Member Rights and Responsibilities

All Blue Shield 65 Plus℠ (HMO) members receive in their *Evidence of Coverage (EOC)* a Statement of Member Rights and Responsibilities. The information below is taken directly from the Blue Shield 65 Plus EOC.

We must provide information in a way that works for you (in languages other than English, in large print, or other alternate formats, etc.)

To get information from us in a way that works for you, please call Member Services at (800) 776-4466 [TTY 711] 8 a.m. to 8 p.m. seven days a week, from October 1 through February 14, and 8 a.m. to 8 p.m., weekdays, from February 15 through September 30.

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in large print, or other alternate formats if you need it. If you are eligible for Medicare because of disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call (877) 486-2048.

We must treat you with fairness and respect at all times.

Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' Office for Civil Rights (800) 368-1019, TTY (800) 537-7697, or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

We must ensure that you get timely access to your covered services and drugs.

As a member of our plan, you have the right to choose a primary care physician (PCP) in the plan's network to provide and arrange for your covered services. Call Member Services to learn which doctors are accepting new patients. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

Member Rights and Responsibilities *(cont'd.)*

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, please refer to Chapter 9 of the EOC for details on how to make a complaint about quality of care, waiting times, and other concerns.

We must protect the privacy of your protected health information.

Federal and state laws protect the privacy of your medical records and protected health information. We protect your protected health information as required by these laws.

Your "protected health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practices" that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These following exceptions are allowed or required by law:
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will consider your request and decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine. If you have questions or concerns about the privacy of your protected health information, please call Member Services.

Member Rights and Responsibilities *(cont'd.)*

We are always committed to protecting the privacy of your personal and health information. Our Notice of Confidentiality and Privacy Practices describes both your privacy rights as a member and how we protect your personal and health information. To obtain a copy of our privacy notice, you can:

1. Go to blueshieldca.com and click the "Privacy" link at the bottom of the homepage.
2. Call the Member Services phone number on your Blue Shield member ID card to request a copy.
3. Call the Blue Shield Privacy Office toll-free at (888) 266-8080 (TTY 711), 8 a.m. to 3 p.m., Monday through Friday.
4. Email us at: privacy@blueshieldca.com

We must give you information about the plan, its network of providers, and your covered services.

As a member of Blue Shield 65 Plus, you have the right to get information from us in a way that works for you, including getting the information in languages other than English, in large print, or other alternate formats, such as:

- Information about our plan. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare Advantage health plans.
- Information about our network providers including our network pharmacies.
    - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
    - For a list of the providers in the plan's network, see the Provider Directory.
    - For a list of the pharmacies in the plan's network, see the Pharmacy Directory.
    - For more detailed information about our providers or pharmacies, you can call Member Services or visit *Find a Doctor* on blueshieldca.com.
- Information about your coverage and the rules you must follow when using your coverage.
    - In Chapters 3 and 4 of the EOC we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
    - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of the EOC plus the plan's List of Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs (Formulary), tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
    - If you have questions about the rules or restrictions, please call Member Services.
- Information about why something is not covered and what you can do about it.

Member Rights and Responsibilities *(cont'd.)*

- If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.

- If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of the EOC. It gives you the details about how to ask the plan for a decision about your coverage and how to make an appeal if you want us to change our decision. (Chapter 9 in the EOC also tells about how to make a complaint about quality of care, waiting times, and other concerns.)

- If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of the EOC.

You have the right to know your treatment options and participate in decisions about your health care.

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- To know about all of your choices. This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

- To know about the risks. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

- The right to say "no." You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

- To receive an explanation if you are denied coverage for care. You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of the EOC explains how to ask the plan for a coverage decision.

Member Rights and Responsibilities *(cont'd.)*

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself.

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

- Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself.

- Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "advance directives." There are different types of advance directives and different names for them. Documents called "living will" and "power of attorney for health care" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- Get the form. If you want to have an advance directive, you can get a form from your lawyer, a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. There are several organizations in California that can provide information about advance directive forms, including the California Coalition for Compassionate Care (www.coalitionccc.org/advance-health-planning.php) and POLST (Physician Orders for Life-Sustaining Treatment) California (http://www.capolst.org/). You can also contact Member Services for this form.

