October 15, 2021

Subject: **Notification of January 2022 Updates to the Blue Shield *HMO IPA/Medical Group Procedures Manual***

Dear IPA/medical group:

We have revised our *HMO IPA/Medical Group Procedures Manual.* The changes listed in the following provider manual sections are effective January 1, 2022.

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 PDF version of the revised *HMO IPA/Medical Group Procedures Manual* be emailed to you or mailed to you in CD format, once it is published, by emailing providermanuals@blueshieldca.com.

The *HMO IPA/Medical Group Procedures Manual* is referenced in the agreement between Blue Shield of California (Blue Shield) and those IPAs and medical groups contracted with Blue Shield. If a conflict arises between the *HMO IPA/Medical Group Procedures Manual* and the agreement held by the IPA or medical group and Blue Shield, the agreement prevails.

If you have any questions regarding this notice about the revisions that will be published in the January 2022 version of this manual, please contact your Blue Shield Provider Relations Coordinator.

Sincerely,

Aliza Arjoyan
Senior Vice President
Provider Partnerships and Network Management

T12058 (10/21)

UPDATES TO THE JANUARY 2022
HMO IPA/MEDICAL GROUP PROCEDURES MANUAL

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.

Section 2.4 Blue Shield Added Advantage POS℠ (Point-of-Service) Plan

PLAN BENEFITS

Clarified *language in boldface type below:*

Emergency Admissions

In the case of an admission for emergency services, Blue Shield should receive Emergency Admission Notification within 24 hours or as soon as reasonably possible following medical stabilization, **whichever is later.**

CLAIMS SUBMISSION

Added *instructions for submitting Professional and Institutional self-referral claims electronically.*

Section 2.6 Exclusions and Limitations

GENERAL EXCLUSIONS AND LIMITATIONS

Updated *the exclusions/limitations by removing language (strikethrough) and adding language (boldface).*

25. For or incident to vocational, educational, recreational, art, dance, music or reading therapy; weight control programs; or exercise programs; nutritional counseling except as specifically provided for under Diabetes Care Benefits. This exclusion shall not apply to medically necessary services which Blue Shield is required by law to cover ~~for Severe Mental Illnesses or Serious Emotional Disturbances of a Child~~ **the treatment of mental health and substance use disorders.**

26. Learning disabilities or behavioral problems or social skills training/therapy, or for testing for intelligence or learning disabilities This exclusion shall not apply to medically necessary services which Blue Shield is required by law to cover ~~for Severe Mental Illnesses or Serious Emotional Disturbances of a Child~~ **the treatment of mental health and substance use disorders**.

38. For inpatient and Other Outpatient Mental Health and Substance Use Disorder Services unless authorized by the MHSA **except for medical services for the treatment of gender dysphoria, eating disorder and substance use disorder treatment which are the responsibility of the IPA/Medical Group.**

Section 2.8 Benefits and Benefits Programs

CARE MANAGEMENT

Added *a new care management program called Connect. The program description is as follows:*

Connect. Connect offers an integrated, holistic, and personalized healthcare experience based on each member's needs, including a broad spectrum of robust, member-focused interventions driven

by a smart-data platform with predictive analytics that leverage our best-in-class member care teams and digital wellness tools. The Connect care team is composed of specialists across claims and benefits, clinicians and care managers, pharmacists and technicians, behavioral health navigators and social workers to address any questions that could be asked during the first call. In those rare instances in which additional information is needed and a call cannot be resolved, the Connect care team takes complete ownership for any remaining tasks and offers to call the member back once resolved. The Connect care team proactively engages members, either digitally or over the phone, when early interventions or extra communications might lead to better health outcomes. Members are guided to available programs and resources to address their health issues, prevent emergency-room visits, and avoid higher costs associated with inpatient admissions in the future.

PHARMACEUTICAL BENEFITS

Childhood Immunizations

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

All childhood immunizations first recommended for use by the Advisory Council on Immunization Practices (ACIP) or the American Academy of Pediatrics (AAP) on or after January 1, 2001 will become the full financial responsibility of Blue Shield unless an IPA/medical group agrees to accept financial responsibility. Childhood immunizations that were part of the ACIP recommendation schedule prior to January 1, 2001 and the cost of vaccine administration are both the financial responsibility of the IPA/medical group. Please note that new combination vaccines of previously recommended immunizations or changes to dosing frequency or age restrictions will not be included in this classification unless they represent a material change in cost under a current contract. Claims must be submitted by the IPA/medical group, not the individual participating providers, for reimbursement regardless of financial responsibility. Please refer to Section 4.4 for encounter and claims processing procedures.

