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B. Blue Shield Eligibility Adds and Terminations Report
C. Claims Compliance and Monitoring
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A Supplement to the Capitated Hospital Manual

January 2019
This supplement has been written as a guide for a “delegated claims operation.” That phrase refers to delegated hospitals, medical service organizations, third party administrators (TPAs) or others who process claims delegated by Blue Shield of California (Blue Shield). Blue Shield hopes the information and procedures in this supplement will assist in meeting claims processing requirements. For any questions or further assistance, please contact your Delegated Claims Oversight Auditor. This supplement includes the following sections:

- Introduction
- Key Terms and Definitions
- Measuring Timeliness and Definitions
- Best Practices and Claim Adjudication
  - Audits and Audit Preparation
  - Balance Billing
  - Check Mailing
  - Contract Auditing
  - Date Stamping
  - Delegated Claims Compliance and Self Reporting
  - Denial Review – Second Level
  - Denials - Retrospective/Concurrent Submission
  - Forwarding Claims
  - Fraud, Waste, and Abuse
  - Inpatient Non-Authorized Services
  - Offshore Monitoring
  - Provider Dispute Resolution (PDR) Process – Medicare Advantage
  - Self-Monitoring and Reporting
  - Sub-Capitated (Sub-Delegated) Claims Monitoring
  - Timely Filing
  - Unclean or Contested Claims (Affiliated or Anaffiliated Providers)
  - Utilization Management Review
- Frequently Asked Questions
Introduction

This supplement to the Blue Shield Hospital and Facility Guidelines is for the delegated hospitals that 1) process their own claims, 2) contracts with a management company or Third Party Administrator (TPA) to process claims on their behalf, or 3) sub-capitates (sub-delegates) some or all of their claims processing responsibilities. If the delegated entity is currently not processing their claims, the delegated entity must share this supplement with their TPA or management company or otherwise ensure that they have the latest version of this specific update. If the delegated entity sub-capitates claims processing, or ever contemplates doing so, please carefully read the “Sub-Capitated (Sub-Delegated) Claims Monitoring” section of this appendix below. It explains the additional responsibilities hospitals assume when they sub-capitate the claims processing function.

By means of this supplement, Blue Shield seeks to describe and follow sound operating principles. This supplement will guide hospitals in providing superior service to our beneficiaries and in applying industry best practices in claims operations. It will verify that you are successful in meeting all applicable requirements. Please don’t hesitate to contact the Blue Shield Delegated Claims Oversight Manager and/or Delegated Claims Oversight Auditors directly for further information or assistance.

Based on the available data, the information in this supplement conforms to all CMS, DMHC, DOL and NCQA requirements. Should information in this supplement fail to reflect any existing or newly enacted statutory requirements, these new or additional requirements will supersede the information contained herein. Blue Shield will notify the delegated hospital of any changes in requirements through supplemental revisions or by other written communications. Throughout this document, wherever possible, Blue Shield distinguishes between Medicare Advantage (HMO) requirements and DMHC (“commercial”) requirements or citations by displaying them side-by-side.

This supplement only describes claims compliance and monitoring. Information on other claims-related topics (i.e., claims operations coordination with Blue Shield; submission of encounter claims or data; claims appeals or grievances; Medicare Secondary Payment (MSP); and coordination of benefits (COB)) are covered in other parts of the Hospital and Facility Guidelines.
Key Terms and Definitions

“Automatically”

The word “automatically” as it refers to paying interest on late commercial claims is defined in CCR Title 28, Section 1300.71. “Automatically” means the payment of the interest due to the provider within five working days of the payment of the claim without the need for any reminder or request by the provider.

Blue Shield 65 Plus (HMO)

Blue Shield’s Medicare Advantage plans; Blue Shield 65 Plus (HMO), Blue Shield Plus Choice Plan (HMO) and Blue Shield Trio Medicare (HMO). The terms “Medicare Advantage,” “MA-PD,” and “Blue Shield 65 Plus (HMO)” may be used interchangeably in this supplement.

Blue Shield 65 Plus Group Medicare Advantage

The Blue Shield Medicare Advantage Prescription Drug Group product. The terms “Group Medicare Advantage” and “GMAPD” may be used interchangeably in this supplement.

Claims Operations

Blue Shield monitors compliance and deficiencies across all aspects of claims operations: receipt and related handling, processing/adjudication and payment. The claim operation begins when the claim is first received from the US Postal Service, electronically or by any other means and ends when the check or disbursement, explanation of benefits (EOB) or notice of denial is electronically transmitted or deposited in the US mail. These operations are defined to include computer systems and their reports, as well as utilization review, and any other ancillary operations in the work flow needed to fully process a claim and deliver the payment and/or denial.

Clean Claim

A Medicare claim which can be paid and/or denied as soon as it is received because it is complete in all aspects, including complete coding, itemization, dates of service, billed amounts, and identification of the billing provider including tax identification number (TIN) and the national provider identifier (NPI).

Emergency services or out-of-area urgently needed services do not need authorization to be considered “clean,” providing that the presenting ICD-10-CM diagnoses codes or accompanying medical records substantiate that they qualify as emergent, urgent under the prudent layperson standard.

Complete Claim

A claim or portion thereof, if separable, including attachments and supplemental information or documentation, which provides “reasonably relevant information” and “information necessary to determine payor liability.”

Compliance

Meeting the regulatory and health plan quantified standards at least 95% of the time unless otherwise specified.
Key Terms and Definitions (cont’d.)

Date of Payment

The date of postmark or electronic mark accurately setting forth the date when the payment was electronically transmitted or deposited in the U.S. Mail or another mail or delivery service, correctly addressed to the claimant’s office or other address of record.

Date of Receipt

Commercial

The working day when a claim, by physical or electronic means, is first delivered to either the plan’s specified claims payment office, post office box, or designated claims processor or to the plan’s capitated provider for that claim. In the situation where a claim is sent to the incorrect party, the “date of receipt” shall be the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim.

Medicare Advantage/Group Medicare Advantage

The working day when a claim, by physical or electronic means, is first delivered to either the plan’s specified claims payment office, post office box, or to the plan’s capitated hospital for that claim. For Medicare Advantage and Group Medicare Advantage, the earliest date, either from the Blue Shield 65 Plus (HMO) or any of the Blue Shield’s network providers, determines the received date of the claims unless documentation can be provided to validate that the earliest stamp(s) does not belong to the Blue Shield 65 Plus HMO network.

Group Medicare Advantage

The product line offered to large group employers with 50 or more retirees who have Medicare Part A and Part B and reside within the plan’s service area. Group Medicare Advantage mirrors Medicare Advantage for rules and regulations with employer group defined benefits.

HMO

Health Maintenance Organization.

Incomplete Claims

A claim or portion thereof, if separable, including attachments and supplemental information or documentation, which does not provide: “reasonably relevant information” and “information necessary to determine payer liability.”
Key Terms and Definitions (cont’d.)

Industry Collaboration Effort (ICE)

The Industry Collaboration Effort (ICE) was established to coordinate and oversee a voluntary multi-disciplinary team that works collaboratively to implement and improve compliance with the requirements of CMS, DMHC, DHS, NCQA and other regulatory agencies and accreditation organizations.

Blue Shield supports and participates in ICE. For more background on ICE and to obtain approved documents, visit their website at iceforhealth.org.

Medicare

The health care coverage program administered by the federal Department of Health and Human Services (DHHS) through the Centers for Medicare & Medicaid Services (CMS).

Medicare Advantage (MA)

The Medicare managed care program that superseded the Medicare Risk program, as promulgated through the Balanced Budget Act (BBA) of 1998 and the implementing regulations (Mega-Reg) issued in June of 1998. Those regulations went into effect January 1, 1999, with some provisions phased in over a period of years. Medicare Advantage (MA) organizations receive a monthly capitation payment from the Federal Government to provide medical care to Medicare Advantage members. Any member claims are the responsibility of the HMO and not reimbursed by Medicare. The alternative to Medicare Advantage is traditional fee-for-service, where claims are adjudicated by Medicare intermediaries or carriers who reimburse providers directly based on CMS fee schedules. Fee-for-service patients are not restricted to a limited set of providers as they are in a Medicare Advantage arrangement.

Member Denial

An adverse benefit determination in which a claim, or any line item(s) on a claim, will not be paid and the member is responsible for payment of the service. Re-coding a claim to better match clinical information and to pay a lesser amount is not a member-denial, nor are rebundling or making other corrections of billing errors that result in reduced payment. Closing a claim without issuing a payment is not a member denial unless the member is responsible to pay. Examples of this would be forwarding a claim to the responsible payor, closing a claim as a duplicate, and/or instructing a contracted provider to write off any unpaid portion of a claim without billing the member because of errors made by that provider. Forwarded claims and/or claims closed as duplicates should be excluded from the monthly timeliness reports. Duplicate claims already paid or denied must be denied as duplicates. A second denial notice may not be mailed to the member for the service provided.
Key Terms and Definitions (cont’d.)

Monitoring and Quality Assurance

Federal and state law specifically requires monitoring of compliance over delegated hospitals. Quality experts define the term “quality” as “meeting the customers’ requirements.” For Medicare Advantage products, CMS and Blue Shield members/beneficiaries are the primary customers. For commercial products, the DMHC, employers and Blue Shield members/beneficiaries are the primary customers. Quality assurance and improvement programs assess the delegated claims operation’s ability to meet timeliness and accuracy requirements. Blue Shield reviews both the monthly and quarterly self-reports of claims timeliness, conducts periodic auditing as part of our Quality Assurance monitoring program and expects every delegated claim organization to monitor itself. Blue Shield expects the delegated claims operation to maintain a complete program of “continuous quality improvement” (CQI) to detect deficiencies early and implement corrective actions.

Present on Admission (POA)

Hospital Acquired Conditions (HAC), conditions not present on admission, are defined as avoidable conditions which could reasonably have been prevented through application of evidence-based guidelines. Such conditions are not present when patients are admitted to a hospital, but occur during the course of the stay. Never Events are defined as “serious and costly errors in the provision of health care services that should never happen.” HACs and Never Events are not payable claims and the member is not liable.

Commercial

Blue Shield adopted a policy effective January 1, 2010 to discontinue paying for HACs and Never Events performed within contracted facilities. HACs and Never Events are not payable claims but may be contested to the facility without member liability. Any inpatient facility claim without the POA indicator should be contested back to the facility for completion.

Medicare Advantage and Group Medicare Advantage

Effective October 1, 2008, the Centers for Medicare & Medicaid Services (CMS) adopted a policy restricting payment for HACs and treatments/surgeries performed erroneously (Never Events). HACs and Never Events are not payable claims but must be denied without member liability. Any inpatient facility claim without the POA indicator should be developed for the missing indicator.
Key Terms and Definitions (cont’d.)

