Blue Cross Medicare Advantage (PPO)

A Supplement to the BlueChoice® Physician and other Professional Provider Provider Manual
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# Blue Cross Medicare Advantage (PPO): Overview

## Introduction

Blue Medicare Advantage (PPO) is pleased to welcome you as a Participating Physician and other Professional Provider. The BlueChoice Physician and other Professional Provider – Provider Manual plus this Supplement explain the policies and procedures of the Blue Medicare Advantage (PPO) network. We hope it provides you and your office staff with helpful information as you serve Blue Medicare Advantage (PPO) members. The information is intended to provide guidance in most situations your office will encounter while participating in Blue Medicare Advantage (PPO). This Supplement to the BlueChoice Physician and other Professional Provider – Provider Manual is applicable only to the operation of Blue Medicare Advantage (PPO).

## The Blue Medicare Advantage (PPO) Network

Blue Medicare Advantage (PPO) is a Medicare Advantage Plan. Blue Medicare Advantage (PPO) maintains and monitors a network of participating physicians and other professional providers including physicians/professional providers, hospitals, skilled nursing facilities, ancillary providers and other providers through which members obtain Covered Services. Although selection of a primary care physician is not required, members are encouraged to have their participating physician and other professional provider coordinate their care with other participating physicians and other professional providers. Members may self-refer to participating Specialty Care Physicians and other professional providers.

Blue Medicare Advantage (PPO) will market its Medicare Advantage Plan to people eligible for Medicare Parts A and B that live in its approved Service Area in the state of Texas.

The approved state of Texas Service Area includes the following counties:

- **Austin area** – Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis and Williamson.
- **Dallas area** – Collin, Dallas, Denton and Tarrant.
- **Houston area** – Fort Bend, Harris and Montgomery.

Blue Medicare Advantage (PPO) will furnish members with a Member Handbook and Evidence of Coverage that will include a summary of the terms and conditions of its plan.
Blue Cross Medicare Advantage (PPO): General Information

**ID Cards & Verification of Coverage**

Each Blue Medicare Advantage (PPO) member will receive a Blue Medicare Advantage (PPO) identification (ID) card containing the member's name, member ID number, and information about their benefits.

**At each office visit**, your office staff should:

- Ask for the member’s ID card
- Copy both sides of the member’s ID card and keep the copy with the patient’s file
- Determine if the member is covered by another health plan to record information for coordination of benefits purposes
- Refer to the member’s ID card for the appropriate telephone number to verify eligibility in the Blue Medicare Advantage (PPO), deductibles, coinsurance amounts, copayments, and other benefit information
- Verify eligibility and for other relevant information

*Continued on next page*
Blue Cross Medicare Advantage (PPO): General Information, continued

Sample ID Card

Blue Cross Blue Shield of Texas

Name: John Doe
ID: ZGD804123456
Plan (80840): 9101000260

RxBin: 011552
RxPCN: MAPDTX
RxGp: 0001/0002/0003
RxID: 804123456

HPID: 1234567890
CMS H1666: 001, 002, 003

Blue Medicare Advantage (PPO)
Office Visit: $15 or 30%
Specialist: $45 or 30%
Emergency Room: $65
BS Plan Code: 401
BC Plan Code: 401

www.bcbstx.com

Submit Medical Claims to:
Blue Medicare Advantage (PPO)
PO Box 660044, Dallas, TX 75266-0044
Send Prescription Drug Claims to:
Blue Medicare Advantage (PPO)
PO Box 14429, Lexington, KY 40512

Pharmacy Line: 1-877-277-7898
Customer Service: 1-877-774-8592
TTY/TDD: 711

Medicare Limiting Charges Apply

Blue Cross and Blue Shield of Texas refers to HCSC Insurance Services Company (HISC), which is a wholly-owned subsidiary of Health Care Service Corporation (HCSC), a Mutual Legal Reserve Company. These companies are independent licensees of the Blue Cross and Blue Shield Association and offer or provide services for Medicare Advantage under contract H1666 with the Centers for Medicare and Medicaid Services. HISC is a Medicare Advantage organization with a Medicare contract.

Continued on next page
The 2013 office visit copayments for Blue Medicare Advantage (PPO) members are:

- $15 (in-network) or 30% (out-of-network) = Primary Care Physician;
- $45 (in-network) or 30% (out-of-network) = Specialty Care Physician or other Professional Provider

**Note:** The office visit copayment (in-network) or coinsurance (out-of-network) is determined by how a physician or other professional provider is contracted for Blue Medicare Advantage (PPO).

- If the physician is contracted for Blue Medicare Advantage (PPO) as a Primary Care Physician, the physician should collect the $15 (in-network) or 30% (out-of-network).
- If the physician or other professional provider is contracted for Blue Medicare Advantage (PPO) as a Specialty Care Physician/Professional Provider, the physician/professional provider should collect the $45 (in-network) or 30% (out-of-network).
- If the physician is contracted as a Primary Care Physician and a Specialty Care Physician, then the physician should collect the $15 (in-network) or 30% (out-of-network).

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Blue Cross Medicare Advantage (PPO): General Information, continued

What is BCBS Medicare Advantage (MA) PPO Network Sharing?
All BCBS MA PPO Plans participate in reciprocal network sharing. This network sharing will allow all BCBS MA PPO members to obtain in-network benefits when traveling or living in the service area of any other BCBS MA PPO Plan as long as the member sees a contracted BCBS MA PPO provider.

What does the BCBS MA PPO Network Sharing mean to me?
If you are a contracted BCBS MA PPO provider with Blue Cross and Blue Shield of Texas and you see BCBS MA PPO members from other BCBS Plans, these BCBS MA PPO members will be extended the same contractual access to care and will be reimbursed in accordance with your negotiated rate with your Blue Cross and Blue Shield of Texas contract. These BCBS MA PPO members will receive in-network benefits in accordance with their member contract.

If you are not a contracted BCBS MA PPO provider with Blue Cross and Blue Shield of Texas and you provide services for any BCBS MA PPO members, you will receive the Medicare allowed amount for covered services. For Urgent or Emergency care, you will be reimbursed at the member’s in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.

How do I recognize an out-of-area BCBS MA PPO member from one of these Plans participating in the BCBS MA PPO network sharing?
You can recognize a BCBS MA PPO member when their Blue Cross Blue Shield Member ID card has the following logo:

![MA PPO Medicare Advantage](image)

The "MA" in the suitcase indicates a member who is covered under the BCBS MA PPO network sharing program. BCBS MA PPO Members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their Blue Cross and/or Blue Shield member ID card.

Continued on next page
Do I have to provide services to BCBS MA PPO members from these other BCBS Plans?
If you are a contracted BCBS MA PPO provider with Blue Cross and Blue Shield of Texas (BCBSTX), you should provide the same access to care as you do for BCBSTX MA PPO members. You can expect to receive the same contracted rates for such services.

If you are not a BCBS MA PPO contracted provider, you may see BCBS MA PPO members from other BCBS Plans but you are not required to do so. Should you decide to provide services to BCBS MA PPO members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member’s out-of-network benefits. For Urgent or Emergency care, you will be reimbursed at the in-network benefit level.

What if my practice is closed to new local BCBS MA PPO members?
If your practice is closed to new local BCBS MA PPO members, you do not have to provide care for BCBS MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members as your local BCBS MA PPO members.

How do I verify benefits and eligibility?
Call BlueCard Eligibility at 800-676-BLUE (2583) and provide the BCBS MA PPO member’s alpha prefix located on the member’s ID card.

You may also submit electronic eligibility requests for BCBS MA PPO members. Follow these three easy steps:
- Log in to Availty, or RealMed or your preferred vendor
- Enter required data elements
- Submit your request

Where do I submit the claim?
You should submit the claim to Blue Cross and Blue Shield of Texas (BCBSTX) under your current billing practices. Do not bill Medicare directly for any services rendered to a BCBS MA PPO member.

What will I be paid for providing services to these out-of-area BCBS MA PPO network sharing members?
If you are a BCBS MA PPO contracted provider with Blue Cross and Blue Shield of Texas, benefits will be based on your contracted BCBS MA PPO rate for providing covered services to BCBS MA PPO members from any BCBS MA PPO Plan. Once you submit the BCBS MA PPO claim, BCBSTX will work with the other Plan to determine benefits and send you the payment.

Continued on next page
Blue Cross Medicare Advantage (PPO): General

Information, continued

What will I be paid for providing services to other BCBS MA out-of-area members not participating in the BCBS MA PPO Network Sharing?
When you provide covered services to other BCBS MA PPO out-of-area members not participating in network sharing, benefits will be based on the Medicare allowed amount. Once you submit the BCBS MA PPO claim, Blue Cross and Blue Shield of Texas will send you the payment. However, these services will be paid under the BCBS MA member’s out-of-network benefits unless for urgent or emergency care.

What is the BCBS MA PPO member cost sharing level and co-payments?
A BCBS MA PPO member cost sharing level and co-payment is based on the BCBS MA PPO member’s health plan. You may collect the co-payment amounts from the BCBS MA PPO member at the time of service. To determine the cost sharing and/or co-payment amounts, you should call the Eligibility Line at 800-676-BLUE (2583).

May I balance bill the BCBS MA PPO member the difference in my charge and the allowance?
No, you may not balance bill the BCBS MA PPO member for this difference. Members may be balance billed for any deductibles, co-insurance, and/or co-pays.

What if I disagree with the reimbursement amount I received?
If there is a question concerning the reimbursement amount, contact Blue Medicare Advantage (PPO) Provider Customer Service at 877-774-8592.

Who do I contact if I have a question about BCBS MA PPO network sharing?
If you have any questions regarding the BCBS MA PPO program or products, contact Blue Medicare Advantage (PPO) Provider Customer Service at 877-774-8592.

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Medical Records
Network providers are required to provide medical records requested by Blue Medicare Advantage (PPO). The medical records are used for CMS audits of risk adjustment data which are used to determine health status adjustments to CMS capitation payments to the Medicare Advantage organization. Medical records are also used for the following:

- Advance determination of coverage
- Plan coverage
- Medical necessity
- Proper billing
- Quality reporting
- Fraud and abuse investigations
- Plan initiated internal risk adjustment validation

24-Hour Coverage
Participating physicians and other professional providers are required to provide coverage for Blue Medicare Advantage (PPO) members 24 hours a day, 7 days a week. When a participating physician and other professional provider is unavailable to provide services, the participating physician and other professional provider must ensure that he or she has arranged for coverage from another participating physician and other professional provider. Hospital emergency rooms or urgent care centers are not substitutes for covering participating physicians and other professional providers. Participating physicians and other professional providers can consult their Blue Medicare Advantage (PPO) Provider Directory to identify physicians and other professional providers participating in the Blue Medicare Advantage (PPO) network. You may also contact the Blue Medicare Advantage (PPO) Provider Customer Service Department at the number listed on the back of the member’s ID card with questions regarding which physicians and other professional providers participate in the Blue Medicare Advantage (PPO) network.

