Independent Physician and Provider Manual

A procedure manual for direct-contract Blue Shield network providers

April 2019
# Table of Contents

## Section 1: Introduction

| Purpose of the Independent Physician and Provider Manual | 1 |
| Manual Orders and Updates | 1 |
| Enrollment and Eligibility | 2 |
| Member Eligibility Verification | 2 |
| Premium Payment Policy | 2 |
| Blue Shield Enrollment Responsibilities to Members on the Exchange | 3 |
| Provider Requests to Transfer or Disenroll Members (Commercial) | 3 |
| Provider Requests to Transfer or Disenroll Members (Blue Shield 65 Plus) | 5 |
| Member Rights and Responsibilities | 9 |
| Statement of Member Rights | 9 |
| Statement of Member Responsibilities | 10 |
| Member Grievance Process | 11 |
| Definitions | 11 |
| Blue Shield Commercial Policy | 12 |
| Blue Shield 65 Plus (HMO) Policy | 13 |
| Standard Review Process | 13 |
| Expedited Review | 14 |
| External Review | 14 |
| Contacting the Appeals and Grievance Department | 14 |
| Fraud Prevention | 15 |
| Provider Audits | 15 |
| Fraud, Waste, and Abuse | 16 |
| Blue Shield’s Code of Conduct and the Corporate Compliance Program | 18 |
| Blue Shield 65 Plus Program Overview | 19 |
| Blue Shield 65 Plus Compliance Program | 19 |
| Auditing and Monitoring | 21 |
| Confirmation of Eligibility of Participation in the Medicare Program | 21 |
| Healthcare Regulatory Agencies | 22 |
| California Department of Insurance (CDI) | 22 |
| California Department of Managed Health Care (DMHC) | 22 |
| Centers for Medicare & Medicaid Services (CMS) | 22 |
Section 2: Provider Responsibilities

General Blue Shield Agreement Terms and Conditions ................................................................. 1
Blue Shield Provider Standards ......................................................................................................... 3
Administrative Compliance .............................................................................................................. 4
  General Administrative Criteria .................................................................................................. 4
  Administrative Procedure for Non-Compliance ....................................................................... 6
Provider Certification ....................................................................................................................... 7
  Reporting Provider Status Changes ......................................................................................... 7
Credentialing and Recredentialing ................................................................................................. 9
Clinical Laboratory Improvement Amendments (CLIA) Program Requirements .................. 10
Medical Record Review ................................................................................................................. 11
  Medical Records Tools ........................................................................................................... 12
  Access to Records .................................................................................................................. 12
  Advance Directives ................................................................................................................... 12
  Confidentiality ......................................................................................................................... 13
Quality Management and Improvement ...................................................................................... 13
  Accreditation ........................................................................................................................... 13
  Provider Responsibilities for Quality Management and Improvement .................................. 14
  HEDIS® Guidelines .................................................................................................................. 14
Home-Based Palliative Care Program Providers .......................................................................... 15
  Enrolling/Disenrolling Members in the Home-Based Palliative Care Program...................... 15
Submission of Laboratory Results Data ....................................................................................... 17
Service Accessibility Standards ....................................................................................................... 18
  Behavioral Health Appointment Access Standards for Medicare Advantage Members ...... 21
After Hours Requirements ............................................................................................................. 21
  After Hours Emergency Instructions ....................................................................................... 21
  After Hours Access-to-Care Guidelines .................................................................................... 21
Provider Availability Standards for Commercial Products ........................................................... 22
  Geographic Distribution .......................................................................................................... 22
  Provider-to-Member Ratio ......................................................................................................... 23
Provider Availability Standards for Medicare Advantage Products ............................................. 24
  Facility Time and Distance Requirements as required by CMS ............................................... 24
  Provider Time and Distance Requirements as required by CMS ............................................. 24
  Provider Minimum Number Requirements .............................................................................. 25
Behavioral Health Requirements – FEP PPO and ASO ............................................................... 26
Linguistic and Cultural Requirement ........................................................................................... 26
Additional Measurements for Multidimensional Analysis ......................................................... 27
Language Assistance for Persons with Limited English Proficiency (LEP) ............................... 28
Section 3: Medical Care Solutions

Medical Care Solutions Program Overview ................................................................. 1
Practice Guidelines ................................................................................................. 3
Mental Health and Substance Use Disorder Clinical Management Program for Self-Insured Accounts (ASO) .................................................. 3
  Program Activities ......................................................................................... 4
  Wellness Assessments ........................................................................... 6
Blue Shield Medical & Medication Policies ............................................................... 8
  Medical Policy .......................................................................................... 8
  Medication Policy .................................................................................. 8
Use of Free-Standing Urgent Care Centers ......................................................... 9
Use of Non-Preferred/Non-Participating Providers ............................................ 9
Referral to Non-Preferred/Non-Participating Providers .................................... 10
Billing Members for Durable Medical Equipment (DME) ................................ 10
Continuity of Care for Members by Non-Contracted Providers ....................... 11
Prior Authorizations .................................................................................... 11
  Prior Authorization Response Times ..................................................... 12
  Specialty Drug Prior Authorization for the Medical Benefit .................. 13
Prior Authorization List for Network Providers ............................................... 15
Organ and Bone Marrow Transplants ................................................................ 19
  Transplant Authorization .................................................................. 20
Drug Formulary ............................................................................................. 21
  Mandatory Generic Drug Policy ......................................................... 23
  Mail Service Prescriptions ................................................................. 23
  Specialty Drugs ............................................................................... 23
Independent Physician and Provider Manual

Section 4: Billing

Overview.............................................................................................................................................. 1
Claims Processing................................................................................................................................... 1
Electronic Claims Submission .................................................................................................................... 1
Encounter Submission................................................................................................................................. 2
Paper Claim Forms (Using the CMS 1500 Claim Form) ........................................................................ 2
Provider Identification............................................................................................................................... 3
Providers Without a Blue Shield Contract ............................................................................................... 3
Filing “Clean” Claims................................................................................................................................. 4
Encounters “Splitting” to Payable Injectable Claims ............................................................................... 4
Instructions for Claim Form Fields Requiring Special Attention ............................................................ 4
Timeliness Requirement ............................................................................................................................. 4
Medicare Crossover................................................................................................................................... 5
Claims Review Monitoring Program ......................................................................................................... 6
Prepayment Claim Review .......................................................................................................................... 6
Retrospective Review................................................................................................................................. 6
Provider on Review.................................................................................................................................. 6
Provider Payment...................................................................................................................................... 7
Blue Shield Provider Allowances ................................................................................................................ 7
Electronic Remittance Advice (ERA)........................................................................................................... 9
Third Party Liability (TPL) ........................................................................................................................ 10
Coordination of Benefits............................................................................................................................. 11
  Determining the Order of Payment ......................................................................................................... 11
  When Blue Shield is the Primary Plan .................................................................................................... 12
  When Blue Shield is the Secondary Plan ............................................................................................... 12
References................................................................................................................................................... 12
BlueCard® Program Claims ....................................................................................................................... 13
Limitations for Duplicate Coverage (Commercial) .................................................................................. 13
Veterans Administration (VA).................................................................................................................... 13
Department of Defense (DOD), TRICARE/CHAMPVA .............................................................................. 14
Medi-Cal .................................................................................................................................................. 14
Medicare Eligible Members......................................................................................................................... 14
Special Billing Situations................................................................................................................................ 15
  Ancillary Claims Filing Requirements ...................................................................................................... 15
  Billing of Exchange-Purchased Plans .................................................................................................... 15
  CRNA Billing .......................................................................................................................................... 15
  Hospice Billing (Commercial) .................................................................................................................. 16
  Hospice Billing (Medicare) ....................................................................................................................... 17
  Major Organ Transplant (MOT) Billing .................................................................................................... 19
  Office-Administered Injectable Medications ............................................................................................ 19
  Office-Based Ambulatory Procedures ..................................................................................................... 20
Claim Inquiries and Corrected Billings ......................................................................................................... 20
  Resubmissions or Corrected Claims ....................................................................................................... 20
  Overpayments ....................................................................................................................................... 21
Provider Inquiries ........................................................................................................................................ 21
Provider Appeals and Dispute Resolution .................................................................................................. 22
  Definitions............................................................................................................................................... 22
  Unfair Billing and Payment Patterns ...................................................................................................... 24
Capitated Entity (IPA/MG/Capitated Hospital) Appeal Resolution Requirements ................................... 31
Provider Appeals of Medicare Advantage Claims.................................................................................... 32
  Contracted ............................................................................................................................................ 32
  Non-Contracted ..................................................................................................................................... 34
# Section 5: Blue Shield Benefit Plans and Programs

**Blue Shield Benefit Plans**

<table>
<thead>
<tr>
<th>Plan Type</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Shield HMO Plans</td>
<td>1</td>
</tr>
<tr>
<td>Access+ Specialist℠ Feature</td>
<td>2</td>
</tr>
<tr>
<td>Blue Shield 65 Plus℠ (HMO) (Medicare Advantage)</td>
<td>3</td>
</tr>
<tr>
<td>Medicare Part D</td>
<td>4</td>
</tr>
<tr>
<td>Part D Eligibility</td>
<td>4</td>
</tr>
<tr>
<td>Fraud, Waste, and Abuse Requirements and Training</td>
<td>4</td>
</tr>
<tr>
<td>Exclusion Lists</td>
<td>5</td>
</tr>
<tr>
<td>Medicare Part D Prescriber Preclusion List</td>
<td>5</td>
</tr>
<tr>
<td>Medication Therapy Management Program (MTMP)</td>
<td>6</td>
</tr>
<tr>
<td>Blue Shield PPO Plans</td>
<td>7</td>
</tr>
<tr>
<td>PPO Primary Care Physician Requirement for IFP PPO Members</td>
<td>7</td>
</tr>
<tr>
<td>Point-of-Service (POS) Plans</td>
<td>8</td>
</tr>
<tr>
<td>Point of Service (POS) Options</td>
<td>8</td>
</tr>
<tr>
<td>Federal Employee Program (FEP)</td>
<td>9</td>
</tr>
<tr>
<td>About the BlueCross and BlueShield Service Benefit Plan</td>
<td>10</td>
</tr>
<tr>
<td>Precertification for Inpatient Hospital Admissions</td>
<td>10</td>
</tr>
<tr>
<td>Mental Health, Substance Abuse, and Behavioral Health Services for FEP</td>
<td>10</td>
</tr>
<tr>
<td>Integrated Case Management Program for FEP</td>
<td>13</td>
</tr>
<tr>
<td>Transitions of Care Program for FEP</td>
<td>14</td>
</tr>
<tr>
<td>Medicare Supplement Plans</td>
<td>15</td>
</tr>
<tr>
<td>Claims Assignment</td>
<td>15</td>
</tr>
<tr>
<td>The BlueCard℠ Program</td>
<td>16</td>
</tr>
<tr>
<td>Other Payors</td>
<td>16</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>17</td>
</tr>
<tr>
<td>Psychiatric Care</td>
<td>17</td>
</tr>
<tr>
<td>Member Self-Referral Number</td>
<td>17</td>
</tr>
<tr>
<td>Primary Care Physician Consultation Line</td>
<td>17</td>
</tr>
<tr>
<td>PCP Behavioral Health Toolkit</td>
<td>17</td>
</tr>
<tr>
<td>Telebehavioral Health Online Appointments</td>
<td>17</td>
</tr>
<tr>
<td>Blue Shield MHSAs Covered Services for PPO Commercial Plan Members</td>
<td>18</td>
</tr>
<tr>
<td>Mental Health Services for Self-Funded Accounts (ASO) and the Federal Employee Program (FEP)</td>
<td>18</td>
</tr>
</tbody>
</table>

**Blue Shield Benefit Programs**

<table>
<thead>
<tr>
<th>Program Type</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care Management</td>
<td>19</td>
</tr>
<tr>
<td>Additional Care Management Programs</td>
<td>21</td>
</tr>
<tr>
<td>Home-Based Palliative Care Program</td>
<td>22</td>
</tr>
<tr>
<td>Eligibility/Referral</td>
<td>22</td>
</tr>
<tr>
<td>Wellness and Prevention Programs</td>
<td>23</td>
</tr>
<tr>
<td>CareTips Clinical Messaging</td>
<td>23</td>
</tr>
<tr>
<td>Daily Challenge</td>
<td>23</td>
</tr>
<tr>
<td>Diabetes Prevention Program</td>
<td>23</td>
</tr>
<tr>
<td>LifeReferrals 24/7℠</td>
<td>24</td>
</tr>
<tr>
<td>NurseHelp 24/7℠</td>
<td>25</td>
</tr>
<tr>
<td>Preventive Health Guidelines</td>
<td>25</td>
</tr>
<tr>
<td>Preventive Health Services Policy</td>
<td>26</td>
</tr>
<tr>
<td>QuitNet</td>
<td>26</td>
</tr>
<tr>
<td>Walkadoo</td>
<td>26</td>
</tr>
<tr>
<td>Wellness Discount Programs</td>
<td>27</td>
</tr>
<tr>
<td>Patient Ally</td>
<td>27</td>
</tr>
</tbody>
</table>
## Section 6: Supplemental Direct Contracting HMO Administrative Procedures and Responsibilities

<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview</td>
<td>1</td>
</tr>
<tr>
<td>HMO Practitioner Responsibilities</td>
<td>2</td>
</tr>
<tr>
<td>Role of the Primary Care Physician (PCP)</td>
<td>2</td>
</tr>
<tr>
<td>Prior Authorizations and Referrals</td>
<td>2</td>
</tr>
<tr>
<td>Role of the HMO Specialist</td>
<td>3</td>
</tr>
<tr>
<td>Standing Specialist Referrals</td>
<td>3</td>
</tr>
<tr>
<td>Access-to-Care Monitoring for HMO Members</td>
<td>3</td>
</tr>
<tr>
<td>Office Review for HMO Providers</td>
<td>4</td>
</tr>
<tr>
<td>HMO Member-Related Issues</td>
<td>5</td>
</tr>
<tr>
<td>Member-Initiated Primary Care Physician Change</td>
<td>5</td>
</tr>
<tr>
<td>Provider Requests to Disenroll HMO Members</td>
<td>5</td>
</tr>
<tr>
<td>Provider Status Changes</td>
<td>7</td>
</tr>
<tr>
<td>Primary Care Physician Termination Notification Requirements</td>
<td>7</td>
</tr>
<tr>
<td>Specialist/Specialty Group Termination Notification Requirements</td>
<td>8</td>
</tr>
<tr>
<td>HMO Claims Submission and Processing</td>
<td>9</td>
</tr>
<tr>
<td>Specialist Claims</td>
<td>9</td>
</tr>
<tr>
<td>Access+ SpecialistSM Claims Processing</td>
<td>9</td>
</tr>
</tbody>
</table>
Appendices

