



**Blue Cross
Blue Shield
of Georgia**

SmartValueSM

**Provider Manual
2010**



**A Medicare Advantage Private
Fee For Service Plan**

TABLE OF CONTENTS

Introduction

Blue Cross Blue Shield of Georgia SmartValue Overview	1
Important Information for Providers	1
Provider Terms and Conditions	2
Provider Manual Overview.....	10
How to Use This Manual.....	10

Benefit Explanations & Limitations

Introduction	11
Authorized Services	11
Authorized Hospital Services.....	13
Limitations	13

Eligibility/Contract Changes/Terminations

Introduction	17
Eligibility Criteria	17
Enrollment.....	17
When Coverage Becomes Effective.....	17
Urgent Care Services.....	18
Termination of Coverage.....	18
Effective/Termination Date Coincides with a Hospital Stay.....	19

Benefit Administration

Introduction	20
Professional Services Administration	20
Right to Audit.....	20
Copayment/Coinsurance Schedule.....	22
Medicare Part D Prescription Drugs.....	23
Deductible	23
Initial Coverage Level (ICL).....	23
Coverage Gap	24
Catastrophic Coverage.....	24
Blue Cross Blue Shield Health Risk Assessment.....	24
General Service Guidelines	24
Payment Methodology.....	27

Provider Administration

Introduction	34
Compliance with CMS Regulations	34
Local Medicare Carrier Coverage Guidelines	34
Member Rights.....	35
Prohibiting Interference with Advice from Health Care Professionals	35
Prohibiting Indemnification by Health Care Professionals or Facilities	35

Member Issues

Overview.....	36
Member Grievance Resolution Procedure.....	36
Medicare Standard Reconsideration and Appeals Procedures.....	37
Medicare Expedited Appeal Procedure	40
Releasing Information to Members	43
Member Responsibility Policy.....	43
Member Remedial Actions.....	44
Prohibition on Discrimination, Discouragement of Enrollment	45
Advance Directives	45

Directory of Services

Introduction	46
Customer Service	46
Claim Submission	46
Medical Services	47
Medical Director.....	47

SECTION 1 – INTRODUCTION

SmartValue Overview

Blue Cross Blue Shield of Georgia (BCBSGA) has entered into a contract with the Centers for Medicare & Medicaid Services (CMS) authorizing it to provide Medicare covered services to Medicare beneficiaries through SmartValue. The SmartValue plans consists of the SmartValue Classic and SmartValue Plus plans.

The Balanced Budget Act of 1997 (BBA) established a Medicare Advantage Program that significantly expands the healthcare options available to Medicare beneficiaries. The introduction of this program represents the most significant change in the Medicare program since its inception in 1965. In 2003, the Medicare+Choice Program was renamed Medicare Advantage.

Section 4001 of the BBA (Public Law 105-33), enacted August 5, 1997, added sections 1851 through 1859 to the Social Security Act establishing a new Part C of the Medicare program, which is the Medicare Advantage Program. The new provisions address a wide range of areas, including eligibility, enrollment, benefits, beneficiary protections, quality assurance, participating healthcare professionals, payments to Medicare Advantage Organizations, premiums, contracting rules, appeals, and grievances. These new provisions are incorporated into the appropriate sections of the SmartValue Provider Manual.

Blue Cross Blue Shield of Georgia is committed to providing our medical partners with an accurate and up-to-date SmartValue Provider Manual. However, there may be instances where new procedures or processes are not immediately reflected in the manual. In such cases, BCBSGA makes every effort to publish updated documentation as quickly and efficiently as possible.

Important Information for Providers

SmartValue is an innovative plan concept that is easy to participate in. SmartValue is available to Medicare beneficiaries in selected areas.

SmartValue is a Medicare Advantage private fee-for-service plan. SmartValue allows members to use any doctor, specialist, or hospital that accept SmartValue's terms and conditions of Plan payment, as long as the provider is lawfully authorized to provide services under Original Medicare.

As a provider, you are deemed to accept Blue Cross Blue Shield of Georgia's terms and conditions if each of the following criteria are met:

- You are aware, in advance of furnishing medical services, that the member receiving the service is enrolled in a SmartValue plan.
- You obtain (or have reasonable opportunity to obtain) information about the SmartValue plans terms and conditions of payment through one or more of the following: the Plans's web site, the postal service, electronic mail, fax or telephone. As a practical matter this requirement is met where you have access to the terms and conditions of payment.
- You subsequently provide covered services to that member.

Once these conditions are met, you are considered a deemed provider for that member for that episode of care. A decision to treat a specific member for a specific episode of care does not obligate you, the provider, to treat other SmartValue members.

IF YOU DO NOT WANT TO BE A DEEMED PROVIDER, YOU SHOULD NOT FURNISH SERVICES TO A SMARTVALUE MEMBER EXCEPT FOR EMERGENCY SERVICES OR URGENTLY NEEDED SERVICES AS DEFINED UNDER 42CFR 422.113.

Providers furnishing emergency or urgently need services will be reimbursed the amounts they would receive under Original Medicare.



Blue Cross Blue Shield of Georgia CONTRACT YEAR 2010 MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLAN – TERMS AND CONDITIONS OF PAYMENT

1. Introduction

SmartValue is a Medicare Advantage private fee-for-service (PFFS) plan offered by Blue Cross Blue Shield of Georgia (BCBSGA). SmartValue allows members to use any provider, such as a physician, health professional, hospital, or other Medicare provider in the United States that agrees to treat the member after having the opportunity to review these terms and conditions of payment, as long as the provider is eligible to provide health care services under Medicare Part A and Part B (also known as 'Original Medicare') or eligible to be paid by SmartValue for benefits that are not covered under Original Medicare.

The law provides that if you have an opportunity to review these terms and conditions of payment and you treat a SmartValue member, you will be “deemed” to have a contract with us. Section 2 explains how the deeming process works. The rest of this document contains the contract that the law allows us to deem to hold between you, the provider, and SmartValue. Any provider in the United States that meets the deeming criteria in Section 2 becomes deemed to have a contract with SmartValue for the services furnished to the member when the deeming conditions are met. **No prior authorization, prior notification, or referral is required as a condition of coverage when medically necessary, plan-covered services are furnished to a member.** However, a member or provider may request an advance organization determination before a service is provided in order to confirm that the service is

medically necessary and will be covered by the plan. Note that the terms prior authorization, prior notification, and advance organization determination have different meanings. Prior authorization and prior notification rules are described in Section 4, and advance organization determination is described in Section 7.

2. When a provider is deemed to accept SmartValue's terms and conditions of payment

A provider is deemed by law to have a contract with SmartValue when all of the following three criteria are met:

1. The provider is aware, in advance of furnishing health care services, that the patient is a member of SmartValue. All of our members receive a member ID card that includes the SmartValue logo that clearly identifies them as PFFS members. The provider may validate eligibility by calling 800-676-BLUE, 24 hours a day, 7 days a week, or 866-364-2374 or by sending an electronic inquiry (HIPAA 270 eligibility) transaction to BCBSGA. Instructions for sending a HIPAA eligibility transaction can be found at www.bcbsga.com.
2. The provider either has a copy of, or has reasonable access to, our terms and conditions of payment (this document). The terms and conditions are available on our website at www.bcbsga.com. The terms and conditions may also be obtained by calling 866-364-2374, 24 hours a day, 7 days a week.

3. The provider furnishes covered services to a SmartValue member.

If all of these conditions are met, the provider is deemed to have agreed to SmartValue's terms and conditions of payment for that member specific to that visit. Note: You, the provider, can decide whether or not to accept SmartValue terms and conditions of payment each time you see a SmartValue member. A decision to treat one plan member does not obligate you to treat other SmartValue members, nor does it obligate you to accept the same member for treatment at a subsequent visit.

For example: If a SmartValue member shows you an enrollment card identifying him/her as a member of SmartValue and you provide services to that member, you will be considered a deemed provider. Therefore, it is your responsibility to obtain and review the terms and conditions of payment prior to providing services, except in the case of emergency services (see below).

If you DO NOT wish to accept SmartValue's terms and conditions of payment, then you should not furnish services to a SmartValue member, except for emergency services. If you nonetheless do furnish non-emergency services, you will be subject to these terms and conditions whether you wish to agree to them or not. Providers furnishing emergency services will be treated as non-contract providers and paid at the payment amounts they would have received under Original Medicare.

3. Provider qualifications and requirements

In order to be paid by SmartValue for services provided to one of our members, you must:

- Have a National Provider Identifier in order to submit electronic transactions to SmartValue, in accordance with HIPAA requirements.

- Submit paper claims to your local Blue Plan.
- Furnish services to a SmartValue member within the scope of your licensure or certification.
- Provide only services that are covered by our plan and that are medically necessary by Medicare definitions.
- Meet applicable Medicare certification requirements (e.g., if you are an institutional provider such as a hospital or skilled nursing facility).
- Not have opted out of participation in the Medicare program under §1802(b) of the Social Security Act, unless providing emergency or urgently needed services.
- Not be on the HHS Office of Inspectors General excluded and sanctioned provider lists.
- Not be a Federal health care provider, such as a Veterans' Administration provider, except when providing emergency care.
- Comply with all applicable Medicare and other applicable Federal health care program laws, regulations, and program instructions, including laws protecting patient privacy rights and HIPAA that apply to covered services furnished to members.
- Agree to cooperate with SmartValue to resolve any member grievance involving the provider within the time frame required under Federal law.
- For providers who are hospitals, home health agencies, skilled nursing facilities, or comprehensive outpatient rehabilitation facilities, provide applicable beneficiary appeals notices (See Section 10 for specific requirements).
- Not charge the member in excess of cost sharing and permitted balance billing under any condition, including in the event of plan bankruptcy.

4. Payment to providers

Plan payment

SmartValue reimburses deemed providers at the amount they would have received as participating or non-participating physicians, as applicable, under Original Medicare for Medicare-covered services, including billing up to the limiting charge for non-participating physicians, minus any member required cost sharing, for all medically necessary services covered by Medicare. SmartValue will pay Physician Quality Reporting Initiative (PQRI) bonus and e-prescribing incentive payment amounts to physicians who would receive them in connection with treating Medicare beneficiaries who are not enrolled in a Medicare Advantage plan.

We will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, then we will pay interest on the claim according to Medicare guidelines. Section 5 has more information on prompt payment rules. Payment to providers for which Medicare does not have a publicly published rate will be based on the estimated Medicare amount. For more detailed information about our payment methodology for all provider types, go to www.bcbsga.com.

Services covered under SmartValue that are not covered under Original Medicare are reimbursed using SmartValue's fee schedule. Please call us at 866-364-2374 to receive information on our fee schedule.

Deemed providers furnishing such services must accept the fee schedule amount, minus applicable member cost sharing, as payment in full.

Member benefits and cost sharing

Payment of cost sharing amounts is the responsibility of the member. Providers should collect the applicable cost sharing from the member at the time of the service when

possible. **You can only collect from the member the appropriate (Plan Name) co-payments or coinsurance amounts described in these terms and conditions.** After collecting cost sharing from the member, the provider should bill (Plan Name) for covered services. Section 5 provides instructions on how to submit claims to us.

If a member is a dual-eligible Medicare beneficiary (that is, the member is enrolled in our PFFS plan and a State Medicaid program), then the provider cannot collect any cost sharing for Medicare Part A and Part B services from the member at the time of service when the State is responsible for paying such amounts (nominal copayments authorized under the Medicaid State plan may be collected). Instead, the provider may only accept the MA plan payment (plus any Medicaid copayment amounts) as payment in full or bill the appropriate State source.

To view a complete list of covered services and member cost sharing amounts under SmartValue, go to www.bcbsga.com. You may call us at 866-364-2374 to obtain more information about covered benefits, plan payment rates, and member cost sharing amounts under SmartValue. Be sure to have the member's ID number when you call.

SmartValue follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by SmartValue, unless specified by the plan. Information on obtaining an advance coverage determination can be found in Section 7. SmartValue does not require members or providers to obtain prior authorization, prior notification, or referrals from the plan as a condition of coverage. Under prior authorization, a plan requires beneficiaries or providers to seek authorization from the plan prior to obtaining services. There is no such requirement for SmartValue members.

Note: Medicare supplemental policies, commonly referred to as Medigap plans, cannot cover cost sharing amounts for Medicare Advantage plans, including PFFS plans. All cost sharing is the member's responsibility.

No prior authorization or referral is required as a condition of coverage when medically necessary, plan-covered services are furnished to members. However, to assist us in better managing care for our members, we request that you notify us prior to the member receiving any of the following services: Inpatient Hospital Care, Inpatient Mental Health Care, and Skilled Nursing Facilities.

