Introduction

Blue Shield has established and approved written policies and procedures that state it does not delegate or sub-delegate any Member Rights and Responsibilities to the IPA/medical groups. This applies to both commercial and Blue Shield 65 Plus (HMO) plans.

All grievances are the responsibility of Blue Shield.

Statement of Member Rights and Responsibilities

Member Rights

All Blue Shield Access+ HMO® plan members have the right to:

1. Receive considerate and courteous care, with respect for their right to personal privacy and dignity.
2. Receive information about all health services available to them, including a clear explanation of how to obtain them.
3. Receive information about their rights and responsibilities.
4. Receive information about their Access+ HMO health plan, the services we offer them, the physicians and other practitioners available to care for them.
5. Select a primary care physician and expect his/her team of health workers to provide or arrange for all the care that they need.
6. Have reasonable access to appropriate medical services.
7. Participate actively with their physician in decisions regarding their medical care. To the extent permitted by law, members also have the right to refuse treatment.
8. A candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage.
9. Receive from their physician an understanding of their medical condition and any proposed appropriate or medically necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so they can make an informed decision before they receive treatment.
10. Receive preventive health services.
11. Know and understand their medical condition, treatment plan, expected outcome and the effect these have on their daily living.
12. Have confidential health records, except when disclosure is required by law or permitted in writing by the member. With adequate notice, members have the right to review their medical record with their primary care physician.
13. Communicate with and receive information from Member Services in a language they can understand.
14. Know about any transfer to another hospital, including information as to why the transfer is necessary and any alternatives available.

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

Member Rights *(cont'd.)*

15. Obtain a referral from their primary care physician for a second opinion.
16. Be fully informed about the Blue Shield grievance procedure and understand how to use it without fear of interruption of health care.
17. Voice complaints or grievances about the Blue Shield Access+ HMO health plan or the care provided to them.
18. Participate in establishing public policy of the Blue Shield Access+ HMO, as outlined in their Evidence of Coverage or Health Service Agreement.
19. Make recommendations regarding Blue Shield's member rights and responsibilities policy.

Member Responsibilities

Blue Shield Access+ HMO® plan members have the responsibility to:

1. Carefully read all Blue Shield Access+ HMO materials immediately after they are enrolled so they understand how to use their benefits and minimize their out-of-pocket costs. Ask questions when necessary. Members have the responsibility to follow the provisions of their Blue Shield Access+ HMO membership as explained in the *Evidence of Coverage* or *Health Service Agreement.*
2. Maintain their good health and prevent illness by making positive health choices and seeking appropriate care when it is needed.
3. Provide, to the extent possible, information that their physician and/or the plan need to provide appropriate care for them.
4. Understand your health problems and take an active role in developing treatment goals with your medical care provider, whenever possible.
5. Follow the treatment plans and instructions they and their Physician have agreed to and consider the potential consequences if they refuse to comply with treatment plans or recommendations.
6. Ask questions about their medical condition and make certain that they understand the explanations and instructions they are given.
7. Make and keep medical appointments and inform the plan physician ahead of time when they must cancel.
8. Communicate openly with the primary care physician they choose so they can develop a strong partnership based on trust and cooperation.
9. Offer suggestions to improve the Blue Shield Access+ HMO plan.
10. Help Blue Shield to maintain accurate and current medical records by providing timely information regarding changes in address, family status and other health plan coverage.
11. Notify Blue Shield as soon as possible if they are billed inappropriately or if they have any complaints.

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

Member Responsibilities *(cont'd.)*

12. Select a primary care physician for their newborn before birth, when possible, and notify Blue Shield as soon as they have made this selection.

13. Treat all plan personnel respectfully and courteously as partners in good health care.

14. Pay their dues, copayments and charges for non-covered services on time.

15. For all mental health and substance abuse services, follow the treatment plans and instructions agreed to by the member and Blue Shield's mental health service administrator (MHSA) and obtain prior authorization for all non-emergency mental health and substance abuse services.

Member Grievance Process

The Blue Shield HMO administers the investigation of member grievances and follows a standard set of procedures for the resolution for both Medicare Advantage and commercial members.

