BlueCross BlueShield of Illinois

BLUE REVIEW℠

For Providers

January 2024

Network Innovation

Reminder: Serving Our Blue High Performance Network®

BlueHPN® members have access to quality and affordable health care in the Chicago, Naperville-Elgin and East St. Louis areas.

Learn More

Wellness and Member Education

Remind Our Members About Cervical and Breast Cancer Screenings

The new year is an opportunity to remind our members to schedule their screenings for cervical cancer and breast cancer.

Learn More

Focus on Behavioral Health

Monitoring Children Using ADHD Medication

Medication for attention-deficit/hyperactivity disorder can help manage symptoms in children, according to the Centers for Disease Control and Prevention.

Learn More

Provider Education

Provider Learning Opportunities

Blue Cross and Blue Shield of Illinois offers free webinars and workshops for the independently contracted providers who work with us. A preview of upcoming training sessions is included in this month's issue.

Learn More

Pharmacy Program

Approaches to Managing GLP-1 Agonist Medications

BCBSIL is committed to providing its members access to safe, appropriate and cost-effective health care within their plan benefits. To ensure the appropriate use of GLP-1s as indicated for diabetes, we're making it easier for some of our members with diabetes to bypass our prior authorization process. Read more on News and Updates.

Oral Oncology Pharmacy Network Transition to IntegratedRx™

As of Oct. 1, 2023, the Prime Therapeutics® oral oncology pharmacy network transitioned to the IntegratedRx network of specialty pharmacies.

Learn More

Pharmacy Program Updates: Prior Authorization Changes Effective Feb. 1 and March 1, 2024

The BCBSIL pharmacy PA program encourages safe, cost-effective medication use by allowing coverage when certain conditions are met. A clinical team of physicians and pharmacists develops and approves the clinical programs and criteria for medications that are appropriate for PA by reviewing U.S. Food and Drug Administration approved labeling, scientific literature, and nationally recognized guidelines. Read more on News and Updates for February 1 and March 1.

Clinical Updates, Reminders and Resources

Medical Policy Updates

Approved, new or revised BCBSIL Medical Policies and their effective dates are posted on our Provider website.

Learn More

Prior Authorization Code Updates for Some Commercial and Government Programs Members, Effective April 1, 2024

BCBSIL is changing prior authorization requirements that may apply to some commercial non-HMO and government programs – Blue Cross Medicare Advantage (PPO)℠, Blue Cross Community Health Plans℠ and Blue Cross Community MMAI (Medicare-Medicaid Plan)℠ – members. Refer to News and Updates for a summary of commercial and government programs changes and code updates.

Update Your Records: New Medicare Open Access PPO Members and ID Cards

New Medicare-eligible retirees have joined our Blue Cross Group Medicare Advantage Open Access (PPO)℠ plans for retirees of employer groups and Blue Cross Medicare Advantage Flex (PPO)℠ plan for individuals. These are open access, national PPO plans without network restrictions. Read more on News and Updates.

Federal Employee Program® Updates to Prior Authorization Requirements and Benefits

As of Jan. 1, 2024, some changes will be in effect for FEP® policy types. Read more on News and Updates.

Claims and Coding

Three New ClaimsXten™ Rules to be Implemented March 1, 2024

On or after **March 1, 2024**, we will update the ClaimsXten software database to better align coding with the reimbursement of claim submissions.

Learn More

Advisory on Telehealth Services – Using Place of Service Codes on Commercial Claims

We're updating our telehealth commercial claims filing guidelines following recommendations from the CMS.

Learn More

Billing Reminder for Illinois Medicaid Providers

All Federally Qualified Health Centers, Rural Health Centers and Encounter Rate Clinics billing for Illinois Medicaid members need to ensure the appropriate taxonomy is billed on the claim for the Billing Provider as outlined in the Illinois Association of Medicaid Health Plans Comprehensive Billing Manual.