Principal Officer

Each hospital that has commercial claims delegated must designate a Principal Officer for claims and provider disputes. These officers are responsible for operations and for reporting the timeliness of those operations. ICE has recommended that this process be mirrored for the Medicare Advantage and Group Medicare Advantage product lines as well.

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, use the form available at the ICE website and submit an original copy with original signatures to Blue Shield. Both quarterly forms can be obtained on the ICE website and should be submitted either by fax to (855) 895-3505, by email to Delegated.Claims.Reports@blueshieldca.com, or by mail to:

Blue Shield of California
Attention: Delegated Claims Oversight
6300 Canoga Avenue 9th Floor
Woodland Hills, CA 91367

Provider Dispute Resolution (PDR) Process - Commercial

A formal process for receiving, resolving, and reporting provider disputes (provider appeals) for commercial claims relating to billing, claims, contracts, utilization management, and other provider appeals is mandated for delegated payors. ICE has created a detailed PDR 101 workbook with all updated information. Providers can find copies of these tools in the Library at the ICE website or by contacting the Blue Shield Delegated Claims Oversight Auditor.

Provider Dispute Resolution (PDR) Process – Medicare Advantage

A formal process for receiving, resolving, and reporting provider disputes (appeals) for Medicare Advantage and Group Medicare Advantage claims relating to payment of non-contracted provider claims. ICE created a detailed PDR 101 workbook with all updated information. Providers can find copies of these tools in the Library at the ICE website or by contacting the Blue Shield Delegated Claims Oversight Auditor.

Unclean Claims

An unclean claim is defined as “one which cannot be paid as soon as it is received” because it lacks the necessary information in order to make a payment and/or denial determination.
Measuring Timeliness and Definitions

Timeliness for claims and disputes is measured from the date the claim or provider dispute is received to the date the check or disbursement, explanation of benefits, denial notice, or dispute resolution correspondence is mailed.

Acknowledgement of Receipt

**Commercial**

Blue Shield validates whether the delegated hospital is able to acknowledge receiving electronic claims within two (2) working days of receipt and paper claims within 15 working days of receipt.

**Commercial Provider Dispute Resolution (PDR)**

Blue Shield validates whether the delegated hospital is able to acknowledge receiving electronic claims within two (2) working days of receipt and paper claims within 15 working days of receipt.

**Group Medicare Advantage**

Not applicable.

**Medicare Advantage**

Not applicable.

**Medicare Advantage/Group Medicare Advantage Provider Dispute Resolution (PDR)**

Not applicable.

**Affiliated/Contracted Provider**

**Commercial**

A provider with whom the plan and/or its delegated claim operations 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.

**Commercial Provider Dispute Resolution (PDR)**

A provider with whom the plan and/or its delegated claim operations 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.
Affiliated/Contracted Provider  

Group Medicare Advantage

A provider with whom the plan and/or its delegated claim operations 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.

Medicare Advantage

A provider with whom the plan and/or its delegated claim operations 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.

Medicare Advantage/Group Medicare Advantage Provider Dispute Resolution

A provider with whom the plan and/or its delegated claim operations 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.

Check Cashing Timeliness

Commercial

Blue Shield accepts the check or electronic transfer date as reasonable evidence of mailing, provided no operational or systematic delays are documented. Blue Shield will confirm the date the check or electronic transfer reached the bank or was charged to the delegated hospital’s bank account during the audit process. Blue Shield requires that a minimum of 75% of all checks be presented for deposit within 14 calendar days of the date the check is reported to have been mailed.

Commercial Provider Dispute Resolution (PDR)

Blue Shield defers the review of check cashing through the Medicare Advantage, Group Medicare Advantage, or Commercial claims audits.
Measuring Timeliness and Definitions (cont’d.)

Check Cashing Timeliness (cont’d.)

Group Medicare Advantage

Blue Shield accepts the check or electronic transfer date as reasonable evidence of mailing, provided no operational or systematic delays are documented. Blue Shield will confirm the date the check or electronic transfer reached the bank or was charged to the delegated hospital’s bank account during the audit process. Blue Shield accepts the check or electronic transfer date as reasonable evidence of mailing, provided no operational or systematic delays are documented. Blue Shield will confirm the date the check or electronic transfer reached the bank or was charged to the delegated hospital’s bank account during the audit process. Blue Shield 65 Plus requires that a minimum of 75% of all checks be presented for deposit within 14 calendar days of the date the check is reported to have been mailed.

Medicare Advantage

Blue Shield accepts the check or electronic transfer date as reasonable evidence of mailing, provided no operational or systematic delays are documented. Blue Shield will confirm the date the check or electronic transfer reached the bank or was charged to the delegated hospital’s bank account during the audit process. Blue Shield accepts the check or electronic transfer date as reasonable evidence of mailing, provided no operational or systematic delays are documented. Blue Shield will confirm the date the check or electronic transfer reached the bank or was charged to the delegated hospital’s bank account during the audit process. Blue Shield 65 Plus requires that a minimum of 75% of all checks be presented for deposit within 14 calendar days of the date the check is reported to have been mailed.

Medicare Advantage/Group Medicare Advantage Provider Dispute Resolution (PDR)

Blue Shield defers the review of check cashing through the Medicare Advantage, Group Medicare Advantage, or Commercial claims audits.

Clean/Complete Claims

Commercial

A complete claim is one that includes all necessary information to determine payer liability.

Information necessary to determine payer liability for the claim includes, but is not limited to, reports or investigations concerning fraud and misrepresentation, necessary consents, releases and assignments, or other information necessary for the delegated claims operation to determine the medical necessity for the health care services provided.

Emergency services or out-of-area urgently needed services do not need authorization to be considered “complete,” providing that the diagnoses codes or accompanying medical records substantiate that they qualify as emergent, urgent under the reasonable person standard.
Claims Compliance and Monitoring

Measuring Timeliness and Definitions (cont’d.)

Clean/Complete Claims (cont’d.)

Commercial Provider Dispute Resolution (PDR)

A written provider dispute that includes all information required under state regulations:

(1) Clear identification of the disputed item(s).

(2) The date of service(s)

(3) Clear explanation of the basis upon which the provider believes the payment amount, request for additional information, and request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect.

Group Medicare Advantage

A clean claim is defined as “one which can be paid and/or denied as soon as it is received, because it is complete in all aspects, including complete coding, itemization, dates of service, billed amounts, and identification of the billing provider including tax identification number (TIN)” and the national provider identifier (NPI).

Emergency services or out-of-area urgently needed services do not need authorization to be considered “clean,” providing that the presenting ICD-10-CM diagnoses codes or accompanying medical records substantiate that they qualify as emergent, urgent under the prudent layperson standard.

Medicare Advantage

A clean claim is defined as “one which can be paid and/or denied as soon as it is received” because it is complete in all aspects, including complete coding, itemization, dates of service, billed amounts, and identification of the billing provider including tax identification number (TIN)” and the national provider identifier (NPI).

Emergency services or out-of-area urgently needed services do not need authorization to be considered “clean,” providing that the presenting ICD-10-CM diagnoses codes or accompanying medical records substantiate that they qualify as emergent, urgent under the prudent layperson standard.

Medicare Advantage/Group Medicare Advantage Provider Dispute Resolution (PDR)

A non-contracted provider payment dispute that includes all information required:

(1) Clear identification of the disputed item(s).

(2) The date of service(s)

(3) Clear explanation of the basis upon which the provider believes the payment amount is incorrect.

Non-contracted provider disputes may be received by a dedicated phone line, email, or through written correspondence.
Measuring Timeliness and Definitions *(cont’d.)*

**Copayments**

**Commercial**

Blue Shield validates the appropriate employer defined copayment has been applied for each date of service by:

(1) Validating the copayment was deducted on the explanation of benefit (EOB),

(2) A global message is provided on the EOB instructing the provider of service to obtain the applicable copayment,

(3) And/or the provider of service contract identifies the provider is responsible for collecting the copayment in addition to the contract payment.

Waiving copayment is strictly prohibited.

**Commercial Provider Dispute Resolution (PDR)**

Blue Shield validates the appropriate employer defined copayment has been applied for each date of service by:

(1) Validating the copayment was deducted on the explanation of benefit (EOB),

(2) A global message is provided on the EOB instructing the provider of service to obtain the applicable copayment,

(3) And/or the provider of service contract identifies the provider is responsible for collecting the copayment in addition to the contract payment.

Waiving copayments is strictly prohibited.

**Group Medicare Advantage**

Blue Shield 65 Plus validates the appropriate employer defined copayment is applied by:

(1) Validating the copayment was deducted on the explanation of benefit (EOB),

(2) A global message is provided on the EOB instructing the provider of service to obtain the applicable copayment,

(3) And/or the provider of service contract identifies the provider is responsible for collecting the copayment in addition to the contract payment.

Waiving copayments is strictly prohibited.
Measuring Timeliness and Definitions (cont’d.)

Copayments (cont’d.)

Medicare Advantage

Blue Shield 65 Plus validates the appropriate employer defined copayment is applied by:

1. Validating the copayment was deducted on the explanation of benefit (EOB),

2. A global message is provided on the EOB instructing the provider of service to obtain the applicable copayment,

3. And/or the provider of service contract identifies the provider is responsible for collecting the copayment in addition to the contract payment.

Waiving copayments is strictly prohibited.

Medicare Advantage/Group Medicare Advantage Provider Dispute Resolution (PDR)

Blue Shield validates the appropriate Blue Shield 65 Plus copayment is applied by:

1. Validating the copayment was deducted on the explanation of benefit (EOB),

2. A global message is provided on the EOB instructing the provider of service to obtain the applicable copayment,

3. And/or the provider of service contract identifies the provider is responsible for collecting the copayment in addition to the contract payment.

Waiving copayment is strictly prohibited.

Claim Denial

Note: This section applies only to delegated HMO Capitated Hospitals.

Claim denials and their associated letters/notices are not normally submitted to Blue Shield for administrative review.

If your hospital is required to submit denials, you will be advised directly by letter or by a Claims Compliance Auditor. The Claims Compliance Auditor will supply you with submission instructions.

Emergency room (ER) denials are claim denials. If Blue Shield’s Medical Management wishes to review these as part of a special, temporary program, they will send the hospital a direct request to submit copies.

Non-contracted providers may be paid at a reasonable and customary (R&C) fee schedule based on the Gould criteria as mandated by Title 28 CCR 1300.71(a)(3).
Measuring Timeliness and Definitions (cont’d.)

Fee Schedule Accuracy

**Commercial**

Contracted providers must be paid accurately at contracted rates.