Office/Facility-Administered Medications

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

For some IPA/medical group commercial contracts, Blue Shield identifies and maintains a separate financial risk classification as dictated by the Richman Injectable List for certain (a) office-administered, (b) high-cost, (c) chemotherapy, and (d) chemotherapy and supportive/adjunctive injectable drugs. Medications are updated to these various risk allocation classifications on a quarterly basis. Please refer to your Division of Financial Responsibility (DOFR) for the classification(s) of drugs that are currently contractually carved out to Blue Shield. This policy does not apply to the Medicare Advantage product, as all IPA/medical groups are capitated on a percent of premium methodology, which is presumably self-adjusting and for which we follow Medicare guidelines in risk allocation.

Regardless of financial risk classification, the IPA/medical group is responsible for reimbursing providers for these medications directly. The IPA/medical group shall submit encounters to Blue Shield. When Blue Shield has risk for drugs on the Richman Injectable List, as defined in the IPA/medical group's contract, the IPA/medical group shall submit encounters to Blue Shield for reimbursement at rates set forth in the IPA/medical group's contract with Blue Shield. Encounters for these medications shall be submitted by the IPA/medical group, not the individual participating providers, with the appropriate National Drug Code (NDC) and HCPCS code. Please refer to Section 4.4 Claims for Medical Benefit Drugs for encounter and claims processing procedures.

For reimbursement of medications administered at an outpatient facility, select drugs may require site of service medical necessity authorization for coverage in addition to the authorization of the drug.

The criteria for classification of High-Cost injectables includes those FDA-approved in 1998 or later with an estimated treatment cost per patient at or above $10,000 average wholesale price (AWP) per year. A validation and reconciliation of the high-cost category will be conducted annually based on the previous years' Blue Shield utilization data using updated AWP pricing information and historical claims data to determine average dosing including duration of therapy. A complete list of High-Cost Injectables and corresponding HCPCS Codes that meet the classification criteria is posted quarterly on Provider Connection at blueshieldca.com/provider under *Claims,* then *Policies & guidelines*, then *Richman injectables*. You may also contact your Provider Relations Coordinator for a listing.

Section 4.1 Network Administration

LANGUAGE ASSISTANCE FOR PERSONS WITH LIMITED ENGLISH PROFICIENCY (LEP)

Added *Korean to list of Blue Shield threshold languages and* ***noted*** *that Blue Shield does not delegate overall responsibility for culturally and linguistically appropriate services to contracted providers unless otherwise noted in their contract with Blue Shield.*

Added *additional online resource for providers to access for resources to comply with the requirements of the LAP:*

- Industry Collaboration Effort (ICE) Cultural and Linguistics Provider Toolkit http://www.iceforhealth.org/library.asp?sf=&scid=1284#scid1284

Section 4.4 Claims Administration

CLAIMS PROCESSING

Removed *the following language as claims are not required to be submitted electronically, however, will be processed faster when submitted this way.*

All claims are required to be submitted electronically unless your provider contract specifically states otherwise.

Section 5.1 Utilization Management

DELEGATION

Updated *language in boldface type below:*

In making utilization management decisions, the IPA/medical group will adhere to all regulatory guidelines **and apply criteria as defined in Blue Shield's Utilization Management Program Description.**

DELEGATION OF UTILIZATION MANAGEMENT (UM)

The list of activities which Blue Shield monitors and reviews for the delegated entity has been ***deleted and replaced*** *with the following language:*

- UM meeting minutes
- UM Program
- Policies and procedures for UM that demonstrate adherence to Blue Shield Medical & Medication Policies
- Adverse determinations with Medical Records
- Approved authorizations with Medical Records
- Case Management Records - if delegated and/or upon request by the health plan

- UM reports
- Evidence of member/provider satisfaction survey with the UM process and results
- UM System Controls review
- UM statistics including, but not limited to:
  - All yearly goals, planned activities, key findings, analysis, and interventions
  - Inpatient metrics: Acute bed days/1000, Acute admits/1000, Acute Readmits/1000, Average Length of Stay
  - Skilled Nursing Facility, Long Term Acute Care & Rehab metrics
  - Referral metrics to include % of medical necessity denials and approvals
  - Emergency room metrics
  - Authorization timeframe compliance for medical necessity, pharmacy, and behavioral health services
  - Over- and under-utilization, including analysis of trends and documented actions to improve performance
  - Documented process to provide access to practitioners and members interested in information about UM decisions and the UM program
  - Job descriptions for UM staff and physicians require education, training, and professional expertise in clinical medical practice. All clinical staff must have evidence of clinical licensure and an unrestricted California license.

UM CRITERIA AND GUIDELINES

*The section regarding Mental Health and Substance Use Disorder medical necessity reviews has been **deleted and replaced** with the following:*

For fully-insured products, Mental Health and Substance Use Disorder (MH/SUD) medical necessity reviews are the responsibility of the IPA/medical group and utilize the American Society of Addiction Medicine (ASAM) criteria, Level of Care Utilization System (LOCUS) guidelines, Child and Adolescent Level of Care Utilization System (CALOCUS) guidelines and Early Childhood Service Intensity Instrument (ECSII) guidelines and World Professional Association for Transgender Health (WPATH) guidelines. Additional MH/SUD guidelines may be added as they become available from non-profit professional associations in accordance with California law.