SmartValue does not require the member or the provider to prior notify the plan as a condition for covering services. To provide prior notification or to obtain more information about our prior notification rules, call us at 866-364-2374 or fill out the form located at bcbsga.com and fax it to 920-923-7572.

Balance billing of members

In addition to collecting applicable plan cost sharing amounts from SmartValue members, you may balance bill the member up to 15 % of the total plan payment amount for the service(s) furnished. Balance billing is allowed for Medicare covered services only.

Note that SmartValue does not permit a provider to balance bill a member who is also enrolled in a state Medicaid program and as a result the beneficiary is held harmless from Medicare cost sharing.

Hold harmless requirements

In no event, including, but not limited to, nonpayment by SmartValue, insolvency of SmartValue, and/or breach of these terms and conditions, shall a deemed provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse

against a member or persons acting on their behalf for plan-covered services provided under these terms and conditions. This provision shall not prohibit the collection of any applicable coinsurance, co-payments, or deductibles in addition to allowed balance billing amounts, billed in accordance with the terms of the member's benefit plan.

If any payment amount is mistakenly or erroneously collected from a member, you must make a refund of that amount to the member.

5. Filing a claim for payment

- o You must submit a claim to SmartValue for an Original Medicare covered services within the same time frame you would have to submit under Original Medicare, which is within 15-27 months from the date of service. Failure to be timely with claim submissions may result in non-payment. The criteria for Original Medicare submission of claims can be found in section 70 of Chapter 1 of the Medicare Claims Processing Manual located at <http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf>.
- **Prompt Payment** SmartValue will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, SmartValue will pay interest on the claim according to Medicare guidelines. A clean claim includes the minimum information necessary to adjudicate a claim, not to exceed the information required by Original Medicare. SmartValue will process all non-clean claims and notify providers of the determination within 60 days of receiving such claims.
- Submit claims using the standard CMS-1500, CMS-1450 (UB-04), or the appropriate electronic filing format.]

- Use the same coding rules and billing guidelines as Original Medicare, including Medicare CPT Codes, HCPCS codes and defined modifiers. Bill diagnosis codes to the highest level of specificity.
- Include the following on your claims:
 - National Provider Identifier.
 - The member's ID number, including the three character alpha prefix (on member ID card).
 - Date(s) of service.
 - Federal Tax ID number
 - Laboratories must include the CLIA number
- For providers that are paid based upon interim rates, include with your claim a copy of your current interim rate letter if the interim rate has changed since your previous claim submission.
- Coordination of Benefits: All Medicare secondary payer rules apply. These rules can be found in the Medicare Secondary Payer Manual located at <http://www.cms.hhs.gov/Manuals/IOM/list.asp>. Providers should identify primary coverage and provide information to SmartValue at the time of billing.
- Where to submit a claim:
 - For electronic claim submission, submit to your local Blue Plan.
 - For paper claim submission, submit to your local Blue Plan.
- If you have problems submitting claims to us or have any billing questions, contact our technical billing resource at 866-364-2374.

6. Maintaining medical records and allowing audits

Deemed providers shall maintain timely and accurate medical, financial and administrative records related to services they render to SmartValue members. Unless a longer time period is required by applicable statutes or regulations, the provider shall maintain such records for at least 10 years from the date of service.

Deemed providers must provide SmartValue, the Department of Health and Human Services, the Comptroller General, or their designees access to any books, contracts, medical records, patient care documentation, and other records maintained by the provider pertaining to services rendered to Medicare beneficiaries enrolled in a Medicare Advantage plan, consistent with Federal and state privacy laws. Such records will primarily be used for Centers for Medicare & Medicaid Services (CMS) audits of risk adjustment data upon which CMS capitation payments to SmartValue are based. Providers are required to furnish member medical records without charge when the medical records are required for government use.

SmartValue may also request records for activities in the following situations: SmartValue audits of risk adjustment data, determinations of whether services are covered under the plan, are reasonable and medically necessary, and whether the plan was billed correctly for the service; to investigate fraud and abuse; and in order to make advance coverage determinations. SmartValue will not use these records for any purpose other than the intended use.

SmartValue will not use medical record reviews to create artificial barriers that would delay payments to providers. Both mandatory and voluntary provision of medical records must be consistent with HIPAA privacy law requirements.

7. Getting an advance organization determination

Providers may choose to obtain a written advance coverage determination (known as an organization determination) from us before furnishing a service in order to confirm whether the service is medically necessary and will be covered by SmartValue. To obtain an advance organization determination, call us at 866-797-9884 or fill out the form located at www.bcbsga.com and fax it to 866-959-1537. SmartValue will make a decision and notify you and the member within 14 days of receiving the request, with a possible 14-day extension either due to the member's request or SmartValue justification that the delay is in the member's best interest. In cases where you believe that waiting for a decision under this time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy, you can request an expedited determination. To obtain an expedited determination, call us at 866-797-9884 or fill out the form located at www.bcbsga.com and fax it to 866-959-1537. We will notify you of our decision within 72 hours.

In the absence of an advance organization determination, SmartValue can retroactively deny payment for a service furnished to a member if we determine that the service was not covered by our plan or was not medically necessary. However, providers have the right to dispute our decision by exercising member appeals rights.

8. Provider payment dispute resolution process

If you believe that the payment amount you received for a service is less than the amount indicated in our terms and conditions of payment, you have the right to dispute the payment amount by following our dispute resolution process.

To file a payment dispute with SmartValue, send a written dispute to:
Anthem Blue Cross Blue Shield of Georgia
Attn: SmartValue Medicare Advantage
P.O. Box 795180
San Antonio, TX 78279

Additionally, please provide appropriate documentation to support your payment dispute e.g., a remittance advice from a Medicare carrier would be considered such documentation. Claims must be disputed within 120 days from the date payment is initially received by the provider.]

Note that in cases where we re-adjudicate a claim, for instance, when we discover that we processed it incorrectly the first time, you have an additional 120 days from the date you are notified of the re-adjudication in which to dispute the claim.

We will review your dispute and respond to you within 30 days from the time the provider payment dispute is first received by the plan. If we agree with the reason for your payment dispute, we will pay you the additional amount you are requesting, including any interest that is due. We will inform you in writing if our decision is unfavorable and no additional amount is owed.

After SmartValue's payment dispute resolution process is completed, if you still believe that we have reached an incorrect decision regarding payment on your claim, you may file an additional request for review with an independent review organization contracted by CMS. To file this additional request for review of a payment dispute with the independent review organization, you may contact the organization directly at:

First Coast Service Options, Inc.
Payment Dispute Resolution Contractor
P.O. Box 44017
Jacksonville, FL 32231-4017

FCSCO may also be reached by email at PDRC@fcso.com and by phone at (904) 791-6430. Note that you must first complete (Plan Name)'s payment dispute resolution process before you can request a review by the independent review organization.

9. Member and provider appeals and grievances

SmartValue members have the right to file appeals and grievances with SmartValue when they have concerns or problems related to coverage or care. Members may appeal a decision made by SmartValue to deny coverage or payment for a service or benefit that they believe should be covered or paid for. Members should file a grievance for all other types of complaints not related to the provision or payment for health care.

A physician who is providing treatment may, upon notifying the member, appeal pre-service organization determination denials to the plan on behalf of the member. The physician may also appeal a post-service organization determination denial as a representative, or sign a waiver of liability (promising to hold the member harmless regardless of the outcome) and appeal the denial using the member appeal process. There must be potential

member liability (e.g., an actual claim for services already rendered, as opposed to an advance organization determination), in order for a provider to appeal utilizing the member appeal process.

A non-physician provider may appeal organization determinations on behalf of the member as a representative, or sign a waiver of liability (promising to hold the member harmless regardless of the outcome) and appeal post-service organization determinations (e.g., claims) using the member appeal process. As noted above, there must be potential member liability in order for a provider to appeal utilizing the member appeal process.

If a provider appeals using the member appeal process, the provider agrees to abide by the statutes, regulations, standards, and guidelines applicable to the Medicare PFFS Member appeals and grievance processes.

The SmartValue Member Evidence of Coverage (EOC) provides more detailed information about the member appeal and grievance processes. The member EOC is posted under the member benefits link on the member information section of our website located at www.bcbsga.com. You can call our Provider Services Department at 866-364-2374 for more information on our member appeals and grievance policies and procedures.

10. Providing members with notice of their appeals rights - Requirements for Hospitals, SNFs, CORFs, and HHAs

Hospitals must notify Medicare beneficiaries, including Medicare Advantage beneficiaries enrolled in PFFS plans, who are hospital inpatients about their discharge appeal rights by complying with the requirements for providing the Important Message from Medicare (IM), including complying with the normal time frames for delivery. For copies of the notice and

additional information regarding this requirement, go to: http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp

Skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities must notify Medicare beneficiaries, including Medicare Advantage beneficiaries enrolled in PFFS plans, about their right to appeal a termination of services decision by complying with the requirements for providing the Notice of Medicare Non-Coverage (NOMNC), including complying with the normal time frames for delivery. For copies of the notice and the notice instructions, go to: <http://www.cms.hhs.gov/MMCAG/Downloads/NOMNCFORM.pdf> and <http://www.cms.hhs.gov/MMCAG/Downloads/NOMNCInstructions.pdf>. As directed in the instructions, the NOMNC should contain (Plan Name)'s contact information somewhere on the form (such as in the additional information section on page 2 of the NOMNC).

Hospitals, home health agencies, comprehensive outpatient rehabilitation facilities, or skilled nursing facilities must provide members with a detailed explanation on behalf of the plan if a member notifies the Quality Improvement Organization (QIO) that the member wishes to appeal a decision

regarding a hospital discharge (Detailed Notice of Discharge) or termination of home health agency, comprehensive outpatient rehabilitation facility or skilled nursing facility services (Detailed Explanation of Non-coverage) within the time frames specified by law.

11. If you need additional information or have questions

If you have general questions about SmartValue's terms and conditions of payment, contact us at 866-364-2374, 7 days a week from 8 a.m. to 8 p.m. CST. Detailed eligibility and benefit information is also available 24 hours a day 7 days a week via our Interactive Voice Response (IVR) telephone system in voice-back or fax-back formats.

Send mail to:

Anthem Blue Cross Blue Shield of Georgia
Attn: SmartValue Medicare Advantage
P.O. Box 795180
San Antonio, TX 78279.

- If you have questions about submitting claims, call us at 866-364-2374.
- If you have questions about plan payments, call us at 866-234-2374



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Provider Manual Overview

BCBSGA is committed to working with both the physician community and members to provide a high level of satisfaction in delivering quality care. The SmartValue Provider Manual is an integral part of this commitment. The manual provides comprehensive benefit information and communicates administrative policies and procedures to the medical community ensuring available and accessible medical care for every SmartValue member.

How to Use this Manual

The SmartValue Provider Manual is divided into sections, covering all aspects of SmartValue administration:

Introduction - This section describes the SmartValue plan's background and function, and it includes important terms and conditions for SmartValue providers. In addition, it explains the fundamentals of the SmartValue Provider Manual.

Benefit Explanations & Limitations - This section provides in-depth information on the benefits and limitations to benefits offered by SmartValue.

Eligibility - Eligibility information, including enrollment and disenrollment criteria, appears in this section.

Benefit Administration - Procedures, guidelines, and processes for administering the SmartValue Plan are described in this section, including providing care, emergency care, and coordination of benefits.

Benefit Payment - Aspects of SmartValue payment methodologies are covered in this section.

Provider Administration - This section provides guidelines for various administrative functions.

Member Issues - Procedures for addressing and resolving quality of care, utilization, and administrative issues are described in this section. Also included are member responsibilities and formal Medicare appeals and grievance procedures.

Directory of Services - Provides point-of-contact personnel who are available to address inquiries.

Exhibits - Examples of forms and letters, approved by the Centers for Medicare & Medicaid Services (CMS), used to communicate with SmartValue members, are included.

SECTION 2 – BENEFIT EXPLANATIONS & LIMITATIONS

Introduction

As Private Fee-for-Service Medicare Advantage Plans, the SmartValue plans cover the same benefits as Medicare. In addition, the SmartValue Plus plan provides members with Medicare Part D prescription drug coverage. The following is a description of the services covered in this program.

Ambulance - Medicare covers limited ambulance service. Ambulance is covered only if transportation in any other vehicle would endanger your patient's life. Air ambulance is paid only in emergency situations. If land ambulance would not seriously endanger your patient's health Medicare will only reimburse land ambulance rates.

Anesthetics - Anesthetic administration in conjunction with surgical services in a hospital, outpatient surgical center, or at the medical group, is covered.

Bone Density Measurement - Measuring bone density for screening and managing female members at high risk for osteoporosis is a covered benefit. These patients must meet Medicare requirements.