Learn More

Reminder: Update Your Records with New Mailing Address for Paper Claims

We announced a new mailing address in September for faster claims processing and responses. Please only submit paper claims if necessary. Read more on News and Updates.

Quality Improvement

MMAI℠ Availability and Access Standards

Appointment availability and access guidelines should be used to help ensure our MMAI members have timely access to medical care and behavioral health care services. Read more on News and Updates.

Blue Cross Medicare Advantage (HMO)℠ and (PPO) Availability and Access Standards

Appointment availability and access guidelines should be followed by providers to ensure timely access to medical care for MMAI and Medicare Advantage members. These guidelines

also apply to behavioral health services and substance use disorder services. Read more on News and Updates.

Notifications and Disclosure

Hospitals Must Provide Medicare Outpatient Observation Notice

Hospitals and Critical Access Hospitals are required to give the standardized Medicare Outpatient Observation Notice to our Blue Cross Medicare Advantage members who are under outpatient observation for more than 24 hours.

Learn More

Patients in the Qualified Medicare Beneficiary Program Should Not Be Billed

If you participate in Blue Cross Medicare Advantage plans, you may not bill our members enrolled in the Qualified Medicare Beneficiary program, a federal Medicare savings program.

Learn More

Reminders

Stay informed!

Watch the News and Updates on our Provider website for important announcements.

Verify and Update Your Information

Verify your directory information every 90 days. Use the **Availity® Essentials** **Provider Data Management** feature or our Demographic Change Form. **Facilities** may only use the Demographic Change Form.

Provider Training

For dates, times and online registration, visit the Webinars and Workshops page.

Contact Us

Questions? Comments? Send an email to our editorial staff.

bcbsil.com/provider

File is in portable document format (PDF). To view this file, you may need to install a PDF reader program. Most PDF readers are a free download. One option is Adobe® Reader® which has a built-in screen reader. You can download other tools and learn more about accessibility at adobe.com.

By clicking this link, you will go to a website/app ("site"). The site may be offered by a vendor or an independent third party. The site may also contain non-Medicare related information. Some sites may require you to agree to their terms of use and privacy policy.

BLUE REVIEW℠
for Providers

January 2024

Reminder: Serving Our Blue High Performance Network®

BlueHPN® members have access to quality and affordable health care in the Chicago, Naperville-Elgin and East St. Louis areas.

BlueHPN is a provider organization network with participation from Blue Cross and Blue Shield Plans nationwide. BlueHPN members must stay in network to receive benefits. There are no out-of-network benefits except for emergency, accident and urgent care scenarios.

Here are some tips as you serve these members:

How to Recognize BlueHPN Members
You can identify BlueHPN members by their member ID card. Look for the Blue High Performance Network name on the front along with the initials “BlueHPN” in a suitcase. This logo indicates that BlueHPN rates apply.

Check eligibility and benefits first:
Use Availity® Essentials or your preferred vendor to check eligibility and benefits for all Blue Cross and Blue Shield of Illinois members before every scheduled appointment. Eligibility and benefit quotes include membership confirmation, coverage status and applicable copayment, coinsurance and deductible amounts. The benefit quote may also include information on applicable prior authorization requirements.

Emergent Care

Members have access to BlueHPN providers as well as non-BlueHPN providers in an emergency.

Treating BlueHPN Members

You may work in multiple locations or for multiple medical groups with multiple tax identification numbers or national provider identifiers. Because BlueHPN members do not have out-of-network benefits, please make sure you're rendering care at an in-network facility under the TIN or NPI that is contracted with BlueHPN.

Referring to Specialists

When BlueHPN members need to see a specialist or another health care provider, refer them to participating BlueHPN providers to **ensure they receive in network benefits**. Check BCBSIL's online Provider Finder® or call the number on the member's ID card to identify other providers in BlueHPN.

Claim Filing

BlueHPN follows the same claims filing process as our commercial members. Submit local and out-of-area BCBS member claims to BCBSIL as you typically would. See the Claim Submission page for more details, including a link to the updated BlueCard Program Manual.