Non-contracted providers may be paid at a reasonable and customary (R&C) fee schedule based on the Gould criteria as mandated by Title 28 CCR 1300.71(a)(3).

**Commercial Provider Dispute Resolution (PDR)**

Contracted providers must be paid accurately at contracted rates.

Non-contracted providers may be paid at a reasonable and customary (R&C) fee schedule based on the Gould criteria as mandated by Title 28 CCR 1300.71(a)(3).

**Group Medicare Advantage**

Title 42, Part 422, Section 214 mandates that “Any provider that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in a Medicare Advantage private fee-for-service plan must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare.”

Blue Shield will accept the following payment structures in determining accuracy on 30-day claims based on the location on where the services were rendered:

1. “Participating” providers are paid at a published Medicare fee schedule less any standard copayment amount,

2. “Non-participating” providers who accept assignment are paid 95% of a published Medicare fee schedule less any standard copayment amount, and

3. “Non-participating” providers who do not accept assignment are paid at the “Limiting Charge,” which is 109.25% of a published Medicare fee schedule less any standard copayment amount.

**Medicare Advantage**

Title 42, Part 422, Section 214 mandates that “Any provider that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in a Medicare Advantage private fee-for-service plan must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare.”

Blue Shield will accept the following payment structures in determining accuracy on 30-day non-contracted provider claims based on the location on where the services were rendered:

1. “Participating” providers are paid at a published Medicare fee schedule less any standard copayment amount,

2. “Non-participating” providers who accept assignment are paid 95% of a published Medicare fee schedule less any standard copayment amount, and

3. “Non-participating” providers who do not accept assignment are paid at the “Limiting Charge” which is 109.25% of a published Medicare fee schedule less any standard copayment amount.
Measuring Timeliness and Definitions (cont’d.)

Fee Schedule Accuracy (cont’d.)

Medicare Advantage/Group Medicare Advantage Provider Dispute Resolution (PDR)

Title 42, Part 422, Section 214 mandates that “Any provider that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in an Medicare Advantage private fee-for-service plan must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare.

Blue Shield will accept the following payment structures in determining accuracy on non-contracted/unaffiliated provider disputes based on the location on where the services were rendered:

(1) “Participating” providers are paid at a published Medicare fee schedule less any standard copayment amount,

(2) “Non-participating” providers who accept assignment are paid 95% of a published Medicare fee schedule less any standard copayment amount, and

(3) “Non-participating” providers who do not accept assignment are paid at the “Limiting Charge” which is 109.25% of a published Medicare fee schedule less any standard copayment amount.

Interest Accuracy

Commercial

Interest is applicable for contracted and non-contracted providers claims paid beyond the statutory deadline. Interest must be calculated beginning with the first day after deadline through the day the payment/check is mailed.

Interest is due on adjustments paid in favor of the provider (in whole or in part) when the delegated hospital was at fault with the original claim process. Interest would be calculated from the original received date of the claim through the date of the mailing of the adjustment payment.

The interest rate is fixed at a 15% annual rate. The amount of interest is calculated by multiplying the daily rate times the number of calendar days late, times the dollar amount paid. The interest should be included with the claim payment except as noted below. The daily rate is the result of dividing the current interest rate by 365 or 366 in the case of a leap-year.

To avoid a mandated $10.00 per claim penalty, the full amount of interest warranted must be paid “automatically.” “Automatically” means that the interest must be included with the claim payment or mailed within five working days of the original claim payment. If the warranted amount of interest is underpaid, the mandated $10.00 per claim penalty must be paid along with the additional interest due.

If the interest amount is less than $2.00 the interest may be paid on that claim along with interest on other such claims within ten (10) calendar days of the close of the calendar month in which the claim was paid as long as a statement identifying the specific claims for which the interest being paid is included.
Measuring Timeliness and Definitions (cont’d.)

Interest Accuracy (cont’d.)

For claims involving emergency services, the minimum amount of interest due is the greater of either $15.00 per calendar year or the interest calculated as described above.

If an emergency service interest spans more than one calendar year, the $15.00 is applicable per calendar year.

Commercial Provider Dispute Resolution (PDR)

Interest is applicable for contracted and non-contracted providers claims paid beyond the statutory deadline. Interest must be paid beginning with the first day after deadline through the day the payment/check is mailed.

Interest is due on adjustments paid in favor of the provider (in whole or in part) when the delegated hospital was at fault with the original claim process in the event that the adjustment is made beyond the statutory deadline. Interest would be calculated from the original received date of the claim through the date of the mailing of the adjustment payment.

The interest rate is fixed at a 15% annual rate. The amount of interest is calculated by multiplying the daily rate times the number of calendar days late, times the dollar amount paid. The interest should be included with the claim payment except as noted below. The daily rate is the result of dividing the current interest rate by 365 or 366 in the case of a leap-year.

To avoid a mandated $10.00 per claim penalty, the interest must be paid “automatically”. “Automatically” states that the interest must be included with the claim payment or mailed within five working days of the original claim payment.

If the interest amount is less than $2.00 the interest may be paid on that claim along with interest on other such claims within 10 calendar days of the close of the calendar month in which the claim was paid as long as a statement identifying the specific claims for which the interest being paid is included.

For claims involving emergency services, the minimum amount of interest due is the greater of either $15.00 per calendar year or the interest calculated as described above.

If an emergency service interest spans more than one calendar year, the $15.00 is applicable per calendar year.

Group Medicare Advantage

Clean claims from unaffiliated/non-contracted providers paid later than the statutory deadline requires interest to be paid. Interest is to be calculated beginning on the thirty-first calendar day through the day the check is mailed.

Interest is due at the current Federal Prompt Payment Interest Rate, which is updated each January and July. Interest is to be calculated based on 1) the number of calendar days over thirty (30), 2) the current Medicare interest rate and, (3) the amount paid. The daily rate is the result of dividing the interest rate in effect at the time the claim was paid by 365 or 366 in the case of a leap year.

The amount of interest is calculated by multiplying the daily rate, times the number of calendar days over 30, times the dollar amount paid. The interest should be included with the claim payment. Interest payments mailed within two weeks of the initial claim payment are considered compliant.
Measuring Timeliness and Definitions (cont’d.)

Interest Accuracy (cont’d.)

Medicare Advantage

Clean claims from unaffiliated/non-contracted providers paid later than the statutory deadline requires interest to be paid. Interest is to be calculated beginning on the thirty-first day through the day the payment/check is mailed.

Interest is due at the current Federal Prompt Payment Interest Rate, which is updated each January and July. Interest is to be calculated based on 1) the number of calendar days over thirty (30), 2) the current Medicare interest rate and, (3) the amount paid. The daily rate is the result of dividing the interest rate in effect at the time the claim was paid by 365 or 366 in the case of a leap year.

The amount of interest is calculated by multiplying the daily rate, times the number of calendar days over 30, times the dollar amount paid. The interest should be included with the claim payment. Interest payments mailed within two weeks of the initial claim payment are considered compliant.

Medicare Advantage/Group Medicare Advantage Provider Dispute Resolution (PDR)

Interest is applicable for non-contracted providers claims paid beyond the statutory deadline. Interest must be paid beginning with the first calendar day after deadline through the day the payment/check is mailed.

Interest is due on adjustments found in favor of the provider (in whole or in part) when the IPA/medical group was at fault with the original claim process. Interest would be calculated from the original received date of the claim through the date of the mailing of the adjustment payment.

Interest is due at the current Federal Prompt Payment Interest Rate, which is updated each January and July. Interest is to be calculated based on (1) the number of calendar days over thirty (30), (2) the current Medicare interest rate and (3) the amount paid. The daily rate is the result of dividing the interest rate in effect at the time the claim was paid by 365 or 366 in the case of a leap year.

The amount of interest is calculated by multiplying the daily rate, times the number of calendar days over 30, times the dollar amount paid. The interest should be included with the claim payment. Interest payments mailed within two weeks of the initial claim payment are considered compliant.

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.

Measuring Timeliness

Commercial

Claim processing begins when a claim is first delivered to delegated payor’s office. The number of days measured are “working” days. The time limit to make payment – 45 working days – applies to all uncontested claims, without regard to whether the billing providers are contracted or non-contracted. If a claim is to be contested the notice to that effect (denial notice to contracted physicians or request for more information) must be mailed within 45 working days. Member-denial notices must be mailed within 30 calendar days of receipt of the claim to fulfill the ERISA and Blue Shield regulations. This policy blends requirements from ERISA regulations, California’s Health and Safety Code and NCQA. To fulfill the state regulations all denial notices must be mailed within 45 working days.
Measuring Timeliness and Definitions (cont’d.)

Measuring Timeliness (cont’d.)

Commercial Provider Dispute Resolution (PDR)

Resolution and a written determination must be completed within 45 working days after the date of receipt of the provider dispute or the amended provider dispute.

If the provider dispute is overturned in favor of the payor, payment is due within five (5) working days of the issuance of the written determination. Per ICE guidelines, if the payment is issued prior to the written determination, the written determination is due to the provider within five (5) working days of the issuance of the payment.

Group Medicare Advantage

Claim processing begins when a claim is received anywhere within a health plan or its contracted network. Accordingly, 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 to the satisfaction of a CMS auditor can be provided to validate that the earliest stamp(s) does not belong to the Blue Shield 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, denied claims, or claims from affiliated/contracted providers. The mailed date of the check and/or correspondence defines the end of the claims turnaround time.

Medicare Advantage

Claim processing begins when a claim is received anywhere within a health plan or its contracted network. Accordingly, 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 to the satisfaction of a CMS auditor can be provided to validate that the earliest stamp(s) does not belong to the Blue Shield 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, denied claims, or claims from affiliated/contracted providers. The mailed date of the check and/or correspondence defines the end of the claims turnaround time.

Medicare Advantage/Group Medicare Advantage Provider Dispute Resolution (PDR)

Resolution and a written determination must be completed within 30 calendar days after the date of receipt of the provider dispute or the amended provider dispute.
Member Denial Notice – Monthly Self Reporting

Commercial

A denied claim is a claim where (1) one or more services will not be paid by the provider claims operation and (2) payment is the financial responsibility of the member.

Member denied claims are reported and monitored separately from paid and “contested” claims. Provider-denials are reported and audited along with other contested claims.

Examples of claims that are not member-denials and should not be reported, submitted or presented to the health plan as member liability “denied” claims include:

- patients who remain enrolled with the health plan but have transferred from one delegated claims operation to another must be forwarded to the health plan or the other entity for processing;
- duplicates to claims already paid or denied must be denied as duplicates, a second denial notice may not be mailed to the member;
- encounter only, capitated claims and no patient liability is involved;
- denials to a contracting provider who must write off the unpaid claim (unless the provider has written evidence that the member understood and accepted payment responsibility); or
- reduced payment amounts due to contract terms, or correction of billing errors such as bundling or inaccurate coding.

