Patrius Health

BLUE ADVANTAGE

Provider Manual

NOTE: All member coverage and provider agreements terminate effective December 31, 2026.



Blue Advantage
A Medicare Approved PPO

PRV20539PAT-2610

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Preface

Patrius Health member coverage and provider agreements end effective December 31, 2026. Questions: Contact Patrius Health Provider Services at 1-888-949-2352.

Introduction

The Balanced Budget Act of 1997 established a Medicare program called the Medicare+Choice (M+C), now known as Medicare Advantage. This action significantly expanded the healthcare options available to Medicare beneficiaries.

Patrius Health, a Blue Cross & Blue Shield of Mississippi and Blue Cross and Blue Shield of Alabama joint venture, contracted with the Centers for Medicare & Medicaid Services (CMS) to provide Medicare-covered services to beneficiaries through a Medicare Advantage Plan. This plan, Blue Advantage, is a Medicare-approved Preferred Provider Organization (PPO) Plan option for beneficiaries. Blue Advantage is offered to beneficiaries residing in the state of Mississippi. Blue Advantage provides the same or higher level of benefits that a beneficiary is entitled to if covered by Medicare.

Blue Advantage works much like the traditional Medicare program. Beneficiaries are free to go to any physician or hospital they choose as long as the provider is an eligible participating Medicare provider and has agreed to participate with the Blue Advantage plan. Agreements for participation are extended to all appropriate providers in order to maintain a sufficient network for beneficiaries. Included is specialty care and direct access to participating providers that specialize in women's healthcare for routine and preventive services. Arrangements will be made for specialty care outside of the coverage area when necessary and for emergency and urgent needs, such as dialysis.

Patrius Health provides CMS with all required information necessary to administer and evaluate the program and provide current and potential beneficiaries with information in order to make informed decisions about their available choices for Medicare coverage. Participating Blue Advantage providers agree to cooperate with any quality and improvement initiatives, medical policies and medical management procedures. Patrius Health shares with CMS the quality and performance indicators regarding enrollee satisfaction with the program health outcomes, and disenrollment rates for beneficiaries enrolled in Blue Advantage for the previous two years.

If Patrius Health terminates Blue Advantage or reduces the service area, a written notice will be given to all beneficiaries in the affected area(s) along with a notice of the effective date of termination or area reduction. Included with that notice will be a description of alternatives for obtaining benefits under a special enrollment period.

Anesthesia

Blue Advantage recognizes services billed by anesthesiologists and certified registered nurse anesthetists (CRNAs). These anesthesia providers must use appropriate modifiers and should report the anesthesia time for the correct allowance calculation. All providers should bill for services rendered utilizing their National Provider Identifier (NPI).

Appointment Wait Time Standards

Patrius Health Network providers in the primary care and behavioral health specialties must be accessible to Blue Advantage members. Per CMS guidance, members must get an appointment scheduled within a minimum number of days of their request.

Primary Care and Behavioral Health Services	Minimum Standards for Appointment Wait Times
Urgently needed services or emergency	Immediately
Services that are not emergency or urgently needed, but the enrollee requires medical attention	Within 7 business days
Routine and preventive care	Within 30 business days

Audits

Patrius Health conducts audits in accordance with Medicare laws, rules and regulations. Other audits will be conducted as needed, such as diagnosis-related groups (DRG) validation, site of care, readmission, etc. Patrius Health may contract with a vendor as a business associate that is covered by the Health Insurance Portability and Accountability Act (HIPAA) to conduct specific audits and/or reviews. Examples of possible reviews include:

- Risk adjustment
- Healthcare Effectiveness Data and Information Set (HEDIS)

Medical records may be requested via web portal, eConnectivity or by mail, or obtained by on-site imaging at the provider's office and/or facility. The on-site reviewer will have the capability to scan and copy medical records as well as the technology to access Electronic Medical Records (EMR). Providers are required to provide medical records in order for Patrius Health to fulfill state and federal regulatory and accreditation obligations.

Claim Denials

Blue Advantage complies with all CMS regulatory requirements for claim denials and the accuracy and timeliness of denial notices. Medicare law regulates claim payment and service authorization processes for Medicare Advantage members, ensures that members receive the benefits they are entitled to, and maintains members' rights to appeal any adverse coverage determination.

Coding

Blue Advantage recognizes all the procedure and diagnosis codes utilized by traditional Medicare. For example, the Healthcare Common Procedure Coding System (HCPCS) administration "G" codes that Medicare uses are accepted as well as the 90000 series Physicians' Current Procedural Terminology (CPT) codes.