Chiropractic Services - Chiropractic services are covered in accordance with Medicare guidelines, and are limited to services performed by a chiropractor licensed by the State. This benefit covers the manual manipulation of the spine to correct a subluxation. (A subluxation is defined as a complete dislocation, off centering, misalignment, fixation, or abnormal spacing of the vertebrae.)

Colorectal Screening - Effective January 1, 1998, colorectal cancer screening is a covered service. The test may consist of any of the following procedures: 1) screening fecal-occult blood test, 2) screening flexible sigmoidoscopy, and 3) screening colonoscopy for high-risk individuals.

Diabetes Education and Home Monitoring - Effective January 1, 1998, diabetes outpatient self-management training services are a covered benefit. These services include educational and training services furnished to an individual with diabetes by a certified healthcare professional in an outpatient setting meeting certain quality standards. Blood glucose monitors and testing strips are now covered for Type II diabetics and without regard to a person's insulin use.

Diagnostic Procedures (Outpatient) - Medically necessary outpatient diagnostic radiology and laboratory procedures, services, and materials are covered.

Dialysis - Hemodialysis, renal dialysis, and peritoneal dialysis are covered services.

Durable Medical Equipment - Durable medical equipment (DME) includes appliances, devices, and equipment that are prescribed by a physician for the treatment of an illness, disease, or injury. Medicare coverage guidelines should be used to determine coverage. The supplier must have a Medicare supplier number. Suppliers need to meet Medicare standards. SmartValue will not pay claims without a supplier number even if supplies are provided by a large chain or department store.

Eye Exam - A routine eye exam is for the purpose of prescribing, fitting, changing eye glasses (and contact lenses), or determining the refractive state of the eyes. While a routine eye exam is not covered by Medicare, SmartValue members are covered for one routine eye exam each year. SmartValue members are responsible for a \$35 copay for up to one routine eye exam every year.

Hearing Exam - A routine hearing exam is performed without relationship to treatment or diagnosis for specific illness, symptom, complaint, or injury and are NOT required by third parties (i.e., insurance companies, business establishments, governmental agencies). While Medicare generally does not cover a hearing exam or hearing aids, SmartValue members are covered for one routine exam every 12 months with a \$35 copay.

Home Health Care - Medicare coverage guidelines should be used to determine coverage. Skilled nursing services are services ordered and included in the written treatment plan established by the patient's physician. The services must be performed by, or under the direct supervision of, a licensed nurse (RN, LPN, LVN) to ensure the patient's safety.

In determining whether a service requires the skill of a nurse, consideration must be given to both the service's inherent complexity and the condition of the patient. A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a licensed nurse. When the nature of the service is such that it can be safely and effectively performed (or self-administered) by the average layperson without the direct supervision of a licensed nurse, the service cannot be regarded as a skilled nursing service even though a licensed nurse actually provides the services.

Hospice - In order to be eligible to elect hospice care, a patient must be entitled to Part A and Part B of Medicare, and must be certified as terminally ill by an attending physician and Hospice Medical Director. To be considered terminally ill, the individual must have a medical prognosis that life expectancy is 6 months or less. Once the member's attending physician has diagnosed the terminal illness and determines the need for hospice care, the member must be advised of the availability of the hospice care. Such services must be provided by Medicare-certified hospice centers. The hospice obtains, from the attending physician, a certification statement that the individual is terminally ill. The hospice also obtains an election of hospice benefits from the patient. The election statement may vary.

Lab Services - Medicare covers medically necessary diagnostic lab services when they are provided by a Clinical Laboratory Improvement Amendments (CLIA) certified laboratory that participates in Medicare.

Mammography - Medicare covers screening mammography on an annual basis for women aged 40 and over. No deductible or copayment applies for this service.

Mental Health Visits - Physician mental health visits to a hospital or skilled nursing facility are covered based on Medicare guidelines.

Nursing Home Care - Medicare coverage guidelines should be used to determine coverage. Most nursing home care is custodial. Generally Medicare does not cover custodial care.

Outpatient Hospital Services - Medicare Part B covers medically necessary outpatient services from a Medicare-participating hospital for diagnosis or treatment of an illness or injury.

Outpatient Prescription Drugs - SmartValue Plus plan members are covered for Medicare Part D prescription drugs. Applicable copayments apply.

Pap Smear and Pelvic Exam - A screening pelvic exam, including a clinical breast examination, is now covered every 24 months. Coverage for both Pap smears and screening pelvic examinations is covered annually for women who are at high risk of developing cervical or vaginal cancer.

Physical Exam - A routine physical exam is performed without relationship to treatment or diagnosis for specific illness, symptom, complaint, or injury and are NOT required by third parties (i.e., insurance companies, business establishments, governmental agencies). SmartValue members are covered for one routine physical exam each year with a \$0 copay (not including lab services).

Prostate Cancer Screenings - Prostate Specific Antigen (PSA) blood tests and digital rectal examinations are covered. Prostate cancer screening tests/procedures for the early detection of prostate cancer are covered for men ages 50 and older.

Radiation Therapy - Radiation services are covered in a hospital inpatient or outpatient setting.

Reconstructive Surgery - is a covered benefit as it is intended primarily to improve bodily function, relieve symptomatology, or improve appearance that is altered by disease, trauma, or previous therapeutic processes (e.g., when surgery is performed to effect breast reconstruction after a mastectomy), or exists because of congenital or developmental abnormality. Cosmetic services do not become reconstructive services because of psychiatric reasons.

Smoking Cessation - Smoking cessation programs for treating nicotine or tobacco use. Up to 8 per year as required by CMS.

Surgical Services - Surgical services in the hospital, at an ambulatory surgical center, or at the medical group, including the surgeon or specialist, assistant, and anesthesiologist's services, together with the appropriate postoperative care, are covered using Medicare guidelines.

Mental and Nervous Disorders - Mental or nervous disorders (psychiatric care) admissions are covered benefits. Psychiatric confinement to a general hospital is covered in the same manner as inpatient services provided for any other condition. Admission to psychiatric hospitals is limited to a 190-day lifetime maximum.

Skilled Nursing Facility (SNF) Care - Medicare covers skilled care in a skilled nursing facility under certain conditions for a limited time.

Skilled nursing services are services ordered and included in the written treatment plan established by the patient's physician. The services must be performed by, or under the direct supervision of, a licensed nurse (RN, LPN, LVN) to ensure the patient's safety.

In determining whether a service requires the skill of a nurse, consideration must be given to both the service's inherent complexity and the condition of the patient. A service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a licensed nurse. When the nature of the service is such that it can be safely and effectively performed (or self-administered) by the average layperson without the direct supervision of a licensed nurse, the service cannot be regarded as a skilled nursing service even though a licensed nurse actually provides the services.

Telephone Consultations - Telephone consultations are covered for PCP and specialists.

Limitations

The following are general limitations to the SmartValue plan. This list provides physicians with general guidelines regarding services that are not covered. Services must be provided by providers who accept the terms, conditions and payments made by SmartValue and who submit claims for members with the exception of vision, out-of-country, and some immunization claims. This service is not covered except as indicated by our Plan. Please call Customer Service for any clarifications. Refer to the current plan Evidence of Coverage (EOC) for detailed benefit and coverage information. Please note that members are responsible for the SmartValue cost-sharing amount when services are covered.

Abortion - Elective abortions are not covered.

Acupuncture This service is not covered except as indicated by our Plan.

Cosmetic Surgery - Cosmetic surgery or other services for beautification, including any complications arising from or as the result of cosmetic surgery. (Medically necessary prosthetic devices and reconstructive surgery provided to restore symmetry following a medically necessary mastectomy are covered.)

Custodial Care or Rest Cures - Inpatient room and board charges in connection with a hospital stay primarily for environmental change, personal or comfort items, physical therapy, chronic pain treatment, or for diagnostic tests that could be performed safely on an outpatient basis.

Dental Services or Supplies - Dental care (except surgery of the jaw or related structures, setting fractures of the jaw or facial bones, or services that would be covered when provided by a physician, except as specifically stated in the member's EOC). Dental plates, bridges, crowns, caps or other dental prostheses, dental services, teeth extraction, or teeth or gum treatment. Cosmetic dental surgery or other services for beautification.

Eye Surgery - Any eye surgery solely for the purpose of correcting refractive eye defects such as nearsightedness (myopia) or astigmatism.

Foot Care - Medicare generally does not cover routine foot care.

Government Treatment - Any services provided by a local, state, or federal government agency, except Medicaid. Veterans Administration hospitals and military treatment facilities are considered for payment according to current legislation.

Hearing Aids This service is not covered except as indicated by our Plan.

Homemaker Services This service is not covered except as indicated by our Plan.

Hospice services in a Medicare-participating hospice are not paid for by SmartValue, but reimbursed directly by Original Medicare.

Naturopath Services - The therapeutic system that does not use drugs but employs natural forces such as light, heat, air, water, and massage.

Not Covered or Medically Necessary:

- Services received before the member's effective date or during an inpatient stay that began before the member's effective date. Services received after the member's coverage ends, except as specifically stated in the member's EOC.

- Services or supplies that are not medically necessary.
- Services not specifically listed in the member's EOC or not covered by Medicare.
- Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency.
- Private room in a hospital, unless medically necessary.
- Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual or athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.
- Any amounts in excess of the Medicare maximum limiting charge for care rendered by a deemed SmartValue provider.
- Services and equipment that does not meet Medicare coverage criteria is excluded.
- Experimental or investigative procedures.

Nursing Home - Services provided by a rest home, a home for the aged, a nursing home, or any similar facility. Services provided by a skilled nursing facility, except as specifically stated in the member's EOC. Custodial care includes, but is not limited to:

1. Getting in and out of bed/repositioning
2. Feeding (not tube feeding)
3. Supervising medications that are ordinarily self administered
4. Personal care
5. Assistance with ambulation; range of motion/ position; walker, cane, or wheelchair use
6. Simple non-sterile dressing changes
7. Simple deciliter non-draining wound dressing care

8. Non-medical enemas
9. Application of warm/cold packs

Nutritional Counseling - Nutritional counseling, food supplements, and meals delivered to the member's home.

Obesity - Services primarily for weight reduction or obesity treatment. This exclusion will not apply to surgical obesity treatment if:

1. Surgical obesity treatment is necessary to treat another life-threatening condition involving obesity and
2. It is documented that non-surgical obesity treatments have failed.

Optometric Services or Supplies - Optometric services, vision/eye exercises, and orthoptics except for eye examinations determining the need for vision correction. Eyeglasses or contact lenses, except an implanted lens that replaces the organic eye lens as specifically stated in the member's EOC. Contact lenses or eyeglasses are covered after cataract surgery.

Orthodontia - Braces, other orthodontic appliances, or orthodontic services.

Orthopedic Shoes - Orthopedic shoes, unless they are part of a leg brace and are included in the orthopedist's charge; except for one pair of therapeutic shoes and inserts per year for those suffering from diabetic foot disease.

Personal Comfort Items - Personal comfort items that are furnished primarily for personal comfort or convenience. Air purifiers, air conditioners, humidifiers, exercise equipment, treadmills, spas, elevators, and supplies for hygiene or beautification.

Prescription Drugs - Outpatient prescription drugs unless prescribed to a registered bed patient in a hospital or skilled nursing facility, or administered in an authorized home health agency program, except as specifically covered by Medicare. Non-prescription contraceptive supplies and devices. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasm or hypogasm. Part D prescriptions drugs are available for members that enroll in Medicare Advantage Prescription Drug Plans (MAPD).

Private Duty Nursing - Inpatient or outpatient services of a private duty nurse unless SmartValue determines that such services are medically necessary in advance of services being rendered.

Services Provided by Family - Professional services received from a person who usually lives with the member or is related to the member by blood, marriage, or adoption.

Sex Transformation or Contraceptive Devices - Procedures or treatments to change characteristics of the body to those of the opposite sex. Reversal of sterilization procedures and sex change operations. Contraceptive devices prescribed for birth control.

Supportive devices for the feet that are not orthopedic or therapeutic shoes (covered for people with diabetic foot disease).

Veteran's Affairs - Services provided in Veteran's Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost sharing is more than the cost sharing required under SmartValue, we will reimburse veterans for the difference.

Voluntary Payment - Services that the member is not legally obligated to pay. Services for which no charge is made to the member in the absence of insurance coverage, except services received at a nongovernmental charitable research hospital. Such a hospital must meet the following guidelines:

1. It must be internationally known as being devoted mainly to medical research
2. At least 10% of its yearly budget must be spent on research not directly related to patient care
3. At least 33% of its gross income must come from donations or grants other than gifts or payments for patient care
4. It must accept patients who are unable to pay
5. At least 66% of its patients must have conditions directly related to the hospital's research

Work-Related Conditions if benefits are recovered or can be recovered, either by adjudication, settlement, or otherwise, under any workers' compensation, employers' liability law, or occupational disease law, even if the member does not claim those benefits. If there is a dispute or substantial uncertainty as to whether benefits may be recovered for those conditions pursuant to workers' compensation, benefits are provided subject to SmartValue's right of recovery and reimbursement.