Appendix for Section 1
A.  Glossary
B.  Acknowledgement of Financial Responsibility Form

Appendix for Section 2
A.  Blue Shield Bylaws
B.  Blue Shield Home Care Referral Form
C.  NCP Guidelines for Palliative Care
D.  Palliative Care Patient Eligibility Screening Tool

Appendix for Section 3
A.  Clinical Practice Guidelines

Appendix for Section 4
A.  Special Billing Guidelines and Procedures
B.  Electronic Claims Submission
C.  Sample CMS 1500 Form
D.  CMS 1500 General Instructions
E.  Guidelines for Successful ICR Processing
F.  Where to Send Claims
G.  Blue Shield Payment Processing Logic
H.  List of Office-Based Ambulatory Procedures

Appendix for Section 5
A.  The BlueCard® Program
B.  Other Payor Summary List

Appendix for Section 6
A.  Blue Shield 65 Plus (HMO) Medicare Advantage Required Billing Elements
Section 1: Introduction

This page intentionally left blank.
# Table of Contents

Purpose of the Independent Physician and Provider Manual ................................................................. 1  
Manual Orders and Updates .................................................................................................................. 1  
Enrollment and Eligibility ..................................................................................................................... 2  
  Member Eligibility Verification .......................................................................................................... 2  
  Premium Payment Policy .................................................................................................................... 2  
  Blue Shield Enrollment Responsibilities to Members on the Exchange ......................................... 3  
  Provider Requests to Transfer or Disenroll Members (Commercial) ............................................. 3  
  Provider Requests to Transfer or Disenroll Members (Blue Shield 65 Plus) .................................. 5  
Member Rights and Responsibilities .................................................................................................... 9  
  Statement of Member Rights ........................................................................................................... 9  
  Statement of Member Responsibilities ............................................................................................. 10  
Member Grievance Process .................................................................................................................. 11  
  Definitions ................................................................................................................................... 11  
  Blue Shield Commercial Policy ...................................................................................................... 12  
  Blue Shield 65 Plus (HMO) Policy .................................................................................................. 13  
  Standard Review Process ............................................................................................................... 13  
  Expedited Review .......................................................................................................................... 14  
  External Review ............................................................................................................................. 14  
  Contacting the Appeals and Grievance Department ...................................................................... 14  
Fraud Prevention ................................................................................................................................ 15  
  Provider Audits ............................................................................................................................. 15  
  Fraud, Waste, and Abuse .................................................................................................................. 16  
  Blue Shield’s Code of Conduct and the Corporate Compliance Program ....................................... 18  
  Blue Shield 65 Plus Program Overview ......................................................................................... 19  
  Blue Shield 65 Plus Compliance Program ..................................................................................... 19  
    Auditing and Monitoring ................................................................................................................ 21  
    Confirmation of Eligibility of Participation in the Medicare Program ....................................... 21  
Healthcare Regulatory Agencies .......................................................................................................... 22  
  California Department of Insurance (CDI) .................................................................................... 22  
  California Department of Managed Health Care (DMHC) ............................................................ 22  
  Centers for Medicare & Medicaid Services (CMS) ....................................................................... 22
Section 1: Introduction

Purpose of the Independent Physician and Provider Manual

The Independent Physician and Provider Manual describes the Blue Shield of California (Blue Shield) administrative guidelines, policies, and procedures for providers who are directly contracted with Blue Shield. The manual applies to providers of health care services for Blue Shield members covered under various Blue Shield health plans, including, but not limited to:

- Blue Shield PPO
- Access+ HMO® (Commercial HMO)
- Blue Shield 65 PlusSM (HMO)1 Individual and Group (Blue Shield’s Medicare Advantage product)

The information in this manual applies to the following types of providers who have signed a Blue Shield provider agreement:

- Physicians
- Acupuncturists
- Audiologists
- Chiropractors
- Hearing Aid Dispensers
- Hemophilia Infusion Providers
- Home Health Providers
- Home Infusion Providers
- Home Medical Equipment Providers
- Hospice Providers
- Laboratories
- Licensed Clinical Psychologists (LCPs)
- Licensed Clinical Social Workers (LCSWs)
- Licensed Professional Clinical Counselors (LPCCs)
- Marriage Family Therapists (MFTs)
- Occupational Therapists
- Opticians
- Optometrists
- Orthotics/Prosthetics Dispensers
- Other providers, as required
- Physical Therapists
- Podiatrists
- Speech and Language Pathologist

Note: The HMO information in this manual does not apply to Blue Shield providers when they provide healthcare services for HMO/POS members through their affiliation with a Blue Shield-contracted IPA/medical group. These providers should contact their affiliated IPA/medical group for information regarding its internal policies and procedures.

While this manual covers many areas regarding delivery and coordination of health care for Blue Shield members, it may not cover your specific issue or question. In those instances, please contact Provider Information & Enrollment at (800) 258-3091 for additional information.

Manual Orders and Updates

Go to Provider Connection at blueshieldca.com/provider to view and download a copy of this manual. The manuals are located under the Provider Manuals section under the Guidelines & Resources tab.

To order a copy of the manual on CD, email providermanuals@blueshieldca.com or contact Provider Information & Enrollment (800) 258-3091.

This manual is updated at least annually, in January.

---

1 The term Blue Shield 65 Plus refers to Blue Shield’s Medicare Advantage plans: Blue Shield 65 Plus (HMO), Blue Shield Plus Choice Plan (HMO), and Blue Shield Trio Medicare (HMO).
Enrollment and Eligibility

Member Eligibility Verification

For routine eligibility verification, the provider may:

- Log onto Provider Connection at blueshieldca.com/provider for current and historical eligibility and benefit information that is updated daily.

- Use the Provider Customer Service toll-free number listed on the member’s ID card.

If eligibility cannot be verified, the provider should obtain written verification that the member agrees to accept financial responsibility if not eligible for Blue Shield coverage.

The provider may use his/her own office form or Blue Shield’s Member Acknowledgment of Financial Responsibility Form for this purpose. A copy of this form can be found in Appendix 1-B of this manual or on Provider Connection at blueshieldca.com/provider under Guidelines and Resources and then Forms.

Premium Payment Policy

The member is responsible for payment of premiums to Blue Shield. Blue Shield does not accept direct or indirect payments of premiums from any person or entity other than the member, his or her family members or a legal guardian, or an acceptable third party payor, which are:

- Ryan White HIV/AIDS programs under Title XXVI of the Public Health Services Act;

- Indian tribes, tribal organizations or urban Indian organizations;

- A lawful local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf; and

- Bona fide charitable organizations and organizations related to the member (e.g., church or employer) when all of the following criteria are met: payment of premiums is guaranteed for the entire plan year; assistance is provided based on defined financial status criteria and health status is not considered; the organization is unaffiliated with a healthcare provider; and the organization has no financial interest in the payment of a health plan claim. (Financially interested institutions/organizations include institutions/organizations that receive the majority of their funding from entities with a financial interest in the payment of health insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a financial interest in the payment of health insurance claims.)

Upon discovery that premiums were paid directly or indirectly by a person or entity other than the member or an acceptable third party payor, Blue Shield has the right to reject the payment and inform the member that the payment was not accepted and that the premiums remain due. Payment of member premiums by a Blue Shield contracted provider represents a material breach of the provider’s agreement. Please note that processing any payment does not waive Blue Shield’s right to reject that payment and future payments under this policy.
Enrollment and Eligibility (cont’d.)

Blue Shield Enrollment Responsibilities to Members on the Exchange

Under the Patient Protection and Affordable Care Act (PPACA) for Exchange-purchased individual insurance policies eligible for premium subsidies, when premiums/dues are not received from members, there will be a three-month (90-day) delinquency period. During this grace period, Blue Shield may not disenroll delinquent members, but may suspend claims payments unless and until member premiums are received in full. See Section 4: Special Billing Situations for Blue Shield’s responsibilities regarding unpaid premiums for Exchange members.

Provider Requests to Transfer or Disenroll Members (Commercial)

Blue Shield policies for involuntary transfer or disenrollment of members are based on Health & Safety Code Section 1365 and California Code of Regulations Section 1300.65. Blue Shield retains sole and final authority to review and act upon the requests from providers to transfer or terminate a member. Members are not transferred against their will nor terminated until Blue Shield carefully reviews the matter, determines that transfer or termination is appropriate, and confirms that Blue Shield’s internal procedures as outlined below have been followed. All transfer requests are carefully reviewed and care is taken to preserve member rights against discrimination due to age, race, gender, or health status.

A Blue Shield provider may not end its relationship with a member because of his or her medical condition or the cost and type of benefits that are required for treatment. A member who alleges that an enrollment has been canceled or not renewed because of the member’s health status or requirements for health care services may request a review by the Department of Managed Health Care (DMHC).

Reasons for Immediate Disenrollment

Blue Shield may terminate coverage of a member for cause, IMMEDIATELY after the member receives written notice for any of the following:

- Fraud or an intentional misrepresentation of any material fact during the enrollment process.
- Permitting a non-member to use a member identification card to obtain services and benefits.
- Obtaining or attempting to obtain services or benefits under the contract using false, materially misleading, or fraudulent information, acts, or omissions.
- Exhibiting disruptive behavior or threatening the life or well-being of Blue Shield personnel, providers of services, or another Blue Shield member.

Reasons for Disenrollment that Require a 31-Day Notice

Blue Shield may terminate coverage of a member for cause after giving 31 DAYS written notice for the following reasons:

- Inability to establish a satisfactory physician-patient relationship.
- Repeated and unreasonable demands for unnecessary medical services including medications when such demands are not in accordance with generally accepted professional standards.
- Failure to pay any copayment or supplemental charge.
Provider Requests to Transfer or Disenroll Members (Commercial) (cont’d.)

Provider Procedures for Disenrollment

Before requesting to transfer or disenroll a member for cause, the provider counsels the member in writing about the problem. The letter to the member is sent by certified mail. If the problem continues, the provider may request disenrollment by sending all documentation, including the initial counseling letter, to the following address:

Blue Shield of California  
Attention: Member Disenrollment  
P.O. Box 272550  
Chico, CA 95927-2550

Please provide Member Disenrollment with sufficient documentation so that Blue Shield will be able to make a decision based on the evidence.

1. Upon receipt of the transfer or disenrollment request and sufficient documentation, Blue Shield reviews the case and may:

   • Decide the evidence is not sufficient to disenroll the member.
   • Send a second counseling letter to the member.
   • Transfer the member to another Blue Shield provider (where the member has been provided appropriate 31 day written notice and there has been an irreconcilable breakdown in the patient/physician relationship).
   • Disenroll the member from the Blue Shield health plan with 31 days written notice.

   Note: If the transfer request is received verbally by Blue Shield, the call is transferred to a Member/Customer Services Supervisor who forwards any pertinent information to Provider Information & Enrollment if necessary. The provider is advised to submit their request in writing to Blue Shield for review and follow-up as noted above.

2. Blue Shield sends the provider written notice of its decision.

   • If the provider does not provide adequate documentation to substantiate an involuntary transfer, Member/Customer Services and/or Provider Information & Enrollment contacts the provider and advises them that they must provide additional written documentation of the issues or events that lead to the transfer request.
   • If Blue Shield determines that a member transfer is warranted, the member is notified in writing (certified, return receipt) under the signature of the appropriate Blue Shield Member/Customer Services department. The transfer notification letter informs the member of the request made by the provider and the member can select another Blue Shield contracted provider. The letter clearly outlines the reasons why the request is being made and informs the member that if they do not select a new Blue Shield provider within 30 days of the date the letter was mailed, a new provider will be selected for them.
Enrollment and Eligibility  (cont’d.)

Provider Requests to Transfer or Disenroll Members (Commercial)  (cont’d.)

3. Once notice is given, members are transferred, effective the first of the following month unless an immediate transfer has been requested by the provider. If applicable, the letter informs the member that Blue Shield may pursue involuntary disenrollment if the events leading to the transfer reoccur. An explanation of the member’s right to a hearing under Blue Shield’s grievance procedures is also included in the letter.

- When a member transfers to another Blue Shield provider, the previous provider provides patient records, reports and other documentation at no charge to Blue Shield, the new provider, or member.
- The existing provider must continue to coordinate care through the date of transfer or disenrollment including timely processing of referrals.

Provider Requests to Transfer or Disenroll Members (Blue Shield 65 Plus)

Blue Shield has established procedures, based on Centers for Medicare & Medicaid Services (CMS) requirements, for when network providers want to end their relationship with a Blue Shield 65 Plus (HMO) member for cause, such as disruptive behavior or legal action by the member against the provider. This section defines acceptable reasons and procedures for processing provider requests to transfer Blue Shield 65 Plus members involuntarily while continuing to provide appropriate treatment with an existing healthcare provider.

Providers may not end a relationship with a member because of the member’s medical condition or the cost and type of care that is required for treatment, or for the member’s failure to follow treatment recommendations.

Blue Shield 65 Plus members may not be involuntarily transferred without Blue Shield 65 Plus approval. An involuntary transfer request would be considered only for the following situations:

- The member is disruptive, abusive, unruly, or uncooperative to the extent that the provider’s ability to provide services is seriously impaired.

In this case, Blue Shield 65 Plus must review any request for an involuntary transfer request. The Blue Shield review, for most situations, looks for evidence that the individual continued to behave inappropriately after being counseled/warned about his or her behavior and that an opportunity was given to correct the behavior. The provider must have made several attempts to provide counseling to the member. A minimum of three (3) documented written warnings must be provided for consideration of an involuntary transfer request. Counseling done by plan providers is considered informal counseling and an initial warning letter related to the member’s behavior must also be sent by Blue Shield. Blue Shield requires documentation/medical records from the physician group prior to sending the member an official warning letter from the plan. If the inappropriate behavior was due to a medical condition (such as any mental health issue or a physical disability), the provider must demonstrate that the underlying medical condition was controlled and was not the cause of the inappropriate behavior.
Section 1: Introduction

Enrollment and Eligibility (cont’d.)

