601 12th Street
Oakland, CA 94607

October 13, 2023

Subject: **Notification of January 2024 Updates to the Blue Shield *Hospital and Facility Guidelines***

Dear Provider:

Blue Shield is revising the *Hospital and Facility Guidelines Manual* (Manual). The changes in each provider manual section listed below are effective January 1, 2024.

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 Manual* 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 included by reference 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 2024 version of this Manual, please contact your Blue Shield Provider Relations Coordinator.

Sincerely,

Aliza Arjoyan
Senior Vice President
Provider Partnerships and Network Management

Updates to the
January 2024 *Hospital and Facility Guidelines Manual*

General Reminders

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

Section 1: Introduction

Fraud Prevention

Fraud, Waste, and Abuse

Corrected the website for Medicare beneficiaries to report complaints, using the MEDIC Complaint Form, as follows:

www.qlarant.com/wp-content/uploads/2020/11/Qlarant_I-MEDIC_Complaint_Form_2020_11_04.pdf.

Blue Shield's Code of Conduct and Corporate Compliance Program

Revised entire section detailing the Code of Conduct Corporate Compliance Program and its commitment to requiring compliance with the law and our policies, helping us keep sight of our values and translating our values into everyday actions.

Section 2: Hospital and Facility Responsibilities

Quality Management and Improvement

Reporting Specified C-Section Rates

Updated the language detailing Covered California reporting requirements, in boldface type as follows:

To comply with Covered California requirements, hospitals must report**,** quarterly **or on a bi-annual basis,** to the Maternal Data Center of the California Maternal Quality Care Collaborative the number of nulliparous women with a term, singleton baby in a vertex position (NTSV) delivered by cesarean section.

Updated the bullet point list of exclusions from reporting Specified C-Section Rates, as follows:

- Exclusions:
  - CD-10-CM Principal Diagnosis Code or ICD-10-CM Other Diagnosis Codes for multiple gestations and other presentations as defined in Appendix A, Table 11.09
  - Less than 8 years of age
  - Greater than or equal to 65 years of age
  - Length of Stay >120 days
  - Enrolled in clinical trials
  - Gestational Age < 37 weeks or UTD

Service Accessibility Standards

Behavioral Health Appointment Access Standards

Added access standard for initial routine visits, as follows:

ACCESS-TO-CARE	STANDARD
Initial routine visits with non-physician practitioners and behavioral health physicians	Within 10 business days

Language Assistance for Persons with Limited English Proficiency (LEP)

Updated this section to include the following NCQA requirements:

- Demographic language services information including membership thresholds
- Cultural awareness and linguistic information, online resources, and training materials
- Language assistance resources for translation and interpretation services
- Multilingual online resources

Facility Directory

Deleted and ***replaced*** list of methods to update provider directory data, as follows:

There are two ways to update provider directory data:

1. Make changes directly on Provider Connection in the *Provider & Practitioner Profiles* section.
2. Log onto Provider Connection and download the Provider Data Validation Spreadsheet then upload the revisions back to Provider Connection.

Instructions for this update process and information on how to attest to data accuracy can be found in the following link www.blueshieldca.com/bsca/bsc/public/common/PortalComponents/provider/StreamDocumentServlet?fileName=PRV_CAA-provider-directory-instructions.pdf.

Section 3: Medical Care Solutions

Transplant Authorizations

Removed CAR-T therapy from list of transplant types that require authorization from the Blue Shield Transplant Team. The Pharmacy Team manages authorizations for CAR-T.

Section 4: Billing and Payment

Claims Submission

UB 04 Form Locators

Removed the Genetic Testing Unit (Form Locater 80).

Claim Inquiries and Adjustments

Corrected Claims

Added language below and updated in boldface type:

Corrected claims should be submitted within 365 days from the claim finalized date unless otherwise specified in the contract.

- Send "**7**" in CLM*05-3 (Loop 2300) to indicate Replacement of Prior Claim.

Provider Appeals and Dispute Resolution

Updates made throughout section to clarify that commercial appeals can be submitted electronically or on paper. Blue Shield will acknowledge paper appeals within 15 working days and electronic submissions within 2 working days. For additional information regarding the appeal process, and to review digital submission options, please visit Provider Connection at www.blueshieldca.com/provider.

Provider Appeals of Medicare Advantage Claims

Non-Contracted Providers

Revised the following language to clarify the dispute process for non-contracted providers:

A provider or supplier has the right to dispute a reimbursement decision made by a MAO Plan. A provider has the right to request a reconsideration of the denial of payment within 60 calendar days for $0 payments and 120 calendar days for underpayments after the receipt of notice of initial determination/decision.