MEDICAL NECESSITY

*This section has been **deleted and replaced** with the following to align with the Blue Shield UM Program Description:*

Medical Necessity (Medically Necessary)*

Coverage for Mental Health and Substance Use Disorder (MH/SUD) services is provided under the same terms and conditions as those applied to medical/surgical services conditions.

Medically necessary treatment of a mental health or substance use disorder* means a service or product addressing the specific needs of that patient, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of an illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of mental health and substance use disorder care.
- Clinically appropriate in terms of type, frequency, extent, site, and duration.
- Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider

*This definition applies to MH/SUD benefits in fully-insured products.

Medical Necessity (Medically Necessary)**

Benefits are provided only for services which are medically necessary.

Services that are medically necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury, or medical condition, and which, as determined by Blue Shield, are:

- Consistent with Blue Shield Medical Policy;
- Consistent with the symptoms or diagnosis;
- Not furnished primarily for the convenience of the patient, the attending physician, or other provider; and
- Furnished at the most appropriate level which can be provided safely and effectively to the patient; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.

Hospital Inpatient Services which are medically necessary include only those services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in a physician's office, an Outpatient department of a hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered. Inpatient services which are not medically necessary include hospitalization:

- Diagnostic studies that can be provided on an Outpatient basis;
- Medical observation or evaluation;
- Personal comfort;
- Pain management that can be provided on an Outpatient basis; and
- Inpatient rehabilitation that can be provided on an Outpatient basis.

Blue Shield reserves the right to review all services to determine whether they are medically necessary, and may use the services of Physician consultants, peer review committees of professional societies or Hospitals, and other consultants.

**This definition applies to medical/surgical benefits in fully-insured and self-funded products and to MH/SUD benefits in self-funded commercial products.

BLUE SHIELD MEDICAL & MEDICATION POLICIES

Medical Policy

Added Evidence Street *to the list of technologies that the Blue Shield Medical Policy Committee uses for medical and behavioral health indications.*

Medication Policy

Added Biosimilar First Requirements *to the list of policies that IPA/medical groups must adhere to when prior authorizing medications for coverage.*

AUTHORIZATION APPROVAL AND DENIAL NOTIFICATIONS PROCESS (AUTHORIZATION/DENIAL DATA FILE) *changed to* **UM AUTHORIZATION REPORTING PROCESS ("AUTH LOGS" APPROVAL/DENIAL DATA FILE REQUIREMENTS)**

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

Submitting Authorization Log Data File

Approval/denial data files ("Authorization Logs") must be delivered via secure email or SFTP file to Blue Shield. To initiate the delivery of authorization logs by means of a SFTP (Secure File Transfer Protocol) or to obtain the Blue Shield standard file layout and data dictionary, please email Medical Care Solutions at IPAAuths@blueshieldca.com.

Authorization logs must be sent, at minimum, on a weekly basis in order to ensure timely data processing. IPA approvals, denials and partial denials should be delivered together on one file. If sent via email, the data MUST be delivered in a file format that is suitable for data processing such as an Excel spreadsheet or delimited fixed width file. Any data file which does not comply to the format, content requirements and/or delivery frequency will be considered out of compliance, rejected by Blue Shield, and returned to the IPA/medical group for correction and resubmission.

Only shared-risk services for which the IPA/Medical Group is delegated to perform UM and Blue Shield is responsible for claim adjudication are required on the data file.

Incomplete or inaccurate information may negatively impact claim processing. Please help expedite the processing of authorization/denial files by providing the following required information for each record submitted:

- Subscriber ID Number
- Patient Last Name
- Patient First Name
- Patient Date of Birth (mm/dd/yyyy)
- Health Plan/Line of Business (CMC, Medi-Cal, Medicare Advantage or Commercial)
- Request Type (Inpatient, Service or Medication)
- Place of Service (Using CMS Industry Standard Place of Service Code Set and/or Name/Description: POS 11/Office, POS 21/Inpatient Hospital, POS 31/Skilled Nursing Facility)
- Admission Bed Type or Level of Care (Using industry standard descriptions: Acute Rehabilitation, Acute Behavioral Health, ICU, LTAC, Med Surg, NICU, NICU Level 1, Observation, SNF Level 1, Sub-Acute, etc.)
- First date of service or Admit date (mm/dd/yyyy)
- Last date of service or Discharge date (mm/dd/yyyy)
- Diagnosis Code(s) (ICD-10-CM Codes) – Primary code and up to 3 additional codes, if applicable
- Procedure Code(s) (CPT-4/HCPC Codes and for inpatient facility claims only ICD-10-PCS Codes) – Primary code and up to 9 additional codes, if applicable
- Units: Number of procedures, treatments, days, sessions, or visits
- Servicing Provider Name
- Servicing Provider NPI Number
- Facility Name (if applicable)
- Facility NPI Number (if applicable)
- Requesting Provider Name
- Requesting Provider NPI Number
- Authorization or Decision Reference Number