- Fill it out and sign it. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.

- Give copies to appropriate people. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.

- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

Member Rights and Responsibilities *(cont'd.)*

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with Livanta. See Chapter 2, section 4 of the EOC for contact information.

You have the right to make complaints and to ask us to reconsider decisions we have made.

If you have any problems or concerns about your covered services or care, Chapter 9 of the EOC tells what you can do. It gives the details about how to deal with all types of problems and complaints.

What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – we are required to treat you fairly.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services.

What can you do if you think you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights.

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' Office for Civil Rights at (800) 368-1019, TTY (800) 537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you think you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can call Member Services.
- You can call the State Health Insurance Assistance Program (HICAP) at (800) 434-0222 [TTY 711].
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Member Rights and Responsibilities *(cont'd.)*

How to get more information about your rights.

There are several places where you can get more information about your rights:

- You can call Member Services.
- You can call the State Health Insurance Assistance Program (HICAP) at (800) 434-0222 [TTY 711].
- You can contact Medicare in one of the following ways:
    - You can visit the Medicare website at medicare.gov to read or download the publication "Your Medicare Rights & Protections."
    - Or, you can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

What are the member's responsibilities?

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use the EOC to learn what is covered for you and the rules you need to follow to get your covered services.
    - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
    - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us. Please call Member Services to let us know.
    - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "coordination of benefits" because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
    - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
    - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

Member Rights and Responsibilities *(cont'd.)*

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
    - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
    - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.
    - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
        - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
    - If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
    - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services.
    - **If you move outside of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
    - **If you move within our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
    - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Member Services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
    - Phone numbers and calling hours for Member Services are printed on the back cover of this booklet.
    - For more information on how to reach us, including our mailing address, please see Chapter 2.

Member Grievance Procedures

Blue Shield investigates Blue Shield 65 Plus member complaints, grievances, and appeals and follows a standard set of procedures for their resolution. All grievances and appeals are handled by Blue Shield. If the member asks the IPA/medical group about filing a complaint, the member should be referred to Blue Shield 65 Plus Member Services. If the IPA/medical group receives a written complaint from a member, the complaint should be immediately forwarded to:

Blue Shield 65 Plus Appeals & Grievances
P.O. Box 927
Woodland Hills, CA 91365-9856
Fax: (916) 350-6510

Blue Shield 65 Plus encourages questions and suggestions regarding any and all aspects of Blue Shield 65 Plus and the care received by its members. Comments are utilized to help improve the service provided. The Blue Shield 65 Plus Member Services Department may be contacted with any problems or questions including those concerning coverage, procedures, physicians, hospitals, medical care, or reimbursement. If the problem or complaint cannot be resolved informally to the member's satisfaction, a member may file a grievance with Blue Shield 65 Plus. The grievance should include information about the complaint, specific facts relating to the complaint, and the reasons for lack of satisfaction.

Once the member files a grievance:

- Blue Shield 65 Plus must acknowledge receipt of the complaint within five calendar days and provide the name of the person who is working on the grievance; and

- Blue Shield 65 Plus will resolve the grievance within 30 calendar days of receipt.

If the member is not satisfied with the resolution of the complaint, the member may file a written request for a grievance hearing. The grievance hearing will be scheduled within 31 days of receipt of request and will be held at the Blue Shield Woodland Hills office location. The panel will include a Blue Shield 65 Plus Medical Director and a representative from the Blue Shield 65 Plus Appeals and Grievances Department.

The member will be invited to attend, and representatives of the involved parties will have the opportunity to present their position. Following the hearing, all parties will receive a proposed resolution from the panel.

To resolve member issues more expeditiously, the Blue Shield 65 Plus Appeals and Grievance Resolution Department has implemented the following process to research and respond to member grievances.