SECTION 3 – ELIGIBILITY/CONTRACT CHANGES/ TERMINATIONS

Introduction

This section provides guidelines on who is eligible for benefits, when benefits become effective, and when they terminate.

Eligibility Criteria

In general a beneficiary is eligible to elect SmartValue when each of the following requirements are met:

1. The beneficiary is entitled to Medicare Part A and enrolled in Part B.
2. The beneficiary has not been medically determined to have ESRD (End Stage Renal Disease) prior to completing the enrollment election. An individual who receives a transplant that restores kidney function should not be considered to have ESRD for purposes of Medicare eligibility.
3. The beneficiary permanently resides in the service area of the Plan.
4. The beneficiary is fully informed of and agrees to abide by the rules of the MA organization that were provided upon enrollment

A MA organization must not deny enrollment to otherwise eligible individuals covered under an employee benefit plan. If the individual enrolls in a Medicare Advantage plan and continues to be enrolled in his/her employer/union or spouse's group health benefit plan, then Coordination of Benefits rules apply. A Medicare Advantage eligible beneficiary may not be enrolled in more than one Medicare Advantage plan at any given time.

Enrollment

If the Medicare beneficiary is eligible as outlined above, the beneficiary may submit a completed enrollment form to Blue Cross Blue Shield of Georgia.

If the Medicare beneficiary is already a member of another Medicare Advantage plan, membership in that Medicare Advantage plan automatically ends on the effective date of his or her enrollment in SmartValue.

When Coverage Becomes Effective

SmartValue allows for four different periods in which beneficiaries may enroll in a Medicare Advantage plan. These include the following:

1. Annual Election Period (AEP) - Occurs November 15th through December 31st of every year. Coverage is effective January 1st of the following year.
2. Initial Coverage Election Period (ICEP) - The period during which a beneficiary newly eligible for Medicare Advantage may make an initial election to enroll in an Medicare Advantage plan. This period begins three months immediately before the individuals first entitlement to BOTH Medicare Part A and Part B and ends on the later of:
 - The last day of the month preceding entitlement to both Part A and Part B, or;
 - The last day of the individual's Part B initial enrollment period.
3. Open Enrollment Period (OEP) - Occurs from January 1st through March 31st. OEP elections must be made to the same type of plan (regarding Medicare prescription drug coverage) in which the beneficiary is already enrolled. Coverage is effective the 1st day following the month in which the election is made.

4. Special Election Period (SEP) - Periods governed by special circumstances such as change in residence, non renewals or terminations, etc. Beneficiaries that may qualify for a SEP should contact their plan. The effective date of coverage varies and is determined by CMS.

From the effective date forward, the member must receive all health care from SmartValue healthcare professionals and facilities that accept the terms and conditions to receive full benefits, with the exception of emergency and urgent care services.

Emergency Services

SmartValue members are instructed, as specified in their Evidence of Coverage, to go to the nearest medical facility. The Evidence of Coverage defines emergency services as services that may be furnished by a healthcare professional due to the immediacy of an injury, condition, or sudden serious illness. Coverage for emergency services is not limited to deemed providers.

Urgent Care Services

Urgently needed care services refers to a non-emergency situation where the beneficiary is inside the United States, and need medical attention right away for an unforeseen illness, injury, or condition, and it isn't reasonable given the situation for the beneficiary to wait to obtain medical care from a physician during normal business hours.

Termination of Coverage

1. Voluntary Disenrollment by the Member - a member may disenroll from a MA plan only during one of the election periods by:
 - a. Enrolling in another plan
 - b. Giving or faxing a signed written notice to the MA organization through his/her employer or union when applicable.
 - c. Submitting a request via the Internet to the MA organization

- d. Calling 1-800-MEDICARE

If the member verbally requests disenrollment from the MA plan, the MA organization must instruct the member to make the request in one of the ways described above.

- 2 Required Involuntary Disenrollment - a MA organization must disenroll a member from a MA plan in the following cases:
 - a. A change in residence that moves the member outside of the MA plan service area (including incarceration) makes the beneficiary ineligible to remain enrolled in the plan.
 - b. The beneficiary loses entitlement to either Medicare Part A or Part B
 - c. The beneficiary dies
 - d. The MA organization contract is terminated or the MA organization discontinues offering the plan in a particular service area.
3. Optional Involuntary Disenrollment - A Medicare Advantage organization may disenroll a member from an Medicare Advantage plan it offers if:
 - a. Premiums are not paid on a timely basis
 - b. The beneficiary engages in disruptive behavior or
 - c. The beneficiary provides fraudulent information on an election form, or if the member permits abuse of an enrollment card in the MA plan.

A member's coverage may not be terminated because of the member's health status or requirements for health care services.

Effective/Termination Date Coincides with a Hospital Stay

If a member's effective date occurs during an inpatient stay in a hospital, SmartValue is not responsible for any services under Medicare Part A during the inpatient stay. (This provision applies to acute hospital stays only, not to stays in a skilled nursing facility.)

Blue Cross Blue Shield of Georgia is responsible for inpatient hospital service under Part A on the day after the day of discharge from the inpatient stay. All other services, other than inpatient hospital services under Part A, are covered under the SmartValue plan beginning on the effective date of enrollment.

If the member's SmartValue coverage terminates while the member is hospitalized, SmartValue is responsible for the facility charges until discharge regardless of the reason for the coverage termination.

SECTION 4 – BENEFIT ADMINISTRATION

Introduction

This section explains the method by which benefits offered in the SmartValue Plan are to be administered. Eligibility, copayment collection, and denial of services are discussed.

Professional Services Administration

When an individual seeks medical attention at a physician's office, it is important that the member's eligibility status be verified. Only after eligibility is verified will SmartValue assume liability for professional care if a person is later determined to be ineligible. Use the following methods to determine eligibility status before providing services.

Identification Card

All subscribers are issued a SmartValue ID card displaying the following information:

1. SmartValue plan name
2. SmartValue group number
3. Subscriber's Health Care identification number
4. Subscriber name
5. Benefit information
6. Phone number for SmartValue Customer Service Department

The ID card should be carried by the member at all times and presented when seeking medical services. If a member loses an ID card, the member should be advised to call SmartValue Customer Service.

Right to Audit

Upon reasonable notice, Providers will allow BCBSGA, its authorized representatives and designees, and duly authorized third parties such as government or regulatory agencies, access to Provider's practice site, without charge, during regular business hours to inspect, review and receive copies of records related to services provided to members.

Release of Medical Records Authorization

All new members are required to fill out an enrollment form containing the Authorization for Release of Medical Records.

Medical Records Confidentiality and Accuracy

For any medical records or other health or enrollment information the physician maintains for SmartValue members, the following procedures must be incorporated:

1. Safeguard the privacy of any information that identifies a particular member. Information from, or copies of, records may be released only to authorized individuals. Be sure that unauthorized individuals cannot gain access to or alter patient records. Original medical records must be released only in accordance with federal or state laws, court orders, or subpoenas.
2. Maintain the records and information in an accurate and timely manner.
3. The member must have timely access to his or her records and information that pertains to them in accordance with federal and state regulations.
4. Abide by all federal and state laws regarding confidentiality and disclosure for mental health records, medical records, and other health and member information.

Determining Covered Benefits/Charges for which a member may be liable and billed

After eligibility is established, the member should complete all the forms required by the physician's office. All treatment must be provided in accordance with the subscriber's SmartValue Evidence of Coverage.

The SmartValue Group number, which is listed on the member's ID card, indicates the benefits to which the member is entitled. The member is liable for payment of any medical services not covered in the member's Evidence of Coverage, provided the member is informed in advance that services are not covered.

The only charges for which a member may be liable and billed are the following:

1. Services not covered under the member's benefit agreement
2. Copayments, deductibles, or coinsurance under the terms of the member's benefit agreement
3. Up to the limiting rate of 15% above the Medicare allowed amount for providers who do not accept Medicare assignment.

Copayment Collection

For professional, urgent care, outpatient, or inpatient services, a copayment or co-insurance should be collected from the member. The physician's office must advise the member of the responsibility to pay a copayment prior to rendering any service that requires a copayment. Since copayments vary, check the benefit schedules before the copayment is collected. Copayments/co-insurance for services are collected at the time services are rendered. However, if immediate copayment collection is not possible, then a billing may be established and sent to the member for payment at a later date.

Copayment or co-insurance amounts should also be collected from SmartValue Plus plan members when they obtain covered outpatient prescription drugs.

Provider further agrees that for Covered Individuals who are dual eligible enrollees for Medicare and Medicaid, that Provider will ensure they will not bill the covered Individual for cost-sharing that is not the Covered Individual's responsibility and such Covered Individuals will not be held liable for Medicare Parts A and B cost sharing when the State is liable for the cost sharing. In addition, Provider agrees to accept the plan payment as payment-in-full or by billing the appropriate state source.

COPAYMENT/COINSURANCE SCHEDULE

2010 SmartValue Member costs for Medicare Covered services are detailed in the following chart. **Please note that Members who are enrolled in this product through their employer group may have different benefits than those listed below.** Please reference the Member's ID card for more information.

<i>Physician Services</i>	<i>Classic</i>	<i>Plus</i>
Office Visits: Primary Care	\$25	\$25
Office Visits: Specialist	\$35	\$35
<i>Hospital Services</i>		
Inpatient Hospital (per calendar year), days 1-6 or per stay Out-of-pocket Max for this benefit is \$1,680 annually.	\$280/day	\$280/day
<i>Emergency and Urgently Needed Care Services</i>		
Emergency Services (if not admitted)	\$50	\$50
Urgently Needed Services	\$25-\$35	\$25-\$35
<i>Ancillary Services</i>		
Skilled Nursing Facility (SNF) per day (each benefit period, 100 day limit):		
days 1-20	\$0	\$0
days 21-100	\$130	\$130
Diagnostic Radiology & Lab Services	\$35 to \$125	\$35 to \$125
Complex Diagnostic Tests (i.e. MRI, PET, CT scans, Cardiac Stress Tests)	\$125	\$125
Durable Medical Equipment (DME)	20%	20%
Prosthetic Devices and Medical Supplies	20%	20%
Outpatient Mental Health Services (individual or group visit)	\$40	\$40
Home Health Care Services	\$0	\$0

Benefits, copayments and coinsurance may change on January 1, 2011.
Contact Blue Cross Blue Shield of Georgia for details.

MEDICARE PART D PRESCRIPTION DRUGS (SMARTVALUE PLUS PLAN MEMBERS ONLY)

Deductible

There is no annual prescription drug deductible.

Initial Coverage Level (ICL)

Following are the copayment/coinsurance amounts that the member is responsible for paying during the initial coverage level (ICL is \$2,830).

Drug Tier	Copayment or Coinsurance		
	Retail Network/ Out of Network Pharmacies (30 day supply)	Select Retail Network or Mail Order Non-Preferred Pharmacies (90 day Supply)	Preferred Mail Order (90-day supply)
<i>SmartValue Plus Plan</i>			
Tier 1 – Generic	\$8	\$24	\$12
Tier 2 – Preferred Brand	\$44	\$132	\$110
Tier 3 – Non- Preferred Brand	\$85	\$255	\$212.50
Tier 4 – Non-Specialty Injectibles	33%	33%	33%
Tier 5 – Specialty Injectibles	33%	N/A	N/A
<i>Plus plan only</i>			
Generics are covered in the gap (yearly costs between \$2,830 and \$4,550)	\$8	\$24	\$12

Generic Benzodiazepines and Barbiturates – SmartValue Plus provide coverage for Generic Benzodiazepines and Barbiturates. Copayments for these drugs do not count toward total drug costs or true out-of-pocket expenses. Generic Benzodiazepines and Barbiturates are covered even after the total drug costs reach \$2,830 and the total out-of-pocket expenses reach \$4,550. The copayments for these generic drugs always apply, regardless of whether you have met either of these coverage limits. In addition to your co-payments or coinsurance at an out-of-network pharmacy, you pay the difference between the actual charge and what the plan will pay at a network pharmacy.

Coverage Gap

SmartValue Plus plan members have generic drug coverage in the gap.

Catastrophic Coverage

During the catastrophic coverage period, the member will be responsible for paying the greater of \$2.50 for generics or preferred brand drugs that are a multi-source drug and \$6.30 for all other drugs or 5% co-insurance.