Continued on next page
Blue Cross Medicare Advantage (PPO): General

**Emergency Services Definition**

Covered inpatient or outpatient services that are:
- furnished by a provider qualified to furnish Emergency Services; and
- needed to evaluate or stabilize an Emergency Medical Condition.

**Emergency Medical Conditions**

Medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to receive immediate medical care could result in:
- Serious jeopardy of the patient’s health;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement

**Emergency Care**

Emergency Care services are health care services provided in a hospital or comparable facility to evaluate and stabilize medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to receive immediate medical care could result in:
- Serious jeopardy of the patient’s health;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement

Emergency Care services necessary to evaluate and stabilize an Emergency Medical Condition are covered by Blue Medicare Advantage (PPO). Members with an Emergency Medical Condition should be instructed to go to the nearest Emergency Provider. Evaluation and stabilization of an Emergency Medical Condition in a hospital or comparable facility does not require precertification. Emergency Care services will be covered at the in-network benefit level.

*Continued on next page*
Blue Cross Medicare Advantage (PPO): General Information, continued

Out-of-Area Renal Dialysis Services

A member may obtain Medically Necessary dialysis services from any qualified physician or other professional provider the member selects when he/she is temporarily absent from the Blue Medicare Advantage (PPO) Service Area and cannot reasonably access Blue Medicare Advantage (PPO) dialysis physicians and other professional providers. Precertification is not required. **Note:** Pre-notification from the member is recommended in order for the member’s case manager to follow-up with the member to make sure that all is going well. Without pre-notification from the member, the case manager will not always know what is taking place for the member. Also, a member may voluntarily advise Blue Medicare Advantage (PPO) if he/she will temporarily be out of the Service Area. Blue Medicare Advantage (PPO) may assist the member in locating a qualified dialysis physician or other professional provider.

Preventive Services

Members may access the following services directly from any applicable participating physician and other professional provider. Some examples are:

- Screening mammograms;
- Annual routine vision exams;
- Glaucoma screening;
- Hearing screening;
- Influenza or pneumococcal vaccinations (*Members are not charged a copayment for influenza or pneumococcal vaccinations*);
- Routine and preventive women’s health services (such as pap smears & pelvic exams).
- Bone Mass Measurements
- Colorectal Screening Exams
- Prostate Cancer Screening Exams
- Cardiovascular Disease Screening
- Diabetes Screening
- Diabetes Self-Management Training
- Medical Nutritional Therapy
- Smoking Cessation
- Annual Physical Exam
- Abdominal Aortic Aneurysm Screening for high risk individuals


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Blue Cross Medicare Advantage (PPO): General

Inpatient Hospital Admissions

All inpatient hospital admissions require precertification from the Blue Medicare Advantage (PPO) Utilization Management (UM) Department. The precertification process for admissions is carried out by the admitting physician, other professional provider or hospital personnel.

Admitting physicians and other professional providers are responsible for contacting the UM Department to request precertification for additional days if an extension of the approved length of stay is required. The admitting physician or other professional provider will provide appropriate referrals for extended care. Blue Medicare Advantage (PPO) UM personnel will assist with coordinating all services identified as necessary in the discharge planning process.

Continued on next page
Blue Cross Medicare Advantage (PPO):
General

Radiology Services

For routine radiology services refer to the BlueChoice Physician and other Professional Provider – Provider Manual – Section B.

Laboratory Services

Clinical Pathology Laboratories (CPL) is one of the participating outpatient clinical reference laboratory services for Blue Medicare Advantage (PPO).

To schedule an appointment, log onto http://www.cpllabs.com/ or call 800-595-1275.

To locate other participating labs in Blue Medicare Advantage (PPO), visit the Online Provider Directory (Provider Finder) through the BCBSTX website.

If lab services are performed at the participating physician’s or other professional provider’s office, the physician or professional provider may bill for the lab services. However, if the physician’s or other professional provider’s office sends the lab specimens to a contracted lab for completion, only the contracted lab can bill Blue Medicare Advantage (PPO) for the lab services.

Note: Claims with lab services will be denied if the CLIA number is not on the CMS-1500 form in field 23.

Reminder of CLIA Requirements

This is a reminder that Blue Medicare Advantage (PPO) follows the same billing and coverage guidelines as original Medicare. This includes the requirement to report the Clinical Laboratory Improvements Amendments of 1988 (CLIA) number on claims submitted by all laboratories, including physician office laboratories. The CLIA number must be included on each Form CMS-1500 claim for laboratory services by any laboratory performing tests covered by CLIA. The CLIA number is required in field 23 of the paper Form CMS-1500. Modifier QW must be reported on claims for CLIA waived laboratory tests. The CLIA number is not required on the Form CMS-1450 (UB04).

Continued on next page
Blue Cross Medicare Advantage (PPO): General Information, continued

Behavioral Health Services

Blue Medicare Advantage (PPO) members requiring Behavioral Health Services (Mental Health and Chemical Dependency) are required to call Behavioral Health Customer Service at 877-774-8592. Telephonic access is available 24 hours a day, 7 days a week.

The Care Managers will provide:

- Precertification for hospital admissions and outpatient care
- Referral services, if required
- Case Management
- Assistance in the selection of a participating physician or other professional provider
- Crisis interventions

The following referral procedures apply to behavioral health services only:

- All behavioral health services must be precertified by BCBSTX Behavioral Health Services.

  **Note**: Whether the services are Medically Necessary must be determined before a precertification number will be issued. **Claims received that do not have a precertification number for a hospital admission or outpatient care will be denied.** Blue Medicare Advantage (PPO) behavioral health professionals or physicians may not seek payment from the member when a claim is denied for lack of a precertification number.

- The call to precertify can be made by the member, the behavioral health professional, physician or a member’s family member.

- Behavioral health professionals and physicians are encouraged to admit patients to a participating facility unless an emergency situation exists that precludes safe access to a participating facility or if the admission is approved for a non-participating facility.

- The member will only receive in-network benefits when services are performed at a participating Blue Medicare Advantage (PPO) facility unless the admission is approved for a non-participating facility.
Claim Information

Participating physicians and other professional providers must submit claims to Blue Medicare Advantage (PPO) within 180 days of the date of service, using the standard claim form or electronically as discussed below. Services billed beyond 180 days from date of service are not eligible for reimbursement. Blue Medicare Advantage (PPO) participating physicians and other professional providers may not seek payment from the member for claims submitted after the 180 day filing deadline.

To expedite claims payment, the following items must be submitted on your claims:

- Member’s name
- Member’s date of birth and sex
- Member’s Blue Medicare Advantage (PPO) ID number
- Individual member’s policy number
- Indication of: 1) job-related injury or illness, or 2) accident-related illness or injury, including pertinent details
- ICD-9 Diagnosis Codes
- CPT Procedure Codes
- Date(s) of service(s)
- Charge for each service
- Physician’s/Professional Provider’s Tax Identification Number
- Name/address of participating physician and other professional provider
- Signature of participating physician and other professional provider providing services.
- Place of Service Code
- National Provider Identifier (NPI) Number

Blue Medicare Advantage (PPO) will process electronic claims consistent with the requirements for standard transactions set forth in 45 CFR Part 162. Any electronic claims submitted to Blue Medicare Advantage (PPO) should comply with those requirements.

Continued on next page
Claim Information, continued

Blue Medicare Advantage (PPO) claims should be submitted as follows:

Blue Medicare Advantage (PPO) claims should be submitted electronically through the Availity Health Information Network for processing.

Blue Medicare Advantage (PPO) Electronic Payor ID # – 84980

For information on electronic filing of Blue Medicare Advantage (PPO) claims, contact the Availity Health Information Network @ 800-282-4548

Blue Medicare Advantage (PPO) claims must be submitted within 180 days of the date of service. Claims that are not submitted within 180 days from the date of service are not eligible for reimbursement. Blue Medicare Advantage (PPO) physicians and other professional providers may not seek payment from the Member for claims submitted after the 180 day filing deadline.

Blue Medicare Advantage (PPO) claims may be submitted -
(1) electronically in the CMS National Standard Format (NSF) or the current version of the ANSI 837 format or
(2) on a completed version of the applicable CMS-1500 claim form and mailed to:

Blue Medicare Advantage (PPO)
P.O. Box 660044
Dallas, TX 75266-0044

Blue Medicare Advantage (PPO) claims (electronic & paper) must be filed with the member’s complete ID number - exactly as shown on the member’s ID card including the 3-digit alpha prefix - ZGD

Blue Medicare Advantage (PPO) claims containing adequate information and submitted in accordance with these guidelines will be paid within 45 days for paper claims and 30 days for electronic claims.

Duplicate Blue Medicare Advantage (PPO) claims may not be submitted prior to the applicable 30-day (electronic) or 45-day (paper) claims payment period.  
**Note:** Claims with lab services will be denied if the CLIA number is not on the CMS-1500 form in field 23.

**Reminder of CLIA Requirements**

This is a reminder that Blue Medicare Advantage (PPO) follows the same billing and coverage guidelines as original Medicare. This includes the requirement to report the Clinical Laboratory Improvements Amendments of 1988 (CLIA) number on claims submitted by all laboratories, including physician office laboratories. The CLIA number must be included on each Form CMS-1500 claim for laboratory services by any laboratory performing tests covered by CLIA. The CLIA number is required in field 23 of the paper Form CMS-1500. Modifier QW must be reported on claims for CLIA waived laboratory tests. The CLIA number is not required on the Form CMS-1450 (UB04).
<table>
<thead>
<tr>
<th><strong>Coordination of Benefits</strong></th>
<th>If a Blue Medicare Advantage (PPO) member has coverage with another plan that is primary to Medicare, please submit a claim for payment to that plan first. The amount payable by Blue Medicare Advantage (PPO) will be governed by the amount paid by the primary plan and Medicare secondary payer law and policies.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claim Disputes</strong></td>
<td>You may dispute a claims payment decision by requesting a claim review. If you have questions regarding claims appeals, please contact the Blue Medicare Advantage (PPO) Provider Customer Service Department at 877-774-8592.</td>
</tr>
<tr>
<td><strong>Process Used to Recover Overpayments on Claims</strong></td>
<td>If an overpayment occurs on a Blue Medicare Advantage (PPO) physician's or other professional provider's claim, the process that will be used to recover an overpayment will be auto-recoupment. Should you have any questions, please contact Blue Medicare Advantage (PPO) Provider Customer Service at 877-774-8592.</td>
</tr>
</tbody>
</table>
| **Balance Billing**         | You **may not** bill a Blue Medicare Advantage (PPO) member for a non-covered service unless:  

  1) You have informed the Blue Medicare Advantage (PPO) member in advance that the service is not covered, and,  

  2) The Blue Medicare Advantage (PPO) member has agreed **in writing** to pay for the services if they are not covered. |
Benefits-Beneficiary Rights

Nondiscrimination
A Medicare Advantage plan may not deny, or limit or condition enrollment to individuals eligible to enroll in a Medicare Advantage plan offered by the organization on the basis of any factor that is related to health status, including, but not limited to the following: claims experience; receipt of health care; medical history and medical conditions arising out of acts of domestic violence; evidence of insurability including conditions arising out of acts of domestic violence and disability.

