October 16, 2020

Subject: **Notification of January 2021 Updates to the Blue Shield *Hospital and Facility Guidelines***

Dear Provider:

We have revised our *Hospital and Facility Guidelines.* The changes listed in the following provider manual sections are effective January 1, 2021.

On that date, you can search and download the revised manual on Provider Connection at www.blueshieldca.com/provider in the *Provider Manuals* section under *Guidelines & resources*.

You may also request a CD version of the revised *Hospital and Facility Guidelines* be mailed to you, once it is published, by emailing providermanuals@blueshieldca.com.

The *Hospital and Facility Guidelines* is referenced in the agreement between Blue Shield of California (Blue Shield) and the hospitals and other facilities contracted with Blue Shield. If a conflict arises between the *Hospital and Facility Guidelines* and the agreement held by the hospital or other facility and Blue Shield, the agreement prevails.

If you have any questions regarding this notice about the revisions that will be published in the January 2021 version of this manual, please contact your Blue Shield Provider Relations Coordinator.

Sincerely,

Aliza Arjoyan
Vice President, Provider Network Management

T11241 (10/20)

UPDATES TO THE JANUARY 2021
HOSPITAL AND FACILITY GUIDELINES

General Reminders

Please visit Provider Connection at blueshieldca.com/provider for updated Forms, Member Rights and Responsibilities, Authorizations, Claims information, Provider Manuals and much more.

New Pharmacy Claims Processing Vendor

Effective January 1, 2021, Blue Shield of California will have a new pharmacy claim processing vendor. CVSH will be processing pharmacy claims for all Blue Shield plans. Members will receive new ID cards with updated RxBIN and RxPCN pharmacy information. Direct Member Reimbursement (DMR) forms will be updated to include CVSH information. Members who have questions about their pharmacy benefits should be directed to contact the Customer Care telephone number on their member ID cards.

Section 2: Hospital and Facility Responsibilities

QUALITY MANAGEMENT AND IMPROVEMENT

Accreditation

Added Medicaid *to list of product types that Blue Shield takes through NCQA accreditation.*

Provider Responsibilities for Quality Management and Improvement

Added *the following to the quality improvement activities that Blue Shield seeks provider representatives' participation in:*

- Investigation of member grievances and quality of care concerns

All affiliated Hospitals are expected to perform at higher than 50% of benchmark for CMS Hospital Compare/CAL Hospital Compare. All affiliated hospitals that perform at less than 50% of the benchmark for CMS Hospital Compare/CAL Hospital Compare will be required to submit an improvement plan of action for the identified performance year.

Deleted *the language in boldface type below:*

Quality management activities are considered privileged communication in conjunction with peer review activities conforming to Evidence Code Section 1157 and Section 1370 of the California Health and Safety Code. **As such, neither the proceedings nor the records of the review may be disclosed to any person outside of those participating in the review process.**

SERVICE ACCESSIBILITY STANDARDS

*Access standards for the following topics have been **deleted and replaced** with the grids below:*

Behavioral Health Appointment Access Standards

CATEGORY	ACCESS STANDARDS
Routine office visit (including non-physician providers)	Within 10 business days
Urgent Care	Within 48 hours
Emergency Care, non-life threatening	Within 6 hours
Follow-Up Routine Care (including a non-physician mental health care provider)	Within 30 Calendar Days Follow-up routine care appointments are visits at later, specified dates to evaluate the patient progress and other changes that have taken place since a previous visit.

Provider Availability Standards for Commercial Products

Blue Shield has provider availability standards to ensure a network of established primary care physicians (PCPs) and high-volume specialty practitioners that is sufficient in number and geographic distribution for applicable commercial products. Please refer to the provider availability standards below.