Health Risk Assessment

Blue Cross Blue Shield of Georgia conducts a new enrollee health risk assessment using the University of Minnesota Pra+[®] survey instrument within 90 days of a new member's effective enrollment.

General Service Guidelines

Emergency Services

SmartValue members are instructed, as specified in their Evidence of Coverage, to go to the nearest medical facility. The Evidence of Coverage defines emergency services as services that may be furnished by a healthcare professional due to the immediacy of an injury, condition, or sudden serious illness.

Emergency Services Denial

In determining whether emergency services are covered, BCBSGA will review the symptoms present at the time services were obtained and must consider the frame of mind and reasonable belief of the member, regardless of the medical outcome of the services.

Denial of Other Services

Blue Cross Blue Shield of Georgia complies with all CMS regulatory requirements in regard to denials and denial notices accuracy and timeliness. Medicare law regulates claim payment and service authorization processes for Medicare Advantage Organizations to ensure beneficiaries receive the benefits to which they are entitled and beneficiaries understand their rights to appeal any adverse coverage determination. Members have the right to appeal to their health plan.

Medicare law and regulations require that Medicare Advantage Organizations process claims promptly and provide beneficiaries with written notices of noncoverage when they deny requests for payment or services. The law and regulations also require that Medicare Advantage Organizations ensure those written notices contain clear reasons for denial and that they provide a complete description of the appeal process.

1. The initial decision: If services are denied SmartValue will review all issues to determine if care meets coverage guidelines. We will inform the member of the member's rights to reconsideration.
2. If the member disagrees with the decision, they can ask to have the decision 'reconsidered' or appealed. After reviewing the appeal SmartValue will decide to stay with the original decision or overturn the decision and give the patient some or all of the care they want.
3. If we turn down the request in step 2 we are required to send the request to an independent review organization that is appointed by the Federal government and not part of Blue Cross Blue Shield of Georgia.
4. If the patient is unhappy with that decision they may request an Administrative Law Judge consider the case and render a decision.
5. This decision can be reviewed by a Departmental Appeals Board. This Board is part of CMS.
6. Finally Federal Court can be requested to review the case if the amount in controversy meets the minimum requirement of medical services. The court will make the final determination.

The reason for these requirements is that the right to appeal denials is one of the most basic and important beneficiary protections in the Medicare Advantage program. If BCBSGA fails to clearly advise beneficiaries of this right in an intelligible and complete manner, beneficiaries will fail to execute this basic right due to lack of information.

Expedited Organization Determination Review Process

The following procedures and time frames were developed to comply with CMS regulations that require establishing an expedited review process for requests for service, care reductions, and care termination in time-sensitive situations.

Specifically, CMS indicated that an expedited organization determination must be granted if the member's life, health, or ability to regain maximum function could be jeopardized by waiting for a decision under the standard 14-day organization determination process. Situations that might warrant an expedited review include the following:

1. Physical therapy termination
2. Skilled nursing facility services or courses of treatment
3. Pre-service requests
 - a. Specialist referrals
 - b. Therapies
 - c. Course of treatment
 - d. Diagnostic tests

Determining whether a case is expedited will be made by SmartValue. Refer all requests for expedited organization determination to SmartValue Customer Service. The Case Management Department determines if the criteria is met. Decisions pertaining to denying claim payments do not qualify for expedited review.

Important Messages from Medicare

Hospitals must notify Medicare beneficiaries who are hospital inpatients about their discharge appeal rights by complying with the requirement for providing the Important Message from Medicare (IMM), including the time frames for delivery. For a copy of the notice and additional information regarding this requirement, go to: http://www.cms.hhs.gov/bni/12_hospitaldischargeappealnotices.asp

Notice of Medicare Non-Coverage (NOMNC)/ Detailed Explanation of Non-Coverage (DENC)

Beginning on January 1, 2004, enrollees of Medicare Advantage plans, such as SmartValue, will have the right to an expedited review by a Quality Improvement Organization (QIO) when they disagree with their Medicare Advantage plan's decision that Medicare coverage of their services from a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) should end. This new right stems originally from the Grijalva lawsuit and was established in regulation in a final rule published on April 4, 2003 (68 FR 16652). It is similar to the longstanding right of a Medicare beneficiary to request a QIO review of a discharge from an inpatient hospital.

Based on the provisions of the April 2003 final rule, SNFs, HHAs, and CORFs must provide an advance notice of Medicare coverage termination to MA enrollees no later than 2 days before coverage of their services will end. If the patient does not agree that covered services should end, the enrollee may request an expedited review of the case by the QIO in that state. Please see the chart on the next page of the QIOs in each state SmartValue offers coverage. SmartValue has delegated the responsibility to deemed SNFs, HHAs, and CORFs to furnish a Detailed Explanation of Non-Coverage (DENC), which explains why services are no longer necessary or covered. The review process generally will be complete within less than 48 hours of the enrollee's request for a review.

Please visit our Website to download the NOMNC and DENC letter templates at www.bcbsga.com/pffs.

For additional information or education on the Grijalva final rule please visit www.cms.hhs.gov/healthplans/appeals

Georgia Medical Care Foundation
1455 Lincoln Parkway, Ste 800,
Atlanta, GA 30346
1-800-979-7217

Workers' Compensation

Workers' compensation coverage is founded on the philosophy that industry should provide employees with injury protection as a cost of doing business, and that benefits should be provided without regard to whom is at fault when an injury occurs in the course of employment.

SmartValue Plans exclude coverage for work-related conditions. However, there are many cases in which an industrial injury is in dispute, and the employer refuses to accept liability for the illness or injury. When these types of cases occur, SmartValue will provide coverage subject to the following guidelines:

1. Once a work-related injury or illness is accepted by an employer, SmartValue denies claims for that illness or injury.
2. However, if SmartValue is advised that the employer's workers' compensation carrier denied payment of the claim, SmartValue will pay the related claims, and file a reimbursement lien if the carrier's decision is appealed.
3. When reimbursement is paid, claims are adjusted to reflect the amount collected.

A physician should question a member seeking medical treatment when the nature of the illness or injury appears to be work-related. Some employers insist that all workers' compensation cases be handled through their private worker's compensation physicians, and only when authorized; these employers will not reimburse any other healthcare professional or facility.

PAYMENT METHODOLOGY GRID

SmartValue generally reimburses deemed providers the amount they would have received under Original Medicare for Medicare covered services, minus any amounts paid directly by Original Medicare (such as for direct graduate medical education) and minus any member required cost sharing, for all medically necessary services covered by Medicare. Payment for certain providers will be based on the estimated Medicare amount and calculated using a proxy method developed by CMS. SmartValue does not do cost settlements. For providers paid on a cost basis, SmartValue makes payment based on the interim rate letter from the fiscal intermediary or Medicare contractor. SmartValue does not pay for hospice services or clinical trials. Hospice and clinical trial providers should continue to file claims with Original Medicare using their current process.

Acute Care Hospital -
Inpatient Services

Payment for covered inpatient services are based upon the Inpatient Prospective Payment System (IPPS). Acute care hospitals are paid a DRG amount using the Medicare Prospective Payment System (PPS) in all states except Maryland. The DRG payments include amounts for capital Indirect Medical Education (IME) and capital Disproportionate Share Hospital (DSH). Organ acquisitions for members are reimbursed on a cost basis at an approved transplant facility. The following items are excluded from our payment, but are paid directly to the hospital by original Medicare:

- 1) DGME
- 2) Operating IME

Acute care hospitals should submit a “no pay” bill to their Medicare contractor for stays by Medicare Advantage members.

Acute Care Hospital -
Inpatient Services
Outliers

Payment is 80% of the excess of the cost of an admission over the sum of the DRG payment (including capital IME and DSH) and a threshold amount determined by CMS. The cost of an admission is determined by multiplying the hospital's cost to charge ratio by its charge.

Acute Care Hospital -
Outpatient Services

Services subject to the Outpatient Prospective Payment System (OPPS) are paid using the Ambulatory Payment Classification (APC) methodology. When processing an APC claim, components that comprise the total reimbursement amount (e.g., accounting for outlier, drugs and devices paid as pass through) will be included. Services excluded from OPPS are reimbursed based on their respective fee schedule. Hospitals exempt from OPPS include those in Maryland, Indian Health Service, and Critical Access Hospitals.

Ambulance

Total reimbursement will equal 100% of the ambulance fee schedule and for providers in certain rural areas, as provided under Original Medicare payment methodology.

PAYMENT METHODOLOGY GRID (CONTINUED)

Ambulatory Surgical Centers (ASC)	ASC's are paid based on the CMS fee schedule. Payments are area wage adjusted.
Anesthesiologists - Personally Performed	Payment will be calculated using the Medicare methodology: the sum of uniform base units and time units multiplied by the anesthesia conversion factor specific to the locality.
Anesthesiologists - Direction of two or more nurse anesthetists concurrently	Payment will be on the basis of 50 percent of the allowance for the service performed by the physician alone.
Assistant at Surgery - Physician	For assistant at surgery services performed by physicians, the fee schedule amount equals 16 percent of the amount otherwise applicable for the global surgery.
Assistant at Surgery - Physician Assistant	For assistant at surgery services performed by physician assistants, the fee schedule amount equals 85 percent x 16 percent of the amount otherwise applicable for the global surgery.
Audiologists	Audiologists are paid the lesser of the actual charge for services or 100% of the Medicare physician fee schedule.
Balance Billing	Providers who do not accept Medicare assignment are allowed to balance bill members up to the limiting rate of 15% above the Medicare allowed amount for Medicare covered services.
Cancer Hospitals - Inpatient Services	The Medicare IPPS methodology will be used as described for Acute Care Hospital Inpatient Services for Cancer Hospitals that are subject to IPPS. For PPS-exempt hospitals, reimbursement is based on the lesser of their actual costs or their TEFRA limited costs. Payment adjustments are then made depending on the difference between these two costs. Facilities are required to supply a copy of their most recent annual FI rate letter to show the interim per diems for inpatient services.
Cancer Hospitals - Outpatient Services	The Medicare OPPS methodology will be used to group/price APC claims for any Medicare approved provider subject to OPPS. For PPS-exempt hospitals, costs are reimbursed using a payment to charge ratio. Facilities are required to supply a copy of their annual FI rate letter to show the cost-to-charge ratios for outpatient services.

PAYMENT METHODOLOGY GRID (CONTINUED)

Certified Registered Nurse Anesthetists (CRNA)	CRNA's are paid the Medicare anesthesia conversion factor by locality x the sum of uniform base units + time units. Payment is made on an assignment basis only. The above allowance is divided between the anesthesiologist and the anesthetist for directed services.
Chiropractors	Chiropractors are paid the lesser of the actual charge for services or 100% of the Medicare physician fee schedule for Medicare covered services.
Children's Hospitals	The Medicare IPPS methodology will be used as described for Acute Care Hospital Inpatient Services for Children's Hospitals that are subject to IPPS. For PPS-exempt hospitals, reimbursement is based on the lesser of their actual costs or their TEFRA limited costs. Payment adjustments are then made depending on the difference between these two costs. Facilities are required to supply a copy of their annual FI rate letter to show the interim per diems for inpatient services.
Children's Hospitals - Outpatient Services	The Medicare OPPS methodology will be used to group/price APC claims for any Medicare approved provider subject to OPPS. For PPS-exempt hospitals, costs are reimbursed using a payment to charge ratio. Facilities are required to supply a copy of their annual FI rate letter to show the cost-to-charge ratios for outpatient services.
Clinical Nurse Specialist	Clinical Nurse Specialists are paid the lesser of the actual charge for services or 85% of the Medicare physician fee schedule.
Clinical Psychologist	Clinical Psychologists are paid the lesser of the actual charge for services or 100% of the Medicare physician fee schedule.
Clinical Social Worker	Clinical Social Workers are paid the lesser of the actual charge for services or 75% of the Medicare physician fee schedule.
Comprehensive Outpatient Rehabilitation Facility (CORF)	Reimbursement is based on the Medicare physician fee schedule.
Co-Surgeons	For each co-surgeon, the allowed amount is 62.5% of the global surgery allowed amount under the Medicare fee schedule.

PAYMENT METHODOLOGY GRID (CONTINUED)

Critical Access Hospitals

Reimbursement for inpatient and outpatient services will be based on the critical access hospital's most recent interim rate letter from their Medicare fiscal intermediary or contractor. Reimbursement is 103% of the interim rate. Exception: If billing for inpatient rehabilitation or psychiatric charges, those specific pricers will be used, NOT the CAH awarded rate. In addition, we do acknowledge Method II reimbursement. In order to ensure appropriate reimbursement, for both CAH & Method II, you are required to provide the interim rate letter to the plan.