Commercial Provider Dispute Resolution (PDR)

Not applicable.
Measuring Timeliness and Definitions (cont’d.)

Member Denial Notice – Monthly Self Reporting (cont’d.)

Group Medicare Advantage

A denied claim is a claim where (1) one or more services will not be paid by the provider claims operation and (2) payment is the financial responsibility of the member.

Examples of claims that are not member-denials and should not be reported, submitted or presented to the health plan as member liability “denied” claims include:

- patients who remain enrolled with the health plan but have transferred from one delegated claims operation to another and you are just forwarding the claim to the health plan or the other entity for processing;
- patients who remain capitated to your organization but payment responsibility belongs to another contracting entity (health plan or hospital) and you are forwarding the claim;
- duplicates to claims already paid or denied;
- encounter only, capitated claims and no patient liability is involved;
- denials to a contracting provider who must write off the unpaid claim (unless the provider has written evidence that the member understood and accepted payment responsibility); or
- reduced payment amounts due to contract terms or allowed Medicare fee schedules, or correction of billing errors such as bundling or inaccurate coding.
Measuring Timeliness and Definitions (cont’d.)

Member Denial Notice – Monthly Self Reporting (cont’d.)

Medicare Advantage

A denied claim is a claim where (1) one or more services will not be paid by the provider claims operation and (2) payment is the financial responsibility of the member.

Examples of claims that are not member-denials and should not be reported, submitted or presented to the health plan as member liability “denied” claims include:

- patients who remain enrolled with the health plan but have transferred from one delegated claims operation to another and you are just forwarding the claim to the health plan or the other entity for processing;
- patients who remain capitated to your organization but payment responsibility belongs to another contracting entity (health plan or hospital) and you are forwarding the claim;
- duplicates to claims already paid or denied;
- encounter only, capitated claims and no patient liability is involved;
- denials to a contracting provider who must write off the unpaid claim (unless the provider has written evidence that the member understood and accepted payment responsibility); or
- reduced payment amounts due to contract terms or allowed Medicare fee schedules, or correction of billing errors such as bundling or inaccurate coding.

Medicare Advantage/Group Medicare Advantage Provider Dispute Resolution (PDR)

Not applicable.
Measuring Timeliness and Definitions (cont’d.)

Member Denial Notice - Standards

Commercial

When health plans and delegated claim operations make decisions to deny claims that result in liability for the enrollee, those decisions must be in accordance with DMHC and DOL law and regulations, including required coverage for emergency care taking the “reasonable person” standard into account. The member must be given clear information including phone numbers and mailing addresses to assist them in contacting the health plan or the delegated claim operations or the consumer assistance agencies for more information or to appeal the denial decision.

Once a denial notice has been sent, no further adverse notices may be sent to the member.

The U. S. Department of Labor mandated and ICE implemented updated member denial and emergency service denial letters to include: the denial code and corresponding meaning, description of available internal appeals, external review processes, and disclosure of the availability of and contact information for the Offices of Health Insurance Consumer Assistance or ombudsman, as established under PHS Act Section 2793. All member denial and emergency service denial letters must include the diagnosis code and corresponding meaning and treatment with the corresponding meaning.

Section 1557 of the Affordable Care Act of 2010 prohibits discrimination based on race, color, national origin, sex, age or disability in certain health programs and activities. Members must be notified about their rights under Section 1557. Specifically, delegated entities must include a nondiscrimination notice in English and taglines in at least the top 15 non-English languages spoken by individuals with limited English proficiency with every member liability denial notice.

Prior to issuing member liability denial notices to the members, non-eligibility must be confirmed through either the Blue Shield website at www.blueshieldca.com or by calling the Customer Service number listed on the back of the member’s Blue Shield identification card.

Commercial Provider Dispute Resolution (PDR)

Not applicable.
Measuring Timeliness and Definitions (cont’d.)

Member Denial Notice – Standards (cont’d.)

Group Medicare Advantage

Federal law, regulations and CMS guidelines govern initial coverage determinations that are adverse to a Medicare beneficiary (i.e., denials that result in financial liability for the beneficiary).

These requirements apply to health plans and thereby to any entity in which authority to make coverage determinations has been delegated. When an adverse determination has been made, the current CMS approved Integrated Denial Notice (IDN) letter format must be sent to the member.

ICE issued revised model notices and updated the denial reasons guide to meet CMS requirements.

Section 1557 of the Affordable Care Act of 2010 prohibits discrimination based on race, color, national origin, sex, age or disability in certain health programs and activities. Members must be notified about their rights under Section 1557. Specifically, covered entities must include a nondiscrimination notice in English and taglines in at least the top 15 non-English languages spoken by individuals with limited English proficiency with every Integrated Denial Notice.

All Integrated Denial Notices (IDN) must contain the Blue Shield 65 Plus HMO CMS material identification number along with the CMS-approved expiration date. The most current IDN letter may be obtained through the Blue Shield’s Delegated Claims Oversight department or the ICE website.

Prior to issuing an IDN, non-eligibility must be confirmed by calling Blue Shield 65 Plus (HMO) Provider Customer Services at (800) 541-6652 [TTY 711]. If identified that the member is eligible with Blue Shield 65 Plus HMO but delegated to another IPA/medical group, the claim must be forwarded to the appropriate payor.

CMS requires that the health plan coordinate all member-initiated appeals. Health plans may not delegate administration of member appeals. Once an Integrated Denial Notice has been sent, no further adverse notices may be sent to the member except by the Center For Healthcare Dispute Resolution (CHDR).
Measuring Timeliness and Definitions (cont’d.)

Member Denial Notice – Standards (cont’d.)

Medicare Advantage

Federal law, regulations and CMS guidelines govern initial coverage determinations that are adverse to a Medicare beneficiary (i.e., denials that result in financial liability for the beneficiary).

These requirements apply to health plans and thereby to any entity in which authority to make coverage determinations has been delegated. When an adverse determination has been made, the current CMS approved Integrated Denial Notice (IDN) letter format must be sent to the member.

ICE issued revised model notices and updated the denial reasons guide to meet CMS requirements.

Section 1557 of the Affordable Care Act of 2010 prohibits discrimination based on race, color, national origin, sex, age or disability in certain health programs and activities. Members must be notified about their rights under Section 1557. Specifically, covered entities must include a nondiscrimination notice in English and taglines in at least the top 15 non-English languages spoken by individuals with limited English proficiency with every Integrated Denial Notice.

All Integrated Denial Notices (IDN) must contain the Blue Shield 65 Plus HMO CMS material identification number along with the CMS-approved expiration date. The most current IDN letter may be obtained through the Blue Shield’s Delegated Claims Oversight department or the ICE website.

Prior to issuing an IDN, non-eligibility must be confirmed through either the Blue Shield 65 Plus voice response unit (VRU). The toll free number is (800) 393-6130. If identified that the member is eligible with Blue Shield 65 Plus HMO but delegated to another IPA/medical group, the claim must be forwarded to the appropriate payor.

CMS requires that the health plan coordinate all member-initiated appeals. Health plans may not delegate administration of member appeals. Once an Integrated Denial Notice has been sent, no further adverse notices may be sent to the member except by the Center For Healthcare Dispute Resolution (CHDR).

Medicare Advantage/Group Medicare Advantage Provider Dispute Resolution (PDR)

Not applicable.

Opt Out

Commercial

Not applicable.

Commercial Provider Dispute Resolution (PDR)

Not applicable.
Measuring Timeliness and Definitions (cont’d.)

Opt Out (cont’d.)

Group Medicare Advantage

Any provider that has chosen not to participate with the CMS Medicare Advantage and Group Medicare Advantage program may not provide services to Medicare Advantage or Group Medicare Advantage members without notifying the member in advance that they have elected to Opt Out of the CMS Medicare Advantage and Group Medicare Advantage program. Upon advanced notification, the member would be responsible for the payment of the services rendered.

Medicare Advantage

Any provider that has chosen not to participate with the CMS Medicare Advantage and Group Medicare Advantage program may not provide services to Medicare Advantage or Group Medicare Advantage members without notifying the member in advance that they have elected to Opt Out of the CMS Medicare Advantage and Group Medicare Advantage program. Upon advanced notification, the member would be responsible for the payment of the services rendered.

Overpayment

Commercial

The delegated hospital has a total of 365 calendar days from the date of payment to initiate an overpayment request. The request must be in writing and allow the provider of service a minimum of 30 working days to contest and/or refund the overpayment. The delegated hospital may only offset an uncontested notice of reimbursement of the overpayment of a claim against a provider’s current claim submission when (1) the provider fails to reimburse within the 30 working day timeframe and (2) the provider has entered into a written contract specifically authorizing the delegated hospital to offset an uncontested notice of overpayment of a claim from the contracted provider’s current claims submissions.

Commercial Provider Dispute Resolution (PDR)

The delegated hospital has a total of 365 calendar days from the date of payment to initiate an overpayment request. The request must be in writing and allow the provider of service a minimum of 30 working days to contest and/or refund the overpayment. The delegated hospital may only offset an uncontested notice of reimbursement of the overpayment of a claim against a provider’s current claim submission when (1) the provider fails to reimburse within the 30 working day timeframe and (2) the provider has entered into a written contract specifically authorizing the delegated hospital to offset an uncontested notice of overpayment of a claim from the contracted provider’s current claims submissions.

Group Medicare Advantage

Overpayments are Medicare payments a provider has received in excess of amounts due and payable under the Centers for Medicare & Medicaid Services (CMS) and/or the provider's contract. The delegated hospital 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 fifteen (15) days after the date of the first demand letter, recoupment (off-set) should start on the 16th day. If the delegated hospital has a written agreement with the provider to automatically off-set any overpayment(s) no written demand letter is required.
Measuring Timeliness and Definitions (cont’d.)

Overpayment (cont’d.)

Medicare Advantage

Overpayments are Medicare payments a provider has received in excess of amounts due and payable under the Centers for Medicare & Medicaid Services (CMS) and/or the provider's contract. The delegated hospital 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 fifteen (15) days after the date of the first demand letter, recoupment (off-set) should start on the 16th day. If the delegated hospital has a written agreement with the provider to automatically off-set any overpayment(s) no written demand letter is required.

Medicare Advantage/Group Medicare Advantage Provider Dispute Resolution (PDR)

Not applicable

Payment Accuracy

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 benefits and (4) ensuring all services submitted have been processed to the correct provider and for the patient billed on the claim. All four criteria must be met for a claim to be considered compliant in payment accuracy.