Common Claim Errors

The goal of this section is to reduce common errors that result in claim rejections or claim denials. Most claim denials or rejections are a result of:

- Billing/data entry errors
- Non-compliance with coverage policy
- Billing for services that are not medically necessary

Proper payment of Blue Advantage claims is a result of the joint efforts of providers, clinicians and billing personnel. Meeting this goal also requires complying with national and local medical policies and criteria.

What Constitutes a Billing/Claim Filing Error?

In many cases, Patrius Health cannot pay a claim as it was initially submitted because the claim needs additional documentation or a correction to the claim data. Billing or data entry errors/omissions generally indicate that required fields were left blank [e.g., no International Classification of Diseases, 10th Revision, Clinical Modification (ICD-10-CM) admitting diagnosis code entered in Field Locator (FL)/Block 76 of the claim form].

Errors also occur when an improper bill type is used. An example of a bill type error is when a claim is submitted with a discharge bill type, but the status code indicates the patient is still in the facility.

Billing errors can also result in an underpaid or overpaid claim or lead to a rejected claim.

The following are common billing errors that result in claim denials:

- Incorrect member alpha-prefix and ID number
- Invalid/missing diagnosis code or procedure code
- Claim filed after the timely filing limit
- Incorrect provider number
- Missing, incorrect or invalid modifier
- Missing or incorrect quantity billed

Do I file claims to Medicare?

Claims for Patrius Health Blue Advantage members should be filed to Blue Cross and Blue Shield of Mississippi. Do not file claims to Medicare with the exception of the followings:

- Services related to hospice care
- Services related to clinical trials

All providers should bill for services rendered using their National Provider Identifier (NPI).

Compliance with CMS Regulations

Participating providers with Blue Advantage must adhere to the terms and conditions of the CMS contract. All Blue Advantage participating providers are required to accept the same terms and conditions where appropriate. Compliance with the following CMS regulations is required:

- Healthcare providers are prohibited from holding a member liable for amounts that are the obligation of Blue Advantage.
- Providers must safeguard the privacy of any information that identifies a member and must maintain records in an accurate and timely manner.
- Providers must submit all data necessary to demonstrate the content and purpose of each encounter with the member.
- Providers are prohibited from discriminating against any member based on health status.
- Providers must provide all services in a manner consistent with professionally recognized standards of healthcare.
- Providers are 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.
- Providers must comply with Medicare appeal/expedited appeal procedures for beneficiaries.
- Any payment and incentive arrangements among Blue Advantage and providers, first-tier entities, and downstream entities shall be specified in all contracts
- Providers must comply with all federal laws and regulations designed to prevent fraud, waste and abuse including, but not limited to, applicable provisions of the federal criminal law, the False Claims Act, the anti-kickback statute, and HIPAA administrative simplifications rules at 45 CFR parts 160, 162 and 164.
- Providers are required to complete the Combating Medicare Parts C and D Fraud, Waste and Abuse training annually. In addition, we recommend that you review the Medicare Provider Compliance Tips on CMS' website.

Providers must comply with the auditing and duplication of billing, payment and medical records requirements that pertain to members.

- Providers must comply with the limitations placed on imposing influenza or pneumococcal vaccine copayments.
- Providers must comply with the provisions regarding member advance directives in a member's medical record.
- Providers must comply with the provisions on risk adjustment data submissions.
- Providers agree to comply with the provisions on maintaining medical policies and procedures.
- Providers must comply with the requirements for billing a member for services not covered by Blue Advantage.
- Providers must comply with the obligation to repay Patrius Health for services paid incorrectly.

Patrius Health must comply with CMS' requirements to provide written notice of suspension or termination to a provider as well as appeal rights. Blue Advantage will adhere to all CMS marketing provisions with regard to marketing and enrolling members into the program.

Note: Providers are required to complete specified courses on an annual basis. Per the Medicare Advantage provider/facility agreement, you should maintain a copy (may be electronic) of your attestation for 10 years for audit purposes.

Data Breach Incident Reporting

In the event of a system compromise of a hospital's network environment or data, the hospital must immediately report to Patrius Health, but no more than 48 hours after becoming aware of the incident. System compromise refers to any unauthorized access, breach or incident that results in unauthorized access, use or disclosure of protected health information (PHI) as defined under the HIPAA Privacy Rule.