Additionally, a Medicare Advantage plan must:


Ensure that its Medicare Advantage plans have procedures in place to insure that members are not discriminated against in the delivery of health care services, consistent with the benefits covered in their policy, based on race, ethnicity, national origin, religion, gender, age, mental or physical disability, sexual orientation, genetic information, or source of payment.

Confidentiality
The Medicare Advantage organization must safeguard the privacy of any information that identifies a particular enrollee and have procedures that specify purposes for which the information will be used within the organization and to whom and for what purpose it will disclose information outside the organization.

Basic Rule
A Medicare Advantage organization offering a Medicare Advantage plan must provide the following to plan enrollees:

- all Part A and Part B, original Medicare services, if the enrollee is entitled to benefits under both parts
- Part B services if the enrollee is a grandfathered “Part B only” enrollee.

The Medicare Advantage organization fulfills its obligation of providing original Medicare benefits by furnishing the benefits directly through arrangements, or by paying for the benefits on behalf of enrollees. The following requirements apply with respect to the rule that the Medicare Advantage organization must cover the costs of original Medicare benefits:

- **Benefits** – Medicare Advantage plans must provide or pay for medically necessary Part A (for those entitled) and Part B covered items and services

Continued on next page
Benefits-Beneficiary Rights, continued

- **Access** – Medicare Advantage enrollees must have access to all medically necessary Parts A and B services. However, Medicare Advantage plans are not required to provide Medicare Advantage enrollees the same access to providers that is provided under original Medicare.

- **Cost-Sharing** – Medicare Advantage plans may impose cost-sharing for a particular item or service that is above or below original Medicare cost-sharing for that service, provided the overall cost-sharing under the plan is actuarially equivalent to that under Original Medicare and the plan cost-sharing structure does not discriminate against sicker beneficiaries.

The following circumstances are exceptions to the rule that Medicare Advantage organizations must cover the costs of original Medicare benefits:

- **Hospice** – Original Medicare (rather than the Medicare Advantage organization) will pay the hospice for the services received by an enrollee who has elected hospice while enrolled in the plan.

- **Inpatient stay during which enrollment ends** – Medicare Advantage organizations must continue to cover inpatient services of a non-plan enrollee if the individual was an enrollee at the beginning of an inpatient stay.

- **Clinical Trials** – Original Medicare pays for the costs of routine services provided to a Medicare Advantage enrollee who joins a qualifying clinical trial. Medicare Advantage plans pay the enrollee the difference between original Medicare cost-sharing incurred for qualifying clinical trial items and services and the Medicare Advantage plan’s in-network cost-sharing for the same category of items and services.

In addition to providing original Medicare benefits, to the extent applicable, the Medicare Advantage organization also furnishes, arranges, or pays for supplemental benefits and prescription drug benefits to the extent they are covered under the plan.

**Uniform Benefits**

All plan benefits must be offered uniformly to all enrollees residing in the service area of the plan and must be offered at uniform premium, with uniform benefits and cost-sharing throughout the plan’s service area.

*Continued on next page*
Benefits-Beneficiary Rights, continued

In the event of a Presidential emergency declaration, a Presidential (major) disaster declaration, a declaration of emergency or disaster by a Governor, or an announcement of a public health emergency by the Secretary of Health and Human Services, but absent an 1135 waiver by the Secretary, Medicare Advantage plans are expected to:

- Allow Part A/B and supplemental Part C plan benefits to be furnished at specified non-contracted facilities;
- Waive in full, requirements for gatekeeper referrals where applicable;
- Temporarily reduce plan-approved out-of-network cost-sharing to in-network cost-sharing amounts; and
- Waive the 30-day notification requirement to enrollees as long as all the changes (such as reduction of cost-sharing and waiving authorization) benefit the enrollee.

Access and Availability Rules

A Medicare Advantage organization may specify the providers through whom enrollees may obtain services if it ensures that all original Medicare covered services and supplemental benefits contracted for, by, or on behalf of Medicare enrollees are available and accessible under the coordinated care requirements. To accomplish this, the organization must meet the following requirements:

- Maintain and monitor a network of appropriate providers, supported by written arrangements, that is sufficient to provide adequate access to covered services to meet the needs of the population served. This involves ensuring that services are geographically accessible and consistent with local community patterns of care.
- Establish and maintain provider network standards that define the types of providers to be used when more than one type of provider can furnish a particular item or service; identify the types of mental health and substance abuse providers in their network; and specify the types of providers who may serve as a member’s primary care physician.

Continued on next page
Benefits-Beneficiary Rights, continued

Access and Availability Rules, cont’d

- Employ written standards for timeliness of access to care and member services that meet or exceed such standards as may be established by CMS. These standards must ensure that the hours of operation of the Medicare Advantage organization’s providers are convenient to, and do not discriminate against, members. The Medicare Advantage organization must also ensure that, when medically necessary, services are available 24 hours a day, 7 days a week. This includes requiring primary care physicians to have appropriate backup for absences. The standards should consider the member’s need and common waiting times for comparable services in the community.

(Examples of reasonable standards for primary care services are:
  1) *urgently needed services or emergency - immediately*;
  2) services that are not emergency or urgently needed, but in need of medical attention - within one week; and
  3) routine and preventive care - within 30 days.)

- Establish, maintain, monitor and validate credentials for a panel of primary care providers from which the member may select a personal primary care provider.

- Provide or arrange for necessary specialist care, and in particular give female enrollees the option of direct access to a women’s health specialist within the network for women’s routine and preventive health care services. The Medicare Advantage organization must arrange for specialty care outside of the plan provider network when network providers are unavailable or inadequate to meet a member’s medical needs.

- Ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all members, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds.

Blue Medicare Advantage (PPO) Member Customer Service *(phone number is listed on back of the member’s ID card)* has available the following services for Blue Medicare Advantage (PPO) members:

- Teletypewriter (TTY) services
- Language services, and
- Spanish speaking Customer Service Representatives

*Continued on next page*
Benefits-Beneficiary Rights, continued

Access and Availability Rules, cont’d

- Establish and maintain written standards, including coverage rules, practice guidelines, payment policies and utilization management protocols that allow for individual medical necessity determinations. These standards must be available to both enrollees and providers.

- Provide coverage for ambulance services, emergency and urgently-needed services, and post-stabilization care services. Ambulance services include services dispatched through 911 or its local equivalent, when either an emergency situation exists or other means of transportation would endanger the beneficiary's health.

Cost-Sharing for In Network Preventive Services

Medicare Advantage organizations are required to cover without cost-sharing all in-network Medicare covered preventive services for which there is no cost-sharing under original Medicare.

Medicare Advantage organizations may not charge for facility fees, professional services, or physician office visits if the only service(s) provided during the visit is a preventive service that is covered at zero cost-sharing under original Medicare. However, if during provision of the preventive service, additional non-preventive services are furnished, then the plan’s cost-sharing standards apply.

Enrollees of a Medicare Advantage organization may directly access (through self-referral to any plan participating provider) in-network screening mammography and influenza vaccine. The Medicare Coverage webpage is at: http://www.cms.gov/center/coverage.asp.

Drugs Covered Under Original Medicare Part B

The following broad categories of drugs may be covered under Medicare Part B, subject to coverage requirements and regulatory and statutory limitations:

- Injectable drugs that have been determined by Medicare Contract Administrative Contractors (MAC) to be "not usually self-administered" and are administered incident to physician services.

- Drugs that the MA enrollee takes through durable medical equipment (i.e., Nebulizers)

- Certain vaccines including pneumococcal, hepatitis B (high or intermediate risk), influenza, and vaccines directly related to the treatment of an injury or direct exposure to a disease or condition

- Certain oral anti-cancer drugs and anti-nausea drugs

- Hemophilia clotting factors

- Immunosuppressive drugs

- Some antigens

Continued on next page
Benefits-Beneficiary Rights, continued

<table>
<thead>
<tr>
<th>Drugs Covered Under Original Medicare Part B, cont’d</th>
<th>Medical Supplies Associated with the Delivery of Insulin</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Intravenous immune globulin administered in the home for the treatment of primary immune deficiency</td>
<td>Medical supplies directly associated with delivering insulin to the body, including syringes, needles, alcohol swabs, gauze, and insulin injection delivery devices not otherwise covered under Medicare Part B, such as insulin pens, pen supplies, and needle-free syringes, can satisfy the definition of a Part D drug. However, test strips, lancets and needle disposal systems are not considered medical supplies directly associated with the delivery of insulin for purposes of coverage under Part D.</td>
</tr>
<tr>
<td>- Injectable drugs used for the treatment of osteoporosis in limited situations</td>
<td></td>
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<tr>
<td>- Certain drugs, including erythropoietin, administered during treatment of end stage renal disease</td>
<td></td>
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<tr>
<td>Some drugs are covered under either Part B or Part D depending on the circumstances.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical Trials</th>
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<tbody>
<tr>
<td>For clinical trials covered under the Clinical Trials National Coverage Determination (NCD), Medicare covers the routine costs of qualifying clinical trials for all Medicare enrollees, including those enrolled in Medicare Advantage plans, as well as reasonable and necessary items and services used to diagnose and treat complications arising from participating in all qualifying clinical trials. The Clinical Trial National Coverage Determination defines what routine costs means and also clarifies when items and services are reasonable and necessary. All other Medicare rules apply. Refer to the Medicare Clinical Trial Policies page at <a href="http://www.cms.gov/ClinicalTrialPolicies/">http://www.cms.gov/ClinicalTrialPolicies/</a> for more information.</td>
<td></td>
</tr>
<tr>
<td>Medicare Advantage plans pay the enrollee the difference between original Medicare.</td>
<td></td>
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</tbody>
</table>

| Advance Directives | The Medicare Advantage organization must provide to its adult enrollees, at the time of initial enrollment, written information on their rights under the law of the state in which the Medicare Advantage organization furnishes services to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment, and the right to formulate advance directives. |
Blue Medicare Advantage (PPO) determinations must be based on:

1. The medical necessity of plan-covered services – including emergency, urgent care and post-stabilization-based – based on internal policies (including coverage criteria no more restrictive than original Medicare’s national and local coverage policies) reviewed and approved by the medical director;

2. Where appropriate, involvement of the Blue Medicare Advantage (PPO) medical director; and

3. The member’s medical history (e.g., diagnoses, conditions, functional status), physician recommendations, and clinical notes. Furthermore, if the plan approved the furnishing of a service through an advance determination of coverage, it may not deny coverage late on the base of a lack of medical necessity.