Joining BlueHPN

Visit our BCBSIL contracting web page for details on joining the BlueHPN network.

Questions? Call the Customer Service number on the member's ID card.

Blue Cross and Blue Shield of Illinois, a Division of Health Care Service Corporation, a Mutual Legal Reserve Company, an Independent Licensee of the Blue Cross and Blue Shield Association

☐ File is in portable document format (PDF). To view this file, you may need to install a PDF reader program. Most PDF readers are a free download. One option is Adobe® Reader® which has a built-in reader. You can download other tools and learn more about accessibility at adobe.com ☐.

☐ You are leaving this website/app ("site"). The new site may be offered by a vendor or an independent third party. The site may also contain non-Medicare related information. Some sites may require you to agree to their terms of use and privacy policy.

BLUE REVIEW℠
for Providers

January 2024

Remind Our Members About Cervical and Breast Cancer Screenings

The new year is an opportunity to remind our members to schedule their screenings for cervical cancer and breast cancer. Regular screening tests can detect problems early when they're easier to treat.

Recommended Screenings

The U.S. Preventive Services Task Force recommends:

- Screening all women for cervical cancer starting at age 21
- Screening women ages 50 to 74 for breast cancer every two years. You may want to discuss with members the risks and benefits of receiving a screening before age 50.

See our preventive care guidelines for more information.

Addressing Health Disparities

According to the American Cancer Society:

- Native American and Hispanic women have the highest rates of cervical cancer.
- Black women are more likely to die from breast and cervical cancer than other racial or ethnic groups.

Other non-medical drivers of health, such as education levels and poverty, are also linked to different health outcomes. See our Health Equity and Social Determinants of Health page for more information on health equity and how you can help.

Closing Gaps in Care

Cervical Cancer Screening and Breast Cancer Screening are Healthcare Effectiveness Data Information

Set measures developed by the National Committee for Quality Assurance. We track data from HEDIS® measures to help assess and improve our members' care.

Cervical Cancer Screening tracks the following:

- Women ages 21 to 64 who had cervical cytology performed within the last three years
- Women ages 30 to 64 who had either:
  - Cervical high-risk human papillomavirus testing within the last five years or
  - Cervical cytology/hrHPV cotesting within the last five years

Breast Cancer Screening assesses the percentage of women ages 50 to 74 who had at least one bilateral mammogram in the past two years.

Tips to Consider

- Talk with our members about risk reduction and prevention.
- We've created resources on cervical cancer and breast cancer screening that may help.
- The Centers for Disease Control and Prevention recommends human papillomavirus vaccines for all people up to age 26 to protect against cervical cancers. We have a tip sheet on coding and documenting for HPV and related cancers.
- Document screenings in the medical record. Indicate the date and result.
- Document medical and surgical history in the medical record, including dates.
- For members who have had a hysterectomy, document the type of hysterectomy and date of surgery. If the member has not had a hysterectomy with removal of cervix, they will need to continue to receive their cervical cancer screening. A documentation of hysterectomy alone is not sufficient to remove the member from the CCS measure. **There must be documentation of absence of cervix.**
- Follow up with members if they miss their appointment and help them reschedule.

bcbsil.com

BLUE REVIEW℠
for Providers

January 2024

Monitoring Children Using ADHD Medication

Medication for attention-deficit/hyperactivity disorder can help manage symptoms in children, according to the Centers for Disease Control and Prevention. Providers who prescribe ADHD medication to children should monitor them to ensure medications are prescribed and managed correctly, according to the National Committee for Quality Assurance. NCQA recommends following up with children who are newly prescribed ADHD medication and who remain on medication long term.

Supporting Quality Care

We track the NCQA quality measure Follow-Up Care for Children Prescribed ADHD Medication. This measure captures the percentage of children ages 6 to 12 who had:

- Initiation phase: One follow-up visit with a provider with prescribing authority within 30 days of the first prescription
- Continuation and maintenance phase: Two or more follow-up visits with a provider in the nine months (270 days) after the initiation phase. The child also has remained on the ADHD medication for at least 210 days

Depending on the member's benefits, visits for both phases can be by telehealth when appropriate.