Member Grievance Procedures *(cont'd.)*

The following summarizes the Blue Shield 65 Plus grievance categories:

1. Complaints (grievances which do not involve quality-of-care issues) such as:

    - Wait time in medical office
    - Telephone access
    - No return telephone call
    - Misplaced medical records
    - Access to providers (scheduling difficulties)

All complaints are tracked and trended for future quality assurance purposes. The IPA/medical group will receive a Provider Notification Memorandum that may require a response within five business days or is informational only. The member receives a written response from Blue Shield 65 Plus concerning such issues.

2. Grievances (include but are not limited to):

    - Inappropriate behavior of provider personnel
    - Delay in referral
    - Referral denials resulting in care being adversely affected (also could be considered an appeal)
    - Quality of care issues
    - Miscommunication between member and provider regarding care/benefits

Grievances are member complaints that require research and response to the member. Grievances involving care issues require medical records. The IPA/medical group will be sent a Provider Notification Memorandum that requests medical records and a written response within five working days. Upon receipt of this information, a Blue Shield 65 Plus Medical Director will review it.

All Requests for Assistance (RFA) received from the Department of Managed Health Care (DMHC) on behalf of the member must be filed as a grievance, if not already done so, on behalf of the member and must have a written letter of response to the member. A personalized written response from Blue Shield 65 Plus will be sent to the member within 30 days from the date the RFA notification was received by the health plan. The purpose of the letter to the member is to explain how his/her grievance was resolved and to educate the member as to how he or she may prevent similar incidents from occurring in the future.

IPA/medical groups must comply with the DMHC and Medicare Advantage requirements by responding to all requests for information to be used for grievance resolution as outlined on the previous page. In accordance with the detailed Provider Notification Memorandum request, the IPA/medical group needs to respond to each request within five working days from the date the Provider Notification Memorandum is sent.

Member Grievance Procedures *(cont'd.)*

All information provided by the IPA/medical group, as part of a response to a grievance, is considered confidential and is protected under peer review confidentiality provisions, according to state regulations.

Blue Shield 65 Plus retains the responsibility for resolving its members' grievances and does not delegate that responsibility to the IPAs/medical groups. The IPAs/medical groups agree to cooperate with Blue Shield 65 Plus in resolving member grievances related to the IPA/medical group or IPA/medical group physicians.

Blue Shield 65 Plus will bring to the IPA/medical group's attention all member complaints involving IPA/medical group physicians. The IPA/medical group will, in accordance with its procedures, investigate such complaints and use its best efforts to resolve them in a fair and equitable manner. Any action taken or proposed action by the IPA/medical group, with respect to the resolution of such complaints and the avoidance of similar complaints in the future, should be reported promptly to Blue Shield 65 Plus.

Member Complaint and Appeals Resolution

A Blue Shield 65 Plus member may appeal any denials, termination, reduction of services, or payment for services. This includes denial of services or denial of payment after service has been rendered. An appeal may also be requested for services rendered for non-plan providers or suppliers that the member believes should have been provided, arranged for or reimbursed by Blue Shield 65 Plus. An appeal may also include any adverse initial determination for treatment or services the member believes he/she is entitled to receive, which includes any delays in providing, arranging, or approving health services. Following the submission of a member appeal, Blue Shield 65 Plus will request that the IPA/medical group provide the necessary medical records and a copy of the initial determination mailed to the member within five business days to thoroughly evaluate the member appeal. In instances where the member has sought or obtained services from a non-contracted provider, Blue Shield 65 Plus will obtain the medical records directly from the provider.

Should a member not agree with an initial determination (denial of service or denial of claim), the member may request an appeal. The member must file the appeal in writing to Blue Shield 65 Plus.

> *Note: All Medicare appeals must be processed by Blue Shield 65 Plus. Medicare appeals are not delegated to IPA/medical groups.*

IPA/Medical Group Responsibility

When the initial determination is made by the IPA/medical group or hospital, the IPA/medical group or hospital will be responsible for sending the member an Initial Determination Letter containing the appropriate CMS-approved appeals language and denial reason.