If the Medicare Advantage organization expects to issue a partially or fully adverse medical necessity (or any substantively equivalent term used to describe the concept of medical necessity) decision based on the initial review of the request, the organization determination must be reviewed by a physician or other appropriate health care professional with sufficient medical or other expertise, including knowledge of Medicare coverage criteria, before the Medicare Advantage organization issues the decision. The physician or other health care professional must have a current and unrestricted license to practice within the scope of his or her profession in a State, Territory, Commonwealth of the United States (that is, Puerto Rico), or the District of Columbia.

Continued on next page
Medical Policy

Physicians and other professional providers participating in the Blue Medicare Advantage (PPO) network should refer directly to Medicare coverage policies when making coverage decisions. There are two types of Medicare coverage policies: National Coverage Determinations and Local Coverage Determinations. As a Medicare Advantage plan, Blue Medicare Advantage (PPO) must cover all services and benefits covered by Medicare. Coverage information concerning original Medicare also applies to Blue Medicare Advantage (PPO).

National Coverage Determinations (NCDs)
The Centers for Medicare and Medicaid Services (CMS) explains NCDs through program manuals, which are found at http://cms.hhs.gov/manuals/. Key manuals for coverage include:

- Medicare National Coverage Determination Manual
- Medicare Program Integrity Manual
- Medicare Benefit Policy Manual

CMS updates program manuals through program transmittals and also sends updated information via articles through the Medicare Learning Network. These articles can be found at www.cms.hhs.gov/MLNMattersArticles/.

Local Coverage Determinations (LCDs)
CMS contractors (e.g., carriers and fiscal intermediaries) develop and issue local coverage determination (LCDs) to provide guidance to the public and provider community within a specific geographical area. LCDs supplement an NCD or explain when an item or service will be considered covered if there is no NCD. An LCD cannot contradict an NCD.

Provider may access our region’s LCDs at the following website addresses:

- Durable Medical Equipment (DMERC): www.cgsmedicare.com
- Medicare Part B: www.trailblazerhealth.com
- Medicare Part A: www.trailblazerhealth.com
- Regional Home Health Intermediary (RHHI): www.palmettogba.com

Continued on next page
Medicare Coverage Database


The following areas may be searched:

- National Coverage Determinations (NCDs)
- National Coverage Analyses (NCAs) – These documents support the NCD process.

Local Coverage Determinations (LCDs) – This section of the Medicare Coverage Database is updated on a monthly basis. Therefore, the most current information should be accessed through the local websites listed in the area above.

In coverage situations where there is an NCD, LCD, or guidance on coverage in original Medicare manuals, a Medicare Advantage organization may adopt the coverage of other Medicare Advantage organizations in its service area. The Medicare Advantage organization may also make its own coverage determination and provide a rationale using an objective evidence based process.

*Continued on next page*
**Blue Cross Medicare Advantage (PPO)℠**

**Preauthorization Requirements**

**Effective May 1, 2015**

The attending physician must obtain preauthorization for the services listed below except in an emergency.

<table>
<thead>
<tr>
<th>Services Requiring Preauthorization</th>
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<tbody>
<tr>
<td><strong>Medical/Surgical</strong></td>
</tr>
<tr>
<td>Acute Inpatient Hospital</td>
</tr>
<tr>
<td>Ambulance (A0430, A0431, A0435, A0436)</td>
</tr>
<tr>
<td>Chemical Denervation Eccrine Glands (64650-64653)</td>
</tr>
<tr>
<td>DME greater than $2500</td>
</tr>
<tr>
<td>Home Health Agency Care</td>
</tr>
<tr>
<td>Inpatient Rehabilitation</td>
</tr>
<tr>
<td>Long Term Care Hospital (LTCH)</td>
</tr>
<tr>
<td>Medications (J0585, J0881, J0882, J0885, J0897, J1745, J3262, J9035, J9310)</td>
</tr>
<tr>
<td>Organ Transplants other than ocular and kidney</td>
</tr>
<tr>
<td>Plastic, Reconstructive and Aesthetic Surgery (15775-15835)</td>
</tr>
<tr>
<td>Prosthetics/Orthotics greater than $2500</td>
</tr>
<tr>
<td>Skilled Nursing Facility (SNF)</td>
</tr>
<tr>
<td><strong>Behavioral Health</strong></td>
</tr>
<tr>
<td>All Inpatient Stays</td>
</tr>
<tr>
<td>Partial Hospitalization Program (PHP)</td>
</tr>
<tr>
<td><strong>Out of Plan / Out of Network Referrals</strong></td>
</tr>
</tbody>
</table>

A referral to an out-of-plan or out-of-network provider which is necessary due to network inadequacy or continuity of care must be reviewed by the BCBSTX Utilization Management prior to a BCBSTX patient receiving care.

The **Blue Cross Medicare Advantage PPO** referring physician or professional provider must contact the Utilization Management Department at the number listed below to request an out-of-plan or out-of-network referral authorization. For requests that are approved, the Utilization Management Department will forward an approval letter to the out-of-plan or out-of-network physician or professional provider.

Requests for out-of-plan or out-of-network referrals should be directed to: BCBSTX Utilization Management Department (For Medical and Behavioral Health Services) (call) 877-774-8592 or (fax) 855-874-4711

Hours: 6 am – 6 pm (CT), M-F and non-legal holidays and 9 am to 12 noon (CT), Saturday, Sunday and legal holidays. Messages may be left in a confidential voice mailbox after business hours.

If the out-of-network/plan provider determines that additional care is needed, the provider must obtain additional approval from the Utilization Management Department.

**Note:** Whether the services are Medically Necessary must be determined before a precertification number will be issued. **Claims received that do not have a precertification number will be denied.** Blue Medicare Advantage (PPO) physicians and other professional providers may not seek payment from the member when a claim is denied for lack of a preauthorization.

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Continued on next page
The admitting physician, other professional provider or hospital or other inpatient facility should notify the Utilization Management (UM) Department if they are admitting a Blue Medicare Advantage (PPO) member to a hospital or other inpatient facility.

The admitting physician, other professional provider or hospital/facility should utilize the iEXCHANGE Web application at bcbstx.com/provider or the iEXCHANGE Interactive Voice Response (IVR) Help Desk at 877-774-8592 (press prompt for help desk) and provide the following information:

- Name of admitting physician or other professional provider
- Member’s name, sex, date of birth and Blue Medicare Advantage (PPO) Member ID number
- Admitting facility/hospital
- Primary diagnosis
- Reason for admission
- Date of admission
- Requested length of stay

The UM Department will review the initial hospitalization request to confirm that the hospitalization and/or procedures are Medically Necessary. If the UM Department concludes that certain services are not Medically Necessary, the physician reviewer will attempt to contact the admitting physician or other professional provider to discuss the treatment plan and treatment options prior to issuing the denial determination.

If an extension of the initially approved length of stay is required, the admitting physician and other professional provider or Hospital/Facility should contact the UM Department to request the extension.

UM Department clinical staff will assist participating physicians and other professional providers and facilities/hospitals in the inpatient discharge planning process. At the time of admission and during the hospitalization, the UM Department clinical staff will discuss discharge planning with the participating physician and professional provider, member and member’s family.
Performance and Compliance Standards – Case Management

The Medicare Advantage organization must ensure continuity of services through arrangements that include, but are not limited to, the following:

- Offering to provide each enrollee with an ongoing source of primary care and providing a primary care source to each enrollee who accepts the offer;
- Establishing coordination of plan services that integrate services through arrangements with community and social service programs.

Utilizing procedures to ensure that enrollees are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health.

- Employing systems to identify and address barriers to enrollee compliance with prescribed treatments or regimens.

To support the above requirements, Blue Medicare Advantage (PPO) has a robust case management program. Our suite of programs includes care transition support, condition management, longitudinal care and complex case management programs. Case managers identify members with complex needs so that timely interventions can be provided to increase positive health outcomes, lower costs, and decrease utilization. Case managers, who are telephonically based, coordinate, monitor and evaluate the options and services required to meet the member’s needs, by ensuring care is provided in the right place and the right time.

Initial Health Risk Assessment

CMS requires that a good faith effort is made to conduct an initial health assessment of all new members within 90 days of the effective date of enrollment and follows up on unsuccessful attempts to contact an enrollee. The original Medicare initial preventive visit (i.e. “Welcome to Medicare” preventive visit), an Annual Wellness Visit, or a recent previous physical examination in a commercial plan (to which the Medicare Advantage organization has access) would fulfill this obligation.

Annual Health Assessment

The Blue Medicare Advantage (PPO) Annual Health Assessment (AHA) serves as a platform to identify essential clinical and care management needs and meets the requirements of the Medicare initial preventive and annual visits. The components of the AHA include the member’s past medical history, social history, family history, review of systems, physical exam (including BMI), preventive screenings, and chronic disease monitoring. These assessments can occur in the provider’s office or member’s home to remove barriers to completion.
Quality improvement is an essential element in the delivery of care and services by Blue Medicare Advantage (PPO). To define and assist in monitoring quality improvement, the Blue Medicare Advantage (PPO) Quality Improvement Program focuses on measurement of clinical care and service delivered by participating physicians and other professional providers against established goals. Key components of the program described below include the Chronic Care Improvement Program (CCIP), Quality Improvement Projects (QIPs) and performance monitoring (HEDIS, CAPHS, HOS). Formal evaluation of the program occurs annually to assess the impact and effectiveness of the program.

**Chronic Care Improvement Program (CCIP)**
A set of interventions designed to improve the health of individuals who live with multiple or sufficiently severe chronic conditions, and include patient identification and monitoring. Other programmatic elements may include the use of evidence-based practice guidelines, collaborative practice models involving physicians as well as support-services providers, and patient self-management techniques.

**Quality Improvement Project (QIP)**
An organization’s initiative that focuses on specified clinical and non-clinical areas.

**Healthcare Effectiveness Data and Information Set (HEDIS®)**
A widely used set of health plan performance measures utilized by both private and public health care purchasers to promote accountability and assess the quality of care provided by managed care organizations.

**Consumer Assessment of Healthcare Providers and Systems (CAHPS®)**
A patient’s perspective of care survey, administered annually, in which a sample of members from provider organizations (e.g., MAOs, PDPs, PFFS) are asked for their perspectives of care that allow meaningful and objective comparisons between providers on domains that are important to consumers; create incentives for providers to improve their quality of care through public reporting of survey results; and enhance public accountability in health care by increasing the transparency of the quality of the care provided in return for the public investment.