Commercial Provider Dispute Resolution (PDR)

Payment accuracy includes: (1) proper payment of interest, (2) proper use of a reasonable and customary fee schedules for non-contracted providers, (3) applying appropriate contract benefits and (4) ensuring all services submitted have been processed to the correct provider and for the patient billed on the claim. All four criteria must be met for a claim to be considered compliant in payment accuracy.

Group Medicare Advantage

Payment accuracy includes: (1) proper payment of interest, (2) proper use of provider fee schedules for non-contracted providers, (3) applying appropriate contract benefits and (4) ensuring all services submitted have been processed to the correct provider and for the patient billed on the claim. All four criteria must be met for a claim to be considered compliant in payment accuracy.

Medicare Advantage

Payment accuracy includes: (1) proper payment of interest, (2) proper use of provider fee schedules for non-contracted providers, (3) applying appropriate contract benefits and (4) ensuring all services submitted have been processed to the correct provider and for the patient billed on the claim. All four criteria must be met for a claim to be considered compliant in payment accuracy.
Payment Accuracy (cont’d.)

Medicare Advantage/Group Medicare Advantage Provider Dispute Resolution (PDR)

Payment accuracy includes: (1) proper payment of interest, (2) proper use of provider fee schedules for non-contracted providers, (3) applying appropriate contract benefits and (4) ensuring all services submitted have been processed to the correct provider and for the patient billed on the claim. All four criteria must be met for a claim to be considered compliant in payment accuracy.

Rescinding Authorization-AB 1324

Commercial

Blue Shield validates that delegated hospitals 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. The delegated hospital may then bill Blue Shield under the eligibility guarantee clause within their contract with Blue Shield.

Commercial Provider Dispute Resolution (PDR)

Blue Shield validates that delegated hospitals 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. The delegated hospital may then bill Blue Shield under the eligibility guarantee clause within their contract with Blue Shield.

Group Medicare Advantage

Not applicable.

Medicare Advantage

Not applicable.

Medicare Advantage/Group Medicare Advantage Provider Dispute Resolution (PDR)

Not applicable.

Unaffiliated/Non-Contracted Provider

Commercial

A provider with whom the plan and/or its delegated claim operations 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). Delegated claims operations may not utilize Blue Shield reciprocity and/or PPO rates without the written consent of the health plan. Commercial non-contracted claims must be adjudicated within 45 working days of the received date to be considered compliant.
Measuring Timeliness and Definitions (cont’d.)

**Unaffiliated/Non-Contracted Provider (cont’d.)**

**Commercial Provider Dispute Resolution (PDR)**

A provider with whom the plan and/or its delegated claim operations 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). Delegated claims operations may not utilize Blue Shield reciprocity and/or PPO rates without the written consent of the health plan. Commercial non-contracted claims must be adjudicated within 45 working days of the received date to be considered compliant.

**Group Medicare Advantage**

A provider with whom the plan and/or its delegated claim operations 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**

A provider with whom the plan and/or its delegated claim operations 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/Group Medicare Advantage Provider Dispute Resolution (PDR)**

A provider with whom the plan and/or its delegated claim operations 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.

**Unclean Claim/Contested Claims**

**Commercial**

A contested claim is defined as a claim or portion thereof is reasonably contested where the delegated claims operation has not received the completed claim and all information necessary to determine payor liability or has not been granted reasonable access to information concerning provider services. Commercial contested claims must be adjudicated within 45 working days of the received date to be considered compliant.

When appropriate, claims may need to be contested for additional information. For example: (1) validate referring physician, (2) confirming member self-referred, (3) validating the member signed a member financial liability form, (4) eligibility verification, and (5) medical records/chart notes.

Contested claims include provider denials and claims pended or closed before a coverage determination can be made. Upon receipt of additional information a new 45 working day cycle begins.
Measuring Timeliness and Definitions (cont’d.)

Unclean Claim/Contested Claims (cont’d.)

Commercial Provider Dispute Resolution (PDR)

A written provider dispute that does not include all information required under state regulations:

(1) Clear identification of the disputed item(s).

(2) The date of service(s)

(3) Clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment, or other action is incorrect.

Commercial disputes must be adjudicated within 45 working days of the received date to be considered compliant.

Group Medicare Advantage

An unclean claim is defined as “one which cannot be paid as soon as it is received, because it is incomplete; missing complete coding, itemization, dates of service, billed amounts, and provider tax identification number.” A non-contracted/unaffiliated provider unclean claim must be adjudicated within 60 calendar days from the earliest date received to be considered compliant.

Medicare Advantage

An unclean claim is defined as “one which cannot be paid as soon as it is received, because it is incomplete; missing complete coding, itemization, dates of service, billed amounts, and provider tax identification number.” A non-contracted/unaffiliated provider unclean claim must be adjudicated within 60 calendar days from the earliest date received to be considered compliant.

Medicare Advantage/Group Medicare Advantage Provider Dispute Resolution (PDR)

An unclean dispute is defined as “one which cannot be resolved as soon as it is received, because it is incomplete; missing member information, dates of service, and the specific reasons that the original claim may have been under paid. An unclean dispute must be resolved within the original 30 calendar days regardless of whether the dispute is unclean. A non-contracted/unaffiliated provider dispute must be adjudicated within 30 calendar days from the earliest date received to be considered compliant.
Best Practices and Claims Adjudication

In this section as well as prior sections, the terms “our” or “your” refer both to health plans and to the delegated hospital. Best practices are recommended for everyone involved in claims processing. When the word “must” is used, Blue Shield regards the standard as the minimum acceptable standard.

Audits and Audit Preparation

Blue Shield, 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 the audit, Blue Shield will send a written confirmation letter including the audit date and describing the materials the delegated hospital will need to prepare and steps that will need to be performed in preparation of the audit. Such preparations include producing claims universe lists, providing detailed information about your claims processing operations and company controls in the industry-standard questionnaire, selecting and retrieving claims, checks, and/or related documents. Without complete sets of sampled claims, related documentation, and photocopies of documents that will be retained the audit will be impeded or incomplete. If the audit is impeded or incomplete the samples may be scored as non-compliant. Electronic submission of all data is highly encouraged.

Blue Shield will concentrate on quantified timeliness and accuracy for data-capturing and processing paid and denied claims. Blue Shield will tour the claims department and check-handling operations, view all claims handling and storage areas, interview selected staff personnel, and view selected functions and records on the claims computer system. Blue Shield will review the documentation of the monthly/quarterly self-reports and the self-monitoring processes.

Blue Shield will share audit results at the conclusion of the audit, unless some elements require additional research for us to complete our work. In the event further research is warranted Blue Shield will make every effort to contact the delegated hospital to discuss all additional findings prior to distributing final results. Blue Shield will provide the delegated hospital with written results within 30 calendar days including an itemization of any deficiencies and whether the delegated hospital must prepare and implement a formal, written corrective action plan or provide additional supporting documentation.

Non-Compliance

When Blue Shield first finds non-compliance or other deficiencies in your operations, Blue Shield will require that you implement corrective actions within a specific time limit, within 30 days after the receipt of the post audit results. Non-compliance that is not remedied may be subject to administrative actions.

Special Studies

In the event CMS or the DMHC require that Blue Shield conduct any special compliance study or effort, Blue Shield may request the delegated hospital support in the study. Such studies would be subject to any regulator-specified time schedules or deadlines.
Balance Billing

Commercial

If a member is billed for a capitated service, a representative from Blue Shield’s Member Services Department will contact the hospital to verify that the provider was paid for the service. The hospital is also required to ensure that the provider ceases billing the member.

California state law prohibits balance billing by contracted providers and non-contracted providers rendering emergent care.

The California Code of Regulations identifies in 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.

The California Code of Regulations identifies this practice as an Unfair Billing Pattern in § 1300.71.39:

Except for services subject to the requirements of Section 1367.11 of the Act, “unfair billing pattern” includes the practice, by a provider of emergency services, including but not limited to hospitals and hospital-based physicians such as radiologists, pathologists, anesthesiologists, and on-call specialists, of billing an enrollee of a health care service plan for amounts owed to the provider by the health care service plan or its capitated provider for the provision of emergency services.

Delegated hospitals no longer have to pay the balance when advised that a non-contracted provider of emergency services is balance billing a member. Delegated hospitals have the right and the obligation to immediately notify the provider in writing that their balance billing of the member is a violation of state law and must stop immediately. Any accounts turned over for collections and/or adverse credit reports filed must be withdrawn. If the provider does not do so immediately, the delegated hospital must notify the provider in writing with a copy to the member to cease and desist. The written notification to the provider must include the provider’s appeal rights including the right to appeal directly to the health plan. If the provider continues to balance bill the member, the hospital 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. The non-contracted provider may appeal to the health plan directly should they disagree with the payment from the delegated hospital.

AB 72 establishes a payment rate and an independent dispute resolution process (IDRP) for claims and claims disputes related to non-emergency covered services provided at a contracted health facility by a non-contracting individual health care professional for health plan contracts and health policies issued, amended, or renewed on or after July 1, 2017. AB 72 also limits the enrollee and insured’s cost sharing for these non-voluntary covered services to no more than the cost sharing required had the services been provided by a contracting health professional and requires the payment made by the health plan or insurer in addition to the applicable cost sharing owed by the enrollee or insured to be payment in full for services rendered unless either party uses the independent dispute resolution process (IDRP).
Balancing Billing (cont’d.)

Claims Compliance includes within the audit process validation that the member be held harmless for any portion of the bill other than applicable copayments and deductibles. For contracted providers of all services, non-contracted providers of emergency services, or non-contracted providers of non-emergency services covered under AB 72 threatening to balance bill the member, the hospital must re-educate the provider and ensure the member is not balance billed. Those providers who refuse to cooperate and continue to balance bill the member should be reported to the health plan directly with documentation of communication with the provider.

If the hospital fails to meet required timeframes for payment and Blue Shield determines that the claim is payable by the hospital, 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.

Section §1371.8 of the Health & Safety Code and §796.04 of the Insurance Code state that an authorization must be honored and payment must be made even if the carrier later determines the enrollee isn’t eligible, regardless of the reason. Note: These codes are applicable to Commercial HMO members only.

Existing law has been expanded to apply only when:

- The plan has authorized a specific type of treatment
- The provider rendered the service in good-faith reliance on the authorization

Note: Within 5 days before the actual date of service, the provider MUST confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Blue Shield validates that delegated administrators pay incurred services if the specific service was pre-authorized, 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. The delegated administrator may then bill Blue Shield under the eligibility guarantee clause within their contract with Blue Shield.

