of Tennessee
1 Cameron Hill Circle
Chattanooga, TN 37402
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BlueAdvantage[SM] Health Management

BlueAdvantage member benefits include access to a comprehensive health management program designed to encompass total health needs and promote access to individualized, appropriate, quality and cost-effective care to improve quality of life. This program assists members in achieving quality outcomes by equipping and guiding them through the entire health care process without delay or interruption of services. Through these programs treatment options and barriers to optimal outcomes are identified.

Some objectives of the program include:
- Maximizing opportunities to positively influence health status and outcomes
- Facilitating practitioner collaboration
- Facilitating member agreement and participation, member education and empowerment
- Facilitating family and community support
- Promoting quality care in the most appropriate setting
- Empowering members to make informed health care decisions

This program focuses on changing health behavior relative to risk identification through member engagement, enrollment into appropriate program(s), health coaching, follow-up, outcomes reporting and integration of services.

Once a member is enrolled in this program, a member of the BlueAdvantage health management team works with him or her for the entirety of the program. The program includes:
- Care Coordination
- Transition of Care
- Disease Management
- Transplant Management
- Case Management
- Behavioral Health Management
- End-of-Life Planning
- Utilization Management
- Emergency Services Management

The BlueAdvantage health management team consists of Medical Directors who are Physicians, Pharmacists, Registered Nurses and Licensed Behavioral Health Professionals and Social Workers with experience in various health care settings. Staff, who assists with outreach activities, education efforts and member referrals to appropriate health management programs, supports these team members.

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The BlueAdvantage health management team is experienced in coordinating and developing management plans specific to each individual's health care needs and the treatment plan ordered by his or her doctor. The health management program is implemented through telephonic, written or web-based communication. Additionally, the program's team works closely with family members or caregivers, doctors and other health care provider to help a member have better control of their health and care, and achieve maximum outcomes.

Care Coordination Program

The Care Coordination Program involves the full spectrum of care coordination. This program is intended to:

- stabilize members' health condition/disease
- promote self-management by providing members with the tools and education they need to make informed decisions about their health care
- encourage and provide members with tools for active participation in managing their condition(s)
- arrange for care in the most appropriate setting and care that is necessary for self-management

This program is particularly helpful to BlueAdvantage members since many of them have multiple chronic diseases. Members are provided access to the highest quality care with optimal utilization of benefits and resources, including appropriate utilization of treatment, services and community resources. Care Coordination is designed to decrease the need for crisis intervention through symptom management and reduce the incidence of emergent care and acute care hospitalization. Members or family members/caregivers are actively involved in determining individual program goals and objectives.

Transition of Care

The Transition of Care (TOC) Program helps members successfully move from the inpatient environment to the appropriate level of post-hospital care. The TOC team confers with hospital utilization review staff, Case Managers, Social Workers, Practitioners and members/responsible parties to identify discharge planning needs. Members of the BlueAdvantage health management team conduct medical review activities to ensure that Skilled Nursing Facilities (SNF) admissions meet clinical criteria. The health management team also follows members in selected hospitals until they are discharges to another facility or until thirty (30) days after discharge to

home. Members who have continued care needs thirty (30) days after hospital discharge are referred to Case Management.

Disease Management

Disease Management involves the same interventions as Care Coordination; however, it is disease specific. It is a system of coordinated health care interventions and communications for members with conditions that require significant patient self-care efforts. Disease Management emphasizes prevention of exacerbations and complications through education and monitoring, and evaluation of clinical outcomes on an ongoing basis with the goal of overall health. Currently, disease states being managed through this program are Diabetes, Congestive Heart Failure and Coronary Artery Disease.

The primary goal of Disease Management is to stabilize the member's health condition/disease and provide them with the tools, education and care necessary for self-management. The program promotes the member and caregiver's active participation in management of the disease process resulting in an increased knowledge of the disease process, prevention and treatment. Additionally, the member increases his/her knowledge of healthy lifestyle changes and co-morbid management. The treating physician's involvement is an integral part of the program and development of an individualized plan of care and desired outcomes. The program supports the physician by reinforcing education, monitoring and reporting.

Transplant Management

Transplant Management focuses on the entire spectrum of transplant care. Member participation in transplant case management is mandatory. The care of the member is managed from the time the possibility of a transplant need is identified and continues up to twelve months post-transplant.