Geographic Distribution

CATEGORY	PRODUCT TYPE	STANDARD	COMPLIANCE TARGET
Total PCPs	HMO/POS PPO - CDI PPO – DMHC IFP ePPO CCSB HMO/PPO	One PCP within 15 miles or 30 minutes of each member	100%
PCP **General Practitioner** **Family Practitioner** **Internist** **Pediatrician**		One PCP within 15 miles or 30 minutes of each member	100%
Obstetrician/Gynecologist		One OB/GYN within 30 miles of each member (non-Medicare)	85%
High Volume Specialists		One of each type of Top High Volume Specialists within 30 miles of each member	90%
Hospitals		One hospital within 15 miles of each member	85%
Radiology		One Radiology facility in 30 miles	90%
Lab		One lab in 30 miles	90%

Pharmacy		One Pharmacy in 10 miles	95%
DME		One DME in 15 miles	85%
ASC		One ASC in 30 miles	95%
SNF		One SNF in 30 miles	95%
Urgent Care		Urban: 1 in 15 miles Suburban 1 in 20 miles Rural: I in 30 miles	90% 85% 75%
Dialysis		Urban: 1 in 15 miles Suburban 1 in 20 miles Rural: I in 30 miles	90% 85% 75%
Acupuncturist	PPO	1 in 15 miles Or 1 in 30 minutes	90%

Provider-to-Member Ratio

CATEGORY	PRODUCT TYPE*	STANDARD	COMPLIANCE TARGET
PCP Family Practitioner, General Practitioner, Internist Pediatrician	HMO DCHMO	One PCP to 2,000 commercial members	100%
Top High Volume Specialties and High Impact Specialties to Member Ratio	HMO PPO-DMHC IFP-ePPO	1 OB/GYN to 10,000 female members. 1 High Volume Specialty of each type and 1 High Impact Specialty to 20,000 members.	100%
Acupuncturist to Member Ratio	PPO	One Acupuncturist to 5,000 commercial members	100%
Ethnic/Cultural and Language Needs	HMO/POS PPO – DMHC	1 PCP speaking a threshold language to 1,200 members speaking a threshold language**	100%

*PPO plans are both Blue Shield PPO – DMHC and PPO – CDI plans. PPO membership excludes ASO/self-insured business.

** Threshold languages are: Spanish, Chinese – Traditional, and Vietnamese

*Access standards for the following topics have been **added** with the grids below:*

Additional Measurements for Multidimensional Analysis for Commercial Products

METRICS	PRODUCT	STANDARD	FREQUENCY
Access related member complaints and grievances	HMO/POS/ PPO	Rate of complains/grievances ≤1 per thousand members per month (non-Medicare) Rate of complains/grievances ≤5 per thousand members per month (Medicare)	Assessed Quarterly against Standard
Availability-related PCP Transfers	HMO	Rate of PCP transfers 1.68 per thousand members per month (Medicare)	Assessed Quarterly against Standard
PCP Turnover	HMO/POS	14%	Assessed Quarterly against Standard
PCP, Specialist, and Hospital Network Change Analysis	IFP ePPO	10% change	Assessed Quarterly against Standard
PCP to Member Ratio	IFP PPO	1:2000	Quarterly
Top HVS Turnover	HMO/PPO/ CDI/ SHOP HMO/PPO	10%	Assessed Quarterly against Standard
Hospital Turnover	HMO/PPO	5%	Ad hoc for Block Transfer Filings and 10% Change Analysis
Open PCP Panel	HMO/POS/ Directly Contracted HMO	85%	Assessed Quarterly against Standard
Member Satisfaction	HMO/POS/ PPO	HMO – Patient Assessment Survey at IPA/MG level HMP/PPO – CAHPS at Health Plan level	Annual

Additional Measurements for Multidimensional Analysis for Medicare Advantage Products

METRICS	COMPLIANCE TARGET	FREQUENCY
Availability related member complaints and grievances	Rate of complaints and grievances 8.81 PTM	Semi-Annual
Availability related PCP Transfers	Rate of PCP transfers per thousand members 1.68 PTM	Semi-Annual
PCP Turnover Rate	14%	Semi-Annual
Top 10 HVS Turnover Rate	10%	Semi-Annual
Hospital Turnover Rate	5%	Semi-Annual
Open PCP Panels	85%	Semi-Annual
PCP to Member Assignment Ratio	1: 1200	Semi-Annual
High Volume and High Impact Specialist to Member Ratio	1:20,000	Annual

FACILITY DIRECTORY

Added *language to align with facility contract language updates regarding maintaining directory data:*

In order to reduce administrative burden on providers, Blue Shield delegates some provider directory maintenance tasks to a vendor. As directed by Blue Shield, the facility must work with the vendor in lieu of Blue Shield to complete directory maintenance tasks. This will entail executing a participation agreement with the vendor and taking other reasonably requested steps to ensure smooth exchange of directory data.