Providers who wish to submit an appeal must also submit a signed Waiver of Liability (WOL) statement holding the member harmless regardless of the outcome of the appeal. Providers 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. If there is no WOL submitted, the plan will make three attempts to request the WOL. If the WOL is not submitted after 3 attempts and before the 60th calendar day, the plan may dismiss the provider appeal.

After the MAO Plan makes its Payment Review Determination (PRD) decision, all Medicare non-contracted zero payment denials are auto forwarded to the Independent Review Entity (IRE). For non-contracted Medicare/CMC underpayments, providers can contact 1-800-Medicare. For cases that are dismissed, the provider has the right within 180 days to ask the plan to vacate (set aside) the dismissal action if the plan determines there is good cause to vacate. The provider also has the right to ask for an independent reviewer contracted with Medicare to review the decision to dismiss the appeal request within 60 calendar days to Maximus Federal Services, Inc.

To appeal the provider organization'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

For additional information regarding the appeal process, and to review digital submission options that will be available to Medicare providers in December 2023, please visit Provider Connection at www.blueshieldca.com/provider.

Section 5: Blue Shield Benefit Plans and Programs

Medicare Part D

Fraud, Waste, and Abuse Requirements and Training

Removed language concerning an annual statement of attestation requirement for network pharmacies, as attestations are no longer required.

Medicare Part D

Exclusion Lists

Updated website listing the General Services Administration (GSA) database of excluded individuals/entities to www.sam.gov.

Updated language requiring entities to review exclusion lists, as follows:

CMS requires that all entities review the list prior to hiring or contracting of anyone and monthly thereafter to ensure that its employees, board members, officers, and first tier entities, downstream entities, or related entities that assist in the administration or delivery or Part D benefits are not included on such lists.

Medicare Part D

Medicare Part D Prescriber Preclusion List

Added the following to the Medicare Part D Prescriber Preclusion List criteria:

(c) Have been convicted of a felony under federal or state law within the previous 10 years that CMS deems detrimental to the best interests of the Medicare program.

Medication Therapy Management Program (MTMP)

Updated information about the Medication Therapy Management Program (MTMP) in strikethrough and boldface type below:

Blue Shield provides a Medication Therapy Management Program (MTMP) for its Medicare Part D members to assist them in managing their chronic conditions. The Blue Shield MTMP is for members meeting all of the following criteria:

- Have **two** of the following conditions:
  - Chronic Heart Failure (CHF)
  - Diabetes
  - Hypertension
  - Osteoporosis
  - ~~Respiratory Disease~~ **Chronic Obstructive Pulmonary Disease (COPD)**
- Receive **seven** or more different covered Part D maintenance medications monthly
- Likely to incur an annual cost threshold established by CMS each calendar year for Medicare covered prescriptions

Blue Shield Medicare (PPO) (Medicare Advantage)

Blue Shield Medicare (PPO) Benefits

Updated language detailing vision services benefits, as follows:

Vision Services

Blue Shield Medicare (PPO) individual and group plans cover vision services that meet Medicare guidelines.

In addition to Medicare-covered services, all Blue Shield Medicare (PPO) individual and some group plans cover routine (non-Medicare covered) eye examinations/screenings. For individual plans, services are provided through VSP Vision Care. Refer to the Blue Shield Medicare (PPO) Summary of Benefits for benefit guidelines.

Blue Shield Medicare (PPO) (Medicare Advantage)

General Benefit Exclusions

Updated bullet point in list of excluded benefits, as follows:

- Routine preventive and diagnostic dental care, such as exams, cleanings, and x-rays are covered by the Blue Shield Medicare (PPO) plan. Additional non-routine dental care, such as fillings, dentures and others are covered only when the member is enrolled in the optional supplemental dental PPO benefit plan.

Care Management

Maternity Management

Added per SB 1207, Health & Safety Code section 1367.625 (Maternal Mental Health), language detailing the clinical referral for the maternity program, as follows:

Providers can refer members to Magellan by calling Customer Service at (877) 263-9952 or request a clinical referral form at BSCClinicalLiaison@MagellanHealth.com.

Additional Care Management Program Descriptions

Changed the Landmark Home-Based Care program name to Home-Based Complex Care.