**Health Outcomes Survey (HOS)**
This survey is the first outcomes measure used in the Medicare program. It is a longitudinal, self-administered survey that uses a health status measure, the VR-12, to assess both physical and mental functioning. A sample of members from each Medicare Advantage organization health plan is surveyed. Two years later these same members are surveyed again in order to evaluate changes in health status.
Quality Improvement, continued

Quality of Care Issues

The Quality Improvement Program includes aggregation and analysis of trend for quality of care issues. A quality of care complaint may be filed through the Medicare health plan’s grievance process and/or a QIO. A QIO must determine whether the quality of services (including both inpatient and outpatient services) provided by a Medicare health plan meets professionally recognized standards of health care, including whether appropriate health care services have been provided and whether services have been provided in appropriate settings.

The QIO is comprised of practicing doctors and other health care experts under contract to the Federal government to monitor and improve the care given to Medicare enrollees. QIOs review complaints raised by enrollees about the quality of care provided by physicians, inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Medicare health plans, and ambulatory surgical centers. The QIOs also review continued stay denials for enrollees receiving care in acute inpatient hospital facilities as well as coverage terminations in SNFs, HHAs and CORFs.

CMS Star Ratings

The Centers for Medicare and Medicaid Services (CMS) posts quality ratings of Medicare Advantage plans to provide Medicare beneficiaries with additional information about the various Medicare Advantage plans offered in their area. CMS rates Medicare Advantage plans on a scale of one to five star and defines the star ratings in the following manner:

- 5 Stars   Excellent performance
- 4 Stars   Above average performance
- 3 Stars   Average performance
- 2 Stars   Below average performance
- 1 Star    Poor performance

The quality scores for Medicare Advantage plans are based on performance measures that are derived from four sources:

- Healthcare Effective Data and Information Set (HEDIS)
- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Health Outcomes Survey (HOS)
- CMS administrative data, including information about member satisfaction, plans’ appeals processes, audit results, and customer service.

Continued on next page
The CMS groups the quality measures into five domains:

- Staying healthy: Screenings, Tests, and Vaccines
- Managing Chronic (long-term) Conditions
- Ratings of Health Plan Responsiveness and Care
- Member Complaints, Problems Getting Services, and Choosing to Leave the Plan
- Health Plan Customer Service

All rated plans receive both summary scores and overall scores. The summary score is used to provide quality-based payments and an overall measure of a plan’s quality based on indicators specific to quality and access to care. The overall score differs from the summary score because it combines a plan’s summary score with its Part D plan rating.

Participating Physicians and other Professional Providers must comply and cooperate with all Blue Medicare Advantage (PPO) Medical Management policies and procedures and in the Blue Medicare Advantage (PPO) Quality Assurance and Performance Improvement Programs. In addition, Participating Physicians and other Professional Providers must cooperate with the independent quality review and improvement organization [Quality Improvement Organization (QIO)] approved by CMS in its review of quality of care and investigation of quality complaints on behalf of the Medicare program. Texas Medical Foundation is the QIO for Blue Medicare Advantage (PPO).

The Utilization Management program does not prohibit physicians and other professional providers from advocating on behalf of members within the utilization management process.

Continued on next page
A member may self-refer to any Blue Medicare Advantage (PPO) participating specialty care physician or other professional provider. A referral is not required to access a participating specialty care physician or other professional provider. If it is necessary to utilize a non-participating specialty care physician or other professional provider due to network inadequacy or continuity of care concerns, the physician or other professional provider must obtain precertification from the UM Department for claims to pay at the in-network benefit level. If precertification is not obtained, claims will be paid at the out-of-network (OON) benefit level.

Members self-referring and participating physicians and other professional providers making referrals to participating specialty care physicians and other professional providers can check the Blue Medicare Advantage (PPO) Provider Directory to identify the specialty care physicians and other professional providers that are participating in the Blue Medicare Advantage (PPO) network.

The referring physician or other professional provider should provide the specialty care physician or other professional provider with the following clinical information:

- Member’s name
- Reason for the consultation
- History of the present illness
- Diagnostic procedures and results
- Pertinent past medical history
- Current medications and treatments
- Problem list and diagnosis
- Specific request of the Specialty Care Physician or other Professional Provider

Following an evaluation of a Blue Medicare Advantage (PPO) Member, the Specialty Care Physician/Professional Provider should:

- Contact the referring Physician/Professional Provider to discuss the Member’s condition and any recommendation for treatment or follow up care, and
- Send the referring Physician/Professional Provider the consultation report including medical findings, test results, assessment, recommendations, treatment plan and any other pertinent information.
Care Management

Blue Medicare Advantage (PPO) will assist in managing the care of members with acute or chronic conditions that can benefit from care coordination and assistance. Blue Medicare Advantage (PPO) participating physicians and other professional providers shall assist and cooperate with the Blue Medicare Advantage (PPO) Care Management Programs. Under its Care Management Program, and in coordination with participating physicians and other professional providers, Blue Medicare Advantage (PPO) shall:

- Implement procedures to ensure that members are informed of specific health care needs that require follow-up and receive, as appropriate, training in self-care and other measures they may take to promote their own health.
- Make best efforts to conduct a health assessment of all new members within 90 days of the effective date of enrollment;
- Identify individuals with complex or serious medical conditions;
- Establish and implement care management plans that:
  - Are appropriate;
  - Facilitate direct access visits to specialty care physicians or other professional providers;
  - Are time specific and updated periodically;
  - Facilitate coordination among physicians and other professional providers; and
  - Consider the member’s input.

The participating physician and other professional provider will diagnose, assess, treat and monitor those conditions on an ongoing basis.

The Care Management Program includes, but is not limited to:

- Identification and monitoring of quality and performance indicators;
- Implementation of measures that contribute to improving quality of care and cost-effective management of targeted conditions;
- Promotion of preventive care strategies to keep members healthy;
- Promotion of member education and behavioral modification that improve outcomes; and
- Evaluation of outcomes and program effectiveness.

Members are informed of available programs through the enrollment process, marketing materials, and discussions with participating physicians and other professional providers. Blue Medicare Advantage (PPO) will proactively identify members who could benefit from Care Management and encourage enrollment in the Care Management Program including the Disease Management Programs for certain chronic care conditions.

Continued on next page
A member may request a second opinion if:

- the member disputes the reasonableness of the treatment recommendation;
- the member disputes necessity of the recommended procedure; or
- the member does not respond to medical treatment after a reasonable amount of time.

Members may self-refer to a participating physician and other professional provider within the Blue Medicare Advantage (PPO) network to obtain a second opinion. The Member will be responsible for the applicable copayments.

Continued on next page
Care Management, continued

Clinical Review Criteria

The Clinical Quality Improvement Committee (CQIC) will review and approve the utilization management processes and clinical review criteria used to determine whether services are Medically Necessary. Blue Medicare Advantage (PPO) currently uses Milliman Care Guidelines® which promotes consistent decisions based on nationally accepted, physician-created clinical criteria for Inpatient Certification and concurrent review requests. For more information or to receive a copy of these guidelines, please contact the Utilization Management (UM) Department at 877-774-8592.

Blue Medicare Advantage (PPO) may develop recommendations or clinical guidelines for the treatment of specific diagnoses, or for the utilization of specific drugs. These guidelines will be communicated to participating physicians and other professional providers through the monthly Blue Review newsletter. Clinical Practice Guidelines are published in the BlueChoice Physician and other Professional Provider – Provider Manual and is also located online at www.bcbstx.com/provider, under the Standards and Requirements area, then click on Manuals.

Utilization Management Appeals Address, Phone and Fax Numbers

Appeals regarding Outpatient or Inpatient Precertification or Referral Authorization or termination of coverage of, a health care service should be sent to:

Blue Medicare Advantage (PPO) – Attn: Appeals
P.O. Box 4288
Scranton, PA 18505

Fax to: 855-674-9185

For an Expedited Appeal Only, call: 877-774-8592

For Claim Inquiries, contact:

Blue Medicare Advantage (PPO)
Provider Customer Service
877-774-8592

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Health Risk Assessment

A health risk assessment (HRA) questionnaire will be sent to Blue Medicare Advantage (PPO) members as a component of the enrollment materials. Medical Care Management staff will evaluate results and:

- Identify healthcare needs;
- Assist with access to healthcare services;
- Assist with coordination of care;
- Provide telephonic educational or written materials via mail as needed; and
- Refer Blue Medicare Advantage (PPO) members to appropriate case and disease management programs as needed.

Disease Management Programs

The Disease Management Programs include:

- **Medical:**
  - Diabetes
  - Chronic Obstructive Pulmonary Disease (COPD)
  - Coronary Artery Disease (CAD)
  - Congestive Heart Failure (CHF)

- **Behavioral Health:**
  - Depression
  - Substance Abuse
  - Schizophrenia/Psychotic disorders
  - Bipolar
  - Anxiety/Panic disorders
  - Alzheimer/Dementia

Member participation is voluntary. Members receive both telephonic and hardcopy educational information to enhance self-management of their condition. The treating physician or other professional provider is an integral part of the disease management program.

For additional information on Disease Management Programs, call the Disease Management Programs phone number listed on the Key Contacts page.

Continued on next page
Physician and other Professional Provider Performance Standards and Compliance Obligations

When evaluating the performance of a participating physician or other professional provider, Blue Medicare Advantage (PPO) will review at a minimum the following areas:

- **Quality of Care** — measured by clinical data related to the appropriateness of a member’s care and member outcomes.

- **Efficiency of Care** — measured by clinical and financial data related to a member’s health care costs.

- **Member Satisfaction** — measured by the members’ reports regarding accessibility, quality of health care, member - participating physician and other professional provider relations, and the comfort of the practice setting.

- **Administrative Requirements** — measured by the participating physician’s or other professional provider’s methods and systems for keeping records and transmitting information, hours of operation, appointment waiting time, and appointment availability.

**Participation in Clinical Standards** — measured by the participating physician’s or other professional provider’s involvement with panels used to monitor quality of care standards.

*Continued on next page*
Physician and other Professional Provider Performance Standards and Compliance Obligations, continued

Blue Medicare Advantage (PPO) participating physician and other professional providers must comply with all applicable laws and licensing requirements. In addition, participating physician and other professional providers must furnish covered services in a manner consistent with standards related to medical and surgical practices that are generally accepted in the medical and professional community at the time of treatment. Participating physicians and other professional providers must also comply with the Blue Medicare Advantage (PPO) standards, which include but are not limited to:

- Guidelines established by the Federal Center for Disease Control (or any successor entity); and
- All federal, state and local laws regarding the conduct of their profession.

Participating physicians and other professional providers must also comply with Blue Medicare Advantage (PPO) policies and procedures regarding the following:

- Participation on committees and clinical task forces to improve the quality and cost of care;
- Precertification requirements and timeframes;
- Participating physician and other professional provider credentialing requirements;
- Care Management & Disease Management Program referrals;
- Appropriate release of inpatient and outpatient utilization and outcomes information;
- Accessibility of member medical record information to fulfill the business and clinical needs of Blue Medicare Advantage (PPO);
- Providing treatment to Members at the appropriate level of care; and
- Providing equal access and treatment to all Blue Medicare Advantage (PPO) members.

