an initial DRG admit, past medical history, provider's orders/treatment plan, IV meds, all pertinent lab values, all pertinent diagnostic testing, diet, activity, prior level of function, therapy notes/evaluation, discharge plans and any other supportive information.

☐ Home Health Services (SN/ST) ☐ Outpatient Speech Therapy ☐ Specialty Pharmacy
Past medical history, prior level of function, provider's orders/treatment plan, activity, therapy notes/evaluation, all pertinent lab values, short term/long term goals, number of visits/units, and any other supportive information.

☐ DME/Otorthotics
CMN if applicable, specific clinical for needs per NCD/LCD, rental/purchase, and any other supportive information.

☐ Advance Determination ☐ Retro Review
Past medical history and physical, provider's orders/treatment plan, office notes, all pertinent labs, diagnostic exams and/or photos if applicable.

BlueChoiceSM Utilization Management Department can be contacted at 1-800-924-7141.
*If you are not a registered user for BlueAccess contact eBusiness Technical Support:
Phone: 423-535-5177 (Option 2) • E-mail: eBusiness_support@bcbs.com
CPT® is a registered trademark of the American Medical Association

BlueChoice Tennessee, an Independent Licensee of the BlueCross BlueShield Association. BlueChoice Tennessee is an HMO plan with a Medicare contract. Enrollment in BlueChoice Tennessee depends on contract renewal.

Y0013 14_HMO Fax Form (02/2015)
BlueAdvantage (PPO)SM Services Authorization Request

Please type/print legibly. Upon completion of this form, please fax to 1-888-535-5243. For a faster response submit online DRG authorization requests via BlueAccessSM at www.bcbst-medicare.com 24-hours-per-day/7-days-per-week.*

Member Name: ____________________________________________
Member Date of Birth: ____________________ Member ID Number: __________________
Sender Name: ____________________________________________
Sender Phone Number: ____________________ Sender Fax Number: __________________
Facility Name: ____________________________________________ Facility Tax ID and/or NPI#: __________________
Facility Address: ____________________________________________
Date of Service/Admit Date: ____________________ Type of Care (elective/emergent): __________________
Diagnosis Code(s): ____________________ Number of Units Requested: __________________
Procedure with CPT®/HCPCS(s) Codes: ____________________
Ordering/Admitting Physician Name: ____________________ Provider ID and/or NPI#: __________________
Physician Address: ____________________________________________

Service Type: [Select appropriate service type and include a list of all pertinent information such as]

☐ Initial DRG ☐ Conversion to DRG ☐ SNF ☐ SNF Concurrent ☐ Inpatient Rehabilitation ☐ LTAC
1st and 2nd day of clinical for the an initial DRG admit, past medical history, provider’s orders/treatment plan, IV meds, all pertinent lab values, all pertinent diagnostic testing, diet, activity, prior level of function, therapy notes/evaluation, discharge plans and any other supportive information.

☐ Home Health Services (SN/ST) ☐ Outpatient Speech Therapy ☐ Specialty Pharmacy
Past medical history, prior level of function, provider’s orders/treatment plan, activity, therapy notes/evaluation, all pertinent lab values, short term/long term goals, number of visits/units, and any other supportive information.

☐ DME/Orthotics
CMN if applicable, specific clinical for needs per NCD/LCD, rental/purchase, and any other supportive information.

☐ Advance Determination ☐ Retro Review
Past medical history and physical, provider’s orders/treatment plan, office notes, all pertinent labs, diagnostic exams and/or photos if applicable.

BlueAdvantageSM Utilization Management Department can be contacted at 1-800-924-7141.
*If you are not a registered user for BlueAccess contact eBusiness Technical Support:
  Phone: 423-535-5177 (Option 2) • E-mail: eBusiness_support@bcbst.com
CPT® is a registered trademark of the American Medical Association
BlueCross BlueShield of Tennessee, Inc., an Independent Licensee of the BlueCross BlueShield Association.
BlueCross BlueShield of Tennessee, Inc. is a PPO plan with a Medicare contract. Enrollment in BlueCross BlueShield of Tennessee, Inc. depends on contract renewal.