Provider Requests to Transfer or Disenroll Members (Blue Shield 65 Plus)
(cont’d.)

- Legal action by a member against a physician or physician group can create a problematic situation in balancing the state and federal 30-day notice provisions related to involuntary disenrollments, along with the physician concerns about continuing to treat an individual who has filed a suit against a physician or physician group. Blue Shield 65 Plus Member Services staff can assist by contacting the member in such a circumstance. Since such litigation demonstrates a breakdown in the patient/physician relationship, Member Services can verify if the member wishes to voluntarily transfer to a new Primary Care Physician (PCP) or physician group. While the circumstances will vary and may require individual review, in general, if a member does not wish to voluntarily transfer, Blue Shield would be required to provide the member with the requisite 30-day notice in order to comply with current legal requirements. In such circumstances, if the physician is not willing to see the patient during the 30-day transition period, the physician must make arrangements for the member to be seen by an alternate physician and notify Blue Shield and the member of the alternate arrangements in writing.

Procedure

Before requesting to involuntarily transfer a member for cause, the PCP must counsel the member verbally and in writing about the problem. Provider warning letters to the member must be sent by the provider via certified mail or a courier service to track that the warning letter was received (a copy of the letter must also be sent to Blue Shield 65 Plus Member Services Department). If the behavior or problem continues, the provider may request Blue Shield to take steps to counsel the member and initiate the protocols required for the plan to involuntarily transfer the member to another provider or physician group.

Providers are required to submit all documentation related to disruptive members to Blue Shield for review. This documentation includes:

- Documentation of the disruptive behavior, including a thorough explanation of the individual’s behavior and how it has impacted the provider’s ability to arrange for or provide services to the individual or other members;
- Written warning letters or counseling letters from the provider and/or the physician group showing serious efforts have been made to resolve the problem with the individual;
- Relevant police reports or documentation of intervention by the Police Department (if applicable);
- Documentation establishing that the member’s behavior is not related to the use, or lack of use, of medical services;
- Proof that the member was provided with appropriate written notice of the consequences of continued disruptive behavior;
- Member information, including diagnosis, mental status, functional status, a description of his or her social support systems, and any other relevant information; and
- Proof of effort to provide reasonable accommodations for individuals with disabilities, if applicable, in accordance with the Americans with Disabilities Act.

The physician’s or physician group’s request for involuntary transfer for disruptive behavior must be complete. All documentation should be submitted to Blue Shield 65 Plus Member Services.
Enrollment and Eligibility (cont’d.)

Provider Requests to Transfer or Disenroll Members (Blue Shield 65 Plus)
(cont’d.)

Upon receipt of the transfer request and all required documentation, Blue Shield reviews the case and may:

- Decide the evidence is not sufficient to involuntarily transfer the member. The provider or physician group (where applicable) will be notified of the plan’s determination.

- Send additional counseling letters to the member. CMS requires the plan to send an official warning letter to Blue Shield 65 Plus members describing the behavior that has been identified as disruptive and how it has impacted the plan’s ability to manage the individual’s care. (Note: If the disruptive behavior ceases after the member receives notice and later resumes, the involuntary disenrollment process must begin again.)

- Request Medical Care Solutions intervention to assist the member in managing their healthcare.

- Transfer the member to another network provider (where the member has been provided appropriate (30 day) written notice and there has been an irreconcilable breakdown in the patient/physician relationship).

  *Note: If the transfer request is received verbally by Blue Shield from a PCP, the call is transferred to the appropriate Member Services Team Leader who will request the written documentation and forward any pertinent information to Provider Relations and Medicare Compliance as necessary. A verbal request will still require that the provider send Blue Shield all written documentation related to the member’s behavior.*

Blue Shield sends the provider a written notice of its decision. Please note that CMS considers counseling done by the PCP or physician group for Blue Shield 65 Plus members as informal notice and only recognizes counseling letters sent from the health plan as formal notification to the member.

  *Note: Providers must work with Blue Shield to provide sufficient documentation so that Blue Shield 65 Plus can send a formal warning notice to members.*

- If the provider does not provide adequate documentation to substantiate an involuntary transfer request, Member Services and/or Provider Relations contacts the provider and advises them that they must provide additional written documentation of the issues or events that led to the transfer request.

- If Blue Shield determines that a member transfer is warranted, the member is notified in writing (certified, return receipt) under the signature of the appropriate Blue Shield Member Services department. The transfer notification letter informs the member of the request made by the PCP and that the member can select another PCP in the same IPA/medical group or (if warranted) in another IPA/medical group. The letter clearly outlines the reasons why the request is being made and informs the member that if they do not select a new PCP within 30 days of the date the letter was mailed, a new PCP will be selected for them.

The member will be transferred once the written notice is given and is effective the first of the following month. If applicable, the letter informs the member that Blue Shield may pursue involuntary disenrollment through CMS if the events leading to the transfer reoccur. An explanation of the member’s rights to a hearing under the Blue Shield 65 Plus grievance procedure is also included in the letter.
Provider Requests to Transfer or Disenroll Members (Blue Shield 65 Plus) (cont’d.)

• When a member transfers to a new IPA/medical group, the previous provider must supply patient records, reports and other documentation at no charge to Blue Shield, the new IPA/medical group, provider or member.

• The existing Primary Care Physician must continue to coordinate care through the date of transfer.

Blue Shield follows regulatory guidelines and retains sole and final authority to review and act upon the requests from providers to transfer a member. Members are not transferred against their will until Blue Shield carefully reviews the matter, determines that transfer is appropriate, and confirms that Blue Shield’s internal procedures have been followed. All transfer requests are carefully reviewed and care is taken to preserve member rights against discrimination due to age, race, gender, or health status.

In the unlikely event that one of the following extreme conditions arises, Blue Shield 65 Plus may have to discontinue benefits:

• Epidemic, riot, war, or major disaster.

• Complete or partial destruction of facilities.

• Loss or disability of a large number of our providers.

Under these extreme conditions, Blue Shield 65 Plus contracted hospitals and contracted providers will continue to make their best efforts to provide services. The member may go to the nearest medical facility for medically necessary services and will be reimbursed by Blue Shield for those charges.
Member Rights and Responsibilities

Blue Shield has established Member Rights and Responsibilities that all Blue Shield members receive in their Evidence of Coverage.

Statement of Member Rights

Blue Shield health plan members have the right to:

1. Receive considerate and courteous care, with respect for their right to personal privacy and dignity.
2. Receive information about all health services available to them, including a clear explanation of how to obtain health services.
3. Receive information about their rights and responsibilities.
4. Receive information about their health plan, the services we offer them, the physicians and other practitioners available to care for them.
5. Select a primary care physician and expect his/her team of health workers to provide or arrange for all the care that they need.
6. Have reasonable access to appropriate medical services.
7. Participate actively with their physician in decisions regarding their medical care. To the extent permitted by law, they also have the right to refuse treatment.
8. A candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage.
9. Receive from their physician an understanding of their medical condition and any proposed appropriate or medically necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so they can make an informed decision before they receive treatment.
10. Receive preventive health services.
11. Know and understand their medical condition, treatment plan, expected outcome, and the effects these have on their daily living.
12. Have confidential health records, except when disclosure is required by law or permitted in writing by them. With adequate notice, they have the right to review their medical record with their primary care physician.
13. Communicate with and receive information from member services in a language they can understand.
14. Know about any transfer to another hospital, including information as to why the transfer is necessary and any alternatives available.
15. Obtain a referral from their primary care physician for a second opinion.
16. Be fully informed about the Blue Shield grievance procedure and understand how to use it without fear of interruption of health care.
17. Voice complaints about the health plan or the care provided to them.
18. Participate in establishing public policy of the Blue Shield health plans, as outlined in their Evidence of Coverage or Health Service Agreement.
19. Make recommendations regarding Blue Shield’s member rights and responsibilities policy.
Member Rights and Responsibilities (cont’d.)

Statement of Member Responsibilities

Blue Shield health plan members have the responsibility to:

1. Carefully read all Blue Shield health plan materials immediately after they are enrolled so they understand how to use their benefits and how to minimize their out-of-pocket costs. Ask questions when necessary. They have the responsibility to follow the provisions of their Blue Shield health plan membership as explained in the Evidence of Coverage or Health Service Agreement.

2. Maintain their good health and prevent illness by making positive health choices and seeking appropriate care when it is needed.

3. Provide, to the extent possible, information that their physician, and/or the plan need to provide appropriate care for them.

4. Understand their health problems and take an active role in developing treatment goals with their medical care provider, whenever possible.

5. Follow the treatment plans and instructions they and their physician have agreed to and consider the potential consequences if they refuse to comply with treatment plans or recommendations.

6. Ask questions about their medical condition and make certain that they understand the explanations and instructions they are given.

7. Make and keep medical appointments and inform the plan physician ahead of time when they must cancel.

8. Communicate openly with the primary care physician they choose so they can develop a strong partnership based on trust and cooperation.

9. Offer suggestions to improve the Blue Shield health plan.

10. Help Blue Shield to maintain accurate and current medical records by providing timely information regarding changes in address, family status, and other health plan coverage.

11. Notify Blue Shield as soon as possible if they are billed inappropriately or if they have any complaints.

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

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

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

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

Blue Shield administers the investigation of member grievances. This process follows a standard set of policies and procedures for the resolution of grievances for both Blue Shield 65 Plus (HMO) and Commercial HMO and PPO members. The process also encourages communication and collaboration on grievance issues among Blue Shield departments and functional areas. Blue Shield requests that contracted providers become familiar with the member grievance process and suggest members use it.

Although it is inadvisable to require patients to sign arbitration agreements as a condition of providing medical care, providers may choose to enter into arbitration agreements with Blue Shield plan members, providing the agreement to arbitrate fully complies with the California Code of Civil Procedure (CCP) Section 1295 including the important provision that the patient is permitted to rescind the arbitration agreement in writing within 30 days of signature, even when medical services have already been provided.

Blue Shield encourages members to resolve their grievances with their Blue Shield providers. If this is not possible, members, member representatives, or an attorney or provider on the member’s behalf, may contact their Customer Service locations for initiation of the grievance process.

A member’s grievance is defined as any of the following:

- Potential Quality Issues (PQI)
- Appeal
- Expedited Review
- Complaint

Definitions

Potential Quality Issue (PQI) – Any suspected deviation from expected provider or health plan performance that deals with the quality of care and/or the quality of service provided by any provider related to any Blue Shield or Blue Shield Life enrollee’s care or treatment, regardless of Line of Business. Possible examples include but are not limited to those listed below. PQIs can be categorized as followed:

- Access to Care
- Referral/Authorization Procedures
- Communication issues
- Provider/Staff Behavior
- Coordination of Care
- Technical Competence or Appropriateness
- Facility/Office Environment
Member Grievance Process (cont’d.)

Definitions (cont’d.)

Appeal – A request for Blue Shield’s or Blue Shield’s Life’s reconsideration of an initial determination (either verbal or written) which resulted in the following:

- Complete denial of service, benefit or claim
- Reduction of benefits or claim payment
- Redirection of service or benefits
- Delay of prospective authorization for service or benefits
- Eligibility related denials

Expedited Review or Expedited Initial Determination (EID) – Any denial, termination, or reduction in care, where the member feels that the determination was inappropriate and the routine decision making process might seriously jeopardize the life or health of the member, or when the member is experiencing severe pain. The expedited review process requires resolution and response to the member as soon as possible to accommodate the member’s condition not to exceed 72 hours of the member’s initial request. The member, his/her representative, or his/her physician on behalf of the member may file this request.

Complaint – An expression of dissatisfaction with a provider, provider group, vendor, or health plan that does not have a clinical aspect or claims monetary component to the issue.

Blue Shield Commercial Policy

All Blue Shield commercial members receive in their Evidence of Coverage or Certificate of Insurance, a Statement of Member Rights and Responsibilities.

Members, member representatives, or an attorney or provider on the member’s behalf, may file a grievance by contacting Blue Shield’s Customer Service Department in writing, by telephone, or by submitting a completed Grievance Form online at blueshieldca.com. Blue Shield researches and investigates all grievances and, as appropriate, the Blue Shield Medical Director may review a grievance.

In compliance with the Department of Managed Health Care (DMHC), California Department of Insurance (CDI), legislative requirements, and NCQA, Blue Shield will resolve all member grievances within 30 calendar days of receipt.

When appropriate, Blue Shield will send copies of the member’s correspondence to the provider and request that he/she review and respond in writing to the Blue Shield Medical Director.
Member Grievance Process *(cont’d.)*

**Blue Shield 65 Plus (HMO) Policy**

All Blue Shield 65 Plus members receive in their *Evidence of Coverage* a Statement of Member Rights and Responsibilities. If a Blue Shield 65 Plus member asks about filing a grievance, complaint, or an appeal, the member should be referred to Blue Shield 65 Plus Member Services.

The Blue Shield 65 Plus Appeals and Grievance Resolution Department will acknowledge receipt of the member’s concern within five calendar days of receipt and provide the member with the name and phone number of the person working on their concern. The complaint will be resolved within 30 calendar days of receipt. Post service appeals (claims) are resolved within 60 days.

If the member is not satisfied with the initial resolution of the grievance or complaint, the member may file a written request for a grievance hearing. The grievance hearing will be scheduled within 31 days of receipt of request and will be held at the Blue Shield Woodland Hills office location. The panel will include a Blue Shield 65 Plus Medical Director and a representative from the Blue Shield 65 Plus Appeals and Grievances Department.

All grievances are researched and investigated by the Blue Shield 65 Plus Appeals and Grievance Resolution Department, and, as appropriate, reviewed by a Blue Shield Medical Director. Medicare policy, such as Medicare National Coverage Determinations (NCDs) and Local Coverage Determinations (LCDs), must be applied in the review of appeals by Blue Shield 65 Plus members.

If a member, member representative, or physician files a grievance, appeal or complaint, you may be required to provide medical records for review as part of the review process. As a Blue Shield contracted provider, you are responsible for the maintenance of a member's medical records and the timely submission of any and all requested documentation considered as part of the review process.