The hospital must notify the Blue Cross & Blue Shield of Mississippi and Patrius Health Incident Response Hotline by calling 601-664-5184.

In order to ensure proper risk management of system connections and to enact alternate operation support processes, the hospital must fully cooperate with Patrius Health to assess and respond to the compromise. This includes the necessary information, documents and assistance to fully mitigate any risks.

eCensus Notifications

Hospitals in the Patrius Health Network (including long-term acute care hospitals, skilled nursing facilities and inpatient rehabilitation facilities) must provide Blue Advantage member information on their daily eCensus notifications.

The following hospital admissions require eCensus notifications:

- Emergency department encounters
- Observation care
- Inpatient admissions

Note: Inpatient includes medical, surgical, maternity, inpatient rehabilitation, long-term acute care hospitals, skilled nursing facilities, behavioral health, and substance use disorders.

Electronic Data Interchange (EDI) and eSolutions

EDI is a way for you to send and receive information about your claims as well as eligibility and benefits information about your patients electronically versus by paper or telephone. It is a more efficient way to perform the daily business functions of healthcare.

The submission and retrieval of information electronically can save you time and money by decreasing paper and postage costs and eliminating the need to call Customer Service. When the information you need is available at your fingertips, more flexibility in how and when tasks are performed is possible.

The following information is available for electronic access::

- Claims Audit Reports
- Claim Status
- Member Eligibility and Benefits
- Remittances
- Payment History
- Biometrics Entry
- Pre-Service Reviews

Contact our EDI Services team at 601-664-4357 for more information about these electronic options.

Fraud, Waste and Abuse

Patrius Health is committed to protecting the integrity of our Medicare Advantage product by preventing, detecting and investigating fraud, waste and abuse (FWA):

- **Fraud:** This includes any type of intentional deception or misrepresentation made with the knowledge that the deception could result in unauthorized benefit to the person committing it or any other person.
- **Waste:** This includes overusing services or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse:** Examples include when healthcare providers or suppliers do not follow good medical practices that result in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.

If you suspect someone of committing fraud waste or abuse, there are several ways you can refer it for investigation::

- Complete the Report Suspected Fraud and Abuse form.
- Call our toll-free hotline at 1-800-824-4391.

You can remain anonymous when reporting healthcare fraud and abuse.

CMS' website offers numerous resources, including fraud prevention training materials, that can be found using the search term "fraud." Additionally, our Fraud and Abuse webpage includes educational information that can educate providers and patients.

Health and Clinical Engagement

The mission of our Blue Advantage team is to support our members' goals for health across physical, mental and social spheres. Managing members in the Member Management and Utilization Management programs is critical to:

- Improving quality of care
- Reducing readmissions
- Controlling costs
- Promoting self-management

Member assistance is provided to improve the healthcare experience, remove medical and social barriers and find solutions to support members' self-management of their

own health. The Health and Clinical Engagement division is dedicated to providing programs and services to help optimize health and improve the quality of care for our members.

Our multidisciplinary Medicare Advantage team is integral to the success improving our members' health as well as complex medical management efforts. Our team consists of medical directors, registered nurses, licensed social workers, pharmacists, and advocates who work collaboratively to deliver a holistic approach to supporting the member.

Our interactive Patient Health Snapshot displays any potential Health and Clinical Engagement programs for which the member is eligible. This tool is readily available on the Patrius Health provider site accessed securely via myBlue Provider. Member Services can transfer a provider to Case Management for patient referrals. Additionally, providers can contact the Care Coordinator at 1-888-927-5873 concerning patient referrals.

Health Risk Assessments and Wellness Visits

Health risk assessments (HRA) are important for capturing your Blue Advantage patients' full picture of health, including their chronic conditions and medications. The assessments are often performed during the patients' wellness visits.

Patrius Health's HRA, called the Health Risk 360 (HR360), allows providers to document vital patient data and complete these assessments during wellness visits, including annual wellness visits (AWVs).

Patrius Health Network Providers who perform wellness visits (see specific impacted codes below) for Blue Advantage members are required to complete and submit an accompanying HR360 to Patrius Health in order to receive payment for the wellness visit claim.

Patrius Health Network Providers impacted by this requirement include those who are a doctor of medicine, doctor of osteopathy, physician assistant or nurse practitioner in any of the following specialties: family practice, general practice, geriatrics, internal medicine or OB-GYN.