Y0013_14_PPO Fax Form (02/2015)

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All Home Health services for BlueAdvantage PPO and BlueChoice HMO should be billed on the CMS-1450 claim form using CMS-1450 Type of Bill 33X. When submitting ANSI-837 electronic claims, the Institutional format must be used. Home Health services should be billed using the following Revenue Codes and billing units:

<table>
<thead>
<tr>
<th>Type of Service</th>
<th>Description</th>
<th>Revenue Code</th>
<th>Procedure Code</th>
<th>Billing Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Agency Visits</td>
<td>Home Health Agency Physical Therapy</td>
<td>0421</td>
<td>Not required</td>
<td>1 unit per visit</td>
</tr>
<tr>
<td>Home Health Agency Visits</td>
<td>Home Health Agency Occupational Therapy</td>
<td>0431</td>
<td>Not required</td>
<td>1 unit per visit</td>
</tr>
<tr>
<td>Home Health Agency Visits</td>
<td>Home Health Agency Speech Therapy</td>
<td>0441</td>
<td>Not required</td>
<td>1 unit per visit</td>
</tr>
<tr>
<td>Home Health Agency Visits</td>
<td>Home Health Agency Skilled Nursing (RN or LPN)</td>
<td>0551</td>
<td>Not required</td>
<td>1 unit per visit</td>
</tr>
<tr>
<td>Home Health Agency Visits</td>
<td>Home Health Agency Medical Social Services</td>
<td>0561</td>
<td>Not required</td>
<td>1 unit per visit</td>
</tr>
<tr>
<td>Home Health Agency Visits</td>
<td>Home Health Agency Home Health Aide</td>
<td>0571</td>
<td>Not required</td>
<td>1 unit per visit</td>
</tr>
</tbody>
</table>

Home Health services not billed with the indicated revenue codes will be rejected or denied. A procedure code may be billed to further identify the service provided. While not required, supplying the appropriate initial evaluation CPT® code for PT, OT, and ST services will distinguish the initial evaluation, which does not require an authorization, from subsequent services, which do require an authorization. Doing so will facilitate claims administration.

To facilitate claims administration, a separate line item must be billed for each date of service and for each service previously indicated.

Supplies on the BlueCross Home Health Agency Non-Routine Supply List should be billed using the indicated revenue codes and HCPCS codes. Units should be billed based on the HCPCS code definition in effect for the date of service. HCPCS code definitions can be found in the Healthcare Common Procedure Coding System (HCPCS) manual.

Supplies not billed with the indicated Revenue Codes and HCPCS codes will be rejected or denied.

Reimbursement for supplies not indicated on the BlueCross Home Health Agency Non-Routine Supply List used in conjunction with the above services are included in the maximum allowable for the Home Health service and will not be reimbursed separately.

Billing of supplies including those provided by third party vendors such as medical supply companies that are used in conjunction with a Home Health visit are the responsibility of the Home Health Agency.

Supplies not used in conjunction with a Home Health visit are not billable by the Home Health Agency provider.

The only supplies that may be billed in addition to the above services are those indicated on the following BlueCross Home Health Agency Non-Routine Supply List.

The following codes should be used when billing Home Health Agency Non-Routine Supplies with Revenue Code 0270:

A4212 A4331 A4357 A4375 A4390 A4407 A4422 A4455 A5056 A5105 A7503 A7527 T4532
A4248 A4333 A4358 A4376 A4391 A4408 A4423 A4456 A5057 A5112 A7504 S8185 T4533
A4310 A4334 A4360 A4377 A4392 A4409 A4424 A4459 A5061 A5113 A7505 S8210 T4534
A4311 A4338 A4361 A4378 A4393 A4410 A4425 A4461 A5120 A5114 A7506 T4521 T4535
A4312 A4340 A4362 A4379 A4394 A4411 A4426 A4463 A5062 A5121 A7507 T4522 T4537
A4313 A4344 A4363 A4380 A4395 A4412 A4427 A4481 A5063 A5122 A7508 T4523 T4540
A4314 A4346 A4364 A4381 A4396 A4413 A4428 A4623 A5067 A5126 A7509 T4524 T4541
A4315 A4349 A4366 A4382 A4397 A4414 A4429 A4625 A5072 A5131 A7520 T4525 T4542
A4316 A4351 A4367 A4383 A4398 A4415 A4430 A4426 A5073 A6413 A7521 T4526 T4543
A4320 A4352 A4368 A4384 A4399 A4416 A4431 A5051 A5081 A6531 A7522 T4527
A4321 A4353 A4369 A4385 A4400 A4417 A4432 A5052 A5082 A6532 A7523 T4528
A4326 A4354 A4371 A4387 A4404 A4418 A4433 A5053 A5083 A7047 A7045 T4529
A4328 A4355 A4372 A4388 A4405 A4419 A4434 A5054 A5093 A7501 A7524 T4530
A4330 A4356 A4373 A4389 A4406 A4420 A4435 A5055 A5102 A7502 A7526 T4531