Appendices

Appendix 4-D List of Incidental Procedures

Added the following procedural codes:

15853	Removal Sutr/Stapl Xreq Anes
15854	Remove Sutr & Stapl Xreq Anes
93569	Njx Cth Slct P-Art Angrp Uni
93573	Njx Cath Slct P-Art Angrp Bi
93574	Njx Cath Slct Pulm Vn Angrph
93575	Njx Cath Slct P Angrph Mapca
0777T	R-t prs sensing edrl gdn sys
C9143	Cocaine hcl nasal (numbrino)
C9144	Inj, bupivacaine (posimir)
G0316	Prolong inpt eval add 15 m

Deleted the following procedure codes:

0471T	Oct skn img acquisj i&r addl
0514T	Intraop vis axis id pt fixj

Appendix 4-E List of Office-Based Ambulatory Procedures

Added the following procedure codes:

C7513	Cath/angio dial cir w/aplasty
C7514	Cath/angio dial cir w/stents
C7515	Cath/angio dial cir w/embol

Appendix 4-F UB-04 General Instructions

FL78 – FL79 Other Provider Name and Identifiers (including NPI)

Added the following language to the definition:

Note: When submitting claims for a Blue Shield POS member who has self-referred enter the words "self-referral."

FL80 Genetic Testing Unit

Deleted *and* ***replaced*** with the following:

Not applicable

Appendix 5-A The BlueCard Program

Updated "out-of-state" to "other state," throughout Appendix 5-A.

Products Included in the BlueCard Program

Removed the "Medigap" bullet-point from the list of products that the BlueCard Program offers.

Three-Character Prefix

Deleted *and* ***replaced*** with the following:

The three-character prefix at the beginning of the member's identification number is the key element used to identify and correctly route claims. The prefix identifies the Blue plan to which the member belongs. It is critical for confirming a patient's membership and coverage.

To ensure accurate claim processing, it is critical to capture all ID card data. If the information is not captured correctly, you may experience a delay with the claim processing. Please make copies of the front and back of the ID card and pass this key information to your billing staff. Do not make up prefixes.

As a provider serving other state Blue plan members, you may find the following tips helpful:

- Ask the member for his or her most current Blue ID card at every visit. Since new ID cards may be issued to members throughout the year, this will ensure you have the most up-to-date information in your patient's file.
- Member IDs must be reported exactly as shown on the ID card and must not be changed or altered. Do not add or omit any characters from the member ID.

Medical Records Requests and Processing

Updated the following bullet point in the list of steps that Blue Shield performs to ensure delivery of medical record requests and processing:

- When providers respond to requests and submit medical records to us, to help us ensure that all records are sent electronically to the member's Blue plan within three business days of their receipt, please include the medical records request letter with all supporting documentation.

BlueCard Claim Tips

Updated the following bullet point in the list of helpful tips for providers to improve their claim experience:

- If medical records are requested, send them to the claims address along with the medical request letter you received from Blue Shield.

Added instructions for providers to access the online Chat feature at www.blueshieldca.com/provider, for questions about BlueCard claims.

Submitting BlueCard Claims

Removed the EDI inquiry form and EDI email address as a means to inquire about claims. All questions about electronic claims submission should be directed to the Blue Shield EDI Help Desk at (800) 480-1221.

Traditional Medicare-Related Claims

Added the following bullet point in the list of methods to contact Blue Shield when Blue Shield is the secondary healthcare coverage carrier for the patient:

- Provider Chat feature available online at www.blueshieldca.com/provider.

Medical Records

Updated the list methods to assist in timely processing of medical records in boldface type below:

Helpful Ways You Can Assist in Timely Processing of Medical Records

- If the records are requested following submission of the claim, forward all requested medical records **and a copy of the medical records request letter**, to Blue Shield's dedicated BlueCard Customer Service team at: Blue Shield of California, BlueCard Program, P. O. Box 272630, Chico, CA 95927-2630.
- Include the **medical records request** letter you received with the request when submitting the medical records. This is necessary to make sure the records are routed properly once received by Blue Shield.

Provider Claim Appeals

Added the following language detailing how to submit an online claim appeal:

You now have the option to submit claim appeal online, in addition to using the existing mail-in process.

How it works

You will need the claim number to get started:

- Log in to your account on Provider Connection at www.blueshieldca.com/provider/account-tools/login/home.sp, search for a claim, then from the *Claim* page, click the *Resolve claim issue or dispute* link at the top of the page, or
- If you already know the claim number, log in and enter it on the *Claim issues & disputes* page at www.blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/claims/pdr/claim-issues.