Welcome to Medicare	
HCPCS	**Description**
G0402	Initial Preventive Physical Examination (IPPE) – first 12 months of enrollment into Medicare Part B

Annual Wellness Visit (AWV)	
HCPCS	**Description**
G0438	Annual Wellness Visit (AWV), Initial – Includes a personalized prevention plan of service (PPS) – after the first 12 months of enrollment
G0439	Annual Wellness Visit (AWV), Subsequent – Includes a personalized plan of service (PPS)

Identifying a Blue Advantage Member

Blue Advantage members have a Patrius Health identification (ID) card and should provide their ID card when requesting services. The "MA" in the suitcase indicates members who are covered under the Medicare Advantage Preferred Provider Organization network sharing program.

The front of the card includes:

- The member's name, also called the enrollee, subscriber or contract holder
- The member's prefix and ID, also called the contract number, made up of characters either alpha or numeric
- The group number

The back of the card includes important addresses, telephone numbers, and claim filing instructions.

The three-character alpha prefix at the beginning of a member's identification number is the key element Patrius Health uses to identify and correctly route claims. Providers should still verify each member's coverage and plan via Eligibility and Benefits on *my*Blue Provider. To ensure accurate claims processing, it is critical that providers capture all ID card data. If the information is not captured correctly, providers may experience a delay in claims processing. Providers should make a copy of the front and back of the member's ID card, and provide the key information to their billing staff.

Mandatory Medicare Outpatient Observation Notice (MOON)

The standardized Medicare Outpatient Observation Notice (MOON), form CMS-10611, is available. All hospitals and critical access hospitals (CAHs) are required to provide the MOON, per CMS guidance, to all Medicare beneficiaries. This notice informs patients that they are being treated as outpatient receiving observation services and not as inpatient of the hospital or critical access hospital (CAH). You should provide the form to patients receiving observation for more than 24 hours.

The MOON form is mandatory under the Federal Notice of Observation Treatment and Implication for Care Eligibility Act (NOTICE Act).

Medical Policies

Go to **Policies.PatriusHealth.com** to view and search for medical and drug policies.

National Coverage Determinations

If the policy you are searching for is not listed in the Blue Advantage medical policies or the local coverage determinations, please refer to the **CMS National Coverage Database***.

Local Coverage Determinations

If the policy you are searching for is not listed in the Blue Advantage medical policies, please refer to the following local coverage determinations sites*::

- Novitas Solutions Inc. Local Coverage Determinations*
- CIGNA Government Services DME MAC Jurisdiction C Local Coverage Determinations*
- Blue Advantage will follow Palmetto GBA MolDX* when there is no Local Coverage Determination or National Coverage Determination related to a Molecular Diagnostic Test.

***Note:** These links will take you out of the Patrius Health website. These sites are not the responsibility of, or under the control of, Patrius Health.

Medicare Learning Network

Visit CMS' **Medicare Learning Network** to view MLN Matters articles.

Medication Therapy Management (MTM)

CMS requires that all Medicare Part D plans offer a Medication Therapy Management program (MTM). This program is for members who meet certain CMS criteria around chronic conditions and out-of-pocket prescription drug expense. Members who qualify for this program tend to have the highest number of providers and specialists, and the program aims to promote coordinated care and improve medication adherence.

To qualify, members must have three of the following chronic conditions: chronic obstructive pulmonary disease (COPD); osteoporosis; diabetes; chronic heart failure (CHF); or dyslipidemia (high cholesterol).

If you are contacted by MTM pharmacists or nurses to discuss your patient's medications, we encourage you to work with them and consider medication changes as appropriate. The information requested from you is intended to supplement and coordinate your patient's care. It is not intended to substitute your clinical judgement.

The MTM program offers eligible members an opportunity to have a Comprehensive Medication Review (CMR) conducted with the member by clinical staff. We are able to provide the member a comprehensive look at their medication utilization using their prescription drug claim history, and we can alert them to any potential issues. This service is free of charge to the member and serves to reinforce prescriber guidance around their medications in an effort to increase drug efficacy while reducing potential side effects or drug-to-drug interactions.

Should your member qualify for this service, please encourage them to contact us to complete the review at 1-866-686-2223.

Member Eligibility and Benefits

Visit **PatriusHealth.com** for a summary of Blue Advantage member eligibility and benefits. Access to the Summary of Benefits for each plan is available through "Compare & Enroll."

Be sure to always verify each member's eligibility and benefits through ***my*Blue Provider** or your practice management software.