**Standard Review Process**

The standard review process for member grievances allows a 30 calendar day period of resolution from the date the grievance is received by Blue Shield to the time the member is informed of the decision. When the grievance is received, Blue Shield will acknowledge receipt of the member’s grievance within five calendar days of receipt and provide the member with the name of a person to contact regarding their grievance. Generally, the member must participate in Blue Shield’s grievance process for 30 calendar days before submitting a complaint to the DMHC or CDI. The DMHC or CDI can waive this requirement in “extraordinary and compelling cases.” In these events, Blue Shield has five working days to respond to the grievance. The Blue Shield grievance system allows members to file grievances within 180 days following any incident or action that is the subject of the enrollee’s dissatisfaction.
Member Grievance Process (cont’d.)

Expedited Review

In keeping with the Knox Keene Act, Blue Shield provides an expedited review process in those circumstances where a member believes that his/her health or ability to function could be seriously harmed by waiting the 30 calendar days for a standard grievance. There are specific criteria that must be met in order for a grievance to be considered expedited. If there is a question as to whether a specific grievance qualifies, the member, member representative, or an attorney or provider on behalf of the member may contact Customer Services and request an expedited review. If the grievance meets the expedited criteria, the case will be handled within the expedited review process. If the grievance does not meet the criteria, the member will be informed of this decision and the review will be conducted under the standard review process guidelines. The expedited review process requires resolution and response to the member as soon as possible to accommodate the member’s condition not to exceed 72 hours of the member’s initial request. The member, his/her representative, his/her attorney or his/her physician on behalf of the member may file this request.

External Review

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

Contacting the Appeals and Grievance Department

To contact the Appeals and Grievance Department, please refer to the contact list on Provider Connection at https://www.blueshieldca.com/provider/about-this-site/contact-us/contact-us-claims.sp.
Fraud Prevention

Each year hundreds of millions of dollars are lost due to health care fraud, waste, and abuse. The mission of the Blue Shield Special Investigations Unit (SIU) is to ensure we provide the best investigative services for the company and stakeholders by being nimble and highly responsive to a broad spectrum of suspected fraudulent activities. The SIU is accountable for leading in investigations and criminal/civil prosecutions of internal and external entities and is the primary liaison with all levels of law enforcement. In conjunction, the SIU coordinates efforts to recover erroneous payments, misrepresentative billing, fraud, abuse or other acts resulting in overpayments.

Providers can help us to stop this pervasive problem by reporting suspicious incidents. To learn more, as well as how and what to report, go to Provider Connection at blueshieldca.com/provider, click on the Privacy link at the bottom, and then the Fraud Prevention link to the left. Here, providers can get guidance related to billing practices and prevention of inappropriate practices. Investigators in the Special Investigations Unit research suspicious billing practices.

Providers can also email Special Investigations directly at stopfraud@blueshieldca.com, or call Blue Shield’s 24-hour Fraud hotline at the toll-free telephone number (855) 296-9092. Callers and emailers may remain anonymous, if desired.

Provider Audits

The Blue Shield Special Investigations Unit (SIU) has the duty and responsibility to conduct periodic provider audits. The SIU monitors and analyzes billing practices in order to ensure services are correctly billed and paid.

Audits are also conducted to ensure compliance with:

- Blue Shield of California Medical, Medication and Payment Policies
- Accepted CPT, HCPCS, ICD-10-CM, and ICD-10-PCS billing and coding standards
- Scope of Practice
- Blue Shield’s policies and procedures on claims submissions
- State and federal laws and regulations

All audits comply with federal and state regulations pertaining to the confidentiality of patient records and the protection of personal health information.

SIU personnel shall contact the provider’s office to schedule onsite audits five (5) business days in advance or earlier if mutually agreed upon. The provider shall allow inspection, audit and duplication of any and all records maintained on all members to the extent necessary to perform the audit or inspection. This includes any and all Electronic Health Records (EHR) and systems including any electronically stored access logs and data entry for electronic systems. Blue Shield requires that all records and documentation be contained in each corresponding Patient chart at the time of the audit. Audit findings will be communicated in writing.

Provider audits may result in a determination of overpayment and a request for refund. Please refer to Section 4, Billing, Claim Inquiries and Corrected Billings, Overpayments for information on the Blue Shield’s process and procedures for notification of overpayments and offset.
Section 1: Introduction

Fraud Prevention (cont’d.)

Fraud, Waste, and Abuse

The Medicare Prescription Drug benefit has been implemented by the Centers for Medicare & Medicaid Services (CMS) to allow all Medicare beneficiaries access to prescription drug coverage. In its effort to combat fraud in the Medicare prescription drug program, CMS has added several Medicare Drug Integrity Contracts (MEDICs). In California, the MEDIC is Health Integrity, LLC. Health Integrity, LLS is responsible for monitoring for fraud, waste, or abuse in the Medicare Part C and Part D programs on a national level.

Health Integrity, LLC has been authorized by CMS to monitor Medicare fraud, waste, and abuse and to investigate any beneficiary complaints related to Medicare Part C & D benefits.

Health Integrity, LLC is interested in receiving reports of potential fraud, waste or abuse from Medicare beneficiaries. Examples of these types of complaints may include:

- An individual or organization pretends to represent Medicare and/or Social Security, and asks the beneficiary for their Medicare or Social Security number, bank account number, credit card number, money, etc.
- Someone asks the beneficiary to sell their Medicare prescription ID card.
- Someone asks the beneficiary to get drugs or medical services for them using their Medicare ID card.
- The beneficiary feels a Medicare Advantage or standalone Part D plan has discriminated against them, including not letting them sign up for a specific plan because of their age, health, race, religion, or income.
- The beneficiary was encouraged to disenroll from their current health plan.
- The beneficiary was offered cash to sign up for a Medicare Advantage or standalone Part D plan.
- The beneficiary was offered a gift worth more than $15 to sign up for a Medicare Advantage or standalone Part D plan.
- The beneficiary’s pharmacy did not give them all of their drugs.
- The beneficiary was billed for drugs or medical services that he/she didn’t receive.
- The beneficiary believes that he/she was charged more than once for their premium costs.
- The beneficiary’s Medicare Advantage or standalone Part D plan did not pay for covered drugs or services.
- The beneficiary received a different drug than their doctor ordered.

Medicare beneficiaries should contact Health Integrity, LLC at (877) 772-3379 to report complaints about any of these types of fraud, waste and abuse issues or a related complaint. Health Integrity, LLC may also be contacted via facsimile at (410) 819-8698 or at their website www.healthintegrity.org. Reports may also be submitted directly to Blue Shield’s Special Investigations Unit at (855) 296-9092, the Medicare Compliance Department at (855) 296-9084, or via email at stopfraud@blueshieldca.com.
Fraud Prevention (cont’d.)

Medicare Compliance and Fraud, Waste, and Abuse Training Requirements

Blue Shield has a comprehensive program in place to detect, prevent and control Medicare Fraud, Waste, and Abuse (FWA) as part of the General Compliance Plan Requirements (42 C.F.R. § 423.504(b)(4)(vi)(H)) and 42 C.F.R. § 422.503(b)(4)(vi).

The Medicare Compliance and Fraud, Waste, and Abuse training is a requirement under CMS for anyone who works with the Medicare programs. Blue Shield's Medicare Compliance training is available for First-Tier, Downstream, and Related Entities (FDRs), including but not limited to IPAs, medical groups, providers, independent sales agents, third party marketing organizations (TMOs), and contracted pharmacies to ensure these providers have a thorough understanding Medicare Program requirements. Successful completion is required of anyone involved with the administration or delivery of the Medicare benefit. The training focuses on how to detect, correct, and prevent non-compliance and fraud, waste, and abuse surrounding Medicare programs. To access the online training, please go to https://www.blueshieldca.com/provider/about-this-site/announcements/medicare-compliance-training.sp.

All FDRs must ensure that all personnel, employees and contracted staff involved in the administration or delivery of Medicare benefits complete Blue Shield’s Medicare Compliance and FWA training, alternative equivalent training through another Medicare Plan Sponsor, the CMS web-based Compliance and FWA training, or deemed through enrollment into the Medicare program or accreditation as a durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) supplier.

This requirement applies to all personnel, employees and contracted staff upon initial hire. Evidence of training must be maintained for a minimum of ten (10) years and produced upon request for audit purposes. Training must be completed within 90 days of hire or election to the Board and annually thereafter.

A statement of attestation is required annually by all IPAs, medical groups, and network pharmacies contracted with Blue Shield for the Medicare programs. The compliance statement of attestation indicates that the IPA, medical group or pharmacy staff and downstream providers have completed the Medicare Compliance and Fraud, Waste, and Abuse training, equivalent training from another Plan Sponsor, or the CMS web-based compliance and FWA training.
Blue Shield’s Code of Conduct and the Corporate Compliance Program

Blue Shield is subject to a wide variety of federal, state, and local laws. These include, but are not limited to, laws governing confidentiality of medical records, personally identifiable information, health plan and insurance regulatory requirements, government contracts, kickbacks, fraud, waste, and abuse, false claims and provider payments.

Blue Shield’s Code of Conduct is the foundation of our Corporate Compliance Program, which is designed to prevent, detect and remediate unlawful and unethical conduct by Blue Shield personnel, as well as to promote a corporate culture of integrity. In doing so, the Program is designed to create an environment that facilitates the reporting of actual or suspected violations of the Code and other misconduct without fear of retaliation.

Reporting misconduct demonstrates transparency, responsibility, and integrity to other workforce members, business partners, Board members, and our customers. It also serves to protect our Company, brand, and reputation. We all “own” compliance and integrity with our daily conduct and decisions.

Providers can make confidential reports of concerns via the Compliance and Ethics Help Line at (888) 800-2062 or report actual or potential violations anonymously via the Compliance & Ethics Hot Line at (855) 296-9083. To view Blue Shield’s Code of Conduct, click the link below:

[Blue Shield of California Code of Conduct.pdf](#)

If providers have additional questions about this program, please contact Provider Information & Enrollment at (800) 258-3091.
Section 1: Introduction

Blue Shield 65 Plus Program Overview

The Medicare Prescription Drug Improvement and Modernization Act (MMA) introduced the Medicare Advantage Program and the Prescription Drug Benefit. The prescription drug benefit, as well as an employer subsidy for qualified retiree health plans, is referred to as Medicare Part D. Coverage for the drug benefit is being provided by private prescription drug plans (PDPs) that offer drug-only coverage, or through Medicare Advantage plans that offer both prescription drug and health care coverage (known as Medicare Advantage – Prescriptions Drug (MA-PD) plans.

Blue Shield 65 PlusSM (HMO), Blue Shield 65 Plus Choice Plan (HMO) and Blue Shield Trio Medicare (HMO) are Blue Shield’s Medicare Advantage-Prescription Drug plans that are open to all Medicare beneficiaries, including those under age 65 who are entitled to Medicare on the basis of Social Security disability benefits, who meet all of the applicable eligibility requirements for membership, have voluntarily elected to enroll in Blue Shield 65 Plus, have paid any premiums required for initial enrollment to be valid, and whose enrollment in Blue Shield 65 Plus has been confirmed by the Centers for Medicare & Medicaid Services (CMS). Blue Shield 65 Plus is offered to individual Medicare beneficiaries and to group Medicare beneficiaries retired from employer groups/ unions who have selected the product as an option.

The Blue Shield 65 Plus plan provides comprehensive coordinated medical services to members through an established provider network. Similar to the commercial HMO product, Blue Shield 65 Plus members must choose a Primary Care Physician (PCP) and have all care coordinated through this physician.

The Blue Shield 65 Plus plan is regulated by CMS, the same federal agency that administers Medicare.

Blue Shield 65 Plus Compliance Program

The Medicare Modernization Act (MMA) established the Medicare Advantage (MA) Program, building on the prior compliance requirements for health plans contracted under the Medicare program. The MMA added Medicare Part D and new coverage for prescription drugs and continued to build on the program integrity provisions in the Balanced Budget Act of 1997. Medicare Advantage Organizations and Part D Sponsors are required by CMS to have a compliance program in place through which the organization establishes and maintains compliance with all federal and state standards. Moreover, provisions in the Affordable Care Act (ACA) require that the compliance program be “effective” in preventing and correcting non-compliance with Medicare Program requirements and fraud, waste, and abuse.

The compliance program must include:

- Written Policies, Procedures, and Standards of Conduct
- Compliance Officer, Compliance Committee and High Level Oversight
- Effective Training and Education
- Effective Lines of Communication
- Well Publicized Disciplinary Actions
- Effective System for Routine Monitoring, Auditing and Identification of Compliance Risks
- Procedures and System for Prompt Response to Compliance Issues
Blue Shield 65 Plus Compliance Program (cont’d.)

Blue Shield has a Corporate Compliance Program in place that includes four primary components:

- Model policies for employee, officer and director conduct
- Code of business conduct
- Toll-free hotline for reporting actual or suspected violations
- Special investigations team for fraud and abuse reviews

All the components in our Corporate Compliance Program are supported by Blue Shield values which include:
- doing the right thing; placing customers at the center of what we do; keeping promises; being creative and taking risks; creating an environment that promotes personal, professional, and team fulfillment; and being responsible for maintaining Blue Shield’s heritage. Leadership principles reinforce our organizational commitment to our company values.

While the existing Corporate Compliance Program remains the foundation for our organizational compliance, a separate compliance structure was established for the Medicare Advantage Program and the Medicare Part D Programs. Medicare Compliance is supported by a dedicated team. Under the oversight of Blue Shield’s Vice President, Chief Compliance & Ethics Officer, the Medicare Compliance Department handles communication with CMS and the Blue Shield operating departments regarding the Medicare plans. A dedicated team headed by the Director of Medicare Compliance, Medicare Compliance Managers, staff of compliance analysts and auditors, and delegated claims compliance and performance auditors advise about CMS requirements and monitor compliance within the organization and in relation to Blue Shield’s representatives in the community. The Director of Medicare Compliance leads the day-to-day operations of the Medicare Compliance function and reports directly to the VP, Chief Compliance & Ethics Officer, who provides direct and periodic reports to Blue Shield’s Board of Directors (Audit Committee), the company’s Chief Executive Officer (CEO) and senior management on relevant Medicare Compliance and other Corporate Compliance issues, as appropriate. The Medicare Compliance Department builds on components of our Corporate Compliance Program and Code of Conduct, and the work of the Privacy Office, which is responsible for the oversight of Blue Shield's compliance with state and federal privacy laws, including the privacy components of the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH).