Case Management

Members with complex health care needs, unstable multi-disease states and conditions in which a longer period of management will be required are managed through intensive case management. Complex and catastrophic conditions such as trauma, AIDS, extensive burns and Guillain-Barre' syndrome are managed through an intensive approach of assessing, planning, coordinating, implementing and evaluating care for the multiple health and psychosocial needs of the member.

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Behavioral Health Management

The Behavioral Health Management Program focuses on behavioral needs of the member as well as physical needs. Members with behavioral health diagnoses are monitored closely to identify their immediate and ongoing needs and plan a course of care in collaboration with treating physicians, family members and other members of the health care team.

An important component of Behavioral Health Management is providing education regarding medication compliance, recognizing symptoms, helping the member understand when to contact his or her physician and when to seek emergency treatment. Identifying triggers that exacerbate symptoms is discussed with the member and/or family, and assistance is provided to determine strategies for avoiding these triggers. Other program components include substance abuse strategies, various assessment tools (i.e., suicide risk) as well as identifying and facilitating appropriate alternatives to admissions (i.e., individual or group treatment on an outpatient basis, self-help group referral, day treatment and partial hospitalization).

End of Life Planning

End of Life issues have a significant impact on the Medicare Advantage population due to advanced age and the large numbers of members with chronic conditions. As such, Case Managers empower members by educating them about and assisting them in the development of their own end-of-life plans including necessary discussions with health care providers and caregivers. Case Managers focus on optimal management of the member's condition through:

- symptom and pain management
- promotion of collaboration between all members of the healthcare team
- assuring that the member and/or caregiver is educated, supported and involved in decision making

Emergency Services Management

This program focuses on identifying and assisting members who routinely use emergency services to meet their health and psychosocial needs. By promoting better self-management, this program prevents unnecessary utilization of emergency care. The health management team:

- assesses members' medical and social needs
- provides members with appropriate tools and education for better self-management
- connects members to needed services

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Contact Numbers for the Programs Above

Phone: 1-800-611-3489 or (423) 535-3478
Fax: 1-800-727-0841

Utilization Management

BlueAdvantage health management programs adhere to Centers for Medicare & Medicaid Services (CMS) Medicare Advantage rules and regulations promulgated in 42 CFR § 422 and CMS' Internet Only Medicare Managed Care Manual. CMS requirements for Medicare Advantage vary from the requirements for Original Medicare. Chapter 13 of the Managed Care Manual is a significant reference used to implement BlueAdvantage's health management programs.

The BlueAdvantage Health Management program follows guidelines in accordance with the beneficiary's plan contract and applicable regulations and guidance listed in the BlueCross BlueShield of Tennessee Provider Administration Manual for both decisions and references in making medical necessity determinations.

The hierarchy of decision is that the service must meet clinical information for Medical Appropriateness using:

1. Title 18 of the Social Security Act
2. Title 42 Code of Federal Regulations Parts 422 and 476
3. Coverage in CMS Interpretive Manuals (Claims Processing Manual, Benefit Policy Manual, Program Integrity Manual, Quality Improvement Organization Manual, and Medicare Managed Care Manual)
4. National Coverage Determinations
5. Local Coverage Determinations
6. Milliman Care Guidelines®
7. BlueCross BlueShield of Tennessee Adopted Guidelines
8. BlueCross BlueShield of Tennessee Medical Policy
9. Durable Medical Equipment Regional Carrier Guidelines
10. BlueCross BlueShield of Tennessee claim payment system and other major payer policy and peer reviewed literature

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Advance Determinations for PFFS

Advance Determinations are encouraged to allow members and providers to receive a Medical Necessity and Appropriateness coverage determination before services are rendered to ensure members are receiving Medically Necessary services in the most appropriate setting and allow providers to receive a coverage determination prior to performing a service and requesting reimbursement. Claims submitted for services that are not reviewed prospectively will be reviewed retrospectively for Medical Appropriateness to determine coverage and reimbursement. If claim information alone does not provide sufficient information to make a Medical Appropriateness determination, the provider will receive a written request for medical records. If additional clinical information is requested, the review and claims processing will be completed when the requested information is received. Advance Determination is recommended for the following:

- Medical Necessity and Appropriateness determinations before services are provided
- All acute care facility, skilled nursing facility, rehabilitation and behavioral health facility inpatient stays
- Specialty Pharmacy Medications and some Part B Medications (see www.bcbst.com/providers/pharmacy.shtml)
- Durable medical equipment for purchase or rentals if the purchase price is greater than $500
- Orthotics and prosthetics if the purchase price is greater than $200
- Speech therapy, occupational therapy and physical therapy (excludes physical therapy evaluations)
- Home Health services including those for home infusion therapy

An authorization number is issued when care and treatment are determined to be Medically Necessary and Medically Appropriate.