- Blue Shield IPA/Medical Group Provider Identification # (i.e., IPxxxxxxxxx) – It is highly recommended to include your Blue Shield PIN # to expedite processing. If unknown, the PIN # can be obtained from your Blue Shield Provider Relations representative.
- Receipt Request Date (Date provider requested authorization from IPA/Med Group)
- Decision (Approved, denied, partially denied or void)
- Full/Partial Denial Reason (i.e., Not medically necessary, not a benefit, etc.)
- Decision Date (mm/dd/yyyy)
- Discharge Diagnosis (if applicable)
- Discharge Status (i.e., To Home, SNF…., if applicable)

FOLLOW-UP CARE IN A NON-CONTRACTING HOSPITAL

*This section has been **deleted and replaced** with the following language to align with contract language updates:*

Blue Shield and its delegates may provide authorization for follow-up or continuing care in a non-contracting hospital for only as long as the member's medical condition prevents transfer to a contracting hospital. For out-of-area cases, when the treating physician determines a member's condition is stable and the member is ready for transfer, the Blue Shield UM staff will notify and assist the IPA/medical group, as needed. However, it is a delegated responsibility of the IPA/medical group to identify a receiving physician and a suitable Blue Shield in-network facility and to coordinate the member's transfer back to the appropriate service area/network and contracted facility as soon as the member is identified as stable for transfer. If a bed is not available at the IPA/medical group's affiliated hospital or it does not have the necessary resources, the IPA/medical group must coordinate the transfer to an appropriate Blue Shield in-network facility and provide utilization management. The IPA/medical group is required to convey updates to the Blue Shield Medical Care Solutions staff in a timely manner.

OUTPATIENT PRESCRIPTION DRUGS

***Noted** that Commercial group plans have access to a 90-day supply of prescription drugs at retail pharmacies.*

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

***Added** the following language:*

HMO IPA/Medical Groups are responsible for decisions related to delegated medical services. As such, medical services for the treatment of gender dysphoria, eating disorder or substance use disorder are the responsibility of the IPA/Medical Group.

Blue Shield Mental Health Service Administrator (MHSA) Covered Services and Financial Responsibility

***Removed** World Professional Association for Transgender Health (WPATH) as one of the review criteria from the language below. WPATH is used for medical services and not MH/SUD reviews:*

For fully-insured products, the Blue Shield MHSA will utilize ASAM, LOCUS, CALOCUS and ECSII for mental health and substance use disorder reviews. Additional MH/SUD guidelines may be added as they become available from non-profit professional associations in accordance with California law.

***Removed** from list of services requiring prior authorization by Blue Shield's MHSA:*

- Office-based Opioid Treatment
- Psychological Testing for a mental health disorder

Added *to list services requiring prior authorization by Blue Shield's MHSA:*

- Neuropsychological Testing should be considered for coverage through the patient's mental health benefit when:
  - After completion of a comprehensive Behavioral Health evaluation and neurological evaluation, if the Behavioral Health provider or neurologist determines the neuropsychological testing is required, the provider will request authorization and coordinate the request. Blue Shield MHSA will cover Neuropsychological testing when the purpose of testing is to clarify whether there is a psychiatric diagnosis (even when medical conditions are present).

IPA/Medical Group Covered Services and Financial Responsibility

Added *the following language to list of services that the IPA/medical group is responsible for:*

- HMO IPA/Medical Groups are responsible for decisions related to delegated medical services. As such, medical services for the treatment of gender dysphoria, eating disorder or substance use disorder are the responsibility of the IPA/Medical Group. In making utilization management decisions, the IPA/medical group will adhere to all regulatory guidelines and apply criteria as defined in Blue Shield's Utilization Management Program Description.

PRIOR AUTHORIZATION

Added *the following to list of services requiring prior authorization:*

- Medication administration at an outpatient hospital facility.

MEDICAL CARE SOLUTIONS CONTACT LIST

Added *the following Medicare HMO contact information:*

- Urgent/ER Inpatient Admits: Fax (844) 696-0975
- Prior Authorizations: Fax (844) 807-8997
- Prior Authorizations for Office/Infusion/Home Health Administered Medications: Fax (844) 262-5611

Section 5.2 Quality Management Programs

QUALITY MANAGEMENT AND IMPROVEMENT

Accreditation

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

Blue Shield of California maintains Health Plan Accreditation (HPA) with National Committee for Quality Assurance (NCQA). Blue Shield of California's Commercial HMO/POS, Commercial PPO, Marketplace HMO/POS (Covered CA/Exchange), Marketplace PPO (Covered CA/Exchange), Medicaid, and Medicare HMO hold NCQA Health Plan Accreditation. The NCQA accreditation survey process assesses a health plan's organizational policies and procedures, and performance against NCQA standards every three years.