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The following codes should be used when billing Home Health Agency Non-Routine supplies with Revenue Code 0623:

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m. Durable Medical Equipment (DME)

Basic information needed for processing an advance determination request:

- Member’s identification number and name;
- Practitioner’s name, provider number, NPI, Medicare number; address, and telephone number;
- Hospital/Facility’s name, provider number, NPI, Medicare number, address, and telephone number;
- Date of service; and
- Caller’s name.

Clinical information/documentation required for review:

- Member’s diagnosis and expected prognosis;
- Copy of Certificate of Medical Necessity (CMN) and signed prescription;
- Estimated duration of use;
- Limitations and capability of the Member to use the equipment;
- Itemization of the equipment components, if applicable;
- Appropriate HCPCS codes for equipment being requested; and
- Member’s weight and/or dimensions (needed to determine coverage of manual or power wheelchairs), if available.

n. Speech, Occupational and Physical Therapy, and Chiropractic Manipulation

In order for therapy services to be considered for benefits, the services must be Medically Necessary and Medically Appropriate for the treatment of the Member’s illness or injury. Occupational and Physical Therapy, and Chiropractic Manipulation reviews are performed by our Musculoskeletal Program vendor. Call or fax request to:

Phone  1-866-747-0586
Fax      1-866-747-0587

Basic information needed for processing an advance determination request:

- Member’s identification number, name, and date of birth;
- Practitioner’s name, provider number, NPI, Medicare number; address, and telephone number;
- Hospital/Facility’s name, provider number, NPI, Medicare number, address, and telephone number;
- Date of service; and
- Caller’s name.
Clinical information/documentation required for review:
- Assessment Requirements (Evaluation and Plan of Care) Evaluation;
- Ordering Practitioner and date of last visit;
- Primary diagnosis;
- Date of diagnosis onset;
- Baseline status/current abilities;
- Functional potential;
- Prior level of functioning;
- Current functional abilities;
- Functional potential;
- Expected maximum level of functioning;
- Strength, ROM, if applicable;
- Circulation and sensation;
- Cooperation and comprehension;
- Diagnostic and assessment services used to ascertain the type, causal factors, and severity of speech and language disorders;
- Support system/caregiver;
- Other therapies or treatments;
- Patient's goals; and
- Therapy compliance.

Plan of Care

- Long and short-term goals;
- Discharge goals;
- Measurable objectives;
- Functional objectives;
- Home program, if applicable;
  - Duration of therapy;
  - Frequency of therapy;
  - Date therapy is to begin;
  - Specific therapy techniques;
- Safety and preventive education; and
- Community resources.

O. Orthotics/Prosthetics

Basic information needed for processing an advance determination or prior authorization request:

- Member’s identification number, name, and date of birth;
- Practitioner’s name, provider number, NPI, Medicare number; address, and telephone number;
- Hospital/Facility’s name, provider number, NPI, Medicare number, address, and telephone number;
- Date of service; and
- Caller’s name.

Clinical information/documentation required for review:
- Member's diagnosis and expected prognosis;
- Limitations and capability of the Member to use the equipment;
- Itemization of the equipment components, if applicable; and
- Appropriate HCPCS codes for equipment being requested.
p. **Laboratory Services**  
Providers need to utilize in-network options for all laboratory services requested, unless the specific laboratory test is not available from a participating lab provider. This includes genetic testing that is covered by Medicare. If the Provider refers testing to a non-participating lab and the test was available through a participating Provider, then this cost may be the Provider’s and not the Member’s responsibility through an off-set reconciliation.