CAH Method II - Out of Network Payments

If a physician elects to reassign their claims to the CAH (election of method II), the CAH is paid an extra 15% of Medicare's portion of the physician fee schedule amount. This election can only be made for hospital outpatient physician services.

The MA plan must also pay 115% of the Medicare physician fee schedule for physicians who have reassigned outpatient hospital claims under method II. In this case the hospital bills the physician services on the same bill as the hospital services. The MA plan then does what the fiscal intermediary do; it pays the facility part of the bill to the hospital based on 101% of costs; and it pays 115% of the physician fee schedule to the hospital. The plan does not make payments directly to the physician if payments for a given service were paid directly to the hospital under method II.

Please note that the HPSA and PSA physician fee schedule bonuses apply under both method I (direct billing from the doctor for outpatient services in a CAH) and method II. In other words, under method II billing the HPSA and PSA bonuses are applied to the higher consolidated billing amount.

(reference: <http://www.cms.hhs.gov/medicareadvtspeccratestats/downloads/oon-payments.pdf>)

Durable Medical Equipment (DME)

Reimbursement is calculated using DMEPOS Fee Schedules.

ESRD Facility

Payment is based on the CMS Composite Rate methodology, this includes geographic and patient case-mix adjustments.

Federally Qualified Health Centers (FQHC)

Facilities are required to supply a copy of their most recent annual FI rate letter to show the interim per diems for inpatient services and a valid Medicare billing number. For FQHC services, reimbursement is at 80% of the lesser of the all-inclusive rate or the national limit, plus 20% of the actual charge. Medicare services not covered under the FQHC "all-inclusive rate" are paid at the same rate that the FQHC would receive under original Medicare.

PAYMENT METHODOLOGY GRID (CONTINUED)

Home Health Agencies	Payments are made on a PPS basis, using CMS home health resource groups. Providers are reimbursed per 60-day episode of care via submission of a Request for Accelerated Payment (RAP) and the claim. Reimbursement includes adjustments for Low Utilization (LUPA), Significant Change in Condition (SCIC), Partial Episode Payment (PEP), therapies and outliers. DME is reimbursed based on the DME POS fee schedule.
Laboratories	Payments are based on the CMS lab fee schedule.
Long Term Care (LTC) Hospitals	Payments are made on an inpatient PPS basis using Medicare Severity LTC-DRGs. Rates are adjusted for short stay outliers and high cost outliers.
Maryland Hospitals	Maryland hospitals are paid at rates set by the Health Services Cost Review Commission (HSCRV) in accordance with the Medicare waiver.
Nurse Practitioners	Nurse Practitioners are paid the lesser of the actual charge for services or at 85% of the Medicare physician fee schedule if a physician, facility, or other provider of services does not charge for the same service.
Optometrists	Optometrists are paid the lesser of the actual charge for services or 100% of the Medicare physician fee schedule for Medicare covered services.
Physical, Occupational or Speech Therapists	Physical, Occupational and Speech Therapists are paid the lesser of the actual charge for services or 100% of the Medicare physician fee schedule.
Physicians (MDs and DOs)	MDs and DOs are paid the lesser of the actual charge for the services or 100% of the Medicare physician fee schedule. A 10% bonus is paid if the services are furnished in a Health Professional Shortage Area (HPSA). A 5% bonus is paid if they are furnished in a Physician Scarcity Area (PSA).
Physicians (Podiatrists)	Podiatrists are paid the lesser of the actual charge for the services or 100% of the Medicare physician fee schedule. A 10% bonus is paid if the services are furnished in a Health Professional Shortage Area (HPSA). A 5% bonus is paid if they are furnished in a Physician Scarcity Area (PSA).

PAYMENT METHODOLOGY GRID (CONTINUED)

Physicians (Oral and Maxillofacial Surgeons)	Oral and Maxillofacial Surgeons are paid the lesser of the actual charge for services or 100% of the Medicare physician fee schedule. A 10% bonus is paid if these services are furnished in a Health Professional Shortage Area (HPSA). A 5% bonus is paid if they are furnished in a Physician Scarcity Area (PSA).
Physicians (Dentists)	Dentists are paid the lesser of the actual charge for the services or 100% of the Medicare physician fee schedule. A 10% bonus is paid if these services are furnished in a Health Professional Shortage Area (HPSA). A 5% bonus is paid if they are furnished in a Physician Scarcity Area (PSA).
Physician Assistants	Physician Assistants are paid at the lesser of the actual charge for services or 85% of the Medicare physician fee schedule if a physician, facility, or other provider of services does not charge for the same service.
Physician Quality Reporting Initiative (PQRI)	<p>The Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) (Pub.L.110-275) made the PQRI program permanent, but only authorized incentive payments through 2010.</p> <p>Eligible professionals who meet the criteria for satisfactory submission of quality measures data earn an incentive payment of 2.0 of their total allowed charges for Physician Fee Schedule covered professional services furnished during that same period (the 2009 calendar year)</p> <p>The 2009 PQRI bonus payment are paid on an annual basis and consist of 153 quality measures and 7 measures groups. For further information on the 2009 PQRI quality measures, click on the "Measures/Codes" link located at http://www.cms.hhs.gov/PQRI/.</p> <p>Additional information on the PQRI program, including information for the 2007 and 2008 reporting periods, can be found at http://www.cms.hhs.gov/PQRI/.</p>
Psychiatric Hospitals - Inpatient	Payment is made based on the Inpatient Psychiatric Facility Prospective Payment System (IPFPPS). An outlier payment is made when a psychiatric hospital's estimated total costs for a case exceed a threshold established by CMS plus the total payment amount for the case.
Psychiatric Hospitals - Outpatient	Payment is made based on the Outpatient Prospective Payment System (OPPS).
Registered Dieticians	Registered Dieticians are paid the lesser of the actual charge for services or 85% of the Medicare physician fee schedule.

PAYMENT METHODOLOGY GRID (CONTINUED)

Rehab Hospitals - Inpatient

Rehab hospitals are paid using the Inpatient Rehabilitation Facility Prospective Payment System (IRF PPS). A case-mix adjusted payment is made using Case Mix Groups (CMGs) for varying numbers of days of IRF care.

Rehab Hospitals - Outpatient

Payment is made based on the Outpatient Prospective Payment System (OPPS).

Rural Health Clinics

Rural Health Clinics are reimbursed based on 80% of the per-visit payment limit plus 20% of the actual charges of covered services. The all-inclusive methodology applies only to RHC services, not to other services performed at an RHC such as lab, the technical components of diagnostic tests, etc. RHCs owned by rural hospitals (Critical Access Hospitals) with less than 50 beds are paid on a cost basis and are PPS exempt and paid at 103% of reasonable cost for services. These RHCs are reimbursed based on a per diem rate for inpatient services and on a cost-to-charge ratio basis for outpatient services. To ensure appropriate payment, RHC's must provide a copy of their most recent interim letter from their Fiscal Intermediary or Medicare Contractor and will be paid at 103% of the interim rate. Medicare services not covered under the RHC "all-inclusive rate" are paid at the same rate that the FQHC would receive under original Medicare. An update of the FI interim rate letter is required annually or more often if changes occur.

Skilled Nursing Facilities (SNF)

Payment is made based on the Prospective Payment System (PPS) for SNFs. A case-mix adjusted payment for varying numbers of days of SNF care is made using one of the Resource Utilization Groups (RUGs). The RUG is identified in the first 3 positions of the HIPPS code. There may be an add-on payment for AIDS patients. The obligation on providers to follow coverage limits of Original Medicare benefits (as provided in 42 CFR 422.100) must be met whenever a provider furnishes Original Medicare SNF and inpatient hospital services to enrollees of Medicare Advantage organizations. This obligation applies to all SNFs and applies to both teaching and non-teaching hospitals. This obligation can be implemented by providers submitting to Medicare Administrative Contractors (MACs) no-pay claims (with code, 04). Providers are also required to keep an audit trail on these claims submissions.

Swing Beds Covered swing bed

facility services will be reimbursed based upon the Skilled Nursing Facility Prospective Payment System (SNFPPS). Swing beds in a CAH facility are paid at a per diem based on the rate letter from the FI.

SECTION 5 – PROVIDER ADMINISTRATION

Introduction

This section provides guidelines for various administrative functions in compliance with CMS regulations.

Compliance with CMS Regulations

Blue Cross Blue Shield of Georgia must adhere to the terms and conditions of the CMS contract. All SmartValue healthcare professionals are required to accept the same terms and conditions, as appropriate.

Compliance with the following CMS regulations is required:

1. SmartValue has the ultimate responsibility and accountability for ensuring compliance with CMS guidelines.
2. Healthcare professionals are prohibited from holding a member liable for paying fees that are the obligation of SmartValue.
3. Healthcare professionals must safeguard the privacy of any information that identifies a particular member and must maintain records in an accurate and timely manner.
4. Healthcare professionals must submit to SmartValue all data necessary to characterize content and purpose of each encounter with a member.
5. Healthcare professionals are prohibited from discriminating against members based on health status.
6. Healthcare professionals must provide access to benefits in a manner described by CMS.
7. Healthcare professionals must provide all covered benefits in a manner consistent with professionally recognized standards of healthcare.
8. Healthcare professionals must be subject to all laws applicable to individuals/entities receiving federal funds and must comply with all other laws and regulations including Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975, and the Americans with Disabilities Act.
9. Healthcare professionals must comply with Medicare appeals/expedited appeals procedures for members, including gathering/forwarding information on appeal to SmartValue as necessary.
10. Blue Cross Blue Shield of Georgia has the right to approve, suspend, or terminate arrangements pertaining to selecting healthcare professionals, contractors, or subcontractors.

Local Medicare Carrier Coverage Guidelines

SmartValue is in compliance with its Local Medicare Carrier Guidelines, and incorporated these guidelines into its internal coverage guidelines. Local Medical Review Policy (LMRP) addresses issues not specifically covered nationally by CMS.

Local Medical Review Policy is primarily a Medicare program integrity tool. It is developed by the local Medicare carrier to specify criteria that describe whether a service is covered and under what clinical circumstances it is considered to be reasonable, necessary, and appropriate. The local carrier solicits comments from the medical community through the Carrier Advisory Committee, which meets quarterly and includes the SmartValue Plan.

Member Rights

BBA 422.112 applies existing regulations and policies to establish standards under the Medicare Advantage program. Recommendations from the President's Consumer Bill of Rights and Responsibilities (CBRR) and the Quality Improvement System for Managed Care (QISMC) standards were incorporated.

The physician ensures "cultural competency" in providing healthcare to members, including those with limited English proficiency or reading skills, diverse cultural and ethnic backgrounds, and physical or mental disabilities.

Prohibiting Interference with Advice from Healthcare Professionals

Blue Cross Blue Shield of Georgia is prohibited from interfering with a healthcare provider's ability to care for SmartValue members. A healthcare professional has the right to advise, or advocate on behalf of a patient regarding the following:

1. The patient's health status, medical care, and treatment options (including the risks, benefits, and consequences of treatment).
2. The member's right to refuse treatment and express preferences about future treatment decisions, in accordance with CMS regulations.

Prohibiting Indemnification by Healthcare Professionals or Facilities

BCBSGA may not contract or otherwise provide, directly or indirectly, for any of the following individuals, organizations, or entities to indemnify the organization against any civil liability for damage caused to a member as a result of the physician's denial of medically necessary care:

1. A physician or healthcare professional
2. A healthcare professional or facility
3. Another entity providing healthcare services
4. A group of such professionals, facilities, or entities

SECTION 6 – MEMBER ISSUES

Overview

SmartValue member issues are divided into two types: member grievances and appeals (or reconsiderations). Complaints are resolved through one of two distinct processes, depending on the type of complaint (as defined below). SmartValue procedures are designed to handle member issues expeditiously and equitably, and are administered by the Grievance and Appeal Management Department acting on behalf of SmartValue.

Grievance procedures apply when a member complains about services, quality of care, or involuntary disenrollment issues. The grievance process is not utilized to appeal claim or service denial. Grievance examples include complaints about the cleanliness of a physician's office, lack of follow-up by the office, no return phone calls or inability to reach the office, rude office staff, quality of care issues, or disputing involuntary disenrollment issues.

Appeal procedures apply when a member disagrees with a decision about payment for, or provision of, services. Reconsideration or appeal requests can be about either an initial denial for service authorization or claim denial.

It is possible to have issues that apply both to grievances and appeals. The procedures for grievances and appeals are mutually exclusive. If a member addresses two issues on one complaint, each issue is processed separately and simultaneously under the proper procedure.