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Participating physicians and other professional providers acting within the lawful scope of practice are encouraged to advise patients who are members of Blue Medicare Advantage (PPO) about:

1. The patient’s health status, medical care, or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to make an informed treatment decision from all relevant treatment options;
2. The risks, benefits, and consequences of treatment or non-treatment; and
3. The opportunity for the individual to refuse treatment and to express preferences about future treatment decisions.

Such actions shall not be considered non-supportive of Blue Medicare Advantage (PPO).
Physician and other Professional Provider Performance Standards and Compliance Obligations, continued

Laws Regarding Federal Funds
Payments that participating physicians and other professional providers receive for furnishing services to Blue Medicare Advantage (PPO) members are, in whole or part, from Federal funds. Therefore, participating physicians and other professional providers and any of their subcontractors must comply with certain laws that are applicable to individuals and entities receiving Federal funds, including but not limited to, Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR part 91; the Rehabilitation Act of 1973; and the Americans With Disabilities Act.

Marketing
Participating physicians and other professional providers may not develop and use any materials that market Blue Medicare Advantage (PPO) without the prior approval of Blue Medicare Advantage (PPO) in compliance with Medicare Advantage requirements. Under Medicare Advantage law, generally, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Medicare Advantage plan unless the materials are approved prior to use by CMS or are submitted to CMS and not disapproved within 45 days.

Sanctions under Federal Health Programs and State Law
Participating physicians and other professional providers must ensure that no management staff or other persons who have been convicted of criminal offenses related to their involvement in Medicaid, Medicare or other Federal Health Care Programs are employed or subcontracted by the participating physician and other professional provider.

Participating physicians and other professional providers must disclose to Blue Medicare Advantage (PPO) whether the participating physician and other professional provider or any staff member or subcontractor has been the subject of any prior violation, fine, suspension, termination or other administrative action taken under Medicare or Medicaid laws; the rules or regulations of the state of Texas; the federal government; or any public insurer.

Participating physicians and other professional providers must notify Blue Medicare Advantage (PPO) immediately if any such sanction is imposed on a participating physician, other professional provider, a staff member or a subcontractor.

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Selection and Retention of Participating Physicians and other Professional Providers, continued

<table>
<thead>
<tr>
<th>Participation Requirements</th>
<th>To participate in Blue Medicare Advantage (PPO), the physician or other professional provider:</th>
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<tr>
<td></td>
<td>1) must be a participating BlueChoice physician or other professional provider</td>
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<td></td>
<td>2) must have privileges at one of the Blue Medicare Advantage (PPO) participating hospitals (unless inpatient admissions are uncommon or not required for the physician’s or other professional provider’s specialty)</td>
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<td>3) must have a valid National Provider Identifier (NPI) Number</td>
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<td>4) must sign a Blue Medicare Advantage (PPO) amendment to his/her BlueChoice agreement, and</td>
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<tr>
<td></td>
<td>5) cannot have opted-out of Medicare or have any sanctions or reprimands by any licensing authority or review organizations. Blue Medicare Advantage (PPO) participating physicians and other professional providers cannot be named on the Office of the Inspector General (OIG) or Government Services Administration (GSA) lists which identify physicians/professional providers found guilty of fraudulent billing, misrepresentation of credentials, etc. Blue Medicare Advantage (PPO) participating physician and other professional providers cannot be sanctioned by the Office of Personnel Management or be prohibited from participation in the Federal Employees Health Benefit Program (FEHBP).</td>
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| Credentialing & Recredentialing of Participating Physicians and other Professional Providers | Blue Medicare Advantage (PPO) continuously reviews and evaluates participating physician and other professional provider information, and recredentials participating physicians and other professional providers every three years. The credentialing guidelines are subject to change based on industry requirements and Blue Medicare Advantage (PPO) standards. |

| Credentialing & Recredentialing of Participating Institution Providers | Blue Medicare Advantage (PPO) continuously reviews and evaluates Institution Provider information and recertifies Institution Providers every three years. The credentialing guidelines are subject to change based on industry requirements and Blue Medicare Advantage (PPO) standards. |

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Selection and Retention of Participating Physicians and other Professional Providers, continued

If Blue Medicare Advantage (PPO) decides to suspend, terminate or non-renew a physician’s or other professional provider’s participation status, Blue Medicare Advantage (PPO) will give the affected physician or other professional provider written notice of the reasons for the action, including, if relevant, the standards and profiling data used to evaluate the physician or other professional provider and the numbers and mix of physicians and other professional providers needed by Blue Medicare Advantage (PPO). Blue Medicare Advantage (PPO) will allow the physician or other professional provider to appeal the action to a hearing panel, and give the physician or other professional provider written notice of his/her right to an appeal hearing and the process and timing for requesting a hearing. Blue Medicare Advantage (PPO) will ensure that the majority of the hearing panel members are peers of the affected physician or other professional provider. A recommendation by the hearing panel is advisory and is not binding on Blue Medicare Advantage (PPO).

If a reduction, suspension or termination of a participating physician’s or other professional provider’s participation is final and is the result of quality of care deficiencies, Blue Medicare Advantage (PPO) will notify the National Practitioner Data Bank and any other applicable licensing or disciplinary body to the extent required by law.

Subcontracted physician groups and other professional provider groups must ensure that these procedures apply equally to physicians and other professional providers within those subcontracted groups. (Note: Please refer to the BlueChoice Physician and Other Professional Provider - Provider Manual – Section B-81 – check out for detailed instructions on the appeal process for provider terminations.)

Blue Medicare Advantage (PPO) will make a good faith effort to provide written notice of a termination of a participating physician and other professional provider to all members who are patients seen on a regular basis by that physician or other professional provider at least 30 calendar days before the termination effective date regardless of the reason for the termination.
Medical Records

Medical Record Review
A Blue Medicare Advantage (PPO) representative may visit the participating physician’s or other professional provider’s office to review the medical records of Blue Medicare Advantage (PPO) members as described in the Physician Office Review Program section of the BlueChoice Physician and other Professional Provider – Provider Manual.

Standards for Medical Records
Participating physicians and other professional providers must have a system in place for maintaining medical records that conforms to regulatory standards. Each medical encounter whether direct or indirect must be comprehensively documented in the members’ medical record. Each medical record chart must include all of the elements specified in the BlueChoice Physician and other Professional Provider – Provider Manual. In addition, each medical record must also include the following:

- All physicians or other professional providers participating in the member’s care and information on services furnished by these physicians or other professional providers;
- Prescribed medications, including dosages and dates of initial or refill prescriptions;
- Advance Directives - the physician or other professional provider must document whether or not the member has executed an Advance Directive;
- Physical examinations, necessary treatments, possible risk factors for particular treatments; and
- Evidence of Member input into the proposed treatment plan.

Advance Directive
Participating physicians and other professional providers must document in a prominent part of the member’s current medical record whether or not the member has executed an Advance Directive.

Advance Directives are written instructions, such as living wills or durable powers of attorney for health care, recognized under the law of the state of Texas and signed by a patient, that explain the patient’s wishes concerning the provision of health care if the patient becomes incapacitated and is unable to make those wishes known.

Confidentiality of Member Information
Participating physicians and other professional providers must comply with all state and Federal laws concerning confidentiality of health and other information about members. Participating physicians and other professional providers must have policies and procedures regarding use and disclosure of health information that comply with applicable laws.
<table>
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<tr>
<th>Reporting Obligations</th>
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<tr>
<td><strong>Cooperation in Meeting Centers for Medicare &amp; Medicaid Services (CMS) Requirements</strong></td>
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<tr>
<td>Blue Medicare Advantage (PPO) must provide to CMS information that is necessary for CMS to administer and evaluate the Medicare Advantage program and to establish and facilitate a process for current and prospective members to exercise choice in obtaining Medicare services. Such information includes plan quality and performance indicators such as disenrollment rates; information on Member satisfaction; and information on health outcomes.</td>
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<tr>
<td>Participating physicians and other professional providers must cooperate with Blue Medicare Advantage (PPO) in its data reporting obligations by providing to Blue Medicare Advantage (PPO) any information that it needs to meet its obligations.</td>
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<tr>
<td><strong>Certification of Diagnostic Data</strong></td>
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<tr>
<td>Blue Medicare Advantage (PPO) is specifically required to submit to CMS data necessary to characterize the context and purposes of each encounter between a Member and a physician or other professional provider, supplier, or other practitioner (encounter data). Participating physicians and other professional providers that furnish diagnostic data to assist Blue Medicare Advantage (PPO) in meeting its reporting obligations to CMS must certify (based on best knowledge, information, and belief) the accuracy, completeness, and truthfulness of the data.</td>
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</table>
Initial Decisions, Appeals and Grievances

Initial Decisions

The “initial decision” is the first decision Blue Medicare Advantage (PPO) makes regarding coverage or payment for care. In some instances, a participating physician or other professional provider, acting on behalf of the member, may make a request for an initial inquiry regarding whether a service will be covered.

- If a member asks Blue Medicare Advantage (PPO) to pay for medical care the member has already received, this is a request for an “initial decision” about payment for care.

- If a member, or participating physician or other professional provider acting on behalf of a member, asks for precertification for treatment, this is a request for an “initial decision” about whether the treatment is covered by Blue Medicare Advantage (PPO).

- If a member asks for a specific type of medical treatment from a participating physician or other professional provider, this is a request for an “initial decision” about whether the treatment the member wants is covered by Blue Medicare Advantage (PPO).

Blue Medicare Advantage (PPO) will generally make decisions regarding payment for care that members have already received within 30 calendar days.

A decision about whether Blue Medicare Advantage (PPO) will cover medical care can be a “standard decision” that is made within the standard time frame (typically within 14 calendar days) or an expedited decision that is made more quickly (typically within 72 hours).

A member can ask for an expedited decision only if the member or any physician or other professional provider believes that waiting for a standard decision could jeopardize the life or health of the member or the member’s ability to regain maximum function. The member or a physician or other professional provider can request an expedited decision. If an expedited decision is requested by the member or physician or other professional provider, Blue Medicare Advantage (PPO) will automatically provide an expedited decision.

If Blue Medicare Advantage (PPO) does not make a decision within the required timeframe and does not notify the member regarding why the timeframe must be extended, the member can treat the failure to respond as a denial and may appeal, as set forth below.

Continued on next page
Members have the right to make a complaint if they have concerns or problems related to their coverage or care. “Appeals” and “grievances” are the two different types of complaints. All participating physicians and other professional providers must cooperate in the Blue Medicare Advantage (PPO) Appeals and Grievances process.

- An “appeal” is a complaint a member makes when the member wants Blue Medicare Advantage (PPO) to reconsider and change an initial decision (by Blue Medicare Advantage (PPO) or a participating physician or other professional provider) about what services are necessary or covered or what Blue Medicare Advantage (PPO) will pay for a service.