The hospital is encouraged to use the following letter template for illegal balance billing to communicate with the non-contracted provider of emergency services:
WARNING RE: ILLEGAL BALANCE BILLING

[Physician Name]
[Address]

DEAR [Physician’s name]:

[Name of delegated IPA/medical group] has been advised that you have billed this patient/our enrollee for the emergency services referenced above for amounts other than the copayments, coinsurance or deductible owed by them as noted on our Explanation of Benefits. This balance billing by you is in violation of California law and must cease immediately.

The patient is an enrollee in a health plan regulated under the Knox-Keene Act. As such, balance billing is specifically prohibited as follows:

- Regulations issued by the Department of Managed Health Care (DMHC) deem this balance billing to be an unfair billing practice. See, Title 28 California Code of Regulations § 1300.71.39; and,

- The California Supreme Court has ruled that a provider of emergency services cannot balance bill an enrollee in a Knox-Keene plan. See, Prospect Medical Group v. Northridge Emergency Medical Group (2009) 45 Cal. 4th 497.

Accordingly, your balance billing of this member is a violation of state law and must stop immediately. If the account has been turned over for collections and/or there have been any adverse credit reports filed, those must be withdrawn immediately. If you do not do so immediately, we will report this illegal activity to Blue Shield of California who will in turn report this illegal activity to the DMHC for further action by the state.

If you disagree with this determination you have the right to submit an appeal to [Name of delegated IPA]. If you then disagree with the determination of the appeal submitted to [Name of delegated IPA] you may submit an appeal to Blue Shield of California directly. If you have questions about this letter or about how to initiate an appeal to review the payment made, please contact us at: [(xxx) xxx-xxxx].

[Signature]

[Name]

cc: [Patient/Enrollee]

Notice to enrollee – Please contact us immediately at [(xxx) xxx-xxxx] if this physician continues to bill you for any amounts other than the specified copayments or deductibles found in Blue Shield of California’s evidence of coverage (EOC).
Best Practices and Claims Adjudication (cont’d.)

Balance Billing (cont’d.)

Medicare Advantage and Group Medicare Advantage

Chapter 4 of the Medicare Managed Care Manual, Benefits and Beneficiary Protections, Section 10.21 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 MAO up to the original Medicare rate (115% of the participating rate).

- Non-contracted non-participating DME suppliers can balance bill the MAO the difference between the member’s cost sharing and the DME supplier’s bill.
Best Practices and Claims Adjudication (cont’d.)

Check Mailing

By law, the date of payment is the date that the check was electronically transmitted or deposited in the U.S. Mail. Blue Shield validates the check date as well as the date the payment was mailed. No more than one or two calendar days may elapse between the date printed on the check and the date the check is mailed. The one- or two- calendar day delay must be added into the claims turnaround time calculation. Blue Shield will use the check mailed date as the closure of the claims turnaround time. Blue Shield recommends the delegated hospital conduct detailed, quality assurance (QA) reviews by report, through prospective EOB/RA (explanation of benefits/remittance advice) review, or make such reviews retrospective or confine them to checks with large dollar amounts. The delegated hospital must eliminate delays in routing and check signing, and make the time period from check printing to mailing reliable and consistent. The delegated hospital must report the number of extra days it takes the delegated hospital to mail a check after the check has been printed for health plan, CMS, or the DMHC audits. Documentation must be retained to validate the mailed date. The check mailing delay must be included within the delegated hospital’s check run policy and procedure to keep all parties informed and avoid any appearance of improprieties.

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.

Contract Auditing

Federal Code of Regulations requires that specified provisions be present in all first tier and downstream contracts and/or agreements. Blue Shield 65 Plus HMO has the responsibility to ensure that delegated providers with hospital-risk comply with the CMS requirements. Specifications of the requirements are found in the provisions of the Medicare Modernization Act, the CMS Manuals (specifically chapter 11) and the provisions in the Medicare Improvements for Patients and Providers Act of 2007 (MIPPA).

Date Stamping

Health plans and delegated claim operations must date stamp all claims including facsimiles with the date the claim was received. The stamp should identify the specific delegated hospital. Blue Shield recommends that each page of the claim including any attachments be date stamped. Federal procedures suggest that claims received from the US Postal Service after 4:30 in the afternoon 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 claim office, the time of pickup is what determines the date of receipt. The earliest received date by any Blue Shield 65 Plus network provider must be utilized for Medicare Advantage and Group Medicare Advantage claims.

Delegated Claims Compliance and Self Reporting

Contact Delegated Claims Oversight at (818) 228-6092, fax (855) 895-3505, or Blue Shield of California, Delegated Claims Oversight, 6300 Canoga Ave, 9th Floor, Woodland Hills, CA 91367.
Best Practices and Claims Adjudication (cont’d.)

Denial Review – Second Level

All denial notices should be subject to supervisor, examiner-specialist or manager review prior to release for mailing of the denial notice to ensure accuracy.

Denials - Retrospective/Concurrent Submission

Commercial

Blue Shield will advise the delegated hospital in writing if the denial notices and relevant documentation are required for retrospective or concurrent review. Retrospective review is initiated after the delegated hospital fails three consecutive denial audits in the same category (acknowledgement, accuracy and/or turnaround time). The delegated hospital remains on retrospective review until three consecutive monthly audits are compliant. Retrospective denial documentation is due based on a mutual agreement to Blue Shield with collective results issued monthly. In the event substantial progress is not noted and/or if the delegated hospital does not sustain compliance thereafter, denials will be escalated to concurrent review. Denials and all documentation to support the decision to deny must be emailed to your Delegated Claims Oversight auditor or faxed to Blue Shield daily for review. Blue Shield will complete the review within two business days and email or fax an approval to mail the notice, provide instructions to correct the denial notice, or overturn and require the delegated hospital to pay the claim. Collective results will be issued monthly for concurrent denial review as well. Otherwise, there is no ongoing requirement that the delegated hospital submit claim denials for review. The delegated hospital will need to revise their procedures, perform staff training, and conduct self-audits in response to the feedback received as a result of retrospective or concurrent claim review.

Please note that service denials of member requests for services (i.e., prior authorizations) are entirely separate, and instructions are provided elsewhere in this manual.

Medicare Advantage and Group Medicare Advantage

Blue Shield will advise the delegated hospital in writing if the denial notices and relevant documentation are required for retrospective or prospective review. Retrospective review is initiated after the delegated hospital fails three consecutive denial audits in the same category (accuracy and/or turnaround time). The delegated hospital remains on retrospective review until three consecutive monthly audits are compliant. Retrospective denial documentation is due based on a mutual agreement to Blue Shield with collective results issued monthly. In the event substantial progress is not noted and/or if the delegated hospital does not sustain compliance thereafter, denials will be placed on concurrent review. Denials and all documentation to support the decision to deny must be emailed to your Delegated Claims Oversight auditor or faxed to Blue Shield daily for review. Blue Shield will complete the review within two business days and email or fax an approval to mail the notice, provide instructions to correct the denial notice, or overturn and require the delegated hospital to pay the claim. Collective results will be issued monthly for concurrent denial review as well. Otherwise, there is no ongoing requirement that the delegated hospital submit claim denials for review. The delegated hospital will need to revise their procedures, perform staff training, and conduct self-audits in response to the feedback received as a result of retrospective or concurrent claim review.

Please note that service denials of member requests for services (i.e., prior authorizations) are entirely separate, and instructions are provided elsewhere in this manual.
Best Practices and Claims Adjudication (cont’d.)

Forwarding Claims

Billing providers often submit claims and disputes to the incorrect payor. Blue Shield requires the delegated hospital to forward these claims and disputes directly to the financially responsible entity.

Commercial

Regulations require the delegated hospital to forward misdirected claims to the responsible payor within ten (10) working days of receipt. Health plans are required to forward misdirected claims to the responsible payor within ten (10) working days of receipt for non-contracted providers and all claims for emergent services. For providers contracted with the delegated hospital, the health plan may deny to the provider instructing them to submit their bill to the appropriate payor.

Blue Shield recommends the delegated hospital affix a “forwarded” date stamp with their name on it to provide accurate information about the delegated hospital’s performance to their own quality assurance staff and those to whom they forward claims. Blue Shield requires the delegated hospital to “forward” misdirected provider disputes to the responsible payor within ten (10) working days of receipt.

Blue Shield’s claims operations have implemented a program to forward claims within compliance. When Blue Shield receives claims that are the delegated hospital’s financial risk with requests for Blue Shield to process them, Blue Shield will forward the claims in an EDI 837 format or a paper format facsimile to the delegated hospital or otherwise give the delegated hospital an opportunity to process them with notification back to Blue Shield. If time is critical, Blue Shield may need to pay the claim and alert the delegated hospital to any deductions from the delegated hospital capitation payment after the fact.

Periodic audits may be randomly conducted to ensure that claims misdirected to the health plan and forwarded to the delegated hospital have been resolved by the IPA/medical group in a timely and accurate manner.

Medicare Advantage and Group Medicare Advantage

The claim processing cycle begins with the received date of the forwarding entity (earliest received date). Health plans should forward claims within eight calendar days of initial receipt and the delegated hospital should forward within ten calendar days of receipt.

If the delegated hospital is receiving a significant number of claims that are forwarded late by any entity and the volume of those late claims is enough to impair the delegated hospital’s timeliness performance, Blue Shield 65 Plus HMO will work with the entity forwarding the late claims. Documentation should be sent to your Delegated Claims Oversight Auditor for support.

Medicare Advantage and Group Medicare Advantage Provider Disputes

The dispute processing cycle begins with the received date of the forwarding entity (earliest received date). Health plans should forward disputes within eight calendar days of initial receipt and the delegated hospital should forward within ten calendar days of receipt.

If the delegated hospital is receiving a significant number of disputes that are forwarded late by any entity and the volume of those late claims is enough to impair the IPA/medical group’s timeliness performance, Blue Shield 65 Plus HMO will work with the entity forwarding the late disputes. Documentation should be sent to your Delegated Claims Oversight Auditor for support.
Best Practices and Claims Adjudication (cont’d.)

Fraud, Waste, and Abuse

The Centers for Medicare & Medicaid (CMS) requires that MAO’s have a compliance plan that guards against potential fraud, waste, and abuse. 42 C.F.R. § 422.503(b)(4)(vi) and 42 C.F.R. § 423.504 (b)(4)(vi) became effective on January 1, 2009 through ARRA. The compliance program must include continual education, monitoring and annual training completed by December 31st of each year.

CMS defines Medicare Fraud and Abuse in the following ways:

Fraud
The intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s).

Abuse
A range of the following improper behaviors or billing practices including, but not limited to:

- Billing for a non-covered service;
- Misusing codes on the claim (i.e., the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered); or
- Inappropriate allocating costs on a cost report.