Grievance Criteria:

1. Complaints regarding quality of service/quality of care received by the member
2. Does not involve an adverse initial determination (request for services or claims payment)
3. Involuntary disenrollment issues

Appeal Criteria:

1. Service denial issued by SmartValue or the physician
2. Claims denied by SmartValue or the physician
3. Reimbursement denied for emergency or urgently needed services
4. Discontinuing or reducing services

All appeals and quality of care grievances are handled directly by the Grievance and Appeal Management Department. Quality of service grievances are handled directly by SmartValue. All appeals and quality of care grievances should be forwarded to the following address:

BCBSGA SmartValue
Grievance and Appeal Unit
P.O. Box 1975
Fond du Lac, WI 54936
Phone:(888) 445-8916
Fax: (877) 811-5116

Member Grievance Resolution Procedure

If a member has a complaint regarding the quality of care/quality of service provided by a physician or a dispute pertaining to involuntary disenrollment issues, the member must request a review directly from SmartValue. The Grievance and Appeal unit may receive written complaints issued by the member or an authorized representative (appropriate documentation must be received; e.g., Appointment of Representative form or similar written statement, Power of Attorney records, or other valid legal document or court order) via fax or U.S. mail. Oral complaints may be reported to the Customer Service unit.

Grievances related to quality of care and certain disenrollment issues are forwarded directly to the Grievance and Appeal Management Department for review.

Grievances related to quality of service are handled by SmartValue.

The grievance process is implemented as follows in the Grievance and Appeal Management Department:

1. An acknowledgment letter is sent to the member within 5 business days of receipt of the grievance.
2. The documentation submitted is reviewed by the Grievance and Appeal Management associate. If it is determined that further information is required, a letter is sent to the physician/internal department requesting medical records and/or the physician/internal department response to the member's complaint.
3. If the requested information is not received timely, the Medical Director reviews the case based on the information available.
4. A letter is sent to the member at the review conclusion addressing all the issues and questions raised by the member in his or her grievance. A copy of the letter is sent to the physician if indicated.
5. All quality-of-care cases are reviewed by the Medical Director (or physician designee) and/or by the Grievance and Appeal Management Committee chaired by physicians.
6. If a member disagrees with our decision to not give you a "fast appeal", or if we take an extension on our initial decision or appeal, they have the right to ask for a "fast grievance". SmartValue will respond to the "fast grievance" in 24 hours.
7. All grievances received by the Grievance and Appeal Management Department are logged into the senior grievance and appeal tracking system to document all correspondence and actions taken as a result of the grievance.

A monthly grievance report is generated by the Grievance and Appeal Management Department. The report includes the following data:

- a. Number of grievances received

- b. Resolution turnaround time
- c. Status of cases received (open, closed)
- d. Grievance type
- e. Resolution/outcome

Medicare Standard Reconsideration and Appeals Procedures

BCBSGA provides, as required by CMS, a reconsideration/appeals procedure for all SmartValue members. This procedure pertains to disputes involving an initial claim payment denial or provision of services denial. The appeal must be submitted in writing by the member or by a representative appointed by the member.

Note: Effective 03/13/2009, Medicare Advantage Part C standard pre-service appeals no longer require an Appointment of Representative form when a written request for reconsideration is made by a treating physician.

A standard appeal must be resolved as expeditiously as possible, but no later than 30 calendar days for service appeals and 60 calendar days for claim appeals from receipt of the appeal by BCBSGA. For service denial appeals, a 14-calendar-day extension may be granted if the extension will benefit the members (i.e., additional tests or consultations are needed in order to appropriately review the appeals).

When an initial determination is made by SmartValue, a written notification is sent to the member advising her or him of the determination and of the Medicare appeal procedure. If SmartValue fails to make an initial determination within 14 calendar days (or extended 14 calendar days if beneficial to the member) of the request, it is considered an adverse determination and the member/representative can appeal to SmartValue.

If the physician's office receives an appeal from the member or his or her representative, they must fax the appeal immediately to the Grievance and Appeal Management Department.

The initial determination from SmartValue is final and binding unless a reconsideration is requested by the member/representative in writing to SmartValue and received in SmartValue within 60 days from the date of the notice of the initial determination. An exception to the 60-day time frame may be made for good cause.

If a reconsideration request is submitted more than 60 days and less than 1 year from the date of the initial denial letter, the Grievance and Appeal Management Department requests that the member submit in writing the reason(s) for the submission delay. If the Grievance and Appeal associate cannot identify any good cause for the delay, a letter is sent to the member denying review of his or her appeal request and advising him or her of the grievance process.

Any appeal request submitted more than 1 year from the date of the initial denial letter will not be accepted for review. A letter is sent to the member advising him or her of the rejection of his appeal request for review and advising him or her of the grievance process.

All reconsidered determinations involving coverage denial based on lack of medical necessity must be made by a physician with expertise in the field of medicine that is appropriate for the service at issue.

A member may utilize the reconsideration and appeals procedure for any adverse initial determination rendered by BCBSGA that pertains to the following:

1. Any claims denied in full or partially by BCBSGA.
2. Services that BCBSGA refuses to provide that the member believes should be furnished.
3. Any discontinuation or reduction of services.

An initial organization determination is made by BCBSGA. On any adverse determination, a letter must be sent to the member to advise him or her of the Medicare reconsideration and appeals procedure.

The following is a summary of the appeal procedure:

1. An enrollee may appoint an 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 (surrogate) may be authorized by the court or act in accordance with State law to file an appeal for an enrollee. A surrogate could include, but not limited to, a court appointed guardian, an individual who has Durable Power of Attorney, or a health care proxy, or a person designated under a health care consent statute. To be appointed by an enrollee, both the enrollee making the appointment and the representative accepting the appointment (including attorney) must sign, date, and complete a representative form. The form may be obtained by contacting the plan customer service department using the telephone number located on the back of the members ID card or on the Centers for Medicare and Medicaid Services (CMS) website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>.
2. The Grievance and Appeal Management Department should issue an acknowledgement letter within 5 business days of receiving the appeal.
3. If after reviewing the documentation submitted, it is determined that further information is required, the Grievance and Appeal Management associate sends a request for the necessary information to the appropriate parties. If the appeal is submitted without a copy of the denial letter, a copy is requested from SmartValue.
4. If the requested information related to the appeal is not received timely, the appeal is reviewed by the Medical Director based on the information available.

5. All reconsideration requests including service provision and claims payment are resolved within the 30-day (+ 14 calendar days if extension is needed) requirement for service appeals and 60-day requirement for claim appeals.
6. The member has the right to appear in person and/or have a representative appear to present evidence in support of his or her appeal.
7. If the initial determination is reversed, a written notice of favorable determination is sent to the member and service provision/authorization or payment of the denied claim is made within 30 days (plus an additional 14 calendar days if extension is needed) and 60 days, respectively, of receipt of the appeal.
8. If the initial determination is upheld (in whole or in part), the Grievance and Appeal Management associate forwards the case to CMS's reconsideration contractor, MAXIMUS Federal Services, Inc. (MAXIMUS), with a completed Reconsideration Background Data form, Case Narrative form, and supporting medical documentation. All information is sent to MAXIMUS by overnight mail, no later than 30 calendar days (plus an additional 14 calendar days if extension is applicable) for a service appeal and 60 calendar days for a claim appeal from receipt of the appeal. If the Grievance and Appeal Management Department fails to make a determination within the required time frame, it is considered an adverse determination and the case is forwarded to MAXIMUS.
9. The Grievance and Appeal Management Department provides written notice to the member that his or her request for reconsideration has been forwarded to CMS's reconsideration contractor for further consideration.
10. CMS's reconsideration contractor, MAXIMUS, reviews the information provided and requests any additional documentation needed from either the Grievance and Appeal Management Department or the member. The care management analyst forwards any additional information requested by MAXIMUS within the timeframe requested by MAXIMUS. MAXIMUS will not send a second request for information. If the Grievance and Appeal Management Department receives additional information after submitting the case to MAXIMUS, it may forward the additional information on its own to MAXIMUS within 3 days of receipt of the appeal case file by MAXIMUS. However, MAXIMUS is under no obligation to use this additional information.
11. The reconsideration review results are mailed to the Grievance and Appeal Management Department and to the member by MAXIMUS. If MAXIMUS upholds the Grievance and Appeal Management Department's denial, the notice advises the member of his or her right to a hearing before an Administrative Law Judge (ALJ) if the amount in controversy meets the minimum requirement.
12. A reconsideration determination by MAXIMUS is final and binding unless a request for a hearing before an Administrative Law Judge (ALJ) is filed within 60 days of the date of the MAXIMUS notification letter.
13. If the SmartValue member is dissatisfied with the ALJ hearing decision, they may request a review by the Medicare Appeals Council (MAC) within 60 days of the rendered decision.
14. If the amount in controversy meets the minimum requirement, a final decision of the ALJ or the Board can be appealed to a Federal District Court within 60 days of the Board's decision.

15. If MAXIMUS overturns the Grievance and Appeal Management's denial, SmartValue must (1) authorize the service within 72 hours from the date of receipt of the reversal or provide the service as expeditiously as the member's health condition requires, but no later than 14 calendar days from the date of receipt of the reversal or (2) pay for the service no later than 30 calendar days from the date of receipt of the reversal.
16. The reconsideration determination is final and binding on SmartValue.
17. On a monthly basis, the Grievance and Appeal Management Department generates a reconsideration report that includes the following elements:
 - a. Number of reconsiderations received
 - b. Status of cases (open, closed)
 - c. Resolution turnaround time
 - d. Number of cases forwarded to MAXIMUS
 - e. Timeliness of forwarding cases to MAXIMUS, when applicable
 - f. MAXIMUS resolution (fully favorable, partially favorable, upheld)

Any identified trends are reviewed by the Director of Grievance and Appeal Management and reported to the Medical Director (if applicable). Corrective actions are implemented as indicated.

Medicare Expedited Appeal Procedure

Blue Cross Blue Shield of Georgia provides, as required by CMS, an expedited appeal procedure for all its members. The expedited appeal process only applies to service denials (pre-service or service discontinuation). It does not apply to the administrative law judge level and beyond. Claim denials may only be appealed under the standard 60-day appeal process.

Members, authorized representatives, or treating physicians may request an expedited appeal, either orally or in writing. Expedited appeal request must be resolved within 72 hours of receipt of the request (including weekends and holidays) + 14 calendar day extensions if beneficial to the member.

Members of SmartValue or their representatives may request an expedited appeal, either orally or in writing. Expedited appeal requests must be resolved within 72 hours of receipt of the request (including weekends and holidays) + 14 calendar day extension if beneficial to the member.

Members may submit requests for an expedited appeal in one of the following ways:

1. Fax: (877) 811-5116
2. Phone: See customer service telephone number printed on the back of the member ID card.
3. Mail:
Blue Cross Blue Shield of Georgia SmartValue
Grievance and Appeal Unit
P.O. Box 1975
Fond du Lac, WI 54936

All requests for expedited appeals must be faxed to the Grievance and Appeal Management Department immediately.

BCBSGA may not prohibit or otherwise restrict a healthcare provider from advising or advocating on behalf of the member in the area of medical care relating to treatment options, including risks, benefits, and consequences of treatment or non-treatment, or the member's right to refuse treatment and express preferences about future treatment decisions. BCBSGA may not take or threaten punitive action against a physician acting on behalf or in support of a member requesting an expedited determination or expedited reconsideration, in accordance with Section 422.570(f) of the Balanced Budget Act of 1997.

The expedited appeal procedure is implemented as follows:

1. The member's or physician's request for expedited review, received either orally or in writing, is immediately directed to the Grievance and Appeal Management Department. Any request received orally by a member services representative is documented in writing before it is forwarded to the Grievance and Appeal Management Department.

An expedited appeal may be requested by the member, any physician or any individual appointed by the member. Should the member appoint someone to file an expedited appeal on his or her behalf, the member must submit a CMS-1696, Appointment of Representative (AOR) form. This form can be obtained by contacting the plan customer service department using the telephone number located on the members ID card or on the Centers for Medicare and Medicaid Services website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf>.

2. The request is reviewed by the Grievance and Appeal Management associate to determine whether the request qualifies for expedited review. A request for expedited review must be expedited if any one of these requirements is met:
 - a. The member's condition is such that the 30-day time frame of the standard appeal procedure could seriously jeopardize the life or health of the member or could jeopardize the member's ability to regain maximum function. (See the CMS approved clinical guidelines criteria).
 - b. The request is submitted by a physician or supported by a physician. If the Grievance and Appeal Management associate determines that the request does not meet the criteria for expedited review, the case is reviewed with the Medical Director before issuing a denial of the request for expedited review to the member or representative.

3. If the request does not meet the criteria for expedited review, it is immediately transferred to the standard 30-day process for review (refer to the Medicare standard appeal procedure section).