DELEGATION OF CREDENTIALING

Required Submissions/Notifications of Credentialing Program Activity

Updated *language in boldface type below:*

The IPA/medical group will submit reports to Blue Shield twice a year listing those practitioners who have been credentialed, recredentialed, denied and terminated by their credentialing committee and/or requested a fair hearing, including the outcomes of those determinations. **Reports should also include the practitioners' quality improvement activities.**

SERVICE ACCESSIBILITY STANDARDS

Updated *language in boldface type below regarding compliance with access standards:*

Groups that are found non-compliant with the access standards **may** be required to submit a corrective action plan containing details on how the IPA/medical group will achieve and maintain compliance.

Service Accessibility Standards for Commercial and Medicare

Deleted and replaced *the following standard:*

Access to telephone service	STANDARD
Average Speed to Answer (ASA)	45 seconds

Geographic Distribution – Commercial

Deleted and replaced *the following standards:*

CATEGORY	PRODUCT	STANDARD
Geographic Distribution (Acupuncturist)	PPO	Urban/Suburban: 1 of each specialty within 20 miles of each member's residence or workplace or equivalent to 30 minutes. Rural: 1 of each specialty within 45 miles of each member's residence or workplace or equivalent to 60 minutes.
Availability of Ancillary Care Providers	HMO/POS PPO – DOI & DMHC IFP ePPO CCSB HMO/PPO	Pharmacy: 1 in 15 miles DME: 1 in 15 miles Radiology/Lab/ASC/SNF: 1 in 30 miles Urgent Care/Dialysis: Urban 1 in 15 miles, Suburban 1 in 20 miles, Rural 1 in 30 miles

Additional Measurements for Multidimensional Analysis for Commercial Products

Updated *the assessment frequency from quarterly to semi-annually in the following:*

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 Semi-Annually against Standard
Open PCP Panel	HMO/POS Directly Contracted HMO	85%	Assessed Semi-Annually against Standard

Removed *the following standard from the Commercial and Medicare* Additional Measurements for Multidimensional Analysis *charts:*

METRICS	PRODUCT	STANDARD	FREQUENCY
PCP Turnover	HMO/POS	14%	Assessed Quarterly against Standard

Section 6.1 Blue Shield Medicare Advantage Plan Program Overview

BLUE SHIELD MEDICARE ADVANTAGE COMPLIANCE PROGRAM

Noted *that Health Integrity, LLC, the Medicare Drug Integrity Contractor (MEDIC) in California, is now known as Qlarant Integrity Solutions, LLC.*

Medicare Compliance and Fraud, Waste, and Abuse (FWA) Training Requirements

Updated *the section to indicate that Blue Shield requires all FDRs to complete FWA training on an annual basis. Training materials can be accessed at* https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.

Section 6.2 Blue Shield Medicare Advantage Plan Benefits and Exclusions

BLUE SHIELD MEDICARE ADVANTAGE PLAN BENEFITS

Medication Therapy Management Program (MTMP)

This following has been ***deleted*** *from the list of conditions eligible for the MTMP:*

- Dyslipidemia

EXCLUSIONS TO BLUE SHIELD MEDICARE ADVANTAGE PLAN BENEFITS

Prescription Drug Benefit Exclusions

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

- Drugs when used for the treatment of sexual or erectile dysfunction (ED) **unless offered as supplemental coverage as specified by your plan.**

Section 6.6 Blue Shield Medicare Advantage Member Rights and Responsibilities

Added *the following member right to align with the member's EOC:*

You have the right to receive information about your rights and responsibilities, and to make recommendations regarding our member rights and responsibilities policy.

Appendices

APPENDIX 3-A BLUE SHIELD COMBINED ELIGIBILITY/CAPITATION REPORT

Updated *the Commercial file layout.*

APPENDIX 4-A CLAIMS, COMPLIANCE PROGRAM, IT SYSTEM SECURITY AND OVERSIGHT MONITORING

Measuring Timeliness and Accuracy

Check Cashing Timeliness

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

Blue Shield accepts the check or electronic transfer date as reasonable evidence of mailing, provided no operational or systematic delays are documented via a formal Policy and Procedure. As evidence that the check has been mailed, the Delegated Entity can provide a check mail log that has been signed by a Principal Officer or CFO who is attesting to checks being mailed on the dates reported. Blue Shield will confirm the date the check or electronic transfer was cleared to the Delegated Entity's bank account during the audit process. Blue Shield requires that a minimum of 70% of all checks be presented for deposit within 14 calendar days of the date the check is reported to have been mailed. If the check clearing timeliness is below 70%, Blue Shield requires the Delegated Entity to submit a check cashing attestation to be completed by each provider. The attestation can be requested from your assigned claims delegation oversight auditor.