Section 3: Medical Care Solutions

ORGAN AND BONE MARROW TRANSPLANTS

Added CAR-T Therapy *to list of transplants requiring prior authorization.*

BLUE SHIELD MEDICAL & MEDICATION POLICIES

Medication Policy

Added *language in boldface type below regarding additional authorizations and services that are not medically necessary:*

Authorization for select medical drugs may also be required for the administration of the drug at an outpatient hospital facility site, in addition to authorization of coverage for the drug **which may require step therapy.**

Section 4: Billing and Payment

CLAIMS SUBMISSION

Added *the section below introducing Real Time Claims Settlement, which is an online feature scheduled to go live on Provider Connection at blueshieldca.com/provider in 2020.*

Real Time Claims Settlement

Real-Time Claims Settlement provides an enhanced provider experience through speed, accuracy and most importantly transparency in the claim's adjudication process. The end goal solution Blue Shield is building toward is an end-to-end automated process from claim creation to payment reconciliation.

Current Enhancements

While we are working to fully automate the transaction process, one of our first steps is the creation of a Real Time Claims Web Tool in Provider Connection. This tool will allow you to estimate and submit claims online to process with a target of 3-9 seconds. While it does take some data entry, it can provide a glimpse of how we are working to speed up the claims adjudication process.

The Web Tool will provide two new features:

1. Claim Estimate: Providers will have the ability to submit a claim estimate and receive a response with payment assurance for the total payment (including payer payment and member liability amounts) for services. A claim estimate can be submitted up to 7 days prior to services performed and will be valid up to 7 days.
2. Claim Submission: Providers will have the ability to submit claims to Blue Shield of California and connect with Blue Shield's processing system for real time adjudication. The finalized claim/payment decision is then presented to the provider. Claims are then paid upon the regular payment cadence.

The Real Time Claims Web Tool is available to registered users on Provider Connection at blueshieldca.com/provider. If you are not a registered user, please see the section Welcome to Provider Connection on the home page of blueshieldca.com/provider for instructions on how to register.

Once you are registered on Provider Connection you will need to request access to the Real Time Claims Web Tool via your Account Manager, MSO, or Billing Service. After access is obtained for the Real Time Claims Web Tool it can be opened by clicking Claims on the menu bar then clicking Real Time Claims.

The Real Time Claims Web Tool is an intuitive system designed with provider ease of use in mind. A reference guide and FAQ documentation can be found on the Real Time Claims landing page under RTC Guidelines and Resources.

Future State

To further realize our long-term solution, Blue Shield is working on two other processes to make claims processing automated. These offerings will be coming throughout 2021 and will revolutionize how we as an industry process claims. The upcoming claims processing solutions are further defined below.

1. Utilization of direct system-to-system connection between providers and Blue Shield. This solution will give providers the opportunity to create claims within their own systems and submit them electronically in real time to Blue Shield.

Real Time Claims Settlement *(cont'd.)*

2. Claims are automatically generated, eliminating all administrative burden from providers. This will be accomplished through a connection with the providers' Electronic Health Records (EHR) systems and claim is then sent to Blue Shield through a digital connection to be adjudicated in real time.

UB 04 Form Locators

Moved *UB 04 Form Locators to Appendix 4-F.*

SPECIAL BILLING SITUATIONS

End Stage Renal Dialysis (ESRD) Hospital (Medicare)

This section has been ***deleted and replaced*** *with the following language:*

ESRD claims are paid based on the End Stage Renal Dialysis Prospective Payment System (ESRD PPS).

ESRD PPS payment is based on the following factors: through date, date of birth, condition code 73 or 74, value code A8 and A9/value code amounts, revenue code, patient's height and patient weight to be able to determine the correct payment. Refer to the *Medicare Claims Processing Manual Chapter 8 – Outpatient ESRD Hospital, Independent Facility, and Physician/Supplier Claims.*

CLAIMS INQUIRIES AND ADJUSTMENTS

Late Charges

This section has been ***deleted and replaced*** *with the following language:*

Electronic Submission

Submit late charges and adjustment/corrected claims electronically.

- Wait until the original claim is finalized.
- Create a new line with the date the late charges were incurred by entering the value of "5" in the third digit of the Type of Bill field (Form Locator 4). This identifies the claim as late charges only.
- Resubmit the claim electronically.