Utilization Management

We use Utilization Management (UM) to monitor the appropriateness of healthcare services to our members and to help ensure members get the most out of their healthcare dollars. Our UM program involves review of services before, during and after the services are performed. Our toll-free number for Patrius Health UM is 1-888-927-5873.

Here are some scenarios that may be encountered during the UM process that may require special consideration:

Changes in procedure/service codes
Verify benefits to determine next steps for advanced imaging, behavioral health, genetic testing and Part B Drug requests. Call 1-888-927-5873 and choose the correct option for UM to determine next steps.

Medical necessity approval for acute inpatient stays (medical)
Scenario: Patient admits as inpatient for medical reasons (excludes elective procedures) and discharges 2 – 3 days later prior to medical necessity approval.

Through the *my*BlueProvider portal, send in the request for medical necessity approval prior to claim submission for the medical necessity determination. Note: Some elective procedures need a determination prior to services being rendered. Through the *my*BlueProvider portal, verify benefits and the code needed for medical necessity.

No insurance at time of hospitalization
Patrius Health will allow retrospective medical necessity review for services rendered in which the Beneficiary failed to provide insurance coverage information during the hospital stay. Through the *my*BlueProvider portal, send in the request for medical necessity approval prior to claim submission for the medical necessity determination.

Pre-Service Organization Determinations

Sign into ***my*Blue Provider** to initiate a Pre-Service Organization Determination. Please note: Certain procedures require precertification if they are performed inpatient. Use the pre-service lookup tool to verify if precertification is required for the procedure taking place.

Providers who do not obtain a Pre-Service Organization Determination for services that are not covered by Blue Advantage will have their claims processed showing no patient liability. The service will show as a write off and you will not be able to bill the member for the denied portion of the claim.

Per CMS, providers may bill a Medicare Advantage patient for a potentially noncovered service after a Pre-Service Organization Determination is submitted and a Standardized Denial Notice has been provided to the patient. A Pre-Service Organization Determination is not required for statutorily-excluded services that have been clearly communicated to the patient.

Frequently Asked Questions:

Can I use an Advance Beneficiary Notification (ABN) or a similar form?

No, ABN's and similar forms can't be used with Blue Advantage members.

When do I request a Pre-Service Organization Determination?

Prior to rendering the service, you must determine benefit eligibility and if the service(s) will require a medical necessity determination for claims payment using the Pre-Service Review portal. You can use ***my*Blue Provider** or call the Member Services number on the back of the patient's Patrius Health member ID card.

- If the service doesn't meet coverage criteria the ordering provider and the member will receive a Notice of Denial from Blue Advantage.
- Upon receiving the denial if the member decides to proceed with the service it is patient liability.

How long does it take to complete a Pre-Service Organization Determination?

Under CMS guidelines, effective January 1, 2026, Patrius Health has seven calendar days from the time a request is received to notify the member and provider of a decision for any service or item that requires precertification under the member's contract benefits. Patrius Health must notify members and providers of a decision in 14 calendar days for any service or item that does not require precertification.

- You may request an expedited Pre-Service Organization Determination if you believe waiting for a standard decision could place your patient's life, health or ability to regain maximum function in jeopardy. An expedited Pre-Service Organization Determination is completed within 72 hours from receipt.
- Part B Drugs have a 24-hour expedited turnaround time and 72-hour standard turnaround time.

Member Appeals and Grievances (Medical)

Blue Advantage members have the right to file appeals within a certain timeframe for reconsiderations (appeal) of disputes regarding determinations made by Patrius Health. Members are provided with information describing these rights upon enrollment and in denial determination letters.

Appeal Types	
Pre-Service	Service has not been provided, but a denial has been issued. **Example:** Admission to an acute rehab facility.
Post-Service	Consists of medical necessity or benefit appeals after services have been rendered and a claim has been submitted. **Examples:** • Medical Necessity: DME claims • Benefits: Cost-sharing amounts
Concurrent Review	Applies to concurrent stay (services are ongoing for the member). **Example:** Receiving skilled nursing care in a skilled nursing facility and the continued stay is denied.