Measuring Timeliness

***Added** the following language:*

Commercial Provider Dispute Resolution
Interest and penalties on disputes which result in determination in favor of the provider should be calculated beginning 45 working days following the date of receipt of the original complete claim.

*The sections below have been **deleted and replaced** with the following language:*

Medicare Advantage Claims
Claim processing begins when a claim is received anywhere within a health plan if the claim was received first by the plan's contracted network, contracted clearing house and/or imaging vendor, or post office box of either the health plan or contracted network If a Management Service Organization (MSO) that manages several delegated entities receives a claim from one of their post office boxes and loads the claim into the wrong Delegated Entity's claims system, the original received date of that claim needs to be used when the claim is entered into the correct Delegated Entity's claim system. The earliest date stamp on a claim determines when the timeliness cycle begins and must be entered into the claim system as the received date unless documentation can be provided to validate that the earliest stamp(s) does not belong to the Blue Shield contracted network. The number of days measured is "calendar" days. There are two different types of claims, each with its own processing time limit: 1) 30 calendar days for clean claims from unaffiliated/ non-contracted providers and 2) 60 calendar days for all other claims – "unclean" claims paid or denied from unaffiliated/non-contracted providers, or claims paid or denied from affiliated/contracted providers. The mailed date of the check and/or correspondence defines the end of the claim's turnaround time.

Medicare Advantage Provider Dispute Resolution/Appeals
Provider dispute resolution and appeals includes decisions where a non-contracted provider contends that the amount paid by the payor for a covered service is less than the amount that would have been paid under Original Medicare. Submission of a first level Provider Dispute/Appeal must be filed within a minimum of 120 calendar days after the notice of initial determination. Resolution and a written determination must be completed within 60 calendar days after the date of receipt of the provider dispute. The non-contracted provider may submit a second level written request to Blue Shield within 180 calendar days of written notice from the payor. Second level disputes must be submitted to:

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

The provider payment dispute process cannot be used to challenge denials by organizations that result in zero payment being made to the non-contracted provider. The payment dispute process may not be used to resolve payment disputes between contracted network providers and organizations covered by this process.

Overpayment

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

Medicare Advantage
The Delegated Entity may go back three (3) years from the date the claim was paid to collect an overpayment. Once an overpayment is discovered and a final determination is made, a first written demand letter is sent. If a full payment is not received within 30 calendar days, interest accrues starting on day 31. If the provider agrees with the overpayment by day 15, recoupment can start. If the provider sends a rebuttal follow the Medicare process. If the Delegated Entity has a written agreement with the provider to automatically off-set any overpayment(s) no written demand letter is required.

Payment Accuracy

*The sections below have been **deleted and replaced** with the following language:*

Commercial
Payment accuracy includes: (1) proper payment of interest, (2) proper use of a reasonable and customary fee schedule for non-contracted providers, (3) applying appropriate contract fee schedules, and (4) system configuration All four criteria must be met for a claim or a claim Provider Dispute Resolution (PDR) to be considered compliant in payment accuracy.

Medicare Advantage
Payment accuracy includes: (1) proper payment of interest and (2) proper use of provider fee schedules for non-contracted providers, (3) system configuration The three criteria must be met for a claim or a claim provider dispute to be considered compliant in payment accuracy.

Rescinding Authorization – AB 1324 (Health & Safety Code Section 1371.8)

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

Blue Shield validates that Delegated Entities pay incurred services if the specific service was pre-authorized or referred, even if the member is later found to be ineligible for any reason, when the provider of service relied on the authorization or referral in good faith and validated the eligibility of the member prior to service being rendered. If the Delegated Entity has an approved authorization and service has not been rendered, the Delegated Entity needs to formally rescind the authorization by sending a notice to the authorized rendering provider and to the member. The Delegated Entity can bill Blue Shield under the eligibility guarantee clause within their contract with Blue Shield if services were rendered by a provider who relied on the authorization in good faith.

Best Practices and Claims Adjudication

Audits and Audit Preparation

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

Blue Shield of California, CMS, and the DMHC will conduct periodic audits of claims and provider disputes (where appropriate) to ensure compliance with all regulatory requirements. In advance of Blue Shield's audit, Blue Shield will send a written notification 60 days prior to the audit that includes the documents the Delegated Entity will need to provide along with the scope of the audit and due dates of when the material needs to be submitted. The documentation includes providing claims universes for each category. An industry standard questionnaire will need to be completed that will provide detailed information about your claims processing operations and internal controls. . If required claims documentation is not received, the audit is incomplete and will be scored as non-compliant and a corrective action plan (CAP) will be required by the Delegated Entity along with a follow up audit that will be scheduled. The Delegated Entity will be escalated to the Delegation Oversight Committee as non-compliant for lack of submission of audit documents. Electronic submission of all data is required.