For tips to close gaps in care for this measure, see our tip sheet.

The above material is for informational purposes only and is not a substitute for the independent medical judgment of a physician or other health care provider. Physicians and other health care providers are encouraged to use their own medical judgment based upon all available information and the condition of the patient in determining the appropriate course of treatment. The fact that a service or treatment is described in this material, is not a guarantee that the service or treatment is a covered benefit and members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any service or treatment is between the member and their health care provider.

BLUE REVIEW℠
for Providers

January 2024

Provider Learning Opportunities

Blue Cross and Blue Shield of Illinois offers free workshops and webinars for the independently contracted providers who work with us. These trainings focus on electronic options and other helpful tools and resources. A preview of upcoming training sessions is included below. For more information, refer to our Webinars and Workshops page.

BCBSIL WEBINARS

To register now for a webinar on the list below, click on your preferred session date.

Descriptions:	Dates:	Session Times:
Availity® Essentials, BlueApprovR℠ Prior Authorization and Recommended Clinical Review Tools *Learn how to electronically submit inpatient and outpatient prior authorization handled by BCBSIL using the Availity Essentials Authorizations tool. You'll also learn how to access and submit inpatient and/or outpatient medical/surgical, behavioral health and specialty pharmacy drug prior authorization requests, as well as recommended clinical review, through BlueApprovR.*	Jan. 3, 2024 Jan. 10, 2024 Jan. 17, 2024 Jan. 24, 2024 Jan. 31, 2024	11 a.m. to 12:30 p.m.

Availity Essentials Claim Status, Clinical Appeals, Reconsiderations and Message This Payer *Learn how to verify enhanced claim status, submit clinical claim appeals reconsiderations requests and Message This Payer online using the Availity Claim Status tool.*	Jan. 4, 2024 Jan. 11, 2024 Jan. 18, 2024 Jan. 25, 2024	11 a.m. to 12:30 p.m.
Availity Essentials Instructor-Led Training *Register for this session to better understand how electronic transactions can work for your organization. You'll learn the importance of Manage My Organization, how to use the Patient ID Finder, instruction on how to verify patients' Eligibility and Benefits and more online options.*	Jan. 16, 2024	11 a.m. to noon
Availity Remittance Viewer and Provider Claim Summary *These online tools give providers and billing services a convenient way to view claim detail information from the 835 Electronic Remittance Advice and the Provider Claim Summary. Attend a webinar to learn how to gain or grant access, conduct a search, view general and payer-specific information, and save or print results.*	Jan. 18, 2024	1 to 2 p.m.
BlueApprovR: Prior Authorization Process and RCR Process *Learn how to access via Availity Essentials to submit and secure real-time approvals for specialty pharmacy drug, behavioral health clinical evaluation and medical surgical prior authorization requests, as well as recommended clinical review, for many BCBSIL commercial members.*	Jan. 9, 2024 Jan. 16, 2024 Jan. 23, 2024 Jan. 30, 2024	3 to 4 p.m.
Blue Cross Medicare Advantage (PPO)℠ and Blue Cross Medicare Advantage (HMO)℠ Provider	Jan. 23, 2024	10 to 11 a.m.

Orientation *BCBSIL's Medicare Advantage Plan expanded to additional counties within Illinois. These orientation webinars will give you the opportunity to ask the Provider Network Consultants questions and will highlight topics such as provider enrollment, eligibility and benefits, claim submission and review and additional resources.*		
BCCHP℠ and MMAI Required Provider Training Webinars *If you provide care and services to our Blue Cross Community MMAI℠ and/or Blue Cross Community Health Plans℠ members, please join us for guided webinars that will review all the provider trainings required by the Centers for Medicare & Medicaid Service and/or Illinois Department of Healthcare and Family Services.*	Jan. 16, 2024	10 a.m. to noon
HEDIS® Update and Best Practices for Providers Groups *This session will highlight how Healthcare Effectiveness Data and Information Set tracks measurement to improvement in quality reporting. Discussion also includes HEDIS methods and electronic clinical data systems.*	Jan. 18, 2024	Noon to 1 p.m.
Monthly Provider Hot Topics Webinar *Stay up to date on the latest news from BCBSIL! Engage with our PNCs to learn about upcoming initiatives, program changes and updates, as well as general network announcements.*	Jan. 11, 2024	10 to 11:30 a.m.