Appendix 5-B Other Payor Summary List

This appendix was ***removed*** from the manual. It can be found on the Provider Portal at www.blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/guidelines_resources/policies_standards/other_payor_summary_list where it is updated monthly.

Appendix 6-C Claims, Compliance Programs, IT System Security, and Oversight Monitoring

Clean Claim

Deleted and ***replaced*** the definition for "Clean Claim," as follows:

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).

Contested Claims - Commercial

Deleted *and* ***replaced*** definition for Contested Claims – Commercial, with the following:

Contested Claims - Commercial

A contested claim is defined as a claim or portion thereof that 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. When appropriate, claims may need to be contested for additional information, e.g., medical records and chart notes. Contested claims include provider denials and claims pended or closed before a coverage determination can be made. Commercial contested claims must be adjudicated within 45 working days of the received date to be considered compliant.

Delegated Entity will be audited against and must maintain compliance with Claims Settlement Practices in accordance with Title 28 Section 1300.71 (a)(8)(H) and (I) contesting claims for Medical Records.

(H) The failure to establish, upon the Department's written request, that requests for medical records more frequently than in three percent (3%) of the claims submitted to a plan or a plan's capitated provider by all providers over any 12-month period was reasonably necessary to determine payor liability for those claims consistent with the section (a)(2). The calculation of the 3% threshold and the limitation on requests for medical records shall not apply to claims involving emergency or unauthorized services or where the plan establishes reasonable grounds for suspecting possible fraud, misrepresentation, or unfair billing practices.

(I) The failure to establish, upon the Department's written request, that requests for medical records more frequently than in twenty percent (20%) of the emergency services and care professional provider claims submitted to the plan's or the plan's capitated providers for emergency room service and care over any 12-month period was reasonably necessary to determine payor liability for those claims consistent with section (a)(2). The calculation of the 20% threshold and the limitation on requests for medical records shall not apply to claims where the plan demonstrates reasonable grounds for suspecting possible fraud, misrepresentation, or unfair billing practices.

Upon receipt of additional information, a new 45-working day cycle begins.

Present on Admission (POA)

Deleted the entire "Present on Admission (POA)" sub-section, as this sub-section was not related to capitated hospitals.

Acknowledgement of Receipt

Deleted *and* ***replaced*** the Commercial section with the following:

The Delegated Entity must acknowledge receiving electronic claims within two (2) working days of date of receipt of the claim and paper claims within 15 working days of date of receipt of the claim.

Acknowledgement timeframes are based on the date of receipt. The acknowledgment date for electronic submission claims should be either the date the claim became available to the Delegated Entity from their clearing house or the date the claim arrived directly via direct electronic delivery.

Acknowledgement must be in the same manner as the claim was submitted or provided by electronic means, by phone, website, or another mutually agreed upon accessible method of notification. (CCR Title 28 Section 1300.71(c)).

Blue Shield will validate Delegated Entity/MSO website to assure that directions are provided for a non-contracted provider regarding how they can confirm receipt of claim.

Added the following sections on submitting EOP/RAs:

Commercial Evidence of Payment (EOP)/Remittance Advice (RA)

Each Delegated Entity needs to include the following information in their EOP/RA:

- PDR Verbiage

  California Code of Regulations, Title 28 Section 1300.71.38 (b)
  - (b) Notice to Provider of Dispute Resolution Mechanism(s). Whenever the plan or the plan's capitated provider contests, adjusts or denies a claim, it shall inform the provider of the availability of the provider dispute resolution mechanism and the procedures for obtaining forms and instructions, including the mailing address for a filing a provider dispute.
  - The right to dispute a claim using the approved PDR request form.
  - The dispute must be submitted within 365 calendar days from last claim action.
  - Written determination of the dispute must be made consistent with applicable state and federal law, within 45 working days after the date of receipt of the provider dispute or the amended provider dispute.
  - A provider has the right to submit an appeal if they do not agree with this resolution of this claims dispute. The language should include "you have the right to appeal directly to Blue Shield of California within 60 working days from the Date of Determination." This appeal would only be for Medical Necessity *de novo* review.

Medicare Evidence of Payment (EOP)/Remittance Advice (RA)

Each Delegated Entity needs to include the following information in their EOP/RA:

- Denial Rights
- Waiver of Liability Statement
  - The Waiver of Liability statement can be downloaded from the CMS website at www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/Downloads/Model-Waiver-of-Liability_Feb2019v508.zip

- Per CMS, Delegated Entities cannot provide a link to the CMS web page and give the non-contracted provider the instructions to access the form
- The EOP should have the waiver of liability link referenced above OR
- Waiver of Liability link and form together

Note: Delegated Entities CANNOT have the form only.