Blue Shield will perform an annual audit for claims and compliance oversight which include internal controls and IT system security. Blue Shield will provide a notification of the annual audit that includes the scope of the audit along with interviews of appropriate departments within the Delegated Entity's organization. . Blue Shield will require a walk through and demonstration of the Delegated Entity's operations.

Blue Shield will provide the Delegated Entity with written results within 30 but no later than 45 calendar days including an itemization of any deficiencies and whether or not the Delegated Entity must prepare and submit a formal, written corrective action plan to include root cause and remediation within 30 days of receipt of audit results or provide additional supporting documentation within time period provided by Blue Shield.

Balance Billing

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

<u>Commercial</u>
California state law prohibits balance billing by contracted providers for all services and non-contracted providers of emergency services.

The California Code of Regulations identifies in Title 28 Section 1300.71 (g) (4) that every plan contract with a provider shall include a provision stating that except for applicable copayments and deductibles, a provider shall not invoice or balance bill a plan's enrollee for the difference between the provider's billed charges and the reimbursement paid by the plan or the plan's capitated provider for any covered benefit.

Except for services subject to the requirements of Section 1367.11 of the Act, "unfair billing pattern" includes a provider of emergency services balance billing.

If the provider continuously balance bills the member, the Delegated Entity should submit all written and documented verbal communication with the provider to the health plan who will report the provider to the Department of Managed Health Care (DMHC) for further action by the state. A non-contracted provider may appeal to the health plan directly should they disagree with the payment from the Delegated Entity.

AB 72

AB 72 (Health & Safety Code Section 1300.71.31. Methodology for Determining Average Contracted Rate; Default Reimbursement Rate) establishes a payment rate, which is the greater of the average of a health care service plan (health plan) or Delegated Entity contract rate, as specified, or 125% of the amount Medicare reimburses for the same or similar services. The Delegated Entity must participate in the Independent Dispute Review Process (IDRP) and provide Blue Shield with the contact information to provide to the IDRP contractor managed by DMHC.

If the Delegated Entity fails to meet required timeframes for claims payment and Blue Shield determines that the claim is payable by the Delegated Entity, Blue Shield may pay the claim and deduct the amount of the payment from future capitation. When this occurs, Blue Shield will provide documentation explaining the deduction.

Medicare Advantage

Chapter 4 of the Medicare Managed Care Manual, Benefits and Beneficiary Protections, addresses when beneficiaries may be balanced billed, as identified below.

- Contracted providers are prohibited from balance billing enrollees. They may only collect the copayments and/or coinsurance.
- Non-contracting participating providers are prohibited from balance billing enrollees. They may only collect the copayments and/or coinsurance.
- Non-contracted non-participating providers can balance bill the health plan up to the original Medicare limiting charge.
- Non-contracted non-participating DME suppliers can balance bill the health plan the difference between the member's cost sharing and the DME supplier's bill.

Date Stamping

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

Delegated Entities must date stamp all paper claims, including facsimiles, with the date the claim was received. The stamp should identify the specific Delegated Entity. Blue Shield recommends that each page of the paper claim including any attachments be date stamped.

For Medicare Advantage claims federal procedures suggest that claims received from the U.S. Postal Service after 4:30 PM may be considered "received" on the next business day. If a courier picks up the claims from the post office and transports them to the Delegated Entity's claims office, the time of pickup by the courier is what determines the date of receipt. The earliest received date by any Blue Shield Medicare Advantage HMO and PPO network provider must be utilized for Medicare Advantage claims.

For Commercial claims, date of receipt means the working day when a claim, by physical or electronic means, is first delivered to the Delegated Entity's post office box, claims office or to a subcontractor who is responsible for receipt and processing of claims mail. The claims receipt date can also be the date the Delegated Entity receives a claim forwarded to them by either physical or electronic submission, as they have been determined to be the correct payor.

Disbursement of Payments

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

The date of payment is the date that the funds were electronically transferred (EFT)or the date the check was mailed via postal service to the provider. Blue Shield validates the EFT date as well as the date the payment was mailed. It is recommended that the Delegated Entity does not exceed 3 days

from the paid date to the mail date. The additional mail processing days will 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 provide a mail date policy and procedure to verify the additional days have been included to validate turnaround time for audits.

Forwarding Claims (Misdirected)

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

Billing providers often submit claims and disputes to the incorrect payor. It is a requirement that the Delegated Entity forward claims directly to the financially responsible entity, if known, otherwise deny with a remit message informing the provider the Delegated Entity is not financially responsible for processing of the claim.

The misdirected claim's original received date is used to determine timeliness based upon how the claim was received first by the Delegated Entity's contracted clearing house(s) and/or imaging vendor(s), and/or post office boxes it owns.

If a Management Service Organization (MSO), that manages several Delegated Entities, receives a claim from one of their post office boxes and it loads the claim into the wrong Delegated Entity's claims system, the original received date of that claim needs to be used when the claim is entered into the correct Delegated Entity's claim system.