Review Type	Processing Time Frame
Expedited (All Review Types)	72 hours
Standard Pre-Service	30 Days
Standard Post-Service	60 Days
Part B Drugs	7 Days

Pre-Service Appeals can be requested by the following:

- A member
- A member's representative
- The member's treating physician acting on behalf of the enrollee or staff of the physician's office acting on the physician's behalf
- Any other provider or entity determined to have an appealable interest

Post-Service Appeals can be requested by the following:

- A member
- A member's representative
- Non-contract provider (see Parts C&D Enrollee Grievances, Organization/Coverage Determination, and Appeals Guidance: Section 50.1.1 for non-contract provider payment appeals)
- The legal representative of a deceased member's estate

- Any other provider or entity (other than the MA plan) determined to have an appealable interest in the proceeding
    - Section 50.1 notes the following: **Contract providers (including subcontracted entities) do not have appeal rights under the provisions discussed in this guidance. Contract provider disputes involving plan payment denials are governed by the appeals/dispute resolution provisions in the contract between the provider and the plan**.

      Note: Plan payment disputes must be submitted prior to March 31, 2028.

For Medicare Advantage, CMS refers to appeals as clinical decisions. For inquiries or requests to have claims reviewed if you believe there was an error in processing, please contact Patrius Health Provider Services at 1-888-949-2352.

Refer to Parts C&D Enrollee Grievances, Organization/ Coverage Determination, and Appeals Guidance Section 50.1 for further information.

If the member or treating physician is not requesting the appeal, an appointment of representative (AOR) form or equivalent must be included with the appeal.

Medical records may be requested during the appeal process to ensure the correct decision is made for the member. Failure to submit medical records may result in upheld determinations and claim payment rejection. Please submit medical records when requested to facilitate the correct review of the appeal.

Contact Customer Service to resolve claim issues.

Provider Incentive Program

The Provider Incentive Program is available to network providers practicing in one of the following primary care specialties – internal medicine, family practice, general practice or geriatrics. Information and materials about this program are available on the Patrius Health provider website. Log in to ***my*Blue Provider** and click Blue Advantage Resources on the left-side menu.

Proof of Accreditation for Diagnostic Imaging

Providers who offer advanced diagnostic imaging services to Blue Advantage (PPO) members must provide proof of accreditation to Patrius Health and up expiration of their accreditation in order to continue to render these services and bill Blue Advantage (PPO). This is in accordance with the Medicare Improvement for Patients and Providers Act of 2008 (MIPPA), Section 135(a), which states:

“Physicians, non-physician practitioners and independent diagnostic testing facilities providing the technical component (TC) of diagnostic magnetic resonance imaging (MRI), computed tomography (CT), and nuclear medicine, such as positron emission tomography (PET) services, must be accredited by January 1, 2012.”

Our Blue Advantage plan must follow Medicare’s advanced diagnostic imaging accreditation and billing guidelines.

Accreditation does not apply to the professional component (26) of the imaging procedure and hospitals are excluded. The accreditation organizations approved by the Centers for Medicare & Medicaid Services (CMS) are the American College of Radiology, the Intersocietal Accreditation Commission, and The Joint Commission. For a list of procedures that will require accreditation, refer to CMS’ Advanced Diagnostic Imaging Accreditation policy.

You can mail the accreditation documentation to:

Advanced Health Systems, Inc.
Attn: Provider Partnerships
3545 Lakeland Drive
Flowood, MS 39232

Be sure your entire staff knows you are a Blue Advantage participating provider.

Provider Enrollment and Participation

Blue Advantage Network participants provide care to Medicare eligible beneficiaries and Patrius Health reimburses for covered services at the agreed upon payment rate.

Is there a Blue Advantage Provider Network?

Yes, providers must participate with Medicare. Blue Advantage participating providers must sign a participation agreement.

What providers are eligible for participation?

- Providers who participate with Medicare.
- Moderate to high-risk providers as defined by CMS must participate.

If a provider is a Medicare eligible provider and does not currently participate with Medicare, can they become a Blue Advantage provider?

To participate with Blue Advantage, a provider must be a Medicare eligible provider and a participating provider in traditional Medicare. Providers who have opted out of or have been excluded or precluded from the Medicare program are not eligible.

Can a provider participate with Blue Advantage at one location and not at another?

A provider who chooses to participate will be considered a participating provider at all their locations.

Is there a Blue Advantage Provider Directory?

Yes, Blue Advantage members are provided a directory of participating providers. Blue Advantage providers in their area are also posted at **PatriusHealth.com**.

What if a provider is not a Blue Advantage participating provider?

Providers who are not participating in the Blue Advantage program will be reimbursed at out-of-network benefit levels. These providers are subject to the Medicare Limiting Charge and all the applicable rules for Medicare non-participating providers.