Once the initial claim has finalized in our system, resubmit the Late Charges claim with the appropriate adjustment bill type. You will also need to include the following EDI segments on the adjusted claim:

- Send "5" in CLM*05-3 (Loop 2300) to indicate Late Charges of Prior Claim
  Sample: CLM*12345656*500***11:A:5*Y*A*Y*I~
- Send "F8" in REF01 (Loop 2300)
- Send the 12-digit claim number from the incorrect original claim in REF02 (Loop 2300).
  Sample: REF*F8*12345678912345~

  Note: 12345678912345 should be replaced with the original claim number. Obtain the Blue Shield claim number via the claim status option on Provider Connection, from the explanation of benefits (EOB), or from the electronic remittance advice (ERA).

Corrected Claims

Updated *the instructions where you indicate the replacement of Prior Claim, in boldface type below:*

- Send "**5**" in CLM*05-3 (Loop 2300) to indicate Replacement of Prior Claim

  Sample: CLM*12345656*500***11:A:7*Y*A*Y*I~

PROVIDER APPEALS AND DISPUTE RESOLUTION

Non-Contracted

This section has been ***deleted and replaced*** *with the following language:*

Provider appeals include any decisions where a non-contracted/deemed provider contends that the amount paid by the organization (MAO and/or delegated entity) for a covered service is less than the amount that would have been paid under original Medicare. The disputes may also include instances where there is a disagreement between a non-contracted/deemed provider and the organization about the plan and/or delegated entity's decision to pay for a different service than that billed. An example would include down coding.

A provider or supplier has the right to dispute a reimbursement decision made by a MAO Plan and/or delegated entity. The time frame for disputing a reimbursement issue to the MAO Plan and/or delegated entity is 120 calendar days from the initial determination for all non-contracted underpayments. The provider has 60 calendar days from the initial determination date for all non-contract zero payment claims.

If the required information to process the dispute has not been submitted, Blue Shield will send a letter to the provider requesting the necessary documentation. If the additional documentation is not received within 60 calendar days from the date of request, Blue Shield will conduct a review based on the information that is available.

Blue Shield will resolve the appeal within 60 calendar days of the receipt of the appeal. In the event that the additional payment is warranted in favor of the provider and was due to an error by Blue Shield, interest will be included along with the additional payment.

In the event that the payment dispute is resolved not in the favor of the provider, the non-contracted appeals language directive noted below must be included on the determination.

Provider has the right to request a reconsideration of the denial of payment within 60 calendar days for $0 payments and 120 calendar days for underpayments after the receipt of notice of initial determination/decision. Provider who wishes to submit an appeal must also submit a signed Waiver of Liability statement holding the member harmless regardless of the outcome of the appeal. Provider should include documentation such as a copy of the original claim, remittance notification showing the denial and any clinical records and other documentation that supports the provider's argument for reimbursement.

After the MAO Plan and/or delegated entity makes its payment review determination (PRD) decision, if a deemed or non-contracted provider or supplier still disagrees with the pricing decision of a MAO Plan and/or delegated entity, a second level review may be requested in writing within 180 days of written notice from the MAO Plan and/or delegated entity of its payment review determination.

To appeal the provider organization and/or delegated entity's decision upholding initial payment, the provider must submit a written request to:

Blue Shield of California
Medicare Provider Appeals Department
P.O. Box 272640
Chico, CA 95927

Section 5: Blue Shield Benefit Plans and Programs

BLUE SHIELD MEDICARE ADVANTAGE PLANS

*This subsection regarding enrollment eligibility for members with End Stage Renal Disease (ESRD) has been **deleted and replaced** with the following language:*

On May 22, 2020, CMS issued a Final Rule that permits enrollment of individuals with End Stage Renal Disease (ESRD) in MA-PD plans effective January 1, 2021 as long as they meet the Medicare Advantage carriers' eligibility criteria.

BLUE SHIELD MEDICARE (PPO) (MEDICARE ADVANTAGE)

Vision Services

***Updated** provider who delivers vision services for individual plans to VSP Vision Care.*

Exclusions to the Blue Shield Medicare (PPO) Benefits

***Updated** the following plan exclusion in boldface type below:*

- Routine acupuncture, **except for chronic low back pain**, unless specifically indicated as covered by the Blue Shield Medicare Advantage (PPO) plan in which the member is enrolled.