The Director of Medicare Compliance chairs the Plan’s Medicare Compliance Committee, which has representation from all areas of the company that touch the Medicare programs. The Committee serves as the forum for program direction and oversight relative to operating requirements, performance measures and the definition and implementation of effective corrective actions, when indicated. The Medicare Compliance Committee, and Medicare Compliance Department staff, as well as the Blue Shield team of internal auditors, validates the continuing compliant operations of functional areas within the company and the compliant performance of contractors and agents through:

- Monitoring, auditing performance and regulatory compliance
- Auditing of delegated and downstream providers' compliant execution responsibilities
- Monitoring of corrective actions imposed by internal and external entities
- Training and education of employees, temporary employees, and contracted providers and agents in Medicare program requirements and Blue Shield policies on privacy, compliance, fraud, waste, and abuse detection and reporting
- Tracking of changes in CMS requirements and educating operating units, accordingly
- Verifying current written policies and procedures
- Tracking and submission of required certifications and reporting to CMS
Blue Shield 65 Plus Compliance Program (cont’d.)

The Medicare Compliance Program sets the framework for our oversight vision and processes, and lays out monitoring programs and activities relative to our overall compliance with CMS regulatory requirements. It is our expectation that the Medicare Compliance Program will not only enable Blue Shield to meet increasing CMS requirements, but also to improve the quality of care and service provided to our Medicare Advantage and Medicare Part D members. The overall compliance structure incorporates the Code of Conduct and the Compliance Program to promote ethical behavior, equal opportunity, and anonymity in reporting of any improprieties within the Medicare product or elsewhere within the organization. Blue Shield has and enforces a strict non-retaliation policy for reporting actual or suspected legal, policy or Code violations, or any other misconduct, in good faith. Key compliance indicators or benchmarks, as well as concerns raised through internal and external monitoring activities, are reviewed by the Medicare Compliance Committee to help proactively identify potential issues and facilitate internal corrective actions or policy changes, as indicated. These elements of the Blue Shield Medicare Compliance Program provide examples of policies and programs that providers might wish to establish within their own organizations.

Auditing and Monitoring

Blue Shield has various departments, e.g., Provider Claims Compliance and Delegation Oversight, that audit first-tier entities for compliance with CMS Program requirements. However, providers are tasked with the oversight and audit of the entities with which they contract to ensure compliance with Medicare Program requirements. Upon request, providers must provide the results of the monitoring and auditing of their downstream entities.

Confirmation of Eligibility of Participation in the Medicare Program

The Office of the Inspector General (OIG) excludes individuals and entities from participation in Medicare, Medicaid, the State Children’s Health Insurance Program (SCHIP), and all Federal health care programs (as defined in section 1128B(f) of the Social Security Act (the Act)) based on the authority contained in various sections of the Act, including sections 1128, 1128A, 1156, and 1892. The OIG and the General Services Administration (GSA) maintains a sanction list that identifies those individuals and entities found guilty of fraudulent billing, misrepresentation of credentials, etc. Delegated entities managing Medicare members are responsible for checking the sanction list at minimum on a monthly basis to ensure their Board of Directors, owners or employees are not on the list. The delegated entity, its MSO, or any sub-delegates are prohibited from hiring, continuing to employ, or contracting with individuals named on the OIG List of Excluded Individuals and Entities (LEIE) and the GSA Excluded Parties Lists System (EPLS). Below are links to the LEIE and EPLS:

- [https://oig.hhs.gov/exclusions/index.asp](https://oig.hhs.gov/exclusions/index.asp)
- [https://www.sam.gov/portal/SAM](https://www.sam.gov/portal/SAM)

Upon audit, providers must provide evidence that you are checking your employees, temporary workers, Board of Directors against the excluded provider data bases upon hire, contracting, or election to the Board, and monthly thereafter.
Section 1: Introduction

Healthcare Regulatory Agencies

California Department of Insurance (CDI)

The California Department of Insurance (CDI) is responsible for regulating health insurance. The Department’s Health Claims Bureau has a toll-free number (800) 927-HELP (4357) or TDD (800) 482-4833 to receive complaints regarding health insurance from either the insured or his or her provider. If you have a complaint against your insurer, you should contact the insurer first and use their grievance process. If you need the Department’s help with a complaint or grievance that has not been satisfactorily resolved by the insurer, you may call the Department’s toll-free telephone number 8a.m. to 5p.m., Monday - Friday (excluding holidays). You may also submit a complaint in writing to: California Department of Insurance, Health Claims Bureau, 300 S. Spring Street, South Tower, Los Angeles, California 90013, or through the website at http://www.insurance.ca.gov/01-consumers/101-help.

California Department of Managed Health Care (DMHC)

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If the member has a grievance against Blue Shield, they should first telephone Blue Shield at the number provided in their Evidence of Coverage booklet and use our grievance process before contacting DMHC. Utilizing Blue Shield’s grievance process does not prohibit any potential legal rights or remedies that may be available to the member. If the member needs help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by Blue Shield, or a grievance that has remained unresolved for more than 30 days, the member may call DMHC for assistance. The member may also be eligible for an Independent Medical Review (IMR). If they are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by Blue Shield related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

The DMHC also has a toll-free telephone number (888) HMO-2219 and a TDD line (877) 688-9891 for the hearing and speech impaired. The DMHC’s website at http://www.hmohelp.ca.gov has complaint forms, IMR application forms, and online instructions.

Centers for Medicare & Medicaid Services (CMS)

The Centers for Medicare & Medicaid Services (CMS) is the federal agency that administers the Medicare program. Blue Shield has entered into contracts with CMS to provide benefits to Medicare beneficiaries. Blue Shield 65 PlusSM (HMO), Blue Shield 65 Plus Choice Plan (HMO) and Blue Shield Trio Medicare (HMO) are Blue Shield’s Medicare Advantage-Prescription Drug plans. These plans are open to all individual Medicare beneficiaries who have Medicare Part A and Part B, who permanently reside within the plan service area, and who do not have End-Stage Renal Disease at the time of enrollment in the MA-PD plan. Blue Shield also offers a group Medicare Advantage-Prescription Drug plan to Medicare beneficiaries retired from employer groups/unions who have selected the product as an option.

Blue Shield also offers two stand-alone Medicare prescription drug plans, Blue Shield Rx Plus (PDP) and Blue Shield Rx Enhanced (PDP). These plans are open to all individual Medicare beneficiaries who have Medicare Part A and/or Part B and permanently reside within the plan’s service area. Additionally, Blue Shield offers a group Medicare prescription drug plan to Medicare beneficiaries retired from employer groups/unions who have selected the product as an option. Information about CMS or the Medicare program is available by calling (800)-MEDICARE [(800) 633-4227] and through the websites www.medicare.gov/ and www.cms.hhs.gov.
Section 2: Provider Responsibilities
This page intentionally left blank.
Section 2: Provider Responsibilities

Table of Contents

General Blue Shield Agreement Terms and Conditions ....................................................................................... 1
Blue Shield Provider Standards ............................................................................................................................ 3
Administrative Compliance ................................................................................................................................. 4
    General Administrative Criteria .................................................................................................................. 4
    Administrative Procedure for Non-Compliance ..................................................................................... 6
Provider Certification ........................................................................................................................................... 7
    Reporting Provider Status Changes ...................................................................................................... 7
Credentialing and Recredentialing..................................................................................................................... 9
Clinical Laboratory Improvement Amendments (CLIA) Program Requirements .............................................. 10
Medical Record Review ..................................................................................................................................... 11
    Medical Records Tools .......................................................................................................................... 12
    Access to Records ................................................................................................................................ 12
    Advance Directives .................................................................................................................................... 12
    Confidentiality ............................................................................................................................................ 13
Quality Management and Improvement ............................................................................................................. 13
    Accreditation ........................................................................................................................................... 13
    Provider Responsibilities for Quality Management and Improvement ..................................................... 14
    HEDIS® Guidelines ................................................................................................................................. 14
Home-Based Palliative Care Program Providers ............................................................................................... 14
    Enrolling/Disenrolling Members in the Home-Based Palliative Care Program ........................................ 15
Submission of Laboratory Results Data .............................................................................................................. 17
Service Accessibility Standards .......................................................................................................................... 18
    Behavioral Health Appointment Access Standards for Medicare Advantage Members ........................... 21
After Hours Requirements ................................................................................................................................... 21
    After Hours Emergency Instructions .................................................................................................... 21
    After Hours Access-to-Care Guidelines ................................................................................................. 21
Provider Availability Standards for Commercial Products ................................................................................ 22
    Geographic Distribution .......................................................................................................................... 22
    Provider-to-Member Ratio ....................................................................................................................... 23
Provider Availability Standards for Medicare Advantage Products .............................................................. 24
    Facility Time and Distance Requirements as required by CMS ............................................................ 24
    Provider Time and Distance Requirements as required by CMS ........................................................... 24
    Provider Minimum Number Requirements ............................................................................................ 25
Behavioral Health Requirements – FEP PPO and ASO ....................................................................................... 26
Linguistic and Cultural Requirement .................................................................................................................... 26
Additional Measurements for Multidimensional Analysis ................................................................................ 27
Language Assistance for Persons with Limited English Proficiency (LEP) ..................................................... 28
Section 2: Provider Responsibilities

This page intentionally left blank.
General Blue Shield Agreement Terms and Conditions

All Blue Shield providers must adhere to the administrative requirements and responsibilities outlined in this section (unless otherwise noted). Any transaction between you, the provider, Blue Shield of California (Blue Shield) and/or any clearinghouse may be subject to federal or state legislation, such as the Health Insurance Portability and Accountability Act (HIPAA).

- Blue Shield provider agreements stipulate that Blue Shield providers agree to accept Blue Shield allowances as payment in full for covered services on all plans administered by Blue Shield. A Blue Shield agreement signed by an individual or group extends to all office locations.

- Blue Shield providers agree to render covered services and manage the health care needs of Blue Shield members.

- Providers must bill Blue Shield directly for covered services and not require full payment from a member at the time of service.

- Blue Shield contracted providers are permitted to collect a specifically identified copayment from a member as described in the Evidence of Coverage (EOC) or member’s identification card. Contracted providers are allowed to collect an estimated member liability due based on the member’s benefits and the contracted rate or agreed to allowance for a specific service that is to apply to the remaining plan deductible and/or out of pocket for the member on the plan.

- All Blue Shield payments are based on our allowances. Once Blue Shield receives and processes a claim, the provider receives payment and an Explanation of Benefits (EOB).

- Except as otherwise specified in the agreement, Blue Shield agreements generally encompass all Blue Shield health plans – Traditional Plans, Preferred Provider Organization (PPO) plans, and Health Maintenance Organization (HMO) plans, including the Blue Shield 65 Plus (HMO) product (where Blue Shield is licensed to offer this Medicare Advantage Plan in selected California counties).

- Blue Shield will notify providers when they are required to provide direct HMO services in situations where Blue Shield does not have a contracted HMO Independent Provider Association (IPA) or Medical Group.

- Providers agree to render services to patients covered under arrangements between Other Payors and Blue Shield or its subsidiaries. (Refer to Appendix 5-B for the Other Payor Summary List). Under such arrangements, providers agree to look only to the applicable Other Payor (and not to Blue Shield or its subsidiaries) for payment for services rendered. In addition, providers agree to render services to persons insured by Blue Shield of California Life & Health Insurance Company (Blue Shield Life). All such entities shall be referred to as “Other Payors.”

- Providers agree to have their names, practice locations, phone numbers, and other pertinent information listed in provider directories for use and dissemination by Blue Shield and/or Other Payors.

- Physicians and podiatrists are required to provide and keep current the admitting privileges at hospitals contracted with the insurer.
General Blue Shield Agreement Terms and Conditions (cont’d.)

- Providers must notify Blue Shield within five days of opening or closing their practices to new patients. Providers who close their practices to new patients may only remain closed for a maximum of one year.

- If a provider who is not accepting new patients is contacted by an enrollee or potential enrollee seeking to become a new patient, the provider shall direct the enrollee or potential enrollee to both the plan for additional assistance in finding a provider and to the department to report any inaccuracy with the plan’s directory or directories.

- Individual or group providers are limited to three practice locations per individual or group.

- If you provide authorized covered services in reasonable reliance upon verification of a patient’s eligibility provided by Blue Shield, and the patient is subsequently determined not to have been a member at the time services were provided, Blue Shield’s compensation for such services will be at the rates set forth in your contract with Blue Shield, less amounts, if any, due to you from any other health care service plan, insurer or third party payor (including Medicare) by which the patient is covered. If the patient was covered by another health plan during the time period involved and the service is covered by that health plan, insurer, or third party payor, you must first bill the other payor for those services. If no payment is received from or the claim is denied by the other carrier, please submit a copy of the other carrier’s claim determination (e.g., letter or EOB) to Blue Shield.

If you fail to verify the patient’s eligibility in accordance with this manual, Blue Shield shall have no obligation to compensate you for any services provided to patients who are not members at the time such services are rendered. This provision does not apply to Medicare Advantage, the Federal Employee Program, and self-funded groups.
Blue Shield Provider Standards

Blue Shield provider Agreements stipulate that Blue Shield providers agree to comply with the following standards. Failure to comply with the standards will be cause for termination of the provider’s Agreement.

- Providers agree to promote the interest of Blue Shield and its members and, through their own conduct, to uphold the good name of Blue Shield.

- Providers agree to deliver quality medical services that are cost-effective and meet prevailing community standards. In the delivery of health care services, providers do not discriminate against any person because of race, color, national origin, religion, sex, sexual orientation, disability, physical handicap, or available benefits. Providers seek to educate and encourage subscribers to follow health practices that improve their lifestyle and well-being.

- Providers agree not to refer members for non-covered services or perform non-covered services unless the member signs an “Acknowledgement of Financial Responsibility Form” (see Appendix 1-B) prior to the date of service. The Acknowledgement of Financial Responsibility must include specific information regarding the non-covered service being provided, the date of service, the billed amount and a breakdown of the specific non-covered services being performed. Providers agree to accept Blue Shield allowances as payment in full for covered services on all plans administered by Blue Shield. Providers are permitted to collect specifically identified copayment and estimated member liability due based on the member’s benefits and the contracted rate/allowance for a specific service that is to apply to the remaining deductible and/or out-of-pocket for the member on the plan.

- Providers agree to abstain from assessing against members any concierge, boutique or membership fees, or any fees that qualify as surcharges as defined in the Health and Safety Code.

- Providers maintain appropriate licensure for their practice, as well as for any individuals for whom they have direct responsibility, and restrict their practice to the scope of their licensure.