- Appeal Rights
- PDR Second Level Verbiage
  - "You have the right to dispute this decision directly with Blue Shield of California within 180 days from the determination of the payer."

Member Denial Notice – Standards (Commercial)

Added the following language:

All member emergency and non-emergency denial letters must include the denial code and denial reason. The denial reason code should match what is being submitted on the EOB/RA.

Best Practices and Claims Adjudication

Deleted and ***replaced*** language detailing the audit preparation process, as follows:

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 Blue Shield's audit, Blue Shield will send a written notification 60 days prior to 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. Also provided is a cover sheet that needs to be completed and attached to each claim sample. Note that the claim sample must include the following documentation from the contract with the provider: the first and last page (signature) and rate sheet. All documentation is required to be submitted with a sample claim as noted on the cover sheet.

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. This will include a demonstration of a life of a claim from end to end (mailroom to disposition of payment and/or denial) which will include operational systems and interviews with staff associated with specific functional areas. To assure end to end processes are formally documented, Blue Shield requires submission of

Policy and Procedures (P&P) noted in the industry standard questionnaire as well as P&Ps requested during the audit claims assessment questions interview on the scheduled audit day. As part of the assessment, Blue Shield evaluates that P&Ps are reviewed annually via evidence that they were approved via committee or appropriate authority signature and dated.

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 provide the Delegated Entity with written results within 30 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.

Updated language detailing the process for date-stamping paper claims, in boldface type below:

Date Stamping

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. **If a paper claim is received and then scanned for audit purposes, it should be batched for scanning by the original received date and include a unique identifier of the received date on the image.**

Corrective Action/Follow Up Audits

Added the following sub-section concerning the annual claims and PDR audit:

Blue Shield performs, at a minimum, an annual claims and PDR audit. Follow-up audits will be scheduled by the assigned auditor if the Delegated Entity fails the annual audit. If applicable, as a result of a non-compliant follow-up audit, additional monitoring and/or remediation validation audits will be performed based upon outcome of escalation to the Delegation Oversight Committee. For those Delegated Entities who are subject to DMHC audits, if deficiencies are determined during the review, a corrective action plan (CAP) is required to be sent to Blue Shield by the date provided by the auditor. Additionally, Blue Shield may perform an unannounced audit dependent upon other indicators.

Compliance Program Effectiveness Oversight Audit

Changed name of sub-section from "Compliance Program/Fraud, Waste, and Abuse" to "Compliance Program Effectiveness Oversight Audit."

Deleted and replaced with the following language:

Delegation Oversight will perform an annual audit of the effectiveness of your organization's Compliance Program. The audit includes the assessment of the following:

- Compliance Program structure (the effectiveness of your organization's compliance program.
- Risk Bearing Organization (RBO) and Management Services Organization (MSO) ownership and hours of availability.
- Training material and the training your organization conducts for all employees (including temporary and contracted employees).
- Implemented policies and procedures
- FWA reporting
- Monitoring and auditing internal risks
- Organization's internal controls and organization capacity structure

This audit will be performed either via Blue Shield Delegation Oversight Compliance Team individually on an annual basis or as a shared audit through HICE (Health Industry Collaborative Effort).

The Compliance audit evidence grid will be provided by the Delegation Oversight Auditor prior to the scheduled audit date. The grid should be used as a guide for audit documentation submission guidelines and as well as policy and business rules to assist with understanding the audit history and requirements. To download a copy of the Compliance Audit Evidence Grid, go to the Blue Shield provider website at www.blueshieldca.com/provider and navigate to the *Forms* section, then *Delegation oversight forms*. All requested documents from the evidence grid must be submitted to BSCandPHP_DOCPEAudit@blueshieldca.com.

For more information on the shared audit process and joining, please visit the HICE website at www.iceforhealth.org/teamactivities.asp.

IT System Security

Deleted and ***replaced*** language concerning the IT system integrity audit, as follows:

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

- Operational effectiveness
- Access to programs and data access rights definition
- Access to programs and data access control mechanisms and password complexity
- Program changes/standard change management
- Computer operations (backup, recovery, and resumption)/HIPAA compliance
- Program changes
- Access to IT privileged functions

Claims Delegate Reporting Instructions

Changed the due date of the quarterly Organization Determinations, Appeals, and Grievances (ODAG) Report to the 15th of each quarter (April 15, July 15, October 15, and January 15).