Member Complaint and Appeals Resolution *(cont'd.)*

Blue Shield 65 Plus Responsibility

Blue Shield is responsible for:

1. Acknowledging receipt of filed appeals within five calendar days.

2. Ensuring that a proper Initial Determination Letter was sent to the member by the appropriate party. If not, Blue Shield 65 Plus will request that the appropriate letter be issued by the responsible party. Through the delegation oversight process, a corrective action plan may be requested, if there is a failure to comply with this request.

3. Requesting a response from the IPA/medical group or hospital within nine (9) calendar days from the receipt of an appeal for all medical information used in making the determination. If additional medical records, in conjunction with the clinical information used in making the determination, are required for Blue Shield 65 Plus to properly evaluate the member appeal, Blue Shield will request that the IPA/medical group provide this additional information.

4. Either making a determination that is in the member's favor and informing the member, IPA/medical group, or hospital of the fully favorable determination within 30 calendar days from the receipt of an appeal for a pre-service denial or 60 calendar days for a claims denial; or, if the request is denied or partially denied, submitting the appeal request to Maximus Federal Services (Maximus) for external review. Maximus is an independent CMS contractor that reviews appeals by members of Medicare managed care plans, including Blue Shield 65 Plus.

   Maximus will either uphold or overturn the Initial Determination. If Maximus chooses to uphold the denial, Maximus will inform Blue Shield and the member. If Maximus overturns the Initial Determination, it will inform the member and copy Blue Shield 65 Plus, which will inform the IPA/medical group or hospital of the overturn.

   If the decision is favorable to the member, for standard service denials, Blue Shield 65 Plus will authorize within 72 hours of Maximus' decision or provide the service in question as quickly as the member's health requires, but no later than 14 days following the receipt of Maximus' decision. For expedited service denials, Blue Shield 65 Plus will authorize or provide the service in question as quickly as the members health requires but no later than 72 hours following the receipt of Maximus' decision.

   In instances where Maximus overturns a claim denial, Blue Shield 65 Plus will process the claim(s) either at contracted rates or Medicare allowable charges, whichever is applicable. The IPA/medical group or hospital is given the opportunity to respond within 10 days whether or not the claim(s) should be processed at a fee schedule different than the Medicare allowable rate.

   Maximus decisions are final and binding on all parties. If a member is unsatisfied with the Maximus' resolution, he/she may request a hearing before an Administrative Law Judge (ALJ) of the Social Security Administration if the amount in question is $100 or more. Maximus will be responsible for arranging the ALJ hearing and will notify Blue Shield 65 Plus.

Expedited Appeals

The Center for Medicare & Medicaid Services (CMS) requires an Expedited Appeal process be made available to all members. Expedited appeals apply to denied services/referrals or discontinuation of service or referral. When a member believes that his/her health or ability to function could be seriously harmed by waiting the 30 days for a standard appeal, he/she may request an Expedited Appeal. Medicare regulations require expedited requests be processed within 72 hours (including weekends). The expedited request may be filed by the member, a member representative, or by a physician on behalf of the member, and must be filed within 60 days of the denial of or discontinuation of the services.

A Blue Shield 65 Plus Medical Director will determine within 72 hours if the request meets criteria for an Expedited Appeal. Those requests which do not meet the criteria will be automatically transferred to the standard 30-day appeal process. Expedited Appeals may be requested by contacting the Blue Shield 65 Plus Member Service Department at (800) 541-6652 (for providers), (800) 776-4466 (for members) [TTY 711]. A request may be faxed to (800) 303-5828 during business hours, 8 a.m. to 5 p.m., Monday through Friday.

Expedited Initial Request for Services

Section 422.562(a) of the Balanced Budget Act of 1997 requires that providers adhere to Medicare's procedures for expedited requests for treatment and expedited appeals for all MA Organization (MAO) enrollees, including gathering/forwarding information on appeals to MAO.

CMS has established that beneficiaries in MAOs (like Blue Shield 65 Plus) are entitled to the review of any request for a service or treatment within specific timeframes. CMS further requires MAOs to ensure that any delegated functions meet federal guidelines.