Availity is a trademark of Availity, LLC, a separate company that operates a health information network to provide electronic information exchange services to medical professionals. Availity provides administrative services to BCBSIL. BCBSIL makes no endorsement, representations or warranties regarding any products or services provided by third party vendors and the products and services they offer.

HEDIS is a registered trademark of NCQA.

Checking eligibility and benefits and/or obtaining prior authorization is not a guarantee of payment of benefits. Payment of benefits is subject to several factors, including, but not limited to, eligibility at the time of service, payment of premiums/contributions, amounts allowable for services, supporting medical documentation, and other terms, conditions, limitations, and exclusions set forth in the member's policy certificate and/or benefits booklet and or summary plan description. Regardless of any prior authorization or benefit determination, the final decision regarding any treatment or service is between the patient and the health care provider. If you have any questions, call the number on the member's BCBSIL ID card.

☐ File is in portable document format (PDF). To view this file, you may need to install a PDF reader program. Most PDF readers are a free download. One option is Adobe® Reader® which has a built-in reader. You can download other tools and learn more about accessibility at adobe.com ☐.

☐ You are leaving this website/app ("site"). The new site may be offered by a vendor or an independent third party. The site may also contain non-Medicare related information. Some sites may require you to agree to their terms of use and privacy policy.

BLUE REVIEW℠

for Providers

January 2024

Oral Oncology Pharmacy Network Transition to IntegratedRx™

As of **Oct. 1, 2023**, the Prime Therapeutics® oral oncology pharmacy network transitioned to the IntegratedRx network of specialty pharmacies.

IntegratedRx is a clinically integrated program that allows members to receive their oral oncology and other select medications at their health care provider's clinic or hospital pharmacy. The doctor and pharmacist are part of the same team and have direct communication.

Members have access to more than 400 clinic-based pharmacies for oncology and more than 10 clinic-based pharmacies for cystic fibrosis.

An updated list of Blue Cross and Blue Shield of Illinois in-network specialty pharmacy vendors can be found on our Provider website. Members can view the specialty network list by logging into their Blue Access for Members℠ or MyPrime.com accounts.

Call the number on your patient's member ID card to verify coverage or for further help with your patient's benefits.

BCBSIL contracts with Prime Therapeutics to provide pharmacy benefit management and related other services. BCBSIL, as well as several independent Blue Cross and Blue Shield Plans, has an ownership interest in Prime Therapeutics. MyPrime.com is an online resource offered by Prime Therapeutics.

The relationship between BCBSIL and the specialty pharmacies is that of independent contractors.

The information mentioned here is for informational purposes only and is not a substitute for the independent medical judgment of a physician. Members should refer to their certificate of coverage for more details, including benefits, limitations and exclusions. Regardless of benefits, the final decision about any medication is between the member and their health care provider.

BLUE REVIEW℠
for Providers

January 2024

Medical Policy Updates

Approved, new or revised Blue Cross and Blue Shield of Illinois Medical Policies and their effective dates are usually posted on our Provider website. Medical policies, both new and revised, are used as guidelines for benefit determinations in health care benefit programs for most BCBSIL members, unless otherwise indicated. These policies may affect your reimbursement and your patients' benefits.

Although medical policies can be used as a guide, providers serving HMO members should refer to the HMO Scope of Benefits in the BCBSIL Provider Manual, located in the Standards and Requirements section.