Prescription Drug Benefit Exclusions

***Updated** the following plan exclusion in strike through and boldface type below:*

- ~~Drugs when used to promote fertility~~ **Drugs related to assisted reproductive technology (ART)**

Section 6: Capitated Hospital Requirements

CAPITATED SERVICES CLAIMS PROCESSING (Medicare Advantage/Group Medicare Advantage)

***Added** the following language in boldface type below:*

If the unaffiliated clean claim is not paid within the specified time period, interest shall accrue, **if applicable**, at the applicable current prompt payment rate. **Interest payments are only applicable to out-of-network providers.**

INCORRECT CLAIMS SUBMISSIONS (Medicare Advantage/Group Medicare Advantage)

***Updated** language in boldface and strikethrough type below:*

Health plans should forward claims within **ten (10) working days of the original receipt date.** ~~eight (8) calendar days of initial receipt and the hospital should forward within 10 calendar days of receipt.~~

BILLING FOR COPAYMENTS (Medicare Advantage/Group Medicare Advantage)

*This section has been **deleted and replaced** with the following language:*

With the exception of authorized deductibles, copayments and/or coinsurance, billing a member for covered benefits is absolutely prohibited under federal law. Whenever the provider fails to collect the deductibles, copayment or coinsurance at the time of service and bills the member, the bill should clearly indicate that the amount due is for the deductibles, copayment or coinsurance only. Deductibles, copayments and coinsurances may not be waived. Providers or the sub-contracted hospital must issue receipts to members whenever deductibles, copayments or coinsurance are collected.

Members are informed of their deductibles, copayment and coinsurance responsibility in the Blue Shield *Evidence of Coverage* (EOC) provided to all Blue Shield members.

***Added** the following language to comply with 42 C.F.R. Part 2 regulations:*

CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS

In 1975, Congress enacted 42 U.S.C. 290dd-2 and its supporting regulations at 42 C.F.R. Part 2. The law is formally referred to as the Confidentiality of Substance Use Disorder Patient Records Act, and informally referred to as "Part 2." The purpose of Part 2 is to protect the privacy of substance use disorder (SUD) patient records by prohibiting unauthorized use and disclosure of SUD patient records except with patient consent and in limited circumstances.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services (HHS) that regulates and enforces Part 2.

If, as a provider, you are a Part 2 Program, you must comply with all of the applicable legal requirements of the Part 2 laws and regulations.

To assist you in meeting your legal obligations, you may inform Blue Shield that you have the patient's consent to disclose their SUD patient records to Blue Shield when submitting an electronic claim (837 P or I) for Part 2 services by placing a "1" in the CLM09 field.

When submitting an electronic claim (837 P or I) for Part 2 services, under the NTE02 segment, you may include in the free-form narrative one of the following mandatory Part 2 disclaimer language options. The shorter version is preferable.

- 42 CFR part 2 prohibits unauthorized disclosure of these records; or
- This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

To help you determine if you are a Part 2 Program, please refer to:
https://www.samhsa.gov/sites/default/files/does-part2-apply.pdf.

To learn more about the Part 2 laws and regulations, please refer to:
https://www.federalregister.gov/documents/2018/01/03/2017-28400/confidentiality-of-substance-use-disorder-patient-records

CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS *(cont'd.)*

To learn more about how Part 2 limits the disclosure of SUD patient records, please refer to: https://www.samhsa.gov/sites/default/files/how-do-i-exchange-part2.pdf

It is recommended that you consult legal counsel if you are uncertain whether or how these provisions apply to you.

Appendices

APPENDIX 4-C WHERE TO SEND CLAIMS

Updated *claims addresses. For the most current list, go to Provider Connection at blueshieldca.com/provider and click on* Claims, How to submit claims, *then* Claims mailing addresses *under* Submitting Claims by mail.