- Physician providers abide by the code of ethics established by the Judicial Council of the American Medical Association and Blue Shield Medical Policy.

- Providers agree to ensure that claims submitted to Blue Shield are coded accurately paying particular attention to the CPT, ICD-10-CM, and ICD-10-PCS descriptors used as well as accurately reflecting the provider of service.

- Providers who have been disciplined by a professional or governmental body in authority, or who have been placed on review by Blue Shield for an extended period of time for not modifying their practice or billing pattern, understand that they may be expelled from membership. Providers further acknowledge that appropriate discipline may be taken should they be found guilty of fraud, willful misrepresentation, or materially departing from accepted practice standards, including providing medically unnecessary services.

- Providers assure accurate, complete, and timely recording of medical records while observing the requirements for confidentiality.
Blue Shield Provider Standards (cont’d.)

- Providers cooperate with Blue Shield practices and procedures and honor the terms and conditions of the subscriber’s health care service plan. Providers refer subscribers to other Blue Shield contracted providers and admit subscribers to Blue Shield Select or Preferred Hospitals. Providers can confirm participating/contract status by calling Blue Shield at (800) 541-6652. Physician providers actively support appropriate utilization of hospital facilities and ancillary medical services, and abide by review procedures and decisions of professional peer review, as well as Blue Shield Medical and Payment Policies.

- Providers that utilize outside vendors to provide ancillary services (e.g., sending blood specimen for special analysis that cannot be done by the lab where the specimen was drawn) should utilize in-network participating ancillary providers to reduce the possibility of additional member liability for covered benefits. A list of in-network participating providers may be obtained by contacting Blue Shield.

Administrative Compliance

The Blue Shield Provider Information & Enrollment Department is charged with administering the Administrative Compliance Review Process. Providers are required to abide by Blue Shield bylaws, rules, and regulations, as well as specific obligations as outlined in their contract. Failure to abide by these requirements could subject the provider to administrative termination.

Note: Quality Issues are addressed by the Credentialing Committee in accordance with California Health and Safety Code Section 1370.

General Administrative Criteria

The following are Blue Shield’s general administrative criteria for all providers (unless otherwise noted):

- Accept Blue Shield Bylaws (Physicians only – Refer to a copy in Appendix 2).

- Accept Blue Shield allowances as payment in full for covered services.

- Bill Blue Shield directly for all covered professional services. No “superbills” are to be given to members to submit for payment.

- Ensure that proper industry standards are used when submitting claims to Blue Shield and that correlating clinical records clearly support the use of such codes as well as documenting that the services billed were performed.

- Comply with Blue Shield Medical Policies.

- Comply with Blue Shield Payment Policies.

- Comply with Blue Shield administrative rules and regulations, including the Provider Responsibilities outlined in this section.

- Comply with Blue Shield's Medical Management Program, including QI, Peer Review, and Credentialing processes, which includes sending the requested medical records for audits.
Administrative Compliance (cont’d.)

General Administrative Criteria (cont’d.)

- Allow Blue Shield, or its agents, access to patient medical records within the guidelines of current confidentiality requirements, or as required by the Centers for Medicare & Medicaid (CMS), the Department of Managed Health Care (DMHC), or other regulatory agencies.

- Have an identifiable practice location and mailing address. Agree to immediately update any change in group/practice affiliation, change in address, billing information, telephone number, or any other provider demographic information required by Blue Shield.

- Comply with Blue Shield’s processes for maintaining the directory of Blue Shield providers that is made available to members. To ensure accuracy of the information listed in the directory, Blue Shield will send to providers the information that Blue Shield has in its directories on a semi-annual basis. The provider is responsible, within thirty (30) business days from receipt, for confirming that all of the information is current and accurate or for updating any incorrect information. If no response is received from the provider within the thirty (30)-business-day period, Blue Shield will attempt to contact the provider to validate the information or to get required updates. If Blue Shield is unable to verify the information or obtain updates within fifteen (15) business days following the initial thirty (30)-business-day period, Blue Shield will provide provider with a ten (10)-business-day advance notice that it will be removed from the provider directory unless the provider responds to the request during this time.

- Agree to ensure that all medical record entries contain the proper legible signature and licensure of all individuals performing such activity and that services performed are within the scope of practice of the provider and or individuals.

- Provider agrees to bill according to acceptable CPT billing standards.

- Provider agrees to bill using ICD-10 code sets.

- Comply with the Non-Profits’ Insurance Alliance of California (NIAC) rules of Coordination of Benefits.

- Comply with CMS Rules & Regulations related to Medicare Beneficiaries.
Section 2: Provider Responsibilities

Administrative Compliance (cont’d.)

Administrative Procedure for Non-Compliance

Non-compliance with Blue Shield's general criteria or the administrative requirements of a particular program may result in the initiation of the Administrative Procedure for Non-Compliance. This process can result in the exclusion of the provider from further participation in the applicable program or, ultimately, from Blue Shield. The following is a summary of the Administrative Procedure for Non-Compliance when Blue Shield identifies administrative compliance issues:

- Repeated examples of lack of compliance with non-quality of care driven criteria may result in the immediate administrative cancellation of the provider’s contract. (See notation below.)

- The matter is referred to the appropriate Blue Shield department (Provider Compliance Review) for research and contact with the provider. This may include identification of issues, corrective action plans and timeframe for re-reviews, etc.

- If the provider does not agree to comply, the provider would then be subject to administrative cancellation of their contract.

- If the issue remains unresolved and the provider agrees to comply with a corrective action plan, then a corrective action period commences. Further proceedings are suspended for a given period of time, pending re-evaluation.

- If Blue Shield concludes that the provider is not compliant with recommendations, or if follow-up monitoring does not show adequate improvement, the provider is notified that he or she is being administratively terminated from Blue Shield. The provider may be permanently ineligible to re-apply as a Blue Shield provider. Re-application may be considered on a case-by-case basis and subject to probationary conditions.

Note: Documented examples of fraudulent or egregious abusive billing behavior, practicing outside the scope of the provider license, as defined by the California Business and Profession Code, California Regulations, or material breach of the provider contract will result in immediate administrative termination of the provider.

Examples of egregious abusive billing behavior include, but are not limited to: repeated examples of the submission of CPT or ICD-10-CM & ICD-10-PCS codes that inaccurately describes the services performed; submission of claims that inaccurately describes the provider of service; repeated examples of billing for cosmetic services; billing for services not documented; billing for services provided by other entities such as laboratory studies; repeated examples of unbundling billed services; “claim splitting” (submitting separate claims for the same date of service and where the CPT codes are spread over several claims); and where these activities have the effect of enhancing the level of provider reimbursement.

In the event of administrative termination by Blue Shield, providers will be entitled to those due process procedures, which are required of Blue Shield by state or federal law.
Provider Certification

All Blue Shield providers are assigned a Provider Record which is identified by NPI, Tax ID, and service location(s). To request a new record or to add a provider to a current group record, use the Provider Enrollment Application found on Provider Connection at blueshieldca.com/provider under the Guidelines and Resources tab, then Forms. Submit the completed application to:

Blue Shield of California
Provider Information & Enrollment
P.O. 629017
El Dorado Hills, CA 95762-9017
Fax (916) 350-8860

Reporting Provider Status Changes

To keep Blue Shield directories and credentialing records current, Providers are required to notify Provider Information & Enrollment within 5 days when making changes to their practice (e.g., change of address or Tax ID number, plans to incorporate, close or open a practice, add new providers to a group, etc.). Use the Provider Enrollment Application form to report practice changes.

Providers also are required to notify Blue Shield Provider Information & Enrollment whenever there are changes in their credentials status (i.e., license status, state probation, liability carrier, accusation, etc.), as well as changes in their demographic information.

Submit all changes in writing to Blue Shield Provider Information & Enrollment at the mailing address or fax number above.
Provider Certification (cont’d.)

Reporting Provider Status Changes (cont’d.)

The appropriate documents required for reporting various changes are noted below:

<table>
<thead>
<tr>
<th>Type of Change</th>
<th>Reporting Document</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice address</td>
<td>Provider Enrollment Application or letterhead with authorized signature.</td>
</tr>
<tr>
<td>Billing/accounting address</td>
<td>Provider Enrollment Application or letterhead with authorized signature.</td>
</tr>
<tr>
<td>Opening or closing a practice</td>
<td>Written notification on letterhead with authorized signature.</td>
</tr>
<tr>
<td>Retiring</td>
<td>Written notification on letterhead with authorized signature.</td>
</tr>
<tr>
<td>Adding a new practice location</td>
<td>Provider Enrollment Application or letterhead with authorized signature (groups must submit roster of providers practicing at the location).</td>
</tr>
<tr>
<td>Changing Tax ID number</td>
<td>Tax Coupon, SS-4, or Letter 147C from the IRS.</td>
</tr>
<tr>
<td>Incorporating practice</td>
<td>Written request, including Articles of Incorporation, tax ID verification (IRS requires EIN when incorporated).</td>
</tr>
<tr>
<td>Joining a group</td>
<td>When joining a contracted group, each new provider must be credentialed and submit a completed Provider Enrollment Application.</td>
</tr>
<tr>
<td>Leaving a group</td>
<td>Written request from the individual provider on letterhead, noting effective date.</td>
</tr>
<tr>
<td>Changing hospital affiliation</td>
<td>Written notification on letterhead with authorized signature.</td>
</tr>
<tr>
<td>Changing ownership of group</td>
<td>Agreement and Provider Enrollment Application * Tax coupon, SS-4 or letter 147C from IRS</td>
</tr>
<tr>
<td>Changing name of group</td>
<td>Agreement and Provider Enrollment Application * Tax coupon, SS-4 or letter 147C from IRS</td>
</tr>
<tr>
<td>Changing Tax ID number of group</td>
<td>Agreement and Provider Enrollment Application * Tax coupon, SS-4 or letter 147C from IRS</td>
</tr>
</tbody>
</table>

* In addition to the Agreement and Provider Enrollment Application, when applicable, Articles of Incorporation and/ or a Fictitious Name Permit from the Medical Board of California are required. Please include the current roster of providers for each location. The group is responsible for continually updating changes in its roster. For additional information regarding changing a group EIN, please contact Provider Information & Enrollment at (800) 258-3091.

* Credentialing requirements will need to be met. Please see the following pages for additional information.

Note: The Provider Enrollment Application is not an agreement and can only be used for billing purposes in absence of a fully executed and countersigned agreement by Blue Shield. Additionally, billing for providers who are not certified by Blue Shield as members of the group will subject the group to immediate termination as a Blue Shield provider.
Credentialing and Recredentialing

To be accepted as an approved Blue Shield network physician or other health care professional, new credentialing applicants must meet all Blue Shield credentialing standards and must contract with an affiliated IPA/medical group or directly with Blue Shield.

Blue Shield is required to recredential all participating physicians and other contracted health care professionals every three years. Blue Shield views the recredentialing program as an important part of our activities in assuring our members have a quality network available to them.

Blue Shield conducts provider credentialing under the direction of the Chief Medical Officer and the Credentials Committee. This committee, which is staffed by contracted physicians statewide, oversees credentialing, recredentialing and related peer review activities to support Blue Shield’s Quality Management and Improvement Program. The Credentials Committee is responsible for credentialing decisions and for the implementation and oversight of the credentialing function.

Blue Shield’s credentialing program requires providers to submit all of the following:

1. A completed and signed approved application and attestation to correctness
2. A copy of a current Curriculum Vitae.
3. Evidence of professional liability coverage.
4. Details of any professional liability claims history (if applicable).
5. A valid DEA certificate (except chiropractors).
6. Information verifying the absence of any physical or behavioral impairment, which would interfere with patient care or compliance with the Standards for Blue Shield providers.
7. Practice history for the past five years.
8. Attestation of unrestricted hospital medical staff privileges or admitting coverage arrangements by Blue Shield providers.

Additionally, Blue Shield verifies the following:

1. Valid, current, and unrestricted California license.
2. No restricted medical license held in any other state.
3. Board certification by a recognized American Board of Medical Specialties (ABMS) if the physician provider states that he/she is board certified.
4. Education and training if not Board Certified by a recognized ABMS Board.
5. Information from the National Practitioner Data Bank.
6. Clinical privileges in good standing at a Blue Shield contracted hospital designated by the practitioner as the primary admitting facility, as appropriate, or a mechanism for another credentialed physician to cover the practitioner’s patients when hospitalized; (through appropriate means of primary sources or by attestation from provider).
Section 2: Provider Responsibilities

Credentialing and Recredentialing (cont’d.)

Blue Shield maintains final authority for the decision to credential and/or re-credential all network providers. Please note that part of the credentialing process may include site visits for any physician or other health professional that receives grievances or complaints against their practice site.

Failure to participate with the initial credentialing or recredentialing process will result in an administrative denial or termination from Blue Shield. For credentialing questions, please contact the Credentialing Department at (888) 398-2250.

Clinical Laboratory Improvement Amendments (CLIA) Program Requirements

The CLIA mandates that all laboratories, including physician office laboratories, meet applicable Federal requirements and have a CLIA certificate to operate. The CLIA applies to all entities providing clinical laboratory services regardless of whether they or another provider file Medicare claims for the tests. Laboratories billing Medicare have additional responsibilities and requirements.

Blue Shield requires all professional and facility providers to adhere to the CMS and CLIA regulations and maintain a valid CLIA certification for the level of laboratory and/or pathology service they are providing. There are 5 different types of certification. Blue Shield requires any provider billing a laboratory or pathology service to maintain the CLIA certification for the specific test they are performing. For example, if a provider is billing a Q0111 Wet Mount, this provider would be required to have a current Provider Performed Microscopy Procedure (PPMP) certification in order to bill Blue Shield for payment.
Medical Record Review

Consistent and complete documentation in the member's medical record is an essential component of quality patient care.

Providers are required to maintain a medical record for each member that must include patient records of care provided within the provider practice, as well as care referred outside the provider practice.

Blue Shield requires medical record reviews to assess both physician office records and institutional medical records, which are reviewed for quality, content, organization, confidentiality, and completeness of documentation.