Commercial Forwarding Timeliness
Regulations require the Delegated Entity to forward misdirected claims to the responsible payor within ten (10) working days of receipt.

Medicare Advantage Forwarding Timeliness
The misdirected claim's, original received date is used to determine timeliness if the claim was received first by the plan contracted network, contracted clearing houses and/or imaging vendors, post office boxes of either health plans or contracted network.

Health plans and Delegated Entities should forward claims within ten (10) calendar days of initial receipt.

***Added** the following new section:*

Reopenings

A reopening is a remedial action taken to change a binding determination or decision that resulted in either an overpayment or an underpayment, even though the determination or decision was correct based on the evidence of record. Reopenings are separate and distinct from the appeals process.

Reopenings are different from adjustment claims in that adjustment claims are subject to normal claims processing timely filing requirements (that is, filed within one year of the date of service), while reopenings are subject to timeframes associated with administrative finality and are intended to fix an error on a claim for services previously billed (e.g., claim determinations may be reopened within one year of the date of the initial determination for any reason, or within one to four years of the date of the initial determination upon a showing of good cause).

Offshore Monitoring

Changed *section name to* **Monitoring of a Subcontractor (this includes MSO) for a delegated function-offshore/onshore** *and* ***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-delegated functions are interchangeable within this section.

The Delegated Entity is expected to require the sub-delegated claims organization 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. If the Delegated Entity sub-delegates claims functions they will need to demonstrate and provide evidence of their oversight of that entity during the on-site audit. If the Delegated Entity outsources claims functions, that will also need to be monitored.

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

The regulators require all health plans and their contracted delegated entities to demonstrate oversight and monitoring of any subcontractor that it has sub-delegated operational functions that otherwise are audited by a health plan. "Subcontractor" refers to any organization that a sponsor contracts with to fulfill, or help fulfill, requirements of a delegated function. The term "offshore" refers to any country that is not one of the fifty United States or one of the United States Territories (American Samoa, Guam, Northern Marianas, Puerto Rico, and Virgin Islands). In providing oversight, Blue Shield requires all Delegated Entities to submit an annual offshore attestation and proof of an annual audit conducted on the offshore and/or onshore subcontractor. If commercial line of business is offshored, approval is required from Blue Shield prior to offshoring any Blue Shield commercial delegated claims.

Deleted or moved *the following sections:*

- Inpatient Non-Authorized Services – *Language no longer applies.*
- Provider Dispute Resolution Process (Medicare Advantage) – *Moved to Measuring Timeliness section*.
- Claims Reports – *Moved to new section Claims Delegate Reporting Instructions.*
- Sub-delegated Claims Monitoring – *Moved to Monitoring of a Subcontractor (this includes MSO) for a delegated function-offshore/onshore section.*

Added *a subsection* **Claims Delegate Reporting Instructions** *which includes instructions on how to submit reports, report naming conventions, submission schedules and sample reports.*

APPENDIX 4-C ACTUARIAL COST MODEL

Updated *the model with 202 data.*

APPENDIX 5-A UTILIZATION MANAGEMENT DELEGATION STANDARDS

Standards for Program Structure and Processes

Review of Written UM Program Documentation, Policies & Procedures, and Review Criteria

Updated *elements of review criteria to align with Blue Shield's Utilization Management Program Description.*

Use of Qualified Professionals in Decision Making

Added *the following required written procedure:*

- A written procedure for using board-certified consultants to assist in making medical necessity determinations.

Entities Utilization Management Committee Meeting Frequency

Deleted *the following section:*

The entities' UM Committee will meet as often as necessary to provide effective, timely reviews which facilitate patient access to appropriate care.

Initial Organization Determinations (Treatment Authorization Request Decisions) Standards

Overturned Initial Determinations by Health Plan

This section was ***deleted and replaced*** *with the following:*

Blue Shield may overturn any entity's decision that does not meet Blue Shield approved medical policy or recommended medical necessity review criteria. A decision to overturn the determination of the entities will be made by the Blue Shield Medical Director or a designated physician advisor, involving discussion with and/or notification to the entity's Medical Director. Groups are required to submit any information that is related to a denial when it is requested by Blue Shield.

UM Decision Timeliness Standards – Centers for Medicare & Medicaid Services (CMS)

Medicare Expedited Initial Determination Process and Tracking

Removed *language indicating the health plan maintains responsibility for logging and tracking compliance for expedited initial determination requests. This is no longer a function of the health plan.*

Added *the following new section:*

UM System Controls

IPA/medical groups are required to have policies and procedures describing system controls specific to UM denial notification dates that:

1. Define the date of receipt consistent with NCQA requirements.
2. Define the date of written notification consistent with NCQA requirements.
3. Describe the process for recording dates in systems.
4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate.
5. Specify how the system tracks modified dates.
6. Describe system security controls in place to protect data from unauthorized modification.
7. Describe how the organization audits the processes and procedures in factors 1-6.