You may view active, new, and revised policies, along with policies pending implementation, by visiting the BCBSIL Medical Policy page. Select "View all Active and Pending Medical Policies." After confirming your agreement with the Medical Policies disclaimer, you will be directed to the Medical Policies homepage.

You also may view draft medical policies that are under development or are in the process of being revised by selecting "View and comment on Draft Medical Policies." After confirming your agreement with the Medical Policies disclaimer, you will be directed to the Draft Medical Policies page. Click on the title of the draft policy you wish to review, and then select "Comments" to submit your feedback to us.

Visit the Standards and Requirements section of our website for access to the most complete and up-to-date BCBSIL Medical Policy information. You'll find a Recommended Clinical Review (Predetermination) Code List in the Related Resources on our Recommended Clinical Review (Predetermination) page – this

list is updated on a monthly basis. In addition to medical policies, other policies and information regarding payment can be found on the Clinical Payment and Coding Policies page.

The BCBSIL Medical Policies are for informational purposes only and are not a substitute for the independent medical judgment of health care providers. Providers are instructed to exercise their own clinical judgment based on each individual patient's health care needs. The fact that a service or treatment is described in a medical policy is not a guarantee that the service or treatment is a covered benefit under a health benefit plan. Some benefit plans administered by BCBSIL, such as some self-funded employer plans or governmental plans, may not utilize BCBSIL Medical Policies. Members should contact the customer service number on their member ID card for more specific coverage information.

BLUE REVIEW℠
for Providers

January 2024

Three New ClaimsXten™ Rules to be Implemented March 2024

On or after **March 1, 2024**, Blue Cross and Blue Shield of Illinois will update the ClaimsXten software database to better align coding with the reimbursement of claim submissions.

These are the changes:

Bundled Service	This rule identifies claim lines containing procedure codes indicated by the Centers for Medicare & Medicaid Services to be always bundled when billed with any other procedure. According to the CMS National Physician Fee Schedule Relative Value File, this procedure has a status code indicator of “B,” which is defined as: “Payment for covered services is always bundled into payment for other services not specified.” This rule is appropriate for professional claims only.
CMS Add-on Without Base Code Facility	This rule identifies claim lines containing a Current Procedural Terminology or Healthcare Common Procedure Coding System assigned add-on code when billed without acceptable supporting primary procedure/base code by the same practitioner for the same patient on the same date of service, per CMS. According to CMS, add-on codes are always performed in addition to the primary service or procedure and must never be reported as a stand-alone code. An add-on code is eligible for

	payment if its related primary procedure/base code is also eligible for payment to the same practitioner for the same patient on the same date of service. This rule is appropriate for outpatient facility claims only.
Ancillary Procedures	This rule identifies claim lines billed by the same or a different provider either on the same day or different day (depending on the procedure code) after a non-covered service. This rule can consider both facility and non-facility claims. Before denying an ancillary service, the rule check for other covered services that may have been performed on the same day as the non-covered procedure. If found, the rule will allow the ancillary service. This rule is appropriate for professional claims and outpatient facility claims only.

To determine how coding combinations may be evaluated during claim adjudication, use Clear Claim Connection™. Refer to the Clear Claim Connection page for answers to frequently asked questions about ClaimsXten and details on how to gain access to C3.

bcbsil.com

BLUE REVIEW℠
for Providers

January 2024

Advisory on Telehealth Services – Using Place of Service Codes on Commercial Claims

We're updating our telehealth commercial claims filing guidelines following recommendations from the Centers for Medicare & Medicaid Services.

When filing commercial claims, follow these POS code recommendations from CMS:

- **POS 10** is for use on claims for "Telehealth Provided in Patient's Home"
- **POS 02** is for use on claims for "Telehealth Other than in Patient's Home"

The above POS code changes designate where the patient is located when receiving services through telehealth.

This notification applies to claims for commercial Blue Cross and Blue Shield of Illinois members.

Refer to the CMS website for more information.