For more information on the member grievance process and complaint resolution procedures for Blue Shield 65 Plus (HMO) (Blue Shield's Medicare Advantage members), see Section 6.6 of this manual.

Blue Shield has a comprehensive review process to address matters when members wish to exercise their right to file a grievance. The program also encourages communication and collaboration on grievance issues among Blue Shield departments and functional areas. Although it is inadvisable to require patients to sign arbitration agreements as a condition of providing medical care, providers may choose to enter into arbitration agreements with Blue Shield plan members, providing the agreement to arbitrate fully complies with the California Code of Civil Procedure (CCP) Section 1295 including the important provision that the patient is permitted to rescind the arbitration agreement in writing within 30 days of signature, even when medical services have already been provided.

Grievances are disputes regarding potential quality issues, access to care, or delay/modification/denial of treatment issues. All grievances are researched and investigated by Blue Shield's Appeals and Grievance Department (AGD). Blue Shield requests that IPA/medical groups help identify, process, and resolve all member grievances in a timely manner.

Blue Shield encourages members to informally resolve their grievances with their Blue Shield HMO providers. If this is not possible, members, member representatives, or an attorney or provider on the member's behalf, may call Blue Shield HMO Member Services to initiate a grievance.

Members, member representatives, or an attorney or provider on the member's behalf may file a grievance by contacting Blue Shield's Customer/Member Service Department in writing, by telephone, or by submitting a completed Grievance Form online at blueshieldca.com. Blue Shield provides all IPA/medical groups with an optional member grievance form that is available in the offices for all Blue Shield members. (This form is distributed to all IPA/medical groups through the Provider Relations Department.)

Member Grievance Process *(cont'd.)*

To comply with the Department of Managed Health Care (DMHC), legislative requirements, and National Committee for Quality Assurance (NCQA), Blue Shield resolves all member grievances within 30 calendar days of receipt. Generally, the member must participate in Blue Shield's grievance process for 30 calendar days before submitting a grievance to the DMHC. However, the DMHC can waive this requirement in "extraordinary and compelling cases." In these events, Blue Shield has five days to respond to the grievance.

When it is necessary to coordinate a grievance with the member's provider, Blue Shield will send a copy of the member's grievance to the IPA/medical group and request that the IPA/medical group review it and respond to Blue Shield in writing within ten calendar days from receipt for normal grievances or 24 hours from receipt for urgent or escalated grievances.

The Member Grievance Process ensures that:

- Members are informed of their right to report grievances
- Member grievances are responded to and resolved timely
- No sanctions/penalties or interruption of health care results from using the Grievance Program
- Tracking, analyzing, and reporting of individual and aggregate grievance data
- Identification of systemic quality of care, access to care, and quality of service issues
- Compliance with DMHC, regulatory requirements, and NCQA standards

Resolution Options

The Member Grievance Process is designed to allow the member, member representative or provider on their behalf, a complete and timely review within 30 calendar days of Blue Shield's receipt.

The following options are used to resolve a member grievance:

- Standard Review Process
- Expedited Review
- Independent Medical Review (IMR) (offered through the DMHC)

Blue Shield Grievance Process – Standard, Expedited, and External Review

Standard Review Process

If Member Services cannot resolve the issue, the case is forwarded to the Appeals and Grievance Department (AGD) for review and determination. Clinical grievances may include collaboration with a Blue Shield Medical Director.

Resolution occurs within 30 calendar days of the member's initial request. The written response to the member provides a clear and concise statement of the determination with references to applicable provisions in the *Evidence of Coverage* (EOC). The Blue Shield Grievance Process allows members to file grievances within 180 days following any incident or action that is the subject of the member's dissatisfaction.

The Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If the member has a grievance against Blue Shield, the member should first telephone Blue Shield at the number provided in their EOC and use our grievance process before contacting DMHC. Utilizing Blue Shield's grievance process does not prohibit any potential legal rights or remedies that may be available to the member. If the member needs help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Blue Shield, or a grievance that has remained unresolved for more than 30 days, the member may call DMHC for assistance. Members can contact the DMHC at (888) HMO-2219, TDD (877) 688-9891for the hearing and speech impaired, or through their website at www.hmohelp.ca.gov for complaint forms, IMR application forms, and instructions online.

