October 15, 2021

Subject: **Notification of January 2022 Updates to the Blue Shield *Hospital and Facility Guidelines***

Dear Provider:

We have revised our *Hospital and Facility Guidelines.* The changes listed in the following provider manual sections are effective January 1, 2022.

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

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

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

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

Sincerely,

Aliza Arjoyan
Senior Vice President
Provider Partnerships and Network Management

T12059 (10/21)

UPDATES TO THE JANUARY 2022
HOSPITAL AND FACILITY GUIDELINES

General Reminders

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

Section 1: Introduction

FRAUD PREVENTION

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

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

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

Section 2: Hospital and Facility Responsibilities

Provider Availability Standards for Commercial Products

Geographic Distribution – Commercial

Deleted and replaced *the following standards:*

CATEGORY	PRODUCT TYPE	STANDARD	COMPLIANCE TARGET
High Volume Specialists High Impact Specialists	HMO/POS PPO - CDI PPO – DMHC IFP ePPO CCSB HMO/PPO	One of each type of Top High-Volume Specialists and High Impact Specialists within 30 miles of each member	90%
Hospitals		One hospital within 15 miles of each member	100%
Pharmacy		One Pharmacy in 15 miles	90%
Acupuncturist	PPO	Urban/Suburban: 1 of each specialty within 20 miles of each member's residence or workplace or equivalent to 30 minutes. Rural: 1 of each specialty within 45 miles of each member's residence or workplace or equivalent to 60 minutes.	90%

LANGUAGE ASSISTANCE FOR PERSONS WITH LIMITED ENGLISH PROFICIENCY (LEP)

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

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

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

Section 3: Medical Care Solutions

MEDICAL NECESSITY

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

Medical Necessity (Medically Necessary)*

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

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

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

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

Medical Necessity (Medically Necessary)**

Benefits are provided only for services which are medically necessary.

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

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

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

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

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

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

BLUE SHIELD MEDICAL & MEDICATION POLICIES

Medical Policy

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

UM CRITERIA AND GUIDELINES

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

For fully-insured products, Mental Health and Substance Use Disorder medical necessity review is conducted by Blue Shield's MHSA and utilizes the American Society of Addiction Medicine (ASAM) criteria, Level of Care Utilization System (LOCUS) guidelines, Child and Adolescent Level of Care Utilization System (CALOCUS) guidelines and Early Childhood Service Intensity Instrument (ECSII). Additional guidelines may be added as they become available from non-profit professional associations in accordance with California law. **Medical services for the treatment of gender dysphoria, eating disorder or substance use disorder are reviewed by Blue Shield utilizing the criteria as outlined in the UM Program Description.**

Emergency Services

Updated *language in boldface type below:*

Prior authorization is not required for urgent and emergency services. If these services result in a hospital inpatient admission, the attending physician or the hospital must notify the designated Medical Care Solutions team within 24 hours or by the end of the first business day following **the stabilization of the member**. The member should notify his or her primary care physician (HMO) as soon as it is medically possible for the member to provide notice.

Weekend and holiday admissions, **during which the member was stabilized**, require notification by the next business day. The designated Medical Care Solutions team reviews the request for admission within one day from the receipt of request and notifies the facility of the determination by phone, fax and/or in writing of the decision. Admissions are reviewed for medical necessity, level of care, appropriateness of care, and benefit determination. The hospital, member, and attending physician are also notified in writing of the determination, including the initial authorized length of stay or denial of the authorization request.

ADMISSION AUTHORIZATIONS

Outpatient Authorizations - Mental Health and Substance Use Disorder

Removed *the following from the list of services requiring prior authorization:*

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

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

- Neuropsychological testing when the purpose of testing is to clarify whether there is a psychiatric diagnosis

Updated *Medical Care Solutions contact information for Mental Health and Substance Use Disorder Medicare Advantage plans:*

- (800) 541-6652 Option 6
- Fax: (844) 696-0975
- Online at blueshieldca.com/provider under *Authorizations*, then *Request Medical Authorization*.

Section 4: Billing and Payment

CLAIMS SUBMISSION

Real Time Claims Settlement

Deleted and replaced *the Real Time Claims Settlement – Future State section below:*

To further realize our long-term solution, Blue Shield is working to make claims processing automated. These offerings revolutionize how we as an industry process claims and are expected to begin rolling out in 2022. The upcoming claims processing solutions are further defined below.

Blue Shield is working to create a platform for a direct system-to-system connection between providers and Blue Shield. This solution will make it possible for claims to be automatically generated eliminating all administrative burden from providers. This will be accomplished through a connection with the provider's Electronic Health Records (HER) system and Revenue Cycle Management (RCM) system to create and send a claim to Blue Shield through a digital connection to be adjudicated in real-time.