Fraud and Abuse

- Fraud: To purposely bill for services that were never given or to bill for a service that has a higher reimbursement than the service produced.
- Abuse: Payment for items or services that are billed by mistake by providers, but should not be paid for by Medicare. This is not the same as fraud.
Best Practices and Claims Adjudication (cont’d.)

Fraud, Waste, and Abuse (cont’d.)

Each delegated hospital must have a comprehensive Compliance Plan that should include measures to detect, correct, and prevent fraud, waste, and abuse including but not limited to the following key components.

Key components should include but are not limited to:

1. Written policies, procedures, and standards of conduct articulating the organization’s commitment to comply with all applicable Federal and State Standards.
2. The designation of a compliance officer and compliance committee accountable to senior management.
3. The procedures that will be taken to report the suspected fraud to the MAO.
4. Effective training and education between the compliance officer and the employees, managers, directors, and the downstream and related entities.
5. Effective lines of communication between the compliance officer, members of the compliance committee, the employees, managers and directors, and the downstream and related entities.
7. Procedures for effective internal monitoring and auditing.
8. Procedures for ensuring prompt responses to detected offenses and development of corrective action initiatives relating to the organization’s contract.
9. Respond to and initiate corrective action to prevent similar offenses including a timely responsible inquiry.
10. Conduct timely and reasonable inquiries.
11. Conduct appropriate corrective actions in response to the potential violation.
12. Include procedures to voluntarily self report potential fraud or misconduct to the health plan and or CMS.
13. Development and implementation of regular, effective education, and training that occurs annually.
14. Retain records of the annual training of employees, including attendance logs and material distributed at training sessions.
15. Policies to consistently enforce standards and addresses dealing with individuals or entities that are excluded from participating in CMS programs.
16. Include a system to receive, record, and responds to compliance questions, or reports of potential or actual non-compliance, while maintaining confidentiality. The delegated entity will report compliance concerns and suspected or actual misconduct without retaliation when reporting in good faith involving the MA or Group MA (GMA) to the MAO.
17. Policy shall allow any state, federal government or CMS to conduct on-site audits.
18. Performance of data analysis of procedures codes, diagnostic codes, utilization, quantity, etc., to detect fraud.
Best Practices and Claims Adjudication (cont’d.)

Fraud, Waste, and Abuse (cont’d.)

19. Ensure program includes the monitoring of claims for accuracy which includes ensuring coding reflects services provided.

20. Be able to produce proof to show compliance with all requirements.

21. Check the Office of Inspector General (OIG) and the General Services Administration (GSA) exclusion lists for all new employees and on a regular basis or at least once a year thereafter to validate that employees and other entities that assist in the administration or delivery of services are not included on such lists.

22. Check the Office of Inspector General (OIG) and the General Services Administration (GSA) exclusion lists for all providers on a regular basis to validate that the providers that assist in the administration or delivery of services are not included on such lists.

Reporting

Please use one of the following ways to report fraud, waste, and abuse to Blue Shield 65 Plus HMO:

- Call the Blue Shield 24-hour Anti-Fraud Hotline at (800) 221-2367. This hotline is managed by Blue Shield’s Special Investigations Unit.
- Send an email to MedicareStopFraud@blueshieldca.com.

CMS mandates that each health plan and its delegated hospital have a Fraud, Waste, and Abuse program in place and further mandates that all employees are required to take the training, at a minimum, annually. To ensure Blue Shield 65 Pus is meeting all CMS requirements, Delegated Claims Oversight will include in their annual claims oversight, the review of each delegated hospital’s Compliance Program, including a Fraud, Waste, and Abuse program and assurance that all employees have taken the Blue Shield Compliance Program training.
Best Practices and Claims Adjudication (cont’d.)

Inpatient Non-Authorized Services

Prior to denying emergent out-of-network ancillary professional inpatient services for lack of authorization, the delegated hospital must contact Blue Shield to confirm that the health plan did not authorize the emergent inpatient stay. If services were authorized as medically necessary by Blue Shield, the ancillary professional inpatient services must be paid by the delegated hospital. If the inpatient stay was not authorized by Blue Shield and/or the delegated hospital, only then may the delegated hospital deny the ancillary services to the member as not authorized.

Offshore Monitoring

The Centers for Medicare & Medicaid Services (CMS) require all Managed Care Organizations to be “contractors,” for the purposes of delivering Medicare Part C benefits, responsible for safeguarding personal health information (PHI). “Subcontractor” refers to any organization that a sponsor contracts with to fulfill, or help fulfill, requirements in their Part C reporting. Subcontractors include all first tier, downstream, and/or related entities. 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 65 Plus HMO requires all delegated provider organizations to submit an annual attestation.
Best Practices and Claims Adjudication (cont’d.)

Provider Dispute Resolution (PDR) Process – Medicare Advantage

Contracted

Contracted providers have the right to file an appeal related to any initial claim decision by filing a request for redetermination. Medicare Advantage Appeals (for Individual or Group Medicare Advantage members) must be submitted to:

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

Required Information/Appeal

An appeal must be submitted in writing and contain the following information:

- The provider’s name
- The National Provider Identifier (NPI) and/or the provider's tax or social security number.
- Contact information – mailing address and phone number
- Blue Shield’s Internal Control Number (ICN)/Claim Number, when applicable
- The patient’s name
- The patient’s Blue Shield subscriber number
- The date of service
- A clear explanation of issue the provider believes to be incorrect including supporting medical records, when applicable.
- Proof of participation in the IPA’s provider appeal process and when the original determination was made by the IPA (such as a copy of the IPA Appeal denial letter and/or denial letter EOB).
Best Practices and Claims Adjudication (cont’d.)

Provider Dispute Resolution (PDR) Process – Medicare Advantage (cont’d.)

Timeframe for Submitting Appeal

Initial appeals must be submitted within 365 days, or the time specified in the provider's contract, whichever is greater, of Blue Shield's date of contest, denial, notice or payment.

If a contracted provider or capitated entity fails to submit an initial appeal within the required timeframes, the provider or capitated entity:

- Waives the right for any remedies to pursue the matter further
- May not initiate a demand for arbitration or other legal action against Blue Shield
- May not pursue additional payment from the member

In instances where the provider’s contract specifies timeframes that are greater than the timeframes stipulated in Blue Shield's Provider Appeal Resolution process, the provider’s contract takes precedence.

Blue Shield will review the untimely submission of a provider appeal when the provider’s contract includes a good cause clause for the untimely submissions of provider appeals.

Resolution

Blue Shield will, within 60 days of receipt of the provider request for redetermination, review the appeal and respond to the physician or provider using the Provider Appeal Resolution letter or Remittance advice with either additional payment or an explanation for upholding the original claim determination.

The delegated hospital must have a process in place to handle all contracted provider requests for redetermination, resolving them in a timely manner, and in accordance with contractual agreements following CMS regulations.
Best Practices and Claims Adjudication (cont’d.)

Provider Dispute Resolution (PDR) Process – Medicare Advantage (cont’d.)

Non-Contracted

CMS requires Medicare Advantage Organizations (MAO) to apply the provider dispute resolution process for payment disputes between non-contracted and deemed providers. Non-contracted and deemed providers are defined as follows:

- A non-contracted provider is one that was not aware the patient was a private fee-for-service member at the time of service, e.g., an emergency situation.
- A deemed provider is one who was aware that the patient was a private fee-for-service member at the time of service, and therefore had the ability to view the plan’s terms and conditions of payment.

Note: The provider dispute resolution process for payment disputes between non-contracted and deemed providers does not include Part D claims.

Provider disputes 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 125 days from the initial determination date.

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.

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 14 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 dispute within 30 calendar days of the receipt of the dispute. 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 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.
Best Practices and Claims Adjudication (cont’d.)

Provider Dispute Resolution (PDR) Process – Medicare Advantage (cont’d.)

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

Self-Monitoring and Reporting

Health plans and the delegated hospital are responsible for paying or denying all claims received. In this section, claims are viewed based on who may be processing them and where that may occur. Whether a delegated hospital has permanent or temporary arrangements in place to process claims, every “reportable” claim must be included in the applicable reports and compliance must be monitored. This reporting and monitoring may involve multiple sites, multiple computer systems, and multiple organizations. Health plans and their delegated claim organization must continually report and audit claims for each and every one of these arrangements. That reporting must be consistent and comprehensive, whether reports are provided for senior management internally, or to external organizations that contract or license with Blue Shield.
Best Practices and Claims Adjudication (cont’d.)

Self-Monitoring and Reporting (cont’d.)

Self-Monitoring

Blue Shield is required to monitor the delegated hospital’s compliance. Establishing a quality assurance program is a best practice and will enable the delegated hospital to ensure compliance. Such a process would include:

1. Regularly scheduled automated or manual reports – Blue Shield recommends weekly internal reports;
2. Self-testing procedures to check timeliness and accuracy weekly or after each check run to allow for problems to be corrected before an entire month’s performance is below compliance. The delegated hospital should include some statistical testing of the staff’s adjudication accuracy and productivity that the health plans monitor, such as payment accuracy, incidence of payment, accuracy of data entry, etc.;
3. Regular internal reporting of results to your executive management;
4. Self-initiated corrective actions; and
5. Application of available standardized industry monitoring/audit and reference tools as issued by CMS or ICE in order to measure actual performance in a similar manner as the health plans.

Claims Reports

Monthly self-reports must be submitted on the ICE industry-standard formats. Report template forms and detailed instructions can be found on the ICE website at iceforhealth.org.

Commercial

The most current monthly and quarterly timeliness reports are available on the ICE website. 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 being reported. These include claims processed during the calendar quarter being reported regardless of date of service.

The reports are a validation of compliance for the delegated hospital and an extension of the delegated hospital’s self-monitoring. The delegated hospital should retain supporting documentation for each self-report as consistent with records retention time limitations. Blue Shield is expected to examine source reports, claim computer records or backup information on manual adjustments the delegated claims organization may make to determine the accuracy of their self-reports. Copies of the supporting documentation may be requested and retained by Blue Shield for any non-compliant delegated hospital.
Claims Compliance and Monitoring

Best Practices and Claims Adjudication (cont’d.)

Self-Monitoring and Reporting (cont’d.)

Claims Reports (cont’d.)

Commercial Provider Dispute Resolution (PDR) Reports

These are submitted quarterly and are due by the end of the first calendar month following the calendar quarter being reported. They include disputes over billing, claims, contracts, utilization management, and other provider appeals.

The reports are a validation of compliance for the delegated hospital and an extension of the delegated hospital’s self-monitoring. The delegated hospital should retain supporting documentation for each self-report as consistent with records retention time limitations. Blue Shield is expected to examine source reports, claim computer records or backup information on manual adjustments the delegated claims organization may make to determine the accuracy of their self-reports. Copies of the supporting documentation may be requested and retained by Blue Shield for any non-compliant delegated hospital.