Requests for Notification:

BlueCross BlueShield of Tennessee should be notified of all emergency admissions within 24 hours or one (1) business day after services have started. Notification is especially important for members who required emergency admissions as they would likely benefit from health management programs.

Specific Medical Review Guidelines for Advance Determinations are located in the BlueCross BlueShield of Tennessee Provider Administrator Manual, Section XXIV, Medicare Advantage at www.bcbst.com.

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Prior Authorization (Required for PPO/NOT required for PFFS)

All health management program requirements, notifications and guidelines are the same for both Preferred Provider Organization (PPO) and Private Fee for Service (PFFS) products except prior authorization is required for the PPO to render determinations of coverage, Medical Necessity and Appropriateness before services are provided. Prior Authorization for coverage and Medical Necessity is required for:

- All acute care facility, skilled nursing facility, rehabilitation and behavioral health facility inpatient stays
- Certain Part B Specialty Pharmacy Medications (see www.bcbst.com/providers/pharmacy.shtml)
- Durable medical equipment for purchase or rentals if the purchase price is greater than $500
- Orthotics and prosthetics if the purchase price is greater than $200
- Speech therapy, occupational therapy and physical therapy (excludes physical therapy evaluations)
- Home Health services including those for Home infusion therapy

An authorization number is issued when care and treatment are determined to be Medically Necessary and Medically Appropriate.

Non-Compliance with Prior Authorization Requirements

Services requiring prior authorization without obtaining approval are considered "non-compliant" when prior authorization is required. Provider must obtain authorization prior to scheduled services.

Non-compliance applies to initial as well as concurrent review for ongoing services beyond dates previously approved. Failure to comply within specified authorization timeframes will result in a denial or reduced benefits due to non-compliance. BlueCross BlueShield of Tennessee providers cannot bill members for covered services denied due to non-compliance by the provider.

If a member does not inform the provider that he/she has BlueCross BlueShield of Tennessee coverage and the provider discovers the member has BlueCross BlueShield of Tennessee coverage, the provider should send a copy of the medical record relevant to the admission or services, along with the face sheet, to the UM Appeals Department. An appeal will only be overturned if both Medical Necessity is determined and there is clear evidence the facility was

not aware the member had BlueCross BlueShield of Tennessee coverage at the time services were rendered.

Retrospective Claims and Clinical Record Review

Retrospective claims reviews are conducted to provide a determination of Medical Necessity, as well as verification of eligibility and benefits. Claims are targeted for review based on National Coverage Determinations, Local Coverage Determinations and BlueCross BlueShield of Tennessee Medical Policy. Reviews are performed prior to claims payment using CMS processing guidelines (i.e., post-acute care transfer policy, low utilization payment adjustments, outlier payments, etc.). Retrospective clinical record reviews may be conducted to meet BlueCross BlueShield of Tennessee's CMS contractual requirements. Record review results support CMS and other regulatory agencies audits, applicable accreditation audits, quality improvement activities, Quality Improvement Organization (QIO) and Independent Review Entity (IRE) review processes and CMS' risk-adjusted payment processes.

Utilization Management Decision Notification

Written notification of the outcome of Medical Necessity reviews is provided to members, practitioners and facilities.

Related to written notification, BlueAdvantage has delegated to providers the responsibility for delivering a **Detailed Notice** (DN) to a member or authorized representative requesting an appeal of discharge from an inpatient facility or when BlueAdvantage no longer intends to continue coverage of a hospital inpatient admission. This notification should be delivered no later than noon of the day after the Quality Improvement Organization's (QIO) notification to BlueAdvantage request for delivery. A signed copy of the notification should be faxed to 1-888-535-5243 or (423) 535-5243.

BlueAdvantage has also delegated to Home Health Agencies (HHA), Skilled Nursing Facilities (SNF) and Comprehensive Outpatient Rehabilitation Facilities (CORF) providers the responsibility for delivering a Notice of Medicare Non-Coverage (NOMNC) a standardized written notice that provides specific, and detailed information to Medicare enrollees about why their SNF, HHA or CORF services are ending. The notice should be delivered no later than close of business (typically 4:30 p.m.) the day of the QIO's notification that the member requested an appeal, or the day before coverage ends, whichever is later.