- A “grievance” is a complaint a member makes regarding any other type of problem with Blue Medicare Advantage (PPO) or a participating physician or other professional provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room, and the cleanliness of the participating physicians’ or other professional providers’ facilities are grievances.

Appeals regarding Outpatient or Inpatient Precertification or Referral Authorization for, or termination of coverage of, a health care service should be sent to:

Blue Medicare Advantage (PPO) - Attn: Appeals
P.O. Box 4288
Scranton, PA 18505

Fax to: 855-674-9185

For an Expedited Appeal Only, call: 877-774-8592

For Claim Inquiries, contact:

Blue Medicare Advantage (PPO)
Provider Customer Service
877-774-8592

If a Blue Medicare Advantage (PPO) member has a Grievance about Blue Medicare Advantage (PPO), a physician or other professional provider or any other issue, participating physicians and other professional providers should instruct the member to contact the Blue Medicare Advantage (PPO) Member Customer Service Department at the number listed on the back of the Member’s ID card.

Continued on next page
Initial Decisions, Appeals and Grievances, continued

A member may appeal an adverse initial decision by Blue Medicare Advantage (PPO) or a participating physician or other professional provider concerning a precertification for, or termination of coverage of, a health care service. A member may also appeal an adverse initial decision by Blue Medicare Advantage (PPO) concerning payment for a health care service. A member’s appeal of an initial decision about authorizing health care or terminating coverage of a service must generally be resolved by Blue Medicare Advantage (PPO) within 30 calendar days, or sooner if the member’s health condition requires. An appeal concerning payment must generally be resolved within 60 calendar days.

If the normal time period for an appeal could jeopardize the life or health of the member or the member’s ability to regain maximum function, the member or the member’s physician or other professional provider can request an expedited appeal. Such appeal is generally resolved within 72 hours unless it is in the member’s interest to extend this time period. When a member or physician or other professional provider requests an expedited appeal, Blue Medicare Advantage (PPO) will automatically expedite the appeal.

A special type of appeal applies only to Hospital discharges. If the member thinks Blue Medicare Advantage (PPO) coverage of a Hospital stay is ending too soon, the member can appeal directly and immediately to the Quality Improvement Organization (QIO). However, such an appeal must be requested no later than noon on the first working day after the day the member gets notice that Blue Medicare Advantage (PPO) coverage of the stay is ending. If the member misses this deadline, the member can request an expedited appeal from Blue Medicare Advantage (PPO).

Another special type of appeal applies only to a member dispute regarding when coverage will end for skilled nursing facility (SNF), Home Health Agency (HHA) or comprehensive outpatient rehabilitation facility services (CORF). SNFs, HHAs and CORFs are responsible for providing Members with a written notice at least two days before their services are scheduled to end. If the member thinks their coverage is ending too soon, the member can appeal directly and immediately to the QIO. If the member gets the notice 2 days before coverage ends, the member must request an appeal to the QIO no later than noon of the first day after the day the member gets the notice. If the member gets the notice more than 2 days before coverage ends, then the member must make the request no later than noon the day before the date that coverage ends. If the member misses the deadline for appealing to the QIO, the member can request an expedited appeal from Blue Medicare Advantage (PPO).

Continued on next page
Initial Decisions, Appeals and Grievances, continued

Further Appeal Rights

If Blue Medicare Advantage (PPO) denies the member’s appeal in whole or part, Blue Medicare Advantage (PPO) will forward the appeal to an independent review entity (IRE) that has a contract with the federal government and is not part of Blue Medicare Advantage (PPO). This organization will review the appeal and, if the appeal involves a precertification/preauthorization for health care, make a decision within 30 days. If the appeal involves payment for care, the IRE will make the decision within 60 days. If the appeal involves an expedited reconsideration decision, the IRE will make the decision within 72 hours.

If the IRE issues an adverse decision and the amount at issue meets a specified dollar threshold, the member may appeal to an Administrative Law Judge (ALJ). If the member is not satisfied with the ALJ’s decision, the member may request review by the Medicare Appeals Council (MAC). If the MAC refuses to hear the case or issues an adverse decision, the Member may be able to request Federal Judicial Review (FJR).

Participating Physician and other Professional Provider Obligations – Organization Determinations

At each patient encounter with a Blue Medicare Advantage (PPO) member, the participating physician or other professional provider must notify the member of his or her right to receive, upon request, a detailed written notice from Blue Medicare Advantage (PPO) regarding the member’s services. The participating physician’s or other professional provider’s notification must provide the member with the information necessary to contact Blue Medicare Advantage (PPO) and must comply with any other requirements specified by Centers for Medicare & Medicaid Services (CMS). If a member requests Blue Medicare Advantage (PPO) to provide a detailed notice of a participating physician’s or other professional provider’s decision to deny a service in whole or part, Blue Medicare Advantage (PPO) must give the member a written notice of the determination.

Participating Physician and other Professional Provider Obligations – Appeals

Participating physicians and other professional providers must also cooperate with Blue Medicare Advantage (PPO) and members in providing necessary information to resolve the appeals within the required time frames. Participating physicians and other professional providers must provide the pertinent medical records and any other relevant information. In some instances, participating physicians and other professional providers must provide the records and information quickly in order to allow Blue Medicare Advantage (PPO), the IRE or QIO to make an expedited decision.

Continued on next page
Members’ Rights and Responsibilities

Rights

Blue Medicare Advantage (PPO) members have the right to timely, high quality care, and treatment with dignity and respect. Participating physicians and other professional providers must respect the rights of all Blue Medicare Advantage (PPO) members.

Blue Medicare Advantage (PPO) members have been informed that they have the following rights:

- Choice of a qualified participating physician and other professional provider and contracting hospital;

- Candid discussion of appropriate or Medically Necessary treatment options for their condition, regardless of cost or benefit coverage;

- Timely access to their participating physician and other professional provider and recommendations to specialty care physicians and other professional providers when Medically Necessary;

- To receive Emergency Services when the member, as a prudent layperson, acting reasonably would believe that an Emergency Medical Condition exists;

- To actively participate in decisions regarding their health and treatment options;

- To receive Urgently Needed Services when traveling outside of the Blue Medicare Advantage (PPO) Service Area or in the Blue Medicare Advantage (PPO) Service Area when unusual or extenuating circumstances prevent the member from obtaining care from a participating physician and other professional provider;

- To request the aggregate number of grievances and appeals and dispositions;

- To request information regarding physician and other professional provider compensation;

- To request information regarding the financial condition of Blue Medicare Advantage (PPO);
Members’ Rights and Responsibilities, continued

- To be treated with dignity and respect and to have their right to privacy recognized;

- To exercise these rights regardless of the member’s race, physical or mental ability, ethnicity, gender, sexual orientation, creed, age, religion or national origin, cultural or educational background, economic or health status, English proficiency, reading skills, or source of payment for care;

- To confidential treatment of all communications and records pertaining to the member’s care;

- To access, copy and/or request amendment to the member’s medical records consistent with the terms of HIPAA;

- To extend their rights to any person who may have legal responsibility to make decisions on the member's behalf regarding the member's medical care;

- To refuse treatment or leave a medical facility, even against the advice of physicians and other professional providers (providing the member accepts the responsibility and consequences of the decision); and

- To complete an Advance Directive, living will or other directive to the member’s physicians or other professional providers.

Continued on next page
Members’ Rights and Responsibilities, continued

Responsibilities

Blue Medicare Advantage (PPO) members have been informed that they have the following responsibilities:

- To get familiar with their coverage and the rules they must follow to get care as a member;

- To give their physician or other professional provider and other providers the information they need to care for them, and to follow the treatment plans and instructions that they and their physicians and other professional providers agree upon. To be sure to ask their physician or other professional provider and other providers if they have any questions;

- To act in a way that supports the care given to other patients and to help the smooth running of their physician’s or other professional provider’s office, hospitals, and other offices;

- To pay their plan premiums and any copayments they may owe for the covered service they receive. They must also meet their financial responsibilities; and

- To let Blue Medicare Advantage (PPO) know if they have any questions, concerns, problems, or suggestions.

Continued on next page
Members’ Rights and Responsibilities, continued

Member Satisfaction
Blue Medicare Advantage (PPO) periodically surveys members to measure overall customer satisfaction as well as satisfaction with the care received from participating physicians and other professional providers. Survey information is reviewed by Blue Medicare Advantage (PPO) and results are shared with the participating physicians and other professional providers.

Services Provided in a Culturally Competent Manner
Blue Medicare Advantage (PPO) is obligated to ensure that services are provided in a culturally competent manner to all Blue Medicare Advantage (PPO) members, including those with limited English proficiency or reading skills, and diverse cultural and ethnic backgrounds. Participating physicians and other professional providers must cooperate with Blue Medicare Advantage (PPO) in meeting this obligation.

Blue Medicare Advantage (PPO) Member Customer Service (phone number is listed on the back of the Member’s ID card) has available the following services for Blue Medicare Advantage (PPO) members:
- Teletypewriter (TTY) services
- Language services, and
- Spanish speaking Customer Service Representatives

Advance Directive
Blue Medicare Advantage (PPO) members have the right to complete an “Advance Directive” statement. This statement indicates, in advance, the member’s choices for treatment to be followed in the event the member becomes incapacitated or otherwise unable to make medical treatment decisions. Blue Medicare Advantage (PPO) suggests that participating physicians and other professional providers have Advance Directive forms in their office and available to members.

Member Complaints and Grievances
Blue Medicare Advantage (PPO) tracks all complaints and grievances to identify areas of improvement for Blue Medicare Advantage (PPO). This information is reviewed by the Quality Improvement Committee.
### Obligation to Provide Access to Care

The following appointment availability access guidelines should be used to ensure timely access to medical care and behavioral health care:

- Initial visit – within 30 days
- Preventive care – within 30 days
- Urgent care visit – within 24 hours
- Symptomatic non-urgent care-within 5 days
- Emergency Care immediately or directed to emergency room

Adherence to member access guidelines will be monitored through the office site visits and the tracking of complaints/grievances related to access and availability which are reviewed by the Clinical Quality Improvement Committee.

All participating physicians and other professional providers and hospitals/facilities will treat all Blue Medicare Advantage (PPO) members with equal dignity and consideration as their non-Blue Medicare Advantage (PPO) patients.

### Physician and other Professional Provider Availability

Participating physicians and other professional providers shall provide coverage 24 hours a day, 7 days a week. When a participating physician and other professional provider is unavailable to provide services, he or she must ensure that another participating physician and other professional provider is available. Hours of operation must not discriminate against Blue Medicare Advantage (PPO) members relative to other members.

The member should normally be seen within 30 minutes of a scheduled appointment or be informed of the reason for delay (e.g. emergency cases) and be provided with an alternative appointment.