Medical records are reviewed annually against Blue Shield’s medical record standards. Records are sampled from those submitted for HEDIS review. Blue Shield requires that the physician's office medical records include the following:

- Identifying information on the member (patient ID on each page)
- Problem list noting significant illnesses and medical conditions
- Allergies and adverse reactions prominently noted
- Documentation of preventive health services provided
- Proof that baseline clinical exams were conducted, documented, and pertinent to the patient's presenting complaints
- Current summary sheets of medical history including past surgeries, accidents, illnesses/past diagnoses and medications, and immunization history
- Consultation reports, hospital summaries, emergency room reports, and test reports that are easily accessible and in a uniform location
- Treatment plan consistent with diagnosis
- Evidence of medically appropriate treatment
- Continuity and coordination of care between primary and specialty physicians
- Prescribed medications, including dosages and dates of initial prescription or refills
- Evidence that the patient has not been placed at risk by a diagnostic or therapeutic procedure
- For Medicare Advantage members, evidence on presence or absence of Advance Directives, for adults over age 18 prominently located in the medical record

Providers must also comply with all applicable confidentiality requirements for medical records as imposed by federal and state law. This includes the development of specific policies and procedures, when required by Blue Shield, to demonstrate compliance.

To assist Blue Shield in maintaining continuity of care for its members, providers are required to share medical records of services rendered to Blue Shield members. Members may also be entitled to obtain copies of their medical records, including copies of Emergency Department records, x-rays, CT scans, and MRIs. Upon the reassignment or transfer of a member, the provider must provide one copy of these materials, at no charge, to the member’s new provider. Upon request, additional copies must be provided to Blue Shield at the provider’s reasonable and customary copying costs, as defined by California Health and Safety Code 123110.
Medical Record Review (cont’d.)

Medical Records Tools

Medical Records Tools (Health Maintenance Work Sheets) Make HEDIS Documentation Easier

As part of Blue Shield’s commitment to supporting our practitioners, we offer valuable tools to assist you with your medical records documentation as well as HEDIS® compliance efforts. For the busy clinician, specialized flow sheets and quick disease screening tools are essential for timely comprehensive care, as well as meeting extensive HEDIS documentation requirements. For example, the Child and Adolescent Preventive Flow Sheet can help you provide, record, and summarize years of pertinent clinical care. HEDIS audit requirements would be met for a diabetic patient with a photocopy of the Problem List, the Medication List and the Diabetic Care Flow Sheet (to identify most recent test and value: HbA1C, LDL, and Microalbuminuria).

We encourage providers to use these forms. Using these forms and keeping them current can reduce HEDIS record submission to just a few pages. The HEDIS forms can be downloaded from Provider Connection at blueshieldca.com/provider. Once you have logged on, select Guidelines & Resources, Guidelines and Standards, and then Medical Record Standards.

Access to Records

Physicians and all sub-contracted practitioners and providers must maintain the medical records, books, charts, and papers relating to the provision of health care services and the cost of such services and payments received from members or others on their behalf, as well as make this information available to Blue Shield, the Department of Managed Health Care (DMHC), the Department of Health and Human Services (HHS), any Quality Improvement Organization (QIO) with which CMS contracts, the U.S. Comptroller General, their designees, and other governmental officials as required by law.

The above parties, for purposes of utilization management, quality improvement, and other administrative purposes, shall have access to, and copies of, medical records, books, charts, and papers (including claims) at a reasonable time upon request. All such records must be maintained for at least ten years from the final date of the contract period, or from the completion of any audit, whichever is later.

Note: Federal (HIPAA) law allows the plan to charge a reasonable cost-based fee for copying a designated record set. Additionally, it is Blue Shield’s policy to not charge for the first request but to charge a cost-based fee for subsequent requests. A cost-based fee includes the cost of supplies for and labor of copying the requested records, postage when the request is to mail the records, and preparation for an explanation of summary of the designated record set if agreed to by the member.

Advance Directives

An Advance Directive is a formal document completed by an individual in advance of an incapacitating illness or injury. When individuals are too ill to communicate their wishes concerning their care, providers use the directive as guidance in providing treatment. Blue Shield recommends that all Medicare members and any member 18 years and older, have a signed Advance Directive to communicate their wishes regarding health care decisions to their physician and to their family members as well.
Medical Record Review (cont’d.)

Confidentiality

State and federal laws regulate the release of personal and medical information. Blue Shield supports and maintains all records in keeping with these standards and expects the individual providers to protect and maintain confidentiality on all information related to a Blue Shield member. This means that all records, information, and clinical reports, both personal and medical, are protected from view or contact by anyone not directly responsible for the care provided to the member, or as required by regulatory, law enforcement, or governmental agencies.

Quality Management and Improvement

Blue Shield’s Quality Management Department in collaboration with Blue Shield’s QI Committees selects and oversees quality measurement and improvement activities that meet corporate strategic goals, accreditation and regulatory requirements. Activities are conducted in all areas and dimensions of clinical and non-clinical member care and service, such as: Member Satisfaction, Access and Availability, Case Management, Continuity and Coordination of Care, Wellness, Preventive Health, Health Risk Appraisal, and Healthcare Effectiveness Data and Information Set (HEDIS®) Measurement.

Blue Shield conducts ongoing systematic reviews of the health care and services provided to members. Care and services are coordinated and monitored in accordance with a variety of applicable accrediting standards, regulatory bodies, and statutes, including but not limited to:

- National Committee for Quality Assurance (NCQA)
- California Health and Safety Code
- California Department of Insurance (CDI)
- Department of Managed Health Care (DMHC)
- Department of Labor Employer Retirement Income Security Act (ERISA)
- Centers for Medicare & Medicaid Services (CMS)
- Centers for Disease Control (e.g., ACIP)
- Office of the Patient Advocate
- Covered California

Accreditation

Blue Shield maintains voluntary accreditation status with National Committee for Quality Assurance (NCQA). NCQA Accreditation applies to the Commercial (PPO, HMO/POS, Covered CA/Marketplace) and Medicare HMO product lines. The NCQA review process consists of an audit of health plan performance on NCQA standards and an evaluation of health plan scores relative to other plans on key HEDIS measures including member satisfaction measures.
Section 2: Provider Responsibilities

Quality Management and Improvement (cont’d.)

Provider Responsibilities for Quality Management and Improvement

Blue Shield actively solicits its network providers to participate in Quality Management and Improvement activities as follows:

- Participation on QI Committees
- Expert consultation for Credentialing, Peer Review and Utilization Management determinations
- Expert advisers for clinical QI workgroups
- Participation in focus groups
- Partnership in QI studies

All Blue Shield providers are required to participate in quality management activities by providing, to the extent allowed by applicable state and federal law, member information and medical records for review of quality of care and service.

HEDIS® Guidelines

To comply with NCQA accreditation requirements, Blue Shield collects and reports HEDIS® data as it relates to Blue Shield members. **Blue Shield contracted physicians are required to provide medical records requested for HEDIS data collection in a timely manner.** HIPAA allows data collection for HEDIS reporting thus no special patient consent or authorization is required to release this information.

HEDIS measurements, identified in Appendix 4-A of this manual, have criteria that is required for your patient’s chart or claims review to be considered valid towards HEDIS measurement. When using HEDIS measurements, please use CPT/HCPC codes as well as CPT Category II codes to help your office to meet criteria for HEDIS measures.

Quality Management activities are considered privileged communication in conjunction with peer review activities conforming to Evidence Code Section 1157 and Section 1370 of the Health and Safety Code. As such, neither the proceedings nor the records of the review may be disclosed to any person outside of those participating in the review process.
Home-Based Palliative Care Program Providers

Enrolling/Disenrolling Members in the Home-Based Palliative Care Program

Assessing/Enrolling a Member

Home-based palliative care program providers are responsible for assessing whether a member qualifies for the program after a referral has been made. The assessment must be completed within fifteen (15) business days of the receipt of the referral or, in the case of a hospitalized member, within fifteen (15) days of the member’s discharge from the hospital. If the referral is made by a Blue Shield case manager, the provider will receive the referral on a “Home Care Referral Event Form” (refer to Appendix 2 for a sample form), which will be sent via email. Upon receipt, the provider is asked to confirm that the form has been reviewed and the date of the scheduled assessment.

Conducting the Assessment

Blue Shield requires that home-based palliative care providers follow the current version of the National Consensus Project’s (NCP) Clinical Practice Guidelines for Quality Palliative Care, Domain 1: Structure and Processes of Care, Guideline 1.1 criteria, when conducting the assessment (see Appendix 2).

The provider must notify Blue Shield via email to BSCPalliativeCare@blueshieldca.com within fifteen (15) business days of completing any assessment, whether received from a Blue Shield case manager or another avenue for referral, with the status of the member. If the member was referred by a Blue Shield case manager, an email must also be sent to the referring case manager with the status so that case management can be transitioned to the program provider, as applicable.

The status options are as follows:

- Enrolled, including the date of enrollment
- Accepted but not yet enrolled
- Not eligible
- Enrolled in hospice
- Declined enrollment

Enrolling a Member

A notification of enrollment must be emailed to all the Blue Shield emails listed below within fifteen (15) days of a member’s enrollment, as further described in the agreement.

- ShieldSupport@blueshieldca.com
- BSCPharmacyOperation@blueshieldca.com
- BSCPalliativeCare@blueshieldca.com

A program provider can recommend a member who does not meet the criteria be enrolled in the program by sending an email to BSCPalliativeCare@blueshieldca.com with an explanation for the recommendation along with supporting documentation.
Home-Based Palliative Care Program Providers (cont’d.)

Enrolling/Disenrolling Members in the Home-Based Palliative Care Program (cont’d.)

Disenrolling a Member

Blue Shield must be notified of a member’s disenrollment from the program within fifteen (15) days of the member’s disenrollment, as specified in the agreement, via email sent to BSCPalliativeCare@blueshieldca.com. In addition to the information submitted upon enrollment, the provider shall also include the reason for the program member’s disenrollment from the palliative care program.

Engaging the Palliative Care Team

The palliative care interdisciplinary team includes a physician who provides oversight, as well as a registered nurse (RN), case manager, social worker, home health aide, and chaplain. It may also include a physician assistant (PA), licensed vocational nurse (LVN), pharmacist, dietitian, rehabilitation specialist, physical therapist, etc.

In-person visits must be provided by the palliative care team’s prescribing clinician at least once every three (3) months or when goals of care change. Above and beyond this requirement, the number and frequency of in-person and/or phone or video visits to a specific Blue Shield member in the program should be based on the medical, mental, emotional, social and spiritual needs of that patient. At minimum, each member of the palliative care team should contribute to the in-person assessment and the interdisciplinary team meetings.

Interfacing with Member’s Treating Providers

The member’s treating providers (e.g., PCP, oncologist, etc.) are an integral part of the palliative care team. Therefore, it is expected that the palliative care provider:

- co-develop and/or share palliative care plan with the treating provider(s),
- provide chart notes after every visit and advance care planning documents as completed or revised to treating provider(s),
- collaborate with the treating provider(s) to identify medications that optimally manage symptoms,
- ensure the treating provider(s) receives results on all outpatient orders,
- offer to include the treating provider(s) in palliative care conversations via online or phone conferencing, and
- document and retain records on all interactions with treating provider(s).

Conducting Member and Family Satisfaction Surveys

Home-based palliative care program providers are responsible for delivering a member and family satisfaction survey to all members enrolled in the program on quarterly basis. The aggregated results must be reported to the Blue Shield Palliative Care Program Team within thirty (30) days of the end date of the collection period of the quarterly survey.
Home-Based Palliative Care Program Providers (cont’d.)

Enrolling/Disenrolling Members in the Home-Based Palliative Care Program (cont’d.)

Participating in Quarterly Meetings

Blue Shield’s Palliative Care Program Team will conduct quarterly meetings with each palliative care provider treating Blue Shield patients enrolled in the program. During this meeting, Blue Shield will review patient status, discuss issues, answer questions, provide support, and review quality criteria. Quality criteria for each member in the program includes but is not limited to:

- confirmation that a medical decision maker is on file,
- documentation of advance directive or POLST on file where appropriate,
- member and family satisfaction survey results; Blue Shield will work with providers to set acceptable targets, and
- discussion of any issues arising from Blue Shield’s ongoing and systematic utilization review.

Blue Shield retains the right to audit provider participation in the program to ensure quality of care.

Submission of Laboratory Results Data

All laboratories contracting with Blue Shield are required to submit member-level laboratory results data as part of Blue Shield’s Quality Management and Improvement initiatives. These data elements are used for HEDIS®, Pay For Performance (P4P), disease management programs, and other similar activities.

Results for laboratory tests (analyses) must be submitted using the current version of the CALINX lab data standard, which is based on the Health Level 7 (HL7) industry standard for exchange of laboratory results data. This standard may be obtained on the Integrated Healthcare Association’s website at http://www.iha.org/calinx_lab_standards.html. Coding for analytes must use the LOINC coding system. Blue Shield subscriber and member IDs must be used in each record. Data must be submitted on a monthly basis using Blue Shield’s secure data exchange procedures.

Contact Yuan Hong at (310) 744-2674 or yuan.hong@blueshieldca.com for additional details and requirements, as well as to initiate required submissions of laboratory results data.
Section 2: Provider Responsibilities

Service Accessibility Standards

Blue Shield requires that contracted providers provide access to health care services within the time periods established by Blue Shield, Title 28 CCR 1300.67.2.2, and Title 10 CCR 2240, where applicable and as specified in this manual.

Blue Shield uses the Consumer Assessment of Health Plans Survey (CAHPS), the Patient Assessment Survey (PAS), Provider Satisfaction Survey, Appointment Availability Survey results, and member appeals and grievances to measure compliance with the standards for appointment access. All of the above surveys will be used to demonstrate compliance. Providers that are found non-compliant with the access standards will be required to submit a corrective action plan with details on how the providers will achieve and maintain future compliance.

If it is not possible to grant a member an appointment within the designated timeframes indicated in the Access-to-Care table below, the wait time may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, has determined that a longer waiting time will not have a detrimental impact on the health of the member. Such provider must note in the appropriate record that it is clinically appropriate and within professionally recognized standards to extend the wait time.

If a member is unable to obtain a timely referral to an appropriate provider, the member, member representative, or an attorney or provider on the member’s behalf, may file a grievance by contacting Blue Shield’s Customer Service Department in writing, by telephone, or by submitting a completed Grievance Form online at blueshieldca.com. Blue Shield researches and investigates all grievances and, as appropriate, the Blue Shield Medical Director may review a grievance. For commercial members, call (800) 541-6652 and for Blue Shield 65 Plus call (800) 776-4466.

Members or providers on the member’s behalf may also contact the applicable state regulator to file a complaint at the following toll-free numbers if they are unable to obtain a timely referral to an appropriate provider.