A signed copy of the notification should be faxed to 1-888-535-5243 or (423) 535-5243.

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Chattanooga, TN 37402
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Contact Numbers for Utilization Management Programs

Phone: 1-800-924-7141
Fax Numbers: 1-888-535-5243 or (423) 535-5243

Reminder: Guidelines for reopening, reconsideration and appeal of adverse determinations/denials

Reopening

A Reopening is filed when a provider disagrees with a denial related to Medical Necessity. A reopening is a remedial action taken to change a final determination or decision even though the original determination or decision was correct based on the evidence of record.

There must be new, material evidence not available or known at the time of the determination or decision, and may result in a different conclusion; or the evidence considered in making the determination or decision clearly shows that an obvious error was made at the time of the original determination or decision. The following are guidelines for a reopening request:

- The request must be made in writing
- The request must be clearly stated
- The request must include the specific reason for requesting the reopening (a statement of dissatisfaction is not grounds for a reopening and should not be submitted).
- Timely submission of additional information (CMS 130.2)

For additional information on **Guidelines for a Reopening** go to The Centers for Medicare & Medicaid Services (CMS) website at www.cms.gov.

Reconsideration

Reconsiderations are filed when a provider disagrees with a denial related to coding or reimbursement. The Inquiry/Reconsideration Level is the first step in the Provider Dispute Resolution Procedure.

A written request for a standard reconsideration of the denial must be submitted within sixty (60) calendar days from the date of the notice of the determination. If applicable, include all pertinent information including prior correspondence, medical records and all documentation you wish to have considered in the final determination of the dispute.

Appeal

If dissatisfied with the outcome of the reconsideration review, providers can file an appeal request within thirty (30) days of receipt of the reconsideration response. The appeal request should state:

- The reason for the appeal
- Why the provider is dissatisfied with the reconsideration response
- Any additional information the provider would like considered in support of the appeal request

Guidelines for requesting a reconsideration or appeal are outlined in the Provider Dispute Resolution Procedure (PDRP). The Procedure and Provider Dispute Form is available in the BlueCross BlueShield of Tennessee Provider Administration Manual located on the Blue*Source* Provider Information CD as well as the Provider page of the company website, www.bcbst.com. Requests should be sent to:

BlueCross BlueShield of Tennessee
Attn: BlueAdvantage
1 Cameron Hill Circle
Chattanooga, TN 37402-0005

Authorized Representatives

An authorized representative is an individual appointed by a member or other party to act on behalf of a member or other party involved in the appeal. Unless otherwise stated, the representative will have all of the rights and responsibilities of a member in dealing with any of the levels of the appeals processes (reconsiderations, independent reviews, Administrative Law Judge hearings, Medicare Appeals Council reviews and judicial reviews).

A member may appoint any individual such as a relative, friend, advocate, an attorney or any physician to act as his or her representative and file an appeal on his or her behalf. Also, a representative may be authorized by the court or act in accordance with State law to file an appeal for a member. Either the signed representative form or other appropriate legal papers supporting an authorized representative's status must be included with each appeal. Unless revoked, an appointment is considered valid for one year from the date the appointment is signed by both the member and the representative. The representation is valid for the duration of the appeal. A photocopy of the signed representative form must be submitted with future appeals on

behalf of the member in order to continue representation. Any appeal received with a photocopied representative form that is more than one year old is invalid, and a new form must be executed by the member.

A reconsideration request will not be considered until the appropriate documentation is provided. The timeframe for processing a reconsideration request begins when appropriate documentation is received. A provider, physician or supplier may not charge a member for representation in an appeal. Administrative costs incurred by a representative during the appeals process are not reasonable costs for Medicare reimbursement purposes. A representative may:

- Obtain information about the member's claim to the extent consistent with current federal and state law
- Submit evidence
- Make statements of fact and law
- Make any request or give or receive any notice about the appeal proceedings.

A non-deemed provider, on his or her own behalf, is permitted to file a standard appeal for a denied claim only if the provider completes a waiver of liability statement, which provides that the provider will not bill the member regardless of the outcome of the appeal.