After hours access shall be provided to assure a response to after hour phone calls. Individuals who believe they have an Emergency Medical Condition should be directed to immediately seek emergency services.

### Physician and other Professional Provider Office Confidentiality Statement

Blue Medicare Advantage (PPO) members have the right to privacy and confidentiality regarding their health care records and information. Participating physicians and other professional providers and each staff member will sign an Employee Confidentiality Statement to be placed in the staff member’s personnel file.

Continued on next page
Obligation to Provide Access to Care, continued

**Prohibition Against Discrimination**

Neither Blue Medicare Advantage (PPO) or participating physicians and other professional providers may deny, limit, or condition the coverage or furnishing of services to Members on the basis of any factor that is related to health status, including, but not limited to the following:

1. Medical condition, including mental as well as physical illness;
2. Claims experience;
3. Receipt of health care;
4. Medical history;
5. Genetic information;
6. Evidence of insurability, including conditions arising out of acts of domestic violence;
7. Disability;
8. Race, ethnicity, national origin;
9. Religion;
10. Sex, sexual orientation;
11. Age;
12. Mental or physical disability; or
13. Source of payment

Participating physicians and other professional providers must have practice policies demonstrating that they accept for treatment any member in need of health care services they provide.
### Glossary of Terms

*(For Use in this Blue Medicare Advantage (PPO) Supplement Only)*

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeal</td>
<td>Any of the procedures that deal with the review of adverse organization determinations on the health care services a member is entitled to receive or any amounts that the member must pay for a covered service. These procedures include reconsiderations by Blue Medicare Advantage (PPO), an independent review entity (IRE), hearings before Administrative Law Judge (ALJ), review by the Medicare Appeals Council and Federal Judicial Review.</td>
</tr>
<tr>
<td>Basic Benefits</td>
<td>All health care services that are covered under the Medicare Part A and Part B programs except Hospice services and additional benefits. All Members of Blue Medicare Advantage (PPO) receive all Basic Benefits.</td>
</tr>
<tr>
<td>Centers for Medicare &amp; Medicaid Services (CMS)</td>
<td>The Centers for Medicare &amp; Medicaid Services, the Federal Agency responsible for administering Medicare.</td>
</tr>
<tr>
<td>Covered Services</td>
<td>Those benefits, services or supplies which are:</td>
</tr>
<tr>
<td></td>
<td>• Provided or furnished at the in-network benefit level by participating physicians and other professional providers or authorized by Blue Medicare Advantage (PPO) or its participating physicians and other professional providers;</td>
</tr>
<tr>
<td></td>
<td>• Provided or furnished by non-participating physicians and other professional providers at the in-network benefit level when authorized by Blue Medicare Advantage (PPO) due to network inadequacy or continuity of care concerns;</td>
</tr>
<tr>
<td></td>
<td>• Provided or furnished by non-participating physicians and other professional providers at the out-of-network (OON) benefit level;</td>
</tr>
<tr>
<td></td>
<td>• Emergency Services that are provided or furnished at the in-network benefit level, and may be provided by non-participating physicians and other professional providers;</td>
</tr>
<tr>
<td></td>
<td>• Renal dialysis services provided at the in-network benefit level while the member is temporarily outside the Service Area; and</td>
</tr>
<tr>
<td></td>
<td>• Basic and Supplemental Benefits.</td>
</tr>
</tbody>
</table>

*Continued on next page*
<table>
<thead>
<tr>
<th><strong>Glossary of Terms</strong>, continued</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>(For Use in this Blue Cross Medicare Advantage (PPO) Supplement)</em></td>
</tr>
</tbody>
</table>

### Emergency Medical Condition
Medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson possessing an average knowledge of medicine and health to believe that his or her condition, sickness, or injury is of such a nature that failure to receive immediate medical care could result in:

- Serious jeopardy of the patient’s health;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious disfigurement; or
- Serious jeopardy to the health of the fetus, in the case of a pregnant patient.

### Experimental Procedures and Items
Items and procedures determined by Blue Medicare Advantage (PPO) and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, Blue Medicare Advantage (PPO) will follow CMS guidance (via the Medicare Carriers Manual and Coverage Issues Manual) if applicable or rely upon determinations already made by Medicare.

### Grievance
Any complaint or dispute other than one involving an Organization Determination. Examples of issues that involve a complaint that will be resolved through the Grievance rather than the Appeal process are: waiting times in physician or other professional provider offices; and rudeness or unresponsiveness of Customer Service Staff.

### Home Health Agency
A Medicare-certified agency which provides intermittent Skilled Nursing Care and other therapeutic services in the member’s home when Medically Necessary, when members are confined to their home and when authorized by their participating physician or other professional provider.

### Hospice
An organization or agency, certified by Medicare, which is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

### Hospital
A Medicare-certified institution licensed in the state of Texas, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term "Hospital" does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily Custodial Care, including training in routines of daily living.

*Continued on next page*
### Medically Necessary
Services or supplies that: are proper and needed for the diagnosis or treatment of a medical condition; are used for the diagnosis, direct care, and treatment of a medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of a Member or a member’s physician or other professional provider.

### Medicare
The Federal Government health insurance program established by Title XVIII of the Social Security Act.

### Medicare Part A
Hospital Insurance benefits including inpatient Hospital care, Skilled Nursing Facility care, Home Health Agency care and Hospice care offered through Medicare.

### Medicare Part B
Supplemental medical insurance that is optional and requires a monthly premium. Part B covers physician services (in both Hospital and non-hospital settings) and services furnished by certain non-physician practitioners. Other Part B services include lab testing, durable medical equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services, and blood not covered under Part A.

### Medicare Advantage (MA) Plan
A policy or benefit package offered by a Medicare Advantage Organization under which a specific set of health benefits are offered at a uniform premium and uniform level of cost-sharing to all Medicare beneficiaries residing in the service area covered by the Medicare Advantage Organization. A Medicare Advantage Organization may offer more than one benefit Plan in the same Service Area. HISC is a Medicare Advantage Organization and Blue Medicare Advantage (PPO) is a Medicare Advantage Plan.

### Member
The Medicare beneficiary entitled to receive Covered Services, who has voluntarily elected to enroll in the Blue Medicare Advantage (PPO) and whose enrollment has been confirmed by CMS.

### Non-Contracting Medical Physician or other Professional Provider or Facility
Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the state of Texas or Medicare to deliver or furnish health care services; and who is neither employed, owned, operated by, nor under contract with Blue Medicare Advantage (PPO) to deliver Covered Services to Blue Medicare Advantage (PPO) members.
### Glossary of Terms, continued
*(For Use in this Blue Cross Medicare Advantage (PPO) Supplement)*

| **Participating Physician or other Professional Provider** | The participating physician or other professional provider who a member chooses to coordinate their health care is responsible for providing covered services for Blue Medicare Advantage (PPO) members and coordinating specialty care. Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the state of Texas and Medicare to deliver or furnish health care services. This individual or institution has a written agreement with Blue Medicare Advantage (PPO) to provide services directly or indirectly to Blue Medicare Advantage (PPO) members pursuant to the terms of the agreement. |
| **Quality Improvement Organization (QIO)** | The independent quality review and improvement organization approved by CMS. Texas Medical Foundation is the QIO for Blue Medicare Advantage (PPO). |
| **Service Area** | A geographic area approved by CMS within which an eligible individual may enroll in a Medicare Advantage Plan. The approved state of Texas Service Area for Blue Medicare Advantage (PPO) includes the following counties: |
| | - **Austin area** – Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis and Williamson. |
| | - **Dallas area** – Collin, Dallas, Denton and Tarrant. |
| | - **Houston area** – Fort Bend, Harris and Montgomery. |
# Blue Cross Medicare Advantage (PPO) Key Contacts List

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Customer Service</td>
<td>(call) 877-774-8592</td>
</tr>
<tr>
<td>Member Customer Service</td>
<td>(call) 877-774-8592</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>(call) 877-774-8592 (fax) 855-874-4711</td>
</tr>
<tr>
<td>Appeals &amp; Grievances</td>
<td>Blue Medicare Advantage (PPO)</td>
</tr>
<tr>
<td>&amp; Grievances</td>
<td>P.O. Box 4288</td>
</tr>
<tr>
<td>Provider Customer Service</td>
<td>Scranston, PA 18505</td>
</tr>
<tr>
<td>Member Customer Service</td>
<td>(call) 877-774-8592 (fax) 855-674-9185</td>
</tr>
<tr>
<td>Utilization Management (Preauthorization for</td>
<td>Blue Medicare Advantage (PPO)</td>
</tr>
<tr>
<td>Medical &amp; Behavioral Health Services)</td>
<td>P.O. Box 4288</td>
</tr>
<tr>
<td>Provider Customer Service</td>
<td>Scranston, PA 18505</td>
</tr>
<tr>
<td>Member Customer Service</td>
<td>(call) 877-774-8592 (fax) 855-674-9189</td>
</tr>
<tr>
<td>Electronic Medical Claim Submission</td>
<td>BCBSTX Electronic Payor ID 84980</td>
</tr>
<tr>
<td>Paper Medical Claim</td>
<td>Blue Medicare Advantage (PPO)</td>
</tr>
<tr>
<td>All Other General Correspondence</td>
<td>P.O. Box 660044</td>
</tr>
<tr>
<td>&amp; Grievances</td>
<td>Dallas, TX 75266-0044</td>
</tr>
<tr>
<td>Provider Status</td>
<td>Blue Medicare Advantage (PPO)</td>
</tr>
<tr>
<td>Care Management Programs</td>
<td>P.O. Box 4555</td>
</tr>
<tr>
<td>(Medical &amp; Behavioral Health)</td>
<td>Scranton, PA 18505</td>
</tr>
<tr>
<td>Provider Status</td>
<td>(fax) 855-674-9192</td>
</tr>
<tr>
<td>CMS Website</td>
<td>cms.gov</td>
</tr>
</tbody>
</table>

**iEXCHANGE** (Web-based application used to submit transaction requests for inpatient admissions and extensions, treatment searches, provider / member searches, referral authorizations and select outpatient services and extensions)

- **Web Application** → [bcbstx.com/provider](http://bcbstx.com/provider)
- **IVR** → 877-774-8592 (Press prompt for Interactive Voice Response System Help Desk)

**Behavioral Health Customer Service**

- (call) 877-774-8592

**Care Management Programs**

- (Medical & Behavioral Health)
- (call) 855-390-6567

**Outpatient Clinical Reference Lab**

Clinical Pathology Laboratories (CPL)

- To schedule an appointment, go to [http://www.cpllabs.com](http://www.cpllabs.com)
- Call Customer Service (call) 512-873-1600

**Provider Status**

(To verify a provider’s status, access the Online Provider Directory)

- [Online Provider Directory](http://www.cpllabs.com) (Provider Finder)

**CMS Website**

- cms.gov