APPENDIX 4-D LIST OF INCIDENTAL PROCEDURES

Added *the following codes:*

15772	Grfg autol fat lipo ea addl
15774	Each addl 25cc
20700	Prep and insert drug del device
20701	Removal (deep)
20702	Prep and insert drug del device
20703	Removal (intramedullary)
20704	Prep and insert drug del device
20705	Removal (intra-articular)
C9756	Fluorescence lymph map w/icg

Deleted *the following codes:*

0341T	Quant pupillometry w/rpt
0399T	Myocardial strain imaging

APPENDIX 4-E LIST OF OFFICE-BASED AMBULATORY PROCEDURES

Added/updated *the following procedure codes:*

20560	Ndl insert w/o inj 1 or 2 muscles
20561	Ndl insert w/o inj 3 or more muscles
64454	Inj Aa&/Strd Genicular nrv brnch
64624	Dest Neurolytic agt Genicular nrv
0551T	Tprnl balo cntnc dev adjmt
0563T	Evac Meibomian gld heat bilat
0566T	Autol cell impt adps tiss njx imp knee
0588T	Rev or rem isdns post tibial nrv

APPENDIX 4-E LIST OF OFFICE-BASED AMBULATORY PROCEDURES *(cont'd.)*

Deleted *the following procedure codes:*

0380T	Comp animat ret image series
0482T	Absolute quant myocardial bld flow

Added *new* **APPENDIX 4-F UB-04 GENERAL INSTRUCTIONS** *to include UB-04 Form Locator instructions previously listed in Section 4. Instructions have been updated to align with CMS and the National Uniform Billing Committee (NUBC) guidelines.*

APPENDIX 5-A THE BLUECARD PROGRAM

Products Included in the BlueCard Program

Added *the Blue High Performance Network℠ (HPN℠) plan to Exclusive Provider Organization (EPO) product line.*

How to Identify Members

Added *language about identifiers on the Blue HPN EPO ID card, as follows:*

- An HPN in a suitcase logo with the Blue High Performance Network name in the upper right or lower left corner, for Blue HPN EPO members.

The Blue HPN EPO product includes an HPN in a suitcase logo on the ID card. Members must obtain services from Blue HPN providers to receive full benefits. If you are a Blue HPN provider, you will be reimbursed for covered services in accordance with your contract with Blue Shield of California. If you are not a Blue HPN provider, it is important to note that benefits for services incurred with non-Blue HPN providers are limited to emergent care within Blue HPN product areas, and to urgent and emergent care outside of Blue HPN product areas. For these limited benefits, if you are a PPO provider, you will be reimbursed according to Blue Shield of California PPO provider contract, just as you are for other EPO products.

How to Identify Blue plan HPN Members

Added *language about identifying a Blue HPN member, including a sample ID card, as follows:*

The Blue High Performance Network is a new network that is available to members who live in key metropolitan areas. Blue HPN members must access Blue HPN providers in order to receive full benefits. If you are a Blue HPN provider, you will be reimbursed for services provided to Blue HPN members according to your contract with Blue Shield of California. If you are not a Blue HPN provider, it is important to note that benefits for services incurred with non-Blue HPN providers are limited to emergent care within Blue HPN product areas, and to urgent and emergent care outside of Blue HPN product areas.

You can recognize Blue HPN members by the following:

- The Blue High Performance Network name on the front of the member ID card
- The HPN in a suitcase logo in the bottom right hand corner of the member ID card

APPENDIX 5-A THE BLUECARD PROGRAM *(cont'd.)*

Language regarding benefit limitations is also included on the back of the Blue HPN EPO member ID card. For these limited benefits, if you are not a Blue HPN provider but are a PPO provider, you will be reimbursed according to Blue Shield of California PPO provider contract, just as you are for other EPO products.

Submitting BlueCard Claims

Added *language describing the claims re-routing process should a claim be routed to the wrong processor, as follows:*

Other state independent licensee(s) of the Blue Cross Blue Shield Association may select Blue Shield of California or another licensee of the Blue Cross Blue Shield Association in the State of California as the preferred processor of their BlueCard claims in California for particular accounts, groups, procedures and/or other circumstances. Submitting claims to the wrong processor or payor can cause substantial delays in processing. Blue Shield and its agents will provide best effort to review claims submitted to California processor(s). In the event a claim is submitted to a non-preferred processor, Blue Shield may re-route claims as needed. Re-routing of BlueCard claims may occur in accordance to Blue Shield's agreement(s) with another licensee of the Blue Cross Blue Shield Association. Where other state independent licensee(s) of the Blue Cross Blue Shield Association has selected another independent Blue Cross and Blue Shield licensee in California, as their processor for accounts or groups, Blue Shield will provide best effort to re-route claims to that licensee. This claim review process is integral to our claims processing and claims routing systems and cannot be selectively enabled by Provider. While Blue Shield and its agents will provide best efforts; we cannot ensure that 100% of all claims are reviewed prior to Payor delivery. Blue Shield is not responsible for any delays or liability from the provision or non-provision of this service or subsequent re-routing or non re-routing.