q. **Retrospective Review**  
BlueCross will conduct Retrospective Review within two (2) years of the original claim receipt date to provide a decision based on benefit eligibility, exclusion(s), and Appropriateness and Medical Necessity of services. Specific reasons as to why the service was not requested timely apply to retrospective reviews. References used to determine Appropriateness and Medical Necessity include Title 18 of the Social Security Act, Title 42 Code of Federal Regulations Parts 422 and 476, National Coverage Determinations, Local Coverage Determinations, coverage in CMS’ Interpretive Manuals (Claims Processing Manual, Benefit Policy Manual, Program Integrity Manual, Quality Improvement Organization Manual, and Medical Managed Care Manual), MCG, BlueCross adopted guidelines, the BlueCross claims payment system, DMEMAC associated PSC local coverage determinations and other major payer policy and peer reviewed literature.

r. **Pharmacy (Part B Drugs)**  
In order for Part B drugs to be considered for benefits, the service must be Medically Necessary and Medically Appropriate to the treatment of the Member’s illness or injury according to National Coverage Determinations and/or Local Coverage Determinations.

Certain formulary drugs may be covered under Medicare Part B or D depending upon the circumstances. Information may need to be submitted describing the use and setting of the drug to make a determination.


s. **Organization Determinations**  
An organization determination is a determination of Medical Necessity and Appropriateness related to payment of services. Organization determinations include both advance determinations and retrospective reviews.

An organization determination for an advance determination request will be reviewed as expeditiously as the Member’s health condition requires, but no later than fourteen (14) Calendar days after the date of receipt of request for a Standard Organization Determination.

An expedited organization determination will be performed when requested or supported by a Physician indicating that applying the standard time for making a determination could seriously jeopardize the life or health of the Member or the Member’s ability to regain maximum function. Additionally, the Physician does not need to be appointed as the Member’s authorized representative in order to make this request. A decision will be rendered as expeditiously as the Member’s health condition requires, but no later than Seventy-two (72) hours after receiving the request for expedited review. The time frame will be extended by up to fourteen (14) Calendar days if the Member requests the extension or if the need for additional information and documents are delayed and is in the best interest of the Member. Expedited organization determinations may not be requested for cases in which the only issue involves a claim for payment for services that the Member has already received.

Retrospective reviews are completed within thirty (30) Calendar days of receipt of the request for a Standard Organization Determination.

t. **Reconsideration Process**  
The reconsideration process applies to Members or Member’s representatives. More information is provided for Members in their Evidence of Coverage.

A Standard Reconsideration of an adverse organization determination or termination of services decision may be requested by a Member or Member’s authorized representative. A Standard Reconsideration of the
denial of a request for service will be determined no later than thirty (30) calendar days from the date the request of a Standard Reconsideration is received. The timeframe may be extended up to fourteen (14) calendar days at the Member’s request.

A Member or Member’s authorized representative may submit a verbal or written request for an Expedited Reconsideration in situations where applying the standard of procedure could seriously jeopardize the Member’s life, health, or ability to regain maximum function. If BlueCross approves a request for an Expedited Reconsideration, the review will be completed no later than seventy-two (72) hours after receiving the request. The seventy-two (72)-hour timeframe may be extended up to fourteen (14) calendar days at the Member’s request for an extension.

A request for payment of a service already provided to the Member is not eligible to be reviewed as an Expedited Reconsideration.

u. Advanced Imaging
Prior authorization* is required for select advanced imaging radiology procedures performed in an outpatient setting. Prior authorization is not required for imaging procedures performed during an inpatient admission or emergency room visit. Procedures requiring prior authorization include, but are not limited to:

- Computed tomography (CT)
- Computed tomography angiography (CTA)
- Magnetic resonance imaging (MRI)
- Magnetic resonance angiography (MRA)
- Magnetic resonance spectroscopy (MRS)
- Positron emission tomography (PET)
- Nuclear cardiology

**Bone Density/CT Bone Density Exclusions from Advanced Imaging Program**
*Bone Mass Measurements are for the purpose of establishing the diagnosis of osteoporosis and to assess the individual’s risk for subsequent fracture and are excluded from this requirement. These measurements are considered part of Medicare’s Preventive Services.

To request prior authorization for any of the above listed radiology procedures, call or fax our Advanced Imaging vendor at:

Phone 1-888-693-3211
Fax 1-888-693-3210

3. Oxygen Authorizations

Effective January 1, 2016, BlueAdvantage Members no longer receive lifetime, or multi-year approval for oxygen equipment rentals. Because plan benefits can change at the beginning of each calendar year, a new authorization will be required at the beginning of the new year and will be valid for a maximum of twelve (12) months. If an authorization is approved during the year, it will remain in effect through the end of the Calendar Year and must be recertified for continued approval in the new year.