Provider Referrals

When referring patients to providers for services outside of your practice, referrals should be made only to other in-network participating providers as required by your Medicare Advantage participating provider agreement.

Qualified Medicare Beneficiary (QMB) Program Billing Prohibition

CMS states that all Medicare providers and suppliers, including pharmacies, may not bill beneficiaries enrolled in the QMB program for Medicare cost-sharing. Medicare beneficiaries enrolled in the QMB program have no legal obligation to pay Medicare Part A or Part B deductibles, coinsurance, or copays for any Medicare-covered items and services. For more information, visit **www.cms.gov** and use the search term "QMB" or review the following CMS materials:

- **Prohibition on Billing Dually Eligible Individuals Enrolled in the QMB Program**
- **QMB Program FAQ on Billing Requirements**
- **Qualified Medicare Beneficiary Program Billing Requirements**

Sequestration

The Budget Control Act of 2011 required mandatory across-the-board reductions in federal spending or sequestration. In general, the application of the sequestration cuts to federal funding for Medicare programs, including Medicare Advantage and Medicare Prescription Drug Plans, resulted in about a two percent (2%) reduction in Medicare payments for healthcare services rendered through the duration of the sequestration period.

So long as CMS applies the sequestration reductions and notwithstanding any term of a provider's Blue Advantage Participating Provider Agreement to the contrary, all payments due the Blue Advantage Network Provider under the Agreement and any exhibits and/or addenda will be subject to the same general two percent (2%) sequestration payment reduction. Therefore, after the application of coinsurance, any applicable deductible and any applicable Medicare Secondary Payment adjustments, all remaining payments due Blue Advantage Network Providers shall be reduced by two percent (2%). Blue Advantage Network Provider shall accept these sequester-adjusted payments as payment in full.

Social Determinants of Health

Social determinants of health (SDOH) can greatly impact a patient's health and quality-of-life depending on the factors of their environment. SDOH can be reported by anyone from the patient's care team, such as providers, nurses, social workers, case managers, community health workers and patient navigators. They can be captured while completing the HR360 or during any encounter. Patients can also self-report any SDOH.

Once the SDOH are documented in the medical record, the appropriate Z codes can be applied for data collection. The patient's care team can use this data to:

- Improve the patient's quality of care
- Enhance care coordination
- Implement social needs interventions based on identified community needs

Social Determinants of Health	
ICD-10 Code	**Description**
Z55	Problems related to education and literacy
Z56	Problems related to employment and unemployment
Z57	Occupational exposure to risk factors
Z58	Problems related to physical environment
Z59	Problems related to housing and economic circumstances
Z60	Problems related to social environment
Z62	Problems related to upbringing
Z63	Other problems related to primary support group, including family circumstances
Z64	Problems related to certain psychosocial circumstances
Z65	Problems related to other psychosocial circumstances

Stars and Risk

Each year CMS assigns Star Ratings to reflect its measurement of each Medicare Advantage plan's overall quality. For Patrius Health, this assessment includes our Blue Advantage plan. This Star Rating directly affects our ability to continue to offer the Blue Advantage plan to beneficiaries. Plans are rated on a scale of one to five stars: One star represents poor performance and five stars represents excellent performance. CMS releases Star Ratings annually, and these ratings reflect the experiences of patients enrolled in Medicare Advantage plans. Blue Advantage's success contributes to provider incentive opportunities, enhanced member benefits, and keeping member premiums low.

A Medicare health plan's rating is based on categories that include:

- Staying healthy, screenings, tests and vaccines
- Managing chronic (long-term) conditions
- Member experience with the health plan
- Member complaints, problems getting services and improvement in the health plan's performance
- Health plan customer service

A Medicare drug plan's rating is based on measures in four categories:

- Drug plan customer service
- Member complaints, problems getting services and improvement in the health plan's services
- Member experience with the drug plan
- Patient safety and accuracy of drug pricing

Measures in both groups of these categories are used to rate Medicare Advantage health plans. Annually, CMS sets the thresholds for each measure.

CMS uses risk adjustment to predict the cost and use of healthcare services for members in the Blue Advantage product. CMS provides payments to healthcare plans at the member level for Medicare Advantage based on the health status of a member through risk scoring. The payments received are used to pay healthcare cost and administrative expenses, and offer programs aligned to complex patient care. It is important for providers to ensure all chronic health conditions are documented yearly in patient medical records according to CMS guidelines to ensure appropriate risk scores are assigned by CMS.