ELECTRONIC SUBMISSIONS

Removed *the following language from electronic submission sections throughout this Section 4. Claims are not required to be submitted electronically, however, will be processed faster when submitted this way.*

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

CLAIMS ATTACHMENTS

Removed *the following language from the manual to align with the language in the model agreements. This process is no longer applicable.*

30-Day Readmission Documents

As applicable, a copy of the medical record must be submitted with acute care hospital claims for inpatient admissions that occur within thirty (30) days of the discharge of a member with a prior inpatient admission for the same diagnosis related group (DRG) or principal ICD-10 diagnosis code.

SPECIAL BILLING SITUATIONS

Added *the following example of a self-referred Professional claim:*

For Professional Claims:

Loop 2310F NM103= SELFREFERRAL
Loop 2310F NM104= BLANK
First Name = SELFREFERRAL
Last Name = BLANK
Sample: NM1*DN*1*SELFREFERRAL*****XX*1002233777~

Section 5: Blue Shield Benefit Plans and Programs

MEDICARE PART D

Medication Therapy Management Program (MTMP)

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

- Dyslipidemia

BLUE SHIELD BENEFIT PROGRAMS

Additional Care Management Program Descriptions

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

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

Section 6: Capitated Hospital Requirements

OVERVIEW

*The following language has been **removed** as it is contained in the provider agreement:*

The capitated hospital must either provide these services or have a written agreement with another licensed healthcare provider to render necessary services that the hospital itself is unable to provide. The capitated hospital must accept Blue Shield's monthly capitation payment, along with the member's applicable copayment, as payment in full for covered services provided either directly by the capitated hospital or through arrangements with other healthcare providers.

Monthly Eligibility Reports

*Language describing the timeframe of when eligibility reports are distributed **has been removed** from this section as it is contained in the provider agreement.*

CAPITATION

*This section has been **deleted and replaced** with the following. Language that is contained in the provider agreement has been removed from this section.*

For Commercial HMO and POS members, Blue Shield will be financially responsible for all covered services provided by a capitated hospital to an ineligible person or a retroactively cancelled member for the period of time for which capitation was retroactively adjusted and who had been previously verified as eligible by Blue Shield, as long as the capitated hospital has:

- Provided documentation to Blue Shield of the eligibility error, along with the claim for services.
- Provided documentation that payment was made by the capitated hospital to the provider of service, if applicable. Documentation should include:
  - Member name
  - Member ID number
  - Place, date, and provider of service
  - A claim showing the services provided and the billed/paid amount

If the member is determined to be ineligible or retroactively cancelled, Blue Shield will reimburse the capitated hospital using the payment methodology described in the Blue Shield contract.

Appendices

APPENDIX 4-C WHERE TO SEND CLAIMS

Updated *the BlueCard claims mailing address to the following:*

Blue Shield of California
BlueCard Program
P.O. Box 272630
Chico CA 95927-2630

APPENDIX 4-D LIST OF INCIDENTAL PROCEDURES

Added *the following codes:*

0602T	Transdermal GFR Measurements
0603T	Transdermal GFR Monitoring
0604T	Rem Oct Rta Dev Setup & Education
0605T	Rem Oct Rta Tech support Min 8
0615T	Eye movement alys w/o calbrj I&R
G2211	Complex e/m visit add on
G2212	Prolong outpt/office visit
G2213	Initiat med assist tx in er

Deleted *the following codes:*

36147	Access av dial grft for eval
36148	Access av dial grft for proc
51703	Insert bladder cath, complex
0229T	Njx tfrml eprl w/us cer/thor
0231T	Njx tfrml eprl w/us lumb/sac
0396T	Intraop knetic balnce sensr
0400T	Mltispectrl digital les alys
0401T	Mltispectrl digital les alys
0467T	Revj/rplmnt ch respir eltrd
0468T	Rmvl ch wal respir eltrd/ra
A9604	Sm 153 lexidronam
C5271	Low cost skin substitute app
C5273	Low cost skin substitute app
C5275	Low cost skin substitute app
C5277	Low cost skin substitute app
C9248	Inject, Clevidipien butyrate, 1mg
C9250	Human plasma fib seal,vap-heat solv-detrgnt
C9257	Inj, bevacizumab
G0260	Inj for sacroiliac jt anesth
Q4109	Tissuemend skin sub
Q9969	Non-HEU TC-99M add-on/dose

APPENDIX 4-E LIST OF OFFICE-BASED AMBULATORY PROCEDURES

Deleted *the following procedure codes:*

0228T	Njx tfrml eprl w/us cer/thor
0230T	Njx tfrml eprl w/us lumb/sac
0295T	Ext ecg complete
0296T	Ext ecg recording
0297T	Ext ecg scan w/report
0298T	Ext ecg review and interp
0525T	Insj/rplcmt compl iims