The annual request requires a **Certification of Medical Necessity** completed by the requesting Physician and dated within two (2) months of the request. Oxygen equipment rental is only covered for thirty-six (36) months, in accordance with CMS regulations.
4. Reimbursement for Oxygen Equipment

As required by CMS, Tennessee Local Coverage Determination L11446 and the supporting policy article A33750 released in October 2014, reimbursement for oxygen equipment is limited to thirty-six (36) monthly rental payments. Payment for accessories, delivery, back-up equipment, maintenance and repairs is included in the rental allowance.

The supplier who provides oxygen equipment for the first month must continue to provide any necessary oxygen equipment and all related items and services through the 36-month period. Contents only will continue to be reimbursed beyond thirty-six (36) months.

After thirty-six (36) monthly rental payments have been made there is no further payment for oxygen equipment during the five (5)-year reasonable use lifetime of the equipment. The supplier who provided the equipment during the 36-month rental is required to continue providing the equipment during the five (5)-year reasonable use lifetime of the equipment.

Exceptions and additional information can be found on the Centers for Medicare & Medicaid services (CMS) website at <http://www.cms.gov/medicare-coverage-database/details/article-details.aspx?articleId=33750&version=36&ContrlId=140&ContrVer=2&LCID=11446&ContrSelected=140*2&Contrtr=140&name=CGS+Administrators%2c+LLC+(18003%2c+DME+MAC)&DocType=Active&LCntrctr=140*2&IsPopup=y&>

5. Fusion for Degenerative Joint Disease of the Lumbar Spine

The following documentation is required to request authorization for Fusion for Degenerative Joint Disease of the Lumbar Spine:

- Continued pain and difficulty maintaining ADLs despite activity modification
- A documented home exercise program or supervised physical therapy
- Anti-inflammatory medication
- Results of pertinent imaging studies, full motor and sensory examination of lower extremities
- Response to conservative treatment, such as injection therapy
- Levels planned for instrumentation

Note: Both Tennessee specific Local Coverage Determination criteria and MCG criteria are used to make Medical Necessity determinations for these services.

6. Hemodialysis

Effective August 1, 2015 Nephrologists and Dialysis Providers are required to provide a copy of CMS form 2728 once per year for each Member receiving hemodialysis services. This form should be faxed to BlueCross Medicare Advantage Care Management at 1-888-535-5243.
### I. Valuable Health Tools for Your BlueAdvantage and BlueChoice Patients