BLUE REVIEW SM
for Providers

January 2024

Billing Reminder for Illinois Medicaid Providers

All Federally Qualified Health Centers, Rural Health Centers and Encounter Rate Clinics billing for Illinois Medicaid members need to ensure the appropriate taxonomy is billed on the claim for the Billing Provider as outlined in the Illinois Association of Medicaid Health Plans Comprehensive Billing Manual.

Per the Comprehensive Billing Manual on page 112, all FQHCs, RHCs and ERCs need to use the appropriate taxonomy as outlined per the clinic's specialty enrollment in Illinois Medicaid Program Advanced Cloud Technology. These taxonomy codes are outlined in the table below along with submission guidelines for this code for both paper and electronic submissions.

Paper Claim CMA-1500	HIPAA 5010 837P Loop	HIPAA 5010 837P Segment	Requirements
Box 33	2000A	PRV03	Appropriate taxonomy for the registered provider specialty type in IMPACT: • FQHC Providers: 261QF0400X • ERC Providers: 261QP2300X • RHC Providers:

			261QR1300X

The IAMHP Comprehensive Billing Manual can be found online.

If you have claim-related questions or need more information related to services provided to Blue Cross and Blue Shield of Illinois members, call the number on the member's BCBSIL ID card. If you have other questions, email your assigned Provider Network Consultant.

BLUE REVIEW℠
for Providers

January 2024

Hospitals Must Provide Medicare Outpatient Observation Notice

Hospitals and Critical Access Hospitals are required to give the standardized Medicare Outpatient Observation Notice to our Blue Cross Medicare Advantage℠ members who are under outpatient observation for more than 24 hours. **The notice explains why the members aren't inpatients and what their coverage and cost-sharing obligations will be**.

Steps for Providers To Complete the MOON

- Download the notice from the Centers for Medicare & Medicaid Services website. Forms in English, Spanish and large print are available.
- Fill in the reason the member is outpatient rather than inpatient.
- Explain the notice verbally to the member if they are in observation more than 24 hours.
- Have the member sign to confirm they received and understand the notice. If the member declines, the staff member who provided the notice must certify that it was presented.
- Document all member communications regarding the MOON process in members' records.

The notice **must be completed no later than 36 hours after observation begins or sooner** if the patient is admitted, transferred or released.

Learn more from CMS' notice instructions.

The information provided here is only intended to be a summary of the law that has been enacted and is not intended to be an exhaustive description of the law or a legal opinion of such law. If you have any questions regarding the law mentioned here, you should consult with your legal advisor.

BLUE REVIEW[SM]
for Providers

January 2024

Patients in the Qualified Medicare Beneficiary Program Should Not Be Billed

If you participate in Blue Cross Medicare Advantage[SM] plans, you may not bill our members enrolled in the Qualified Medicare Beneficiary program, a federal Medicare savings program.

QMB patients are dual eligible beneficiaries, which means they are eligible for both Medicare and Medicaid. As a state Medicaid benefit, QMB covers the Medicare Advantage premiums, deductibles, coinsurance and copayments of QMB beneficiaries. **QMB beneficiaries are not responsible for Medicare Advantage cost-sharing or out-of-pocket costs**.

For services you provide to QMB patients, you must:

- Bill both Medicare Advantage and Medicaid
- Accept Medicare Advantage payments and any Medicaid payments as payment in full

Tips to Avoid Billing QMB Patients

Please ensure that you and your staff are aware of the federal billing law and policies governing QMB. It is against federal law for any Medicare provider to bill QMB patients, whether or not the provider accepts Medicaid. Per your Medicare Provider Agreement, you may be sanctioned if you inappropriately bill QMB patients for Medicare Advantage cost-sharing.

To avoid billing QMB patients, please take these precautions:

- Understand the Medicare Advantage cost-sharing billing process
- Be sure your billing software and staff remove QMB patients from Medicare Advantage cost-sharing billing and related collections efforts

Questions?

Call Customer Service at 877-774-8592 to learn more about QMB procedures and ways to identify QMB patients. For more details about QMB, see the Centers for Medicare & Medicaid Services website.