Subrogation

Blue Advantage contains a subrogation and reimbursement provision. Subrogation is the substitution of one party for another when the injured party has a legal claim against another party. It allows Patrius Health to recover from any other payer the cost of our healthcare benefits.

In general, we have the right to recover the cost of a member's medical care, to the extent of what we have paid, from anyone the member has the right to recover from, or to substitute for the member and seek to recover our payment. For example, if automobile or liability insurance is involved, Patrius Health will pay for the services rendered as the primary payer according to the contract. If payment is made to the physician's office by both Patrius Health and insurance other than another health plan, Patrius Health should be notified of the overpayment. We will then request the overpayment from the physician's office, if needed.

In all instances, providers should contact Provider Customer Service so that they may check the contract and advise to whom the refund should be sent.

Timely Filing Guidelines

Claims must be filed within 15 months from the date of service. There may be penalties for violating these filing guidelines. We strongly encourage providers to file all original claims and corrected bills by December 31, 2027, to avoid payment delays. All claims, original and corrected, must be submitted by March 31, 2028.

Transitional Care Management Services

Patrius Health accepts two transitional care management (TCM) Current Procedural Terminology (CPT) codes for services provided to Blue Advantage members who have transitioned in care from a hospital to home. These codes are only accepted for Blue Advantage members.

TCM should include one face-to-face visit within the specified time frames in combination with non-face-to-face services that may be performed by the provider or other qualified healthcare professional and/or licensed clinical staff under the provider's direction.

These requirements are outlined for each CPT code below.

99495 Transitional Care Management Services with the following required elements::

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge
- Medical decision-making of at least moderate complexity during the service period
- Face-to-face visit, within **14 calendar days** of discharge

99496 Transitional Care Management Services with the following required elements::

- Communication (direct contact, telephone, electronic) with the patient and/or caregiver within two business days of discharge
- Medical decision-making of high complexity during the service period
- Face-to-face visit, within **seven calendar days** of discharge

These codes should be used to report managed care services for a patient following a qualified discharge from a hospital, skilled nursing facility or outpatient observation. The services are for a new or established patient whose medical problems require moderate or high-complexity medical decision-making during transitions in care from a hospital to the patient's home, a rehabilitation facility, nursing home or assisted living.

The purpose of these codes is to help prevent the frequency of reoccurring hospital admissions. Prior to submission of claims with these CPT codes, be sure that each required element is met and documented in the patient's medical record.

TruHearing®

Blue Advantage provides routine hearing exams and two hearing aids per year through TruHearing. Blue Advantage members can call 1-844-255-7140 to schedule an appointment (for TTY, dial 711). TruHearing is a registered trademark of TruHearing, Inc.

Acronyms Used in this Manual

ABN: Advance Beneficiary Notification

CAH: Critical Access Hospital

CFR: Code of Federal Regulations

CMR: Comprehensive Medication Review

CMS: Centers for Medicare & Medicaid Services

CPT: Current Procedural Terminology

DME: Durable Medical Equipment

DRG: Diagnosis-Related Group

EDI: Electronic Data Interchange

EMR: Electronic Medical Records

FAQ: Frequently Asked Questions

FEP: Federal Employee Program

FL: Field Locator

HCPCS: Healthcare Common Procedure Coding System

HEDIS: Healthcare Effectiveness Data and Information Set

HIPAA: Health Insurance Portability and Accountability Act

ICD-10-CM: International Classification of Diseases, 10th Revision, Clinical Modification

ITS: Inter-Plan Teleprocessing System

M+C: Medicare+Choice

MOON: Mandatory Medicare Outpatient Observation Notice

MTM: Medication Therapy Management

NPI: National Provider Identifier

PAC: Pre-Admission Certification

PPO: Preferred Provider Organization

PRP: Preferred Radiology Program

TCM: Transitional Care Management

PPO: Preferred Provider Organization

PRP: Preferred Radiology Program

TCM: Transitional Care Management

Patrius Health

Blue Advantage® is a Medicare-approved PPO Plan provided by Patrius Health.
Patrius Health and Blue Cross & Blue Cross of Mississippi are independent licensees of the Blue Cross and Blue Shield Association.

Current Procedural Terminology © 2025 American Medical Association. All rights reserved. Applicable FARS/DFARS apply. ICD-10 is the 10th revision of the International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list by the World Health Organization (WHO).

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