<table>
<thead>
<tr>
<th>Tool</th>
<th>Description</th>
<th>For more information…</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Personal Health Manager</strong></td>
<td>An on-line personal health record. This tool is customizable and provides patients with condition-specific information and recommendations. It also has trackers available to assist them with documenting lab tests, exercise achievements and medications among other many other things.</td>
<td>To access the Personal Health Manager, Members must use their Internet browser and go to <a href="http://www.bcbst-medicare.com">www.bcbst-medicare.com</a>. To register, they must select “Register Now” under the BlueAccess Login section and follow the on-line instructions for registering as a BlueAccess User.</td>
</tr>
<tr>
<td><strong>BluePerks</strong></td>
<td>A discount program that features savings of up to 50 percent on health-related products and elective services typically not covered by the health plan.</td>
<td>Direct your patients to <a href="http://www.bcbst.com/learn/blueperks/">http://www.bcbst.com/learn/blueperks/</a> or they can call the customer service number located on the back of their BlueAdvantage or BlueChoice Member ID card.</td>
</tr>
<tr>
<td><strong>Health Information Library</strong></td>
<td>An automated library of health topics. This tool makes approximately 1,200 health topics available to your patients at their convenience.</td>
<td>BlueAdvantage or BlueChoice Members may call 1-800-999-1658 to access this service. To view the available topics and how to use this service, direct your patients to <a href="http://www.bcbst-medicare.com/docs/2015/Health_Information_Audio_Library.pdf">http://www.bcbst-medicare.com/docs/2015/Health_Information_Audio_Library.pdf</a></td>
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<td><strong>Health Guide for Seniors</strong></td>
<td>A tool that offers health tips and tools to record things such as the date and results of important health screenings, immunizations and current medications, among other things.</td>
<td>To obtain a copy of this tool, direct your patients to call Care Management at 1-800-611-3489, Monday through Friday 9 a.m. to 6 p.m. (ET) or visit <a href="http://www.bcbst-medicare.com/docs/2015/Health_Guide_for_Seniors.pdf">http://www.bcbst-medicare.com/docs/2015/Health_Guide_for_Seniors.pdf</a> to download a printable copy.</td>
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<tr>
<td><strong>Welvie</strong></td>
<td>Welvie is an online surgery decision-support program that helps patients understand all the steps for deciding on preparing for and recovering from surgery.</td>
<td>Direct your patients to <a href="http://www.welvie.com">www.welvie.com</a> or call toll-free 1-888-386-6556.</td>
</tr>
<tr>
<td><strong>24/7 Nurse Line</strong></td>
<td>A nurse line is available 24-hours-a-day, 7-days-a-week to help answer your patient's health concerns. This important resource can also help your patients know when to go to the emergency room if they are unsure.</td>
<td>To access the nurse line, direct your patients to call 1-866 275-1660.</td>
</tr>
<tr>
<td><strong>Care Campaigns</strong></td>
<td>To assist you in your efforts to close your patient's preventive gaps in care, BlueAdvantage and BlueChoice reviews claims data and provides your patients with periodic reminders to get important preventive health services. Gaps in care measures include, but are not limited to: flu/pneumonia shots, annual wellness exams, and diabetic, glaucoma, breast/colorectal cancer screenings, etc.</td>
<td>Outreach conducted by BlueAdvantage and BlueChoice will consist of either directing Members to contact their primary care Physician to schedule an appointment or calling the primary care Physician's office to schedule an appointment on the Member's behalf.</td>
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### J. Pharmacy

1. **Formulary**
   

2. **Prior Authorization**
   
   Certain drugs with special indications require authorization. These drugs are noted on the formulary. For BlueAdvantage and BlueChoice Plans, the prescribing Practitioner is responsible for obtaining the necessary authorization from Express Scripts. Prior authorization must be obtained before the drug is dispensed.

   **Note:** Only Home Infusion Compounds are covered beginning 01/01/16. Compound ingredients are subject to Formulary rules and Medicare requirements. If one ingredient requires prior authorization, the prescribing Practitioner must obtain the necessary authorization before the Compound is dispensed.

   You may request prior authorization by contacting the following:
3. **Quantity Limits or Maximum Drug Limitation**

Some medications have a quantity limit for a given time period. These drugs are noted on the formulary. Greater quantities require Practitioner request for Medical Necessity. You may request prior authorization by contacting:

**BlueAdvantage and BlueChoice**  
*Express Scripts*

Phone 1-844-648-9628
Fax 1-877-328-9799

Websites:


4. **Redetermination**

If Express Scripts has made an adverse determination for a medication or pharmaceutical product, the Member or the Member’s Physician may initiate a pharmacy redetermination. This must be in writing and can be faxed to:

**BlueAdvantage and BlueChoice** (for Reconsideration and Expedited Requests)  
*Express Scripts*

Phone 1-844-648-9628
Fax 1-877-328-9799

5. **Pharmacy Directory**

**BlueAdvantage and BlueChoice**

Websites:


6. Formulary Exceptions

An exception is a type of coverage determination that is unique to the Part D benefit. A Member, Member's authorized representative or Member's prescribing Physician may request a Tiering Exception or a Formulary Exception.

- **Tiering Exception**: Permits Member to obtain a non-preferred drug at the cost-sharing amount applicable to drugs on preferred tiers.

- **Formulary Exception**: Ensures that Member has access to Medically Necessary Part D drugs that are not included on the BlueAdvantage or BlueChoice formulary. Also permits Members to request an exception to a quantity or dose limit, or a requirement that the Member try another drug before BlueCross's Medicare Advantage Plan will pay for the requested drug.

The Physician’s supporting statement must indicate that the requested drug is medically required and other on-formulary drugs and dosage limits will not be effective because:

1. All covered Part D drugs on any tier of the BlueAdvantage or BlueChoice formulary would not be as effective for the Member as the non-formulary drug, and/or would have adverse effects;

2. The number of doses available under a dose restriction for the prescription drug:
   a. Has been ineffective in the treatment of the Member’s disease or medical condition or,
   b. Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the Member, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug’s effectiveness or patient compliance; or

3. The prescription drug alternative(s) listed on the BlueAdvantage or BlueChoice formulary:
   a. Has been ineffective in the treatment of the Member’s disease or medical condition or,
   b. Based on sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug’s effectiveness or patient compliance; or
   c. Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the Member.