The Grievance and Appeal Management associate immediately notifies the member or representative orally (within 72 hours of receipt of the request for expedited review) that the appeal will not be expedited. A subsequent letter of explanation is mailed to the member/representative within 3 calendar days of the oral notification. This letter includes information that (1) the member's request will be processed within 30 calendar days (2) that the member may file an expedited grievance with BCBSGA SmartValue if the member disagrees with the determination (refer to the Member Grievance Resolution Procedure) not to expedite and (3) the member has the right to resubmit the request for expedited reconsideration with a physician support statement.

4. If the request meets the criteria for expedited review, the following process is implemented:
 - a. If medical records are necessary the Grievance and Appeal Management associate immediately faxes a letter to the physician requesting medical records. The physician is requested to respond to the request for information within 24 hours or sooner, if necessary.
 - b. The expedited appeal case is reviewed by the Medical Director and/or by the Grievance and Appeal Management Committee if applicable. A decision is rendered within 72 hours from the time of receipt of the request for expedited review (+ 14 calendar day extension if beneficial to the member).

- c. An extension of up to 14 calendar days is allowed if requested by the member or if the Grievance and Appeal Management Department determines that the extension is beneficial to the member. If the Grievance and Appeal Management Department extends the 72-hour time frame, a letter must be sent to the member/representative advising them of the reasons for the extension and of their right to file an expedited grievance if they disagree with the decision to extend the 72-hour time frame. The member's request for extension is documented in the case file by the Grievance and Appeal Management Department associate.
- d. The appellant is notified of the appeal decision orally within the required time frame. An oral notification of a favorable decision within 72 hours (+ 14-calendar day extension if beneficial to the member) of the request is followed by a confirmation letter within 3 calendar days of the oral notification. If the case is to be forwarded to CMS's reconsideration contractor, MAXIMUS, this is reflected in the notification letter to the member/representative. This notification letter of the denial decision must be sent concurrently to the member/enrollee with the case file to MAXIMUS.
- e. If the Grievance and Appeal Management Department upholds the denial, either in part or in whole, the case is forwarded to MAXIMUS, with the appropriate forms, within 24 hours of making a determination. All information is sent to MAXIMUS by overnight mail.

Note: MAXIMUS will not accept case files by fax; however, we must fax MAXIMUS a notification of an impending expedited case file.

If the Grievance and Appeal Management Department fails to make a determination within the required 72 hours or extended 14 calendar days, it is considered an adverse determination and the case must be forwarded to MAXIMUS within 24 hours of the expired 72 hours or extended 14 calendar days.

- f. If additional information is requested by MAXIMUS, this information must be submitted to MAXIMUS within 3 days from the date of the request or as indicated by MAXIMUS.
 - g. MAXIMUS notifies the member or appointed representative and the Grievance and Appeal Management Department of its determination within 72 hours (plus an additional 14 calendar days if additional information is needed) of receipt of the case file.

Note: The expedited appeal does not extend to the administrative law judge level.
 - h. Regarding continued hospital stay denial, the member must first request PRO review. If the member misses the noon deadline, the member can still request an expedited appeal. However, if PRO review is already being conducted on a case, the Grievance and Appeal Management Department should not process any request for expedited review. While the member is held harmless during the PRO review process, this financial protection does not apply to the expedited appeal process.
5. An expedited appeal determination by MAXIMUS is final and binding unless a request for hearing with the administrative law judge is filed within 60 calendar days of the date of the MAXIMUS notification letter by the member/representative.

6. Expedited appeals are included in the monthly reconsideration report generated by the Grievance and Appeal Management Department. They have a separate identification code to distinguish them from the standard 30-and 60-day appeals.

Any identified trends are reviewed by the Director of Grievance and Appeal Management and reported to the Medical Director (if applicable). Corrective actions are implemented as indicated.

Releasing Information to Members

Blue Cross Blue Shield of Georgia is committed to maintaining the highest level of confidentiality for its members' medical records. To protect members' privacy and standardize the release of information, members' requests for release of information are processed as follows:

1. Members requesting medical information release or those who have questions concerning medical information are directed to call SmartValue's Customer Service Department.
2. Only questions involving verifying claim payments are answered over the telephone. No other information will be given out, including questions on claim type or other claims-related issues. A member requesting any other information is sent a Release of Information Request form.
3. The request must be filled out by the person whose medical information is being requested. A person will not be able to obtain information for a spouse, parent, or independent adult child.
4. Information requested in accordance with the above procedure is sent out within 10 days of receipt of the Release of Information Request form. The Customer Service Department keeps all requests in the member's file, and documents the date and nature of the information being released.

5. The customer service representative checks the signature on all Release of Information Request forms against the signature on file for the member, and the manager or supervisor of Customer Service then signs off on each request. This acts as a double-check system to prevent releasing any confidential information to the wrong party and prevents forgery.
6. Any Release of Information Request forms that are filled out incorrectly will be returned to the member with an explanation of why his or her request cannot be fulfilled and instructions for filling out the form correctly.
7. Any requests for information that are out of the ordinary, or those that appear to be happening on a frequent basis, will be turned over to the Customer Service manager for further follow-up.

Member Responsibility Policy

SmartValue, as a Medicare Advantage Organization, is entitled to review and respond to issues regarding its members and their medical care. The joint responsibilities of SmartValue, its healthcare professionals and facilities, and its members, are defined in the Terms and Conditions executed between these parties.

Failure to uphold these responsibilities may jeopardize the ongoing relationships between the parties and interfere with providing proper medical care.

The remedial action available to BCBSGA is disenrollment, usually after progressive notification. In cases related to members' relationships with physicians requiring remedial actions, the Medical Director and/or the Grievance and Appeal Management Committee serve as a deliberative entity to review the positions of all parties. It is most important, in view of the significance of the issues involved, that there be substantial documentation for each case considered for remedial action.

Requests for disenrollment, progressive notification, will be considered for the following:

1. If the member moves out of SmartValue's service area.
2. If the member knowingly omits or misrepresents a material fact on the membership application.
3. If the member fraudulently applies for any benefits under the SmartValue contract.
4. If the member permits abuse of his or her membership card.
5. If the member fails to pay the required copayments.
6. If the member exhibits disruptive behavior in the course of seeking or receiving care.
7. If the member exhibits dangerous behavior (e.g., attempted physical abuse of personnel or other patients) in the course of seeking or receiving care.
8. If the member utilizes fraud or deception in using SmartValue.
9. If the member persists in conduct that interferes with the effective delivery of healthcare:
 - a. Members may reasonably refuse to accept advice, procedures, or treatments by the physician. Such refusal, if within the bounds of proper behavior, does not constitute a breach of the physician/member relationship.
 - b. Physicians shall use their best efforts to render all necessary and appropriate professional services in a manner compatible with the member's wishes. However, physicians must retain the right to exercise their own judgment as to the requirements of proper medical practice.

Causes of action related to #1 through #5 listed above are reviewed by SmartValue. Causes of action related to #6 through #9 listed above are reviewed by the Grievance and Appeal Management Department.

Member Remedial Actions

Member remedial actions may only be implemented on completing the due process outlined below. Notification of any due process activity or member remedial action must be by written notice, certified mail/return receipt, and delivered no less than 20 working days in advance of the effective date of due process activity or remedial action. Such written notification must also clearly explain the member's right of response/rebuttal and right to file a grievance with SmartValue. The member shall have the opportunity to respond to alleged causes of action #5-9 listed above directly to the Medical Director and/or the Grievance and Appeal Management Committee prior to determining or implementing any remedial action. The member remedial actions available to SmartValue are:

1. **Disenrollment**

Member disenrollment constitutes a total loss of the member's benefits under SmartValue. In such a case, SmartValue will not have any further responsibility to provide care or any funding or reimbursement for care. CMS must be notified of all disenrollment actions taken or intended disenrollment actions.

2. Progressive Notification

Progressive notification is a three-step process and consists of the following:

- a. The member is sent an initial letter detailing the cause of action and requesting that the member work with the physician to remedy the difficulty. The member is informed that failure to do so may jeopardize his or her SmartValue coverage. The member's behavior/actions are tracked by the Grievance and Appeal Management Department. The Medical Director and/or the Grievance and Appeal Management Committees may also intervene on the member's behalf through referral to case management, social service, government, community, or other appropriate agencies.
- b. If the member fails to remedy the cause of action after mailing the initial letter, the Medical Director and/or the Grievance and Appeal Management Committee direct the staff to mail a second letter. The second letter documents the member's failure to remedy the cause of action and warns the member that failure to do so, within a specified time frame, will cause disenrollment. Agency referral, as above, may be initiated by the Medical Director and/or Committee. The member's behavior/actions are tracked by the Grievance and Appeal Management Department.
- c. If the member fails to remedy the cause of action within the specified time frame after mailing the second letter, the case is reviewed with the Medical Director and/or the Grievance and Appeal Management Committee. If the decision is made to proceed with the disenrollment, the case is forwarded to the Director of Medicare Compliance for review before sending a letter to the member notifying him of his failure to remedy the cause of action and of our request to CMS for disenrollment. The

member is advised of his/her right to file a grievance should he/she disagree with the decision. Following disenrollment approval by CMS, a letter is sent to the member advising him/her of the disenrollment approval by CMS and of the effective date of his disenrollment from SmartValue. The member is also advised that until the effective disenrollment date, he or she must continue to have all his or her care provided by SmartValue.

Prohibition on Discrimination, Discouragement of Enrollment

SmartValue and its deemed contracted providers may not:

1. Promote discrimination
2. Discourage enrollment
3. Steer specific subsets of Medicare beneficiaries to particular Medicare Advantage plans
4. Inhibit access to services

Advance Directives

SmartValue expects physicians to honor advance directives, and assist and guide members with regard to these sensitive issues. SmartValue will not provide actual advance directive forms, and does not require the deemed providers to supply forms. Forms are available from hospitals, and various nonprofit organizations. Forms are also available in major stationery stores where legal forms are sold.

SECTION 7 – DIRECTORY OF SERVICES

Introduction

This section assists the provider in reaching the appropriate resources at BCBSGA. It also identifies servicing units and BCBSGA personnel that have the particular expertise needed to address the providers' questions, issues, and concerns.

Customer Service

Customer Service representatives are available to answer both written and telephone inquiries on a variety of topics, including:

1. Eligibility verification and research
2. Benefit questions and explanations
3. Professional services, bills, and claims
4. Hospital services, bills, and claims
5. Membership problems and inquiries
6. Conflict resolution regarding benefit interpretation
7. Reconsideration and appeals process
8. 10. A dedicated provider service line is available to assist with provider specific issues. Direct provider inquires to the SmartValue Dedicated Provider Service Department: 1-866-364-2374, 7:00 a.m. to 8:00 p.m. IVR is available 24 hours a day, 7 days a week.

Customer Service representatives assist providers with a variety of administrative issues, including:

1. Eligibility verification and effective dates
2. Benefit questions and explanations
3. Request for member removal for disciplinary actions

Claim Submission

Please submit claims directly to your local Blue Cross Blue Shield plan. Claims must be submitted in accordance with Medicare guidelines for claims submission timeliness. Providers should follow all standard Medicare claims submission requirements when submitting claims to SmartValue, including submitting claims with their National Provider Identification number (NPI), Tax Identification number and Clinical Laboratory Improvement Amendments (CLIA) number (if applicable). In addition, the Medicare billing number and copies of any special Medicare reimbursement rate assignments may be necessary for correct pricing of claims, and will be requested if not already on file or submitted with the claim for processing. All clean claims will be processed within 30 days of receipt. Interest will be paid on clean claims that are not paid within 30 days. All other claims will be paid or denied within 60 calendar days from the date the claim was received.

If you have questions about submitting your claim, your payment, Member copayments, SmartValue Terms and Conditions, or, if you would like more information on the SmartValue plans, please contact SmartValue at 1-866-364-2374 7 days a week, 8 AM to 8 PM CST. Detailed eligibility and benefits information is also available 24 hours a day via our Interactive Voice Response (IVR) telephone system in voice-back and fax-back formats.

Medical Services

The SmartValue Medical Department is responsible for all medical management functions, and is under the direction and supervision of the SmartValue medical director. Medical management functions include, but are not limited to, quality assurance, case management, member and healthcare professional or facility grievance resolution.

Medical Director

The Medical Director, a BCBSGA-licensed physician, reports to BCBSGA's vice president of Quality Management. The medical director reviews all activities of the SmartValue Quality Management Program. He or she assesses the SmartValue Quality Management Program to evaluate its efficiency and effectiveness, and makes modifications in organization, systems, staff activities, medical policy, and clinical practices where necessary to ensure a high level of performance. When necessary, the Medical Director is actively involved in the problem-resolution process and coordinates quality management activities.



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