APPENDIX 5-B OTHER PAYOR SUMMARY LIST

For the most current list, go to Provider Connection at blueshieldca.com/provider and click on Guidelines & resources, Policies and standards, *then* Other Payor Summary List on the left.

APPENDIX 6-C CLAIMS COMPLIANCE AND MONITORING

Renamed *to* Claims, Compliance Program, IT System Security and Oversight Monitoring *and was* ***updated*** *to align with current CMS, DMHC, DOI and Blue Shield policies and procedures for Delegated Entity claims, Compliance Program, IT system security and other regulatory oversight monitoring policies.*

Key Terms and Definitions

Added *the following definitions:*

Delegated Entity

Any party who enters into a legal agreement by which an organization gives another entity the authority to perform certain functions on its behalf. Although an organization may delegate the authority to perform a function, it may not delegate the responsibility for ensuring that the function is performed appropriately.

Principal Officer

Each Delegated Entity that has claims delegated must designate a Principal Officer for claims and provider disputes. These officers are responsible for attesting to compliant operations and for reporting the timeliness of those operations. The Principal Officer must sign the quarterly reports for both claims and provider disputes. To designate an individual as Principal Officer or report a change of Principal Officer, request a form from the Blue Shield assigned claims auditor or retrieve the form available at the ICE website and submit an original copy with original signatures to Blue Shield. The Principal Officer form should be submitted by email to ClaimsDelegateReport@blueshieldca.com.

Unaffiliated/Non-Contracted Provider

Commercial

A provider with whom the plan and/or its contracted Delegated Entity does not have a signed contractual agreement in place on the date of service (often referred to as a non-contracted or out of network provider). A contractual agreement can be an actual written contract, a one-time letter of agreement (LOA), a memorandum of understanding (MOU), or a provider rendering services while on-call or covering for a contracted provider. Delegated Entities may not utilize Blue Shield reciprocity and/or PPO rates without the written consent of the health plan. Commercial non-contracted provider claims must be adjudicated within 45 working days of the received date to be considered compliant.

Medicare Advantage

A provider with whom the plan and/or its Delegated Entities does not have a signed contractual agreement in place on the date of service (often referred to as a non-contracted or out of network provider). A non-contracted/unaffiliated provider claim must be adjudicated within 30 calendar days from the earliest date received to be considered compliant.

Medicare Advantage Provider Dispute Resolution

A provider with whom the plan and/or its Delegated Entities has a signed contractual agreement in place on the date of service. A contractual agreement can be an actual written contract, a one-time letter of agreement (LOA), a memorandum of understanding (MOU), or a provider rendering services while on-call or covering for a contracted provider.

APPENDIX 6-C CLAIMS COMPLIANCE AND MONITORING *(cont'd.)*

Measuring Timeliness and Accuracy

Fee Schedule Accuracy

This section has been ***deleted and replaced*** *with the following language:*

Commercial

Contracted providers must be paid accurately at contracted rates. During a claims delegation audit this is demonstrated by the Delegated Entity providing the header page and the signature page of the provider contract with the fee schedule and evidence of the system configuration.

Non-contracted providers may be paid at a reasonable and customary (R&C) fee schedule which requires the Delegated Entity as mandated by Title 28 CCR 1300.71(a)(3) – (B) For contracted providers without a written contract and non-contracted providers, except those providing services described in paragraph (C) below: the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration: (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case; and (C) For non-emergency services provided by non-contracted providers to PPO and POS enrollees: the amount set forth in the enrollee's *Evidence of Coverage.*

Best Practices and Claims Adjudication

Compliance Program/Fraud, Waste, and Abuse

Added *the following language:*

Blue Shield will perform review of Delegated Entity's Compliance Program including assessment of the compliance material (program, P&Ps, etc.), training of staff, performance of internal control audits, etc. This oversight is performed either via shared audit through ICE or individually on an annual basis.