APPENDIX 5-A THE BLUECARD PROGRAM

Updated *Blue Plan HPN to BLUEHPN throughout Appendix 5-A.*

Updated *the BlueCard claims mailing address to the following:*

Blue Shield of California
BlueCard Program
P.O. Box 272630
Chico CA 95927-2630

How to Identify Members

Added *language in boldface type below:*

Those BLUEHPN products offered may include fully-insured and self-insured Blue plan members. Language regarding benefit limitations is also included on the back of the BLUEHPN EPO member ID card. For these limited benefits, if you are not a BLUEHPN provider but are a PPO provider, you will be reimbursed according to Blue Shield of California PPO provider contract, just like you are for other EPO products.

APPENDIX 5-B OTHER PAYOR SUMMARY LIST

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

APPENDIX 6-A BLUE SHIELD COMBINED ELIGIBILITY/CAPITATION REPORT

Updated *the Commercial file layout.*

APPENDIX 6-C CLAIMS, COMPLIANCE PROGRAMS, IT SYSTEM SECURITY AND OVERSIGHT MONITORING

Measuring Timeliness and Accuracy

Check Cashing Timeliness

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

Blue Shield accepts the check or electronic transfer date as reasonable evidence of mailing, provided no operational or systematic delays are documented via a formal Policy and Procedure. As evidence that the check has been mailed, the Delegated Entity can provide a check mail log that has been signed by a Principal Officer or CFO who is attesting to checks being mailed on the

dates reported. Blue Shield will confirm the date the check or electronic transfer was cleared to the Delegated Entity's bank account during the audit process. Blue Shield requires that a minimum of 70% of all checks be presented for deposit within 14 calendar days of the date the check is reported to have been mailed. If the check clearing timeliness is below 70%, Blue Shield requires the Delegated Entity to submit a check cashing attestation to be completed by each provider. The attestation can be requested from your assigned claims delegation oversight auditor.

Measuring Timeliness

Added *the following language:*

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

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

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

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

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

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

Overpayment

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

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

Payment Accuracy

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

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

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

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

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

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

Best Practices and Claims Adjudication

Audits and Audit Preparation

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

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

compliant and a corrective action plan (CAP) will be required by the Delegated Entity along with a follow up audit that will be scheduled. The Delegated Entity will be escalated to the Delegation Oversight Committee as non-compliant for lack of submission of audit documents. Electronic submission of all data is required.

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

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

Balance Billing

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

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

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

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

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

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

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

Medicare Advantage

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

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

Date Stamping

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

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

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

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

Disbursement of Payments

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

The date of payment is the date that the funds were electronically transferred (EFT)or the date the check was mailed via postal service to the provider. Blue Shield validates the EFT date as well as the date the payment was mailed. It is recommended that the Delegated Entity does not exceed 3 days from the paid date to the mail date. The additional mail processing days will be added into the claim's turnaround time calculation. Blue Shield will use the check mailed date as the closure of the claim's turnaround time. The Delegated Entity must provide a mail date policy and procedure to verify the additional days have been included to validate turnaround time for audits.

Forwarding Claims (Misdirected)

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

Billing providers often submit claims and disputes to the incorrect payor. It is a requirement that the Delegated Entity forward claims directly to the financially responsible entity, if known, otherwise

deny with a remit message informing the provider the Delegated Entity is not financially responsible for processing of the claim.

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

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

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

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

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

Added *the following new section:*

Reopenings

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

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

Offshore Monitoring

Changed *section name to* **Monitoring of a Subcontractor (this includes MSO) for a delegated function-offshore/onshore** *and* ***deleted and replaced*** *with the following language:*

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

The Delegated Entity is expected to require the sub-delegated claims organization to meet all regulatory requirements and criteria discussed in this supplement. The Delegated Entity must perform the same tasks, e.g., delegation oversight of claims processing, that Blue Shield carries out as the Health Plan, including obtaining timely monthly reporting from them, and include their statistics in the Delegated Entities reports to Blue Shield. The Delegated Entity must audit the sub-delegated

organization annually/periodically and require corrective action plan implementation when their performance results are not compliant. If the sub-delegated organization fails to achieve compliance, the Delegated Entity needs to take the appropriate actions to achieve compliance. If the Delegated Entity sub-delegates claims functions they will need to demonstrate and provide evidence of their oversight of that entity during the on-site audit. If the Delegated Entity outsources claims functions, that will also need to be monitored.

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

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

Deleted or moved *the following sections:*

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

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

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