Medicare Advantage

The Medicare Advantage report format was amended by ICE. The most current monthly and quarterly timeliness reports are available on the ICE website at iceforhealth.org. 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 being reported. These include claims processed during the calendar quarter being reported regardless of date of service.

The reports include sections for reporting reopenings, dismissals, and claims source data. These sections require specific formatting that is indicated in the instructions on each tab located at the bottom of the monthly claims timeliness report.

The reports are a validation of compliance for the delegated hospital and an extension of the delegated hospital’s self-monitoring. The delegated hospital should retain supporting documentation for each self-report as consistent with records retention time limitations. Blue Shield is expected to examine source reports, claim computer records or backup information on manual adjustments the delegated claims organization may make to determine the accuracy of their self-reports. Copies of the supporting documentation may be requested and retained by Blue Shield for any non-compliant delegated hospital.

Group Medicare Advantage

The report format utilized for the Medicare Advantage self reports is utilized for Group Medicare Advantage. See Medicare Advantage above.
Best Practices and Claims Adjudication (cont’d.)

Self-Monitoring and Reporting (cont’d.)

Claims Reports (cont’d.)

**Medicare Advantage and Group Medicare Advantage Provider Dispute Resolution (PDR)**

Provider dispute resolution self-reports are required for Medicare Advantage and Group Medicare Advantage on a quarterly basis and due by the end of the first calendar month following the calendar quarter being reported.

The reports are a validation of compliance for the hospital and an extension of the hospital’s self-monitoring. The hospital should retain supporting documentation for each self-report as consistent with records retention time limitations. Blue Shield is expected to examine source reports, claim computer records or backup information on manual adjustments the delegated claims organization may make to determine the accuracy of their self-reports. Copies of the supporting documentation may be requested and retained by Blue Shield for any non-compliant hospital.
Best Practices and Claims Adjudication (cont’d.)

Sub-Capitated (Sub-Delegated) Claims Monitoring

When the delegated hospital engages a third party administrator (TPA) or contracts with a management company to perform their claims processing. The delegated hospital’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.

If the delegated hospital sub-capitates their claims processing, no matter the extent, the delegated hospital is required to report to Blue Shield and monitor all sub-capitated claims that are reportable by the health plans to the regulators – CMS and the DMHC. The reference to claims is to any and all of the same types of claims and denials described throughout this supplement. The reference to sub-capitation of claims processing includes delegation of claims processing that confers, under capitation, the right to pay or deny fee-for-service claims, which would result in liability for our beneficiaries. Such claims are not those that are purely “encounter-only” claims such as may be “reported” outside of this monitoring program for purposes of stop loss, shared risk or HEDIS reporting. As a consequence of sub-capitating claims processing, the delegated hospital would have to engage or employ staff with claims processing and compliance expertise.

If the delegated hospital sub-delegates claims processing, the delegated hospital are expected to require the delegated claims organizations to meet all the criteria discussed in this supplement. These same criteria should be specified in the delegated hospital’s contract with Blue Shield and in the contract the delegated hospital executes with any sub-capitated organization. The delegated hospital must perform the same tasks Blue Shield carries out as the health plan, including obtaining timely monthly reporting from them, and include their statistics in the delegated hospital reports to Blue Shield. If the delegated hospital sub-capitates to several or many organizations at multiple sites, the delegated hospital must list monthly statistics for each of those sites separately on their monthly report to Blue Shield. The delegated hospital must audit the sub-capitated organization periodically and require corrective action plan implementation when their performance results are not compliant. If the sub-capitated organization fails to achieve compliance over three or more consecutive monthly or quarterly audits, the delegated hospital needs to take the appropriate actions to achieve compliance. When Blue Shield audits the delegated hospital, the universal listing must include all sub-capitated entities’ claims.

The delegated hospital must include claims-related contractual provisions in contract agreements with other provider organizations. Those provisions must be identical to all such provisions in the contract with Blue Shield regarding meeting all regulatory requirements.
Timely Filing

Commercial

AB 1455, implemented in 2004, provides timely filing limitations for commercial claims depending on the provider’s status.

- Contracted – A deadline of less than ninety (90) days after the date of service may not be imposed.
- Non-contracted - A deadline of less than one hundred eighty (180) days after the date of service may not be imposed

Medicare Advantage and Group Medicare Advantage

The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. This Act amended the time period for filing Medicare fee-for-service (FFS) claims as one of many provisions aimed at curbing fraud, waste, and abuse in the Medicare program. The new timeframes for filing Medicare FFS claims are as follows:

- Claims with dates of services prior to October 1, 2009 will be subject to pre-PPACA timely filing rules;
- Claims with dates of services October 1, 2009 through December 31, 2009 and received after December 31, 2010 will be denied as being past the timely filing deadline and;
- Claims with dates of service January 1, 2010 and later received more than one calendar year beyond the date of service will be denied as being past the timely filing deadline.

Medicare Advantage and Group Medicare Advantage Provider Dispute Resolution (PDR)

The submission of a first level provider dispute must be filed within a minimum of 120 calendar days after the notice of initial determination (i.e., explanation of benefits, remittance advice, and/or letters). Additional filing requirements are as follows:

- The payor may allow an additional 5 calendar days for mail delivery
- The payor may extend the time limit for filing a provider dispute if good cause is shown

Unclean or Contested Claims (Affiliated or Unaffiliated Providers)

Commercial

For commercial claims (including provider disputes), the delegated hospital may contest incomplete claims that are missing information. The claim may either be pended and/or contested to the provider and may include a statement that it will receive no further attention if no reply is received. Contested claims are not to be reported as member-denials. The contested or pended claims must be closed prior to the 45th working day. No denial notice should be sent to a commercial member when “closing” a claim pending receipt of additional information.
Best Practices and Claims Adjudication (cont’d.)

Unclean or Contested Claims (Affiliated or Unaffiliated Providers) (cont’d.)

Medicare Advantage and Group Medicare Advantage

For Medicare Advantage and Group Medicare Advantage claims, ICE recommends two separate attempts be made to obtain missing information, allowing sufficient time for the provider to respond to each request and indicating the claim may be denied if no reply is received. When fewer than 6 to 10 calendar days remain in the 60-day deadline, make an initial determination to pay or deny the claim based on the information available. A denial notice may be issued as the delegated hospital’s original correspondence to close an unclean Medicare Advantage and Group Medicare Advantage claim without development; however, best practice is to develop the claim for the missing information prior to issuing a denial. Health plans, delegated hospitals, as a best practice, are expected to make a reasonable attempt to acquire necessary information before paying or denying a Medicare Advantage and Group Medicare Advantage claim.

Utilization Management Review

To obtain timely review and prioritization of “claims in jeopardy of being late” that require medical review, work with the delegated hospital’s Utilization Management review department. To facilitate this review, instruct examiners to use available, standardized industry monitoring and reference tools as issued by CMS or ICE to evaluate out-of-plan urgent and emergent claims’ with presenting diagnosis codes that usually do not require medical review prior to payment. Utilization Management reviews retrospectively will allow the delegated hospital to monitor accurate decision-making by claims staff without reducing the timeliness of the delegated hospital’s processing cycle.
Frequently Asked Questions

Frequently asked questions regarding CMS or DMHC requirements and claims adjudication are answered below.

When is a claim considered paid?

A claim is only considered paid once the check has been mailed or electronically transmitted. Claims adjudicated, but waiting for a multiple-check run, the issuance of a single check, or the mailing of the check, are not considered paid until the check is actually mailed.

Are subcontracted providers considered “affiliated” providers for reporting purposes regarding their Medicare Advantage claims as 60-day claims?

Yes. Any provider that has a signed contract in place agrees to acceptance of a negotiated rate and therefore should be reported within the 60-day claims category. The provider may only collect applicable copayments, coinsurance and/or non-covered services.

Are providers who accept a one-time letter of agreement (LOA) or memorandum of understanding (MOU) considered “affiliated” providers for reporting purposes?

Yes. Any provider that has a signed agreement in place agrees to acceptance of a negotiated rate and therefore should be reporting within the 60-day category. The provider may only collect applicable copayments, coinsurance and/or non-covered services.

If a claim is received without some information filled in or attached and that information can be obtained “in-network” at the HMO or IPA/medical group claims operation, can the claim be pended?

Commercial

It is acceptable to place a suspension status code, often called “pend” codes, in your claims computer system while you retrieve internal information. However, the claim may also be denied to the provider of service only requesting the missing information, which is termed contesting the claim.

Medicare Advantage and Group Medicare Advantage

It is acceptable to place a suspension status code, often called “pend” code, in your claims computer system while retrieving missing information. If the information is available internally, the claim is not considered “unclean.” CMS requires development of an “unclean” claim.

What happens if a group is found to be non-compliant with Claims Regulations?

Blue Shield grants a specific time period during which corrective actions must be implemented. If several attempts at correcting problems are unsuccessful, administrative actions may be applied to the delegated hospital’s claims operation.
Frequently Asked Questions (cont’d.)

Under 1371.8 in the California Health and Safety Code, is a referral the same as an authorization?

Yes. When a referral is issued for a specific service, it constitutes an authorization under the California Health and Safety Code. 1371.8 of the California Health and Safety Code is applicable to commercial claim processing only.

Does a Medicare Advantage or Group Medicare Advantage non-contracted provider payment dispute have to be in writing?

No, the dispute can be received by any method, e.g., phone call, email, written, fax, etc.

Is an email or an electronically-submitted dispute via the intranet a commercial PDR?

An electronic dispute would be one that comes through a website or web portal specifically established by the plan or the plan’s capitated provider for filing a provider dispute.

Is a claim initially denied correctly as not authorized and then submitted requesting a retrospective authorization considered a provider dispute?

Yes. If the request is in writing and appealing the original claim decision for lack of authorization.

Is a commercial provider dispute submitted via fax or email considered an electronic provider dispute?

No. At this time, the DMHC considers a fax or an email as a paper dispute.

If a provider calls and then faxes back-up documentation, is it now a provider dispute?

If a provider call is questioning an original claim determination and then followed by a fax, it is considered a provider dispute.

If an original claim submission is contested for additional information and the provider submits the requested information through the commercial provider dispute process, would the requested information be considered a provider dispute?

No. The additional requested information makes the original claim complete and should be considered a new clean claim with a 45-working-day turnaround time.

What are the guidelines for record retention?

For Medicare Advantage and Group Medicare Advantage claims and corresponding payment activity, the requirement is ten (10) years. The regulation can be found in the Code of Federal Regulations at 42 CFR, Section 422.504.

For commercial claims, the requirement is as least seven years for the medical claims and corresponding payment activity. This can be found in CCR, Title 10, Section 2695.3.