Quality of Care

A Quality of Care complaint may be filed through BlueAdvantage's grievance process and/or a Quality Improvement Organization (QIO) under contract by CMS to monitor and improve the care given to Medicare enrollees. QIOs review complaints raised by members 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 members receiving care in acute inpatient hospital facilities as well as coverage terminations in skilled nursing facilities, home health agencies and comprehensive outpatient rehabilitation facilities.

A QIO will determine whether the quality of services meet professionally recognized standards of health care, including whether appropriate health care services have been provided and whether they have been provided in appropriate settings.
Members have the right to an expedited review by a QIO when they disagree with BlueAdvantage's decision that Medicare coverage of their services should end. The member, or his or her representative, is responsible for contacting the QIO, within the specified timelines, if he or she wishes to obtain an expedited review.

The appeals process described above complies with CMS requirements and more detailed information is located in 42 CFR 422 Subpart M and CMS' Internet Only Managed Care Manual Chapter 13.

Member Rights

Relative to coverage determinations and appeals, member rights include, but are not limited to:

- The right to a timely determination.
- The right to request an expedited determination, or an extension and, if the request is denied, the right to receive a written notice that explains the member's right to file an expedited grievance.
- The right to a written notice from BlueAdvantage of its own decision to take an extension on a request for a determination that explains the reasons for the delay and explains the member's right to file an expedited grievance if he or she disagrees with the extension.
- The right to receive information regarding the member's ability to obtain a detailed written notice from BlueAdvantage regarding the member's services.
- The right to a detailed written notice of BlueAdvantage's decision to deny, terminate or reduce a payment or service in whole or in part, or to reduce the level of care in an ongoing course of treatment which includes the member's appeal rights.
- The right to request an expedited reconsideration.
- The right to request and receive dispute data from BlueAdvantage.
- The right to receive notice when an appeal is forwarded to the Independent Review Entity (IRE).
- The right to automatic reconsideration by an IRE contracted by CMS, when BlueAdvantage upholds its original adverse determination in whole or in part.
- The right to an Administrative Law Judge (ALJ) hearing if the IRE upholds the original adverse determination in whole or in part and the amount remaining in controversy meets the appropriate threshold requirement, as set forth in CMS' Internet Only Managed Care Manual Chapter 13 section 100.2.
- The right to request Medicare Appeals Council (MAC) review if the ALJ hearing decision is unfavorable to the member in whole or in part.
- The right to judicial review of the hearing decision if the ALJ hearing and/or MAC review is unfavorable to the member, in whole or in part, and the amount remaining in controversy meets the appropriate threshold requirement, as set forth in CMS' Internet Only Managed Care Manual Chapter 13 section 120.
- The right to file a quality of care grievance with a QIO.

- The right to request a QIO review of a termination of coverage of inpatient hospital care. If a member receives immediate QIO review of a determination of non-coverage of inpatient hospital care, the above rights are limited. In this case, the member is not entitled to the additional review of the issue by BlueAdvantage. The QIO review decision is subject to an ALJ hearing if the amount in controversy meets the appropriate threshold, and review of an ALJ hearing decision or dismissal by the MAC. Members may submit requests for QIO review of determinations of non-coverage of inpatient hospital care in accordance with the procedures set forth in CMS' Internet Only Managed Care Manual Chapter 13 section 160.
- The right to request a QIO review of a termination of services in skilled nursing facilities (SNF), home health agencies (HHA) and comprehensive outpatient rehabilitation facilities (CORF). If a member receives QIO review of a SNF, HHA or CORF service termination, the member is not entitled to the additional review of the issue by BlueAdvantage. Members may submit requests for QIO review of provider settings in accordance with the procedures set forth in CMS' Internet Only Managed Care Manual Chapter 13 section 90.2.
- The right to request and be given timely access to the member's case file and a copy of that case subject to federal and state law regarding confidentiality of patient information. BlueAdvantage has the right to charge the member a reasonable amount, for example, the costs of mailing and/or an amount comparable to the charges established by a QIO for duplicating the case file material.
- The right to challenge local and national coverage determinations. Under §1869(f)(5) of the Act, as added by §522 of the Benefits Improvement and Protection Act (BIPA), certain individuals ("aggrieved parties") may file a complaint to initiate a review of National Coverage Determinations (NCDs) or Local Coverage Determinations (LCDs). Challenges concerning NCDs are reviewed by the DAB of the Department of Health and Human Services. Challenges concerning LCDs are reviewed by ALJs.