The review process for a tiering exception or formulary exception request will not begin until BlueAdvantage or BlueChoice receives the Physician’s supporting statement.

The Physician’s supporting statement will be evaluated based on:

- Comparisons of quality of the particular medication therapy, including safety, efficacy, effectiveness and cost, as well as, comparison of the drug product within the specific therapeutic class, and
- Medical evidence, such as, peer reviewed medical references, primary research, standards of practice, or relevant findings of government agencies, medical associations, and national commissions.

To request a formulary exception, complete a Medicare Part D Prescription Drug Authorization Request form. This form may be accessed on the following website:
BlueAdvantage and BlueChoice


If an exception is granted, BlueAdvantage or BlueChoice cannot require the Member to request approval for a refill or new prescription from the Prescriber in order to continue using the Part D drug that was approved under the tiering exception and formulary exception process. Approval is for the remainder of the plan year so long as the Member remains enrolled in the Plan, the Physician continues to prescribe the drug and it continues to be safe for treating the Member’s condition.

For formulary changes during the benefit year that result in a Member’s drug no longer being covered, the affected Members will be notified by letter at least sixty (60) days prior to the effective date of such changes. Members may request an appeal of any formulary change and BlueAdvantage and BlueChoice will review the request according to the tiering exception and formulary exception process.

K. Provider Appeal Process

Provider Dispute Resolution Procedure

A. Inquiry/Reconsideration Level (Written or verbal)

B. Appeal Level (Formal, Written request)

- If not satisfied, submit a written appeal within 30 days of receipt of the reconsideration response
- The request should state the following:
  - Reason for the appeal
  - Why dissatisfied with the reconsideration
  - Any additional information the Provider would like considered in support of the appeal

C. Mediation

- All disputes will be resolved through binding arbitration, unless both parties agreed to mediation

D. Binding Arbitration

- If dispute is not resolved to Provider’s satisfaction
- This is the final step in the process

Mail Claim Payment/Reimbursement Level I Reconsideration Requests to:

BlueCross BlueShield of Tennessee
Attn: BlueAdvantage Customer Service
1 Cameron Hill Circle, Ste 0005
Chattanooga, TN 37402-0005
Mail Utilization Management Level I Reopening Requests to:

    BlueCross BlueShield of Tennessee
    Attn: BlueAdvantage Utilization Management
    1 Cameron Hill Circle, Ste 0005
    Chattanooga, TN  37402-0005

If you are dissatisfied with our response to your request for Reconsideration, you may submit your Formal Appeal to:

    BlueCross BlueShield of Tennessee
    Provider Appeals Department
    1 Cameron Hill Circle, Ste 0039
    Chattanooga, TN  37402-0039

To avoid delays in reviewing your request, it is imperative that the Provider Dispute Form be completed accurately and with the appropriate box marked. When supplying records or documentation as part of a Level I Reconsideration or Reopening, or a Level II Appeal, please attach a Provider Dispute Form with your submission. The absence of the form may necessitate the records/documentation being returned to you for clarification of your request.

A sample copy of the Provider Dispute Form follows:
Provider Dispute Form

BlueCross BlueShield of Tennessee
1 Cameron Hill Circle, Suite 0039
Chattanooga, Tennessee 37402-0039

Date
Provider Name
Provider No./NPI
Patient Name
Provider Contact
Member ID No.
Provider Fax No.
Date of Service
Provider Telephone No.
Claim No./Decision/Issue Disputed

— When submitting a Dispute in accordance with the Inquiry or Appeal Level of the Procedure, please indicate a detailed reason for Dispute. If applicable, please include all pertinent information including prior correspondence, medical records, and all documentation you wish to have considered in the final determination of the dispute. (You may use the back of this form as necessary.)

— Indication of Provider Appeal below verifies you have submitted the dispute under the Reconsideration Level of the Procedure and are dissatisfied with the response. (Please attach a copy of the response received from the applicable BCBST Customer Service Department.)