Regulations require that MAOs (and contracted delegated provider organizations) process standard requests to approve a service or referral within 14 calendar days. If a member (or physician) believes that a member has a condition that is "time sensitive" and requires urgent attention, an "expedited or 72-hour" review may be requested. Any service or referral that a member feels requires medical treatment that cannot wait for the standard 14-day timeframe may be requested to be handled as "urgent, speedy, or expedited." If a service request is requested to be expedited, that request must be reviewed as soon as medically indicated, but no longer than 72 hours from the time of the request.

Expedited Appeals *(cont'd.)*

Expedited Initial Request for Services *(cont'd.)*

CMS Definitions related to Expedited Initial Requests

Time Sensitive - Situations where the time frame of the regular decision-making process could seriously jeopardize the life or health of the enrollee or jeopardize the enrollee's ability to regain maximum functioning.

> *Note: If any physician requests a review be expedited, that review must be expedited on behalf of the member.*

Expedited Handling - As soon as medically appropriate, not to exceed 72 hours (including weekends and holidays). The 72 hours is measured from the time the request is received until notification (telephonic notice) to the member of a decision on the request. Should an expedited request be denied, a written notice must be mailed within three calendar days of the telephonic notification. Section 422.572(e)(2) further indicates written approval must follow for full or partial approvals within three calendar days of the oral approval of any expedited appeal. If medical information or medical records from outside the health plan are necessary in order to determine whether a request should be expedited, then the 72 hours begins when those records are received.

An extension of up to 14 calendar days is allowed if requested by the member or if the plan finds that it is in the member's best interest to have additional information, consultation or testing done. Extensions are not allowable for gathering information that should already be available from plan providers.

Blue Shield's Role in Handling Expedited Initial Requests

Should a Blue Shield 65 Plus member feel that his or her health could be jeopardized if an expedited decision is not made, the member is requested to contact Blue Shield 65 Plus Member Services Department to request an expedited initial determination. Blue Shield will document the member's request and immediately forward the request to the contact person in the Medicare Appeals and Grievance Department for processing. All requests for expedited initial determination will be processed according to the CMS guidelines, within 72 hours. Blue Shield will monitor that expedited requests are completed according to the mandatory timeframes and will notify the members of any adverse initial decisions. If a group is unable to meet the mandatory timeframes and does not make a timely initial determination on an expedited request, a Blue Shield medical director will make the decision whether to approve or deny the request. Blue Shield will advise the member of his or her right to appeal.

Blue Shield will advise the member of the IPA/medical group or decision and send the approval letter or denial notice to the members within three calendar days of the decision. All expedited initial requests will be logged and tracked by Blue Shield. If an MAO denies a request for an expedited initial determination, in addition to notifying the member within three calendar days, the MAO must inform the member of the right to submit a request for an expedited reconsideration with any physicians' support.

> *Note: The above process may be extended up to 14 calendar days if it is in the member's interest.*

Expedited Appeals *(cont'd.)*

Expedited Initial Request for Services *(cont'd.)*

IPA/Medical Group Role in Handling Expedited Initial Requests

Members are requested to make all expedited initial requests through Blue Shield. However, if the IPA/medical group receives a request for an "urgent, expedited or 72 hour" review that has not already been forwarded to the IPA/medical group by Blue Shield, the IPA/medical group should contact Blue Shield 65 Plus Appeals and Grievance Department directly at (800) 894-5487.

> *Note: Immediately notify Blue Shield 65 Plus Member Services of any request for an expedited initial determination. Do not delay review of an expedited initial request. Blue Shield will log the request as received as of the date the expedited request is made, as this is in the member's best interest, should an urgent medical issue need to be resolved.*

Blue Shield will assist IPA/medical groups by monitoring that all expedited requests are closed according to federal guidelines. This process also allows Blue Shield to provide CMS with documentation to demonstrate oversight and compliance with the federal requirements.

6.6 Blue Shield 65 Plus (HMO)
Member Rights and Responsibilities

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