The member may also be eligible for an Independent Medical Review (IMR). If they are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by Blue Shield related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

If the grievance involves a medical necessity or experimental/investigational issue, the member is notified of his/her right to request an external Independent Medical Review (IMR). A copy of the IMR form and instructions are included in the response.

Expedited Review

Members have the right to an expedited decision when the routine decision-making process might pose an imminent or serious threat to their health, including, but not limited to severe pain, potential loss of life, limb, or major bodily function. Blue Shield will evaluate the request and medical condition to determine if it qualifies for an expedited decision, which will be processed as soon as possible to accommodate the member's condition not to exceed 72 hours from the initial receipt.

Members, member representatives, or an attorney or provider acting on their behalf, may file a verbal or written request, or can submit a Grievance Form online at blueshieldca.com to obtain an expedited decision by specifically stating that the subscriber's health might be seriously jeopardized by waiting for the standard process.

> *Note: If a Commercial Members employer's health plan is governed by the Employment Retirement Income Security Act (ERISA), they may have the right to bring a civil action under Section 502 (a) of ERISA if all required reviews of their claim have been completed and their claim has not been approved.*

Blue Shield Grievance Process – Standard, Expedited, and External Review *(cont'd.)*

External Independent Medical Review (IMR)

The Knox-Keene Act requires Blue Shield to provide external Independent Medical Review (IMR) when appropriate.

If a member's grievance involves a claim or services for which coverage was denied in whole or in part by Blue Shield, on the grounds that the service is not medically necessary or is experimental/investigational (including the external review available under the Friedman-Knowles Experimental Treatment Act of 1996), the member may choose to have the matter submitted to an independent agency for external review in accordance with California law. The member normally must first submit a grievance to Blue Shield and wait for at least 30 calendar days before requesting external review; however, if the matter would qualify for an expedited decision, as described above, or involves a determination that the requested service is experimental/investigational, the member may immediately request an external review. The member may initiate this review by completing an application for external review, a copy of which can be obtained by contacting Blue Shield Member Services. The Department of Managed Health Care (DMHC) will review the application and, if the request qualifies for external review, will select an external review agency for an independent opinion. There is no cost to the member for this external review. The member and their physician will receive copies of the opinions of the external review agency. This external review agency is binding on Blue Shield. This process is completely voluntary on the member's part; the member is not obligated to request external review.

Members may apply for an IMR if:

1. The member's provider has recommended a health care service as medically necessary.
2. The member has received urgent care or emergency services that a provider determined was medically necessary.
3. In the absence of a provider recommendation or the receipt of urgent care or emergency services, the member has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the member seeks independent review.

Blue Shield Grievance Process – Standard, Expedited and External Review *(cont'd.)*

External Independent Medical Review (IMR) *(cont'd.)*

Upon receipt of DMHC's notification of approval of the member's request for IMR, Blue Shield forwards requested information directly to the review entity selected by the DMHC within three business days, unless there is an imminent and serious threat to the enrollee's health, in which case, Blue Shield must provide the information within 24 hours.

Information provided must include:

- All medical records that are relevant to the member's condition
- All information provided to the member and contracting providers concerning the condition and care
- All information that was submitted by the member
- All written communications by Blue Shield regarding the grievance
- Copies of any other relevant documents or information regarding the grievance, including any section of the *Evidence of Coverage* relied on by Blue Shield in its denial

IMR will be completed within 30 days or within three days for urgent conditions.

Upon completion of the review, the review entity provides written notice of its decision to the member, the member's provider, Blue Shield and the DMHC. Blue Shield will promptly comply with the decision.

Peer Review

Peer review is the review of cases through the grievance and appeals process where actual or potential quality-of-care issues are identified. Cases requiring investigation may involve components of care delivered by an individual practitioner or a health delivery organization such as a hospital, skilled nursing facility, medical group or independent practice association, or other types of organizations designed to deliver care to Blue Shield members.

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