Commercial Member
☐ Level I – Reconsideration
☐ Level II – Appeal

BlueAdvantage Member
☐ Level I Reconsideration
(Attn: Customer Service for administrative disputes)
☐ Level I Reopening
(Attn: Utilization Management for medical necessity disputes)
☐ Level II – Appeal

BlueCard
Tennessee providers and BCBST contracted providers in contiguous counties should submit disputes for all BlueCross BlueShield members to BCBST.
☐ Level I – Reconsideration
☐ Level II – Appeal

BlueCare/TennCareSelect Member
☐ Level I – Reconsideration
(Attn: Correspondence for administrative disputes)
☐ Level I – Reconsideration
(Attn: Utilization Management for medical necessity disputes)
☐ Level II – Appeal

CoverTN, CoverKids, AccessTN Member
☐ Level I – Reconsideration
☐ Level II – Appeal

Out-of-State providers (not in contiguous counties) should submit disputes for all BlueCross BlueShield members to their local BCBS Plan. Failure to do so may result in a delayed response to your request.

Notes/Comments:


GO-553 (1.13)
Provider Dispute Form (Continued)

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<th>Member ID No.</th>
<th>Patient Name</th>
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Notes/Comments (Continued):
Peer-to-Peer Physician Review
To improve Member’s access to care, the following process exists in addition to a Member’s normal appeal rights. Physicians who are not satisfied with the result of a prior authorization review may request a peer-to-peer review with a BlueCross Medical Director or Physician Reviewer by calling 1-800-924-7141. The request must be received within forty-eight (48) hours of the fax notification of the adverse determination and will be performed by a different Physician than the one who made the original determination.

The Physician requesting the review should provide two dates and times for the requested peer-to-peer Monday through Friday, between the hours of 10 a.m. and 3 p.m. (ET).

To reopen a prior authorization, submit additional information within ten (10) days of the fax notification of the adverse determination.

L. Website Related Links

Links to the Centers for Medicare & Medicaid Services (CMS) website, Quarterly Provider Update Site and the Medicare Coverage Home page follow. The Medicare Coverage Home page includes a search function for national and local coverage decisions.

CMS website
http://www.cms.gov/

Quarterly Provider Update

Medicare Coverage Home page
http://www.cms.gov/center/coverage.asp

M. Contact Us

Learn more about BlueCross BlueShield of Tennessee Medicare Advantage plans:

Website: www.bcbst.com
www.bcbstmedicare.com

Provider Service: 1-800-841-7434
Monday through Friday, 8 a.m. to 5 p.m. (ET)

Total Health Management
Phone 1-800-611-3489
Fax 1-800-727-0841

Advance Determinations/ Prior Authorizations:
Phone 1-800-924-7141 Monday through Thursday 8 a.m. to 6 p.m.; Friday 9 a.m. to 6 p.m. (ET)
Fax 1-888-535-5243 or 1-423-535-5243
Online Web Authorization also available via BlueAccess, the secure area on our website, www.bcbst.com

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<table>
<thead>
<tr>
<th>Service</th>
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<tbody>
<tr>
<td>SNF Care Coordination Unit</td>
<td>1-800-611-3489</td>
</tr>
<tr>
<td>Phone</td>
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<tr>
<td>Fax</td>
<td>1-800-727-0841</td>
</tr>
<tr>
<td>Express Scripts</td>
<td>1-844-648-9628</td>
</tr>
<tr>
<td>(BlueAdvantage and BlueChoice</td>
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<tr>
<td>Pharmacy Benefits Manager)</td>
<td>24-hours-a-day, 7-days-a-week</td>
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<td></td>
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<tr>
<td>BlueCard Host Services</td>
<td>1-800-705-0391</td>
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</tbody>
</table>
The Cover Tennessee programs, CoverKids, Cover TN, and AccessTN, were developed by the State of Tennessee to provide affordable and portable health insurance options to meet the needs of the uninsured in our state.

Due to new insurance regulations put in place by the Affordable Care Act (ACA), some of the Cover Tennessee programs (i.e., CoverTN and AccessTN), are no longer needed to fill gaps in coverage. Information detailing the CoverTN and AccessTN programs has been deleted from this Manual.

Information on the CoverKids program can be found in the BlueCare Tennessee Provider Administration Manual located on the BlueCare Tennessee website at http://bluecare.bcbst.com/Providers/Provider-Administration-Manual.html.