Added *the following new subsection:*

Disbursement of Payments

By law, the date of payment is the date that the disbursement was electronically transmitted or deposited in the U.S. Mail. Blue Shield validates the disbursement date as well as the date the payment was mailed. It is recommended that the Delegated Entity does not exceed 3 mail days. The calendar days delay must be added into the claim's turnaround time calculation. Blue Shield will use the check mailed date as the closure of the claim's turnaround time. The Delegated Entity must document the number of extra days it takes the Delegated Entity to mail a check after the check has been printed for health plan, CMS, or the DMHC audits. This can be done via a formal policy and procedure which must be provided during an audit. Documentation must be retained to validate the mailed date.

In the event documentation can be provided that the provider receiving the check was responsible for the delay in depositing the check issued, Blue Shield will remove all checks issued to that provider within the sampling.

APPENDIX 6-C CLAIMS COMPLIANCE AND MONITORING *(cont'd.)*

Offshore Monitoring

Added *the following language:*

If the commercial line of business is offshored, approval is required from Blue Shield prior to offshoring any Blue Shield commercial delegated claims.

Claims Reports

This section has been ***deleted and replaced*** *with the following language:*

Commercial

The monthly claims timeliness report is due to Blue Shield on or before the 15th calendar day of the month following the month being reported. The quarterly report including the first two months of the quarter is due by the end of the first calendar month following the calendar quarter end. These include claims processed during the calendar quarter being reported regardless of date of service. This report must be signed by a Principal Officer.

The reports are a validation of compliance for the Delegated Entity. The Delegated Entity should retain supporting documentation for each self-report as consistent with records retention time limitations. Copies of the supporting documentation may be requested and retained by Blue Shield for any non-compliant Delegated Entity. A corrective action plan is required for each non-compliant monthly claims timeliness report submitted. Additionally, a completed Emerging Pattern of Deficiency document signed by a Principal Officer is also required to be submitted.

Sub-Delegated Claims Monitoring

This section has been ***deleted and replaced*** *with the following language:*

When the Delegated Entity engages a third-party administrator (TPA) or contracts with a management company to perform their claims processing, the Delegated Entity's contract with Blue Shield holds them ultimately responsible for claims compliance. Guidelines for sub-capitated and sub-delegated functions are interchangeable within this section.

The Delegated Entity is expected to require the sub-delegated claims organizations to meet all regulatory requirements and criteria discussed in this supplement. The Delegated Entity must perform the same tasks, e.g., delegation oversight of claims processing, that Blue Shield carries out as the health plan, including obtaining timely monthly reporting from them, and include their statistics in the Delegated Entities reports to Blue Shield. The Delegated Entity must audit the sub-delegated organization annually/periodically and require corrective action plan implementation when their performance results are not compliant. If the sub-delegated organization fails to achieve compliance, the Delegated Entity needs to take the appropriate actions to achieve compliance. During the on-site audit, if the Delegated Entity sub-delegates claims functions they will need to demonstrate and provide evidence of their oversight of that entity. If the Delegated Entity outsources claims functions, it will also need to be included how that is being monitored.

The Delegated Entity must include claims-related regulatory and contractual provisions in contract agreements with other provider organizations.

APPENDIX 6-C CLAIMS COMPLIANCE AND MONITORING *(cont'd.)*

Added *the following new subsections:*

IT System Security

An IT system integrity audit will be conducted to assure system access controls, policy and procedures regarding system changes, security of data, etc. are maintained. The oversight is also performed either via shared audit through ICE or individually on a bi-annual basis with quarterly monitoring.

Oversight Monitoring

Delegated Entity shall implement controls to ensure internal processes are monitored for integrity of mechanisms and procedures to promote accountability and prevent fraud.

- Group shall not allow the same person or departments to have the ability to pay claims and enter or update new providers, vendors and/or eligibility;
- Group shall provide staffing levels and organizational capacity to ensure operations are consistent and maintained at all times;
- Group shall maintain a compliance program, and that the program is independent of fiscal and administrative management;
- Group shall ensure personnel have appropriate access to data, consistent with their job requirements; and
- Group shall ensure that any and all changes made to data contained in entities' databases are logged and audited.