- California Department of Insurance (CDI): (800) 927-HELP (4357) or TTY (800) 482-4833
- Department of Managed Health Care (DMHC): (888) HMO-2219 or TDD (877) 688-9891
- The Centers for Medicare & Medicaid (CMS): (800)-MEDICARE [(800) 633-4227] or TTY/TTD (877) 486-2048
## ACCESS-TO-CARE

<table>
<thead>
<tr>
<th><strong>Preventive Care Appointments</strong></th>
<th><strong>STANDARD</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to preventive care with a PCP, Nurse Practitioner, or Physician Assistant at the same office site as a member’s assigned PCP.</td>
<td>Within 30 calendar days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Regular and routine care PCP</strong></th>
<th><strong>STANDARD</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to routine, non-urgent symptomatic care appointments with a member’s assigned PCP. The time standards must be met unless the referring, treating, or health professional providing triage services determines that a longer waiting time will not have a detrimental impact on the enrollee or the appointment request is for preventive care services.</td>
<td>Within 10 business days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Regular and routine care SPC</strong></th>
<th><strong>STANDARD</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to routine, non-urgent symptomatic care appointments with a specialist. The time standards must be met unless the referring, treating, or health professional providing triage services determines that a longer waiting time will not have a detrimental impact on the enrollee or the appointment request is for preventive care services.</td>
<td>Within 15 business days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Urgent Care Appointment</strong></th>
<th><strong>STANDARD</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to urgent symptomatic care appointments that do not require prior authorization with the PCP, or specialist or covering physician or urgent care provider. The time standards must be met unless the referring, treating, or health professional providing triage services determines that a longer wait time will not have a detrimental impact on the enrollee.</td>
<td>Within 48 hours</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Urgent Care Appointment</strong></th>
<th><strong>STANDARD</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to urgent symptomatic care appointments requiring prior authorization. The time standards must be met unless the referring, treating, or health professional providing triage services determines that a longer wait time will not have a detrimental impact on the enrollee.</td>
<td>Within 96 hours</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Ancillary Care Appointments</strong></th>
<th><strong>STANDARD</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition. The time standards must be met unless the referring, treating, or health professional providing triage services determines that a longer wait time will not have a detrimental impact on the enrollee or the appointment request is for preventive care services.</td>
<td>Within 15 business days</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Rescheduling of Appointments and Authorizations</strong></th>
<th><strong>STANDARD</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>When it is necessary to reschedule an appointment or authorization it must be promptly rescheduled, in line with the health care needs of the patient, and consistent with professional standards. Interpreter services will be coordinated with scheduled appointments to ensure the provision of interpreter services at the time of the appointment.</td>
<td>As determined by licensed healthcare professional</td>
</tr>
</tbody>
</table>
## ACCESS-TO-CARE

<table>
<thead>
<tr>
<th>ACCESS-TO-CARE</th>
<th>STANDARD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>After Hours PCP Access</strong></td>
<td>PCP or covering physician available 24 hours a day, 7 days a week</td>
</tr>
<tr>
<td></td>
<td>* Please see “After Hours Requirements” in the section immediately following for more detail on this requirement.</td>
</tr>
<tr>
<td><strong>Emergency Care</strong></td>
<td>Immediate</td>
</tr>
<tr>
<td><strong>After Hours Emergency Instructions</strong></td>
<td>Specific instructions for obtaining emergency care such as directing the member to call 911 or to go to the nearest emergency room.</td>
</tr>
<tr>
<td>(telephone answering service or machine)</td>
<td>* Please see “After Hours Requirements” in section immediately following for more detail on this requirement.</td>
</tr>
<tr>
<td><strong>In-office Wait Time</strong></td>
<td><strong>Standard</strong>: Member care will not be adversely affected by excessive in-office wait time. <strong>Recommendation</strong>: In the absence of emergencies, medical offices should seek to limit wait time to 15 minutes after patient’s scheduled appointment.</td>
</tr>
<tr>
<td><strong>Hours of Operation</strong></td>
<td>All providers will maintain sufficient hours of operation so as not to cause member-reported access and availability problems with an adverse effect on the quality of care or medical outcome.</td>
</tr>
</tbody>
</table>
Section 2: Provider Responsibilities

Service Accessibility Standards (cont’d.)

Behavioral Health Appointment Access Standards for Medicare Advantage Members

<table>
<thead>
<tr>
<th>ACCESS-TO-CARE</th>
<th>STANDARD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine office visit (including non-physician providers)</td>
<td>Within 10 business days</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>Within 48 hours</td>
</tr>
<tr>
<td>Emergency Care, non-life threatening</td>
<td>Within 6 hours</td>
</tr>
</tbody>
</table>

After Hours Requirements

After Hours Emergency Instructions

Note: Contracted providers must leave emergency instructions that are compliant when contacted by telephone. A list of compliant and non-compliant responses is listed below.

<table>
<thead>
<tr>
<th>COMPLIANT RESPONSES</th>
<th>NON-COMPLIANT RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Hang up and dial 911 or go to the nearest emergency room.</td>
<td>1. Stay on the line and you will be connected to a PCP.</td>
</tr>
<tr>
<td>2. Go to the nearest emergency room.</td>
<td>2. Leave your name and number, someone will call you back.</td>
</tr>
<tr>
<td>3. Hang up and dial 911.</td>
<td>3. Given another number to contact physician.</td>
</tr>
<tr>
<td></td>
<td>4. The doctor or on-call physician can be paged.</td>
</tr>
<tr>
<td></td>
<td>5. Automatically transferred to urgent care.</td>
</tr>
<tr>
<td></td>
<td>6. Transfer to an advise/triage nurse.</td>
</tr>
<tr>
<td></td>
<td>7. No emergency instructions given.</td>
</tr>
</tbody>
</table>

After Hours Access-to-Care Guidelines

Note: Contracted providers must respond to non-emergent After Hours calls within 30 minutes of a patient trying to reach the physician. A list of compliant and non-compliant responses from a physician or a health care professional is furnished below:

<table>
<thead>
<tr>
<th>COMPLIANT RESPONSES</th>
<th>NON-COMPLIANT RESPONSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Immediately, can cross connect</td>
<td>1. Within the next hour</td>
</tr>
<tr>
<td>2. Within 30 minutes</td>
<td>2. Unknown or next business day</td>
</tr>
</tbody>
</table>
### Provider Availability Standards for Commercial Products

Blue Shield has provider availability standards to ensure a network of established primary care physicians (PCPs) and high-volume specialty practitioners that is sufficient in number and geographic distribution for Commercial and Medicare Advantage members. Please refer to the provider availability standards below.

#### Geographic Distribution

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>PRODUCT TYPE*</th>
<th>STANDARD</th>
<th>COMPLIANCE TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total PCPs</td>
<td></td>
<td>One PCP within 15 miles of each member or 30 minutes of each member</td>
<td>85%</td>
</tr>
<tr>
<td>PCP</td>
<td></td>
<td>One PCP within 15 miles of each member or 30 minutes of each member</td>
<td>85%</td>
</tr>
<tr>
<td>General Practitioner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Practitioner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Top 10 High Volume Specialists</td>
<td>HMO/POS</td>
<td>One of each type of Top 10 High Volume Specialists within 30 miles of each member</td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td>PPO – CDI</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>PPO – DMHC</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>IFP ePPO</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CCSB HMO/PPO</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospitals</td>
<td></td>
<td>One hospital within 15 miles of each member</td>
<td>85%</td>
</tr>
<tr>
<td>Radiology</td>
<td></td>
<td>One Radiology facility in 30 miles</td>
<td>90%</td>
</tr>
<tr>
<td>Lab</td>
<td></td>
<td>One lab in 30 miles</td>
<td>90%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
<td>One Pharmacy in 10 miles</td>
<td>95%</td>
</tr>
<tr>
<td>DME</td>
<td></td>
<td>One DME in 15 miles</td>
<td>85%</td>
</tr>
<tr>
<td>ASC</td>
<td></td>
<td>One ASC in 30 miles</td>
<td>95%</td>
</tr>
<tr>
<td>SNF</td>
<td></td>
<td>One SNF in 30 miles</td>
<td>95%</td>
</tr>
<tr>
<td>Urgent Care</td>
<td></td>
<td>Urban: 1 in 15 miles</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suburban: 1 in 20 miles</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rural: 1 in 30 miles</td>
<td>75%</td>
</tr>
<tr>
<td>Dialysis</td>
<td></td>
<td>Urban: 1 in 15 miles</td>
<td>90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suburban: 1 in 20 miles</td>
<td>85%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Rural: 1 in 30 miles</td>
<td>75%</td>
</tr>
<tr>
<td>Acupuncturist</td>
<td>PPO</td>
<td>1 in 15 miles</td>
<td>90%</td>
</tr>
</tbody>
</table>
## Provider Availability Standards for Commercial Products (cont’d.)

### Provider-to-Member Ratio

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>PRODUCT TYPE*</th>
<th>STANDARD</th>
<th>COMPLIANCE TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCP</td>
<td>HMO/PPO – DMHC/PPO – CDI</td>
<td>One PCP to 2,000 commercial members</td>
<td>100%</td>
</tr>
<tr>
<td>Family Practitioner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Practitioner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internist</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatrician</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total PCP To Member Availability Ratio</td>
<td>HMO/PPO – DMHC/PPO – CDI</td>
<td>One PCP to 2,000 commercial members</td>
<td>100%</td>
</tr>
<tr>
<td>Top 10 HVS and top 3 HIS to Member Ratio</td>
<td>HMO/POS PPO – DMHC IFP ePPO</td>
<td>1 OB/GYN to 10,000 commercial members</td>
<td>100%</td>
</tr>
<tr>
<td>Acupuncturist to Member Ratio</td>
<td>PPO</td>
<td>1 acupuncturist to 5,000 members</td>
<td>100%</td>
</tr>
<tr>
<td>Ethnic/Cultural and Language Needs</td>
<td>HMO/POS PPO – DMHC</td>
<td>1 PCP speaking a threshold language to 1,200 members speaking a threshold language**</td>
<td>100%</td>
</tr>
</tbody>
</table>

*PPO plans are both Blue Shield PPO – DMHC and PPO – CDI plans. PPO membership excludes ASO/self-insured business.

**Threshold languages are: Spanish, Chinese, and Vietnamese.
### Provider Availability Standards for Medicare Advantage Products

#### Facility Time and Distance Requirements as required by CMS

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Large Metro</th>
<th>Metro</th>
<th>Micro</th>
<th>Rural</th>
<th>CEAC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Maximum Time (minutes)</td>
<td>Maximum Distance (miles)</td>
<td>Maximum Time (minutes)</td>
<td>Maximum Distance (miles)</td>
<td>Maximum Time (minutes)</td>
</tr>
<tr>
<td>Acute Inpatient Hospitals</td>
<td>20</td>
<td>10</td>
<td>45</td>
<td>30</td>
<td>80</td>
</tr>
<tr>
<td>Cardiac Surgery Program</td>
<td>30</td>
<td>15</td>
<td>60</td>
<td>40</td>
<td>160</td>
</tr>
<tr>
<td>Cardiac Catheterization Services</td>
<td>30</td>
<td>15</td>
<td>60</td>
<td>40</td>
<td>160</td>
</tr>
<tr>
<td>Critical Care Services – Intensive Care</td>
<td>20</td>
<td>10</td>
<td>45</td>
<td>30</td>
<td>160</td>
</tr>
<tr>
<td>Outpatient Dialysis</td>
<td>20</td>
<td>10</td>
<td>45</td>
<td>30</td>
<td>65</td>
</tr>
<tr>
<td>Surgical Services (Outpatient or ASC)</td>
<td>20</td>
<td>10</td>
<td>45</td>
<td>30</td>
<td>80</td>
</tr>
<tr>
<td>Skilled Nursing Facilities</td>
<td>20</td>
<td>10</td>
<td>45</td>
<td>30</td>
<td>80</td>
</tr>
<tr>
<td>Diagnostic Radiology</td>
<td>20</td>
<td>10</td>
<td>45</td>
<td>30</td>
<td>80</td>
</tr>
<tr>
<td>Mammography</td>
<td>20</td>
<td>10</td>
<td>45</td>
<td>30</td>
<td>80</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>20</td>
<td>10</td>
<td>45</td>
<td>30</td>
<td>80</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>20</td>
<td>10</td>
<td>45</td>
<td>30</td>
<td>80</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>20</td>
<td>10</td>
<td>45</td>
<td>30</td>
<td>80</td>
</tr>
<tr>
<td>Inpatient Psychiatric Facility Services</td>
<td>30</td>
<td>15</td>
<td>70</td>
<td>45</td>
<td>100</td>
</tr>
<tr>
<td>Orthotics and Prosthetics</td>
<td>30</td>
<td>15</td>
<td>45</td>
<td>30</td>
<td>160</td>
</tr>
<tr>
<td>Outpatient Infusion/Chemotherapy</td>
<td>20</td>
<td>10</td>
<td>45</td>
<td>30</td>
<td>80</td>
</tr>
</tbody>
</table>

#### Provider Time and Distance Requirements as required by CMS

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Large Metro</th>
<th>Metro</th>
<th>Micro</th>
<th>Rural</th>
<th>CEAC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Maximum Time (minutes)</td>
<td>Maximum Distance (miles)</td>
<td>Maximum Time (minutes)</td>
<td>Maximum Distance (miles)</td>
<td>Maximum Time (minutes)</td>
</tr>
<tr>
<td>Primary Care</td>
<td>10</td>
<td>5</td>
<td>15</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>Allergy and Immunology</td>
<td>30</td>
<td>15</td>
<td>45</td>
<td>30</td>
<td>80</td>
</tr>
<tr>
<td>Cardiology</td>
<td>20</td>
<td>10</td>
<td>30</td>
<td>20</td>
<td>50</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>30</td>
<td>15</td>
<td>45</td>
<td>30</td>
<td>80</td>
</tr>
<tr>
<td>Dermatology</td>
<td>20</td>
<td>10</td>
<td>45</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>30</td>
<td>15</td>
<td>60</td>
<td>40</td>
<td>100</td>
</tr>
<tr>
<td>ENT/Otolaryngology</td>
<td>30</td>
<td>15</td>
<td>45</td>
<td>30</td>
<td>80</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>20</td>
<td>10</td>
<td>45</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>30</td>
<td>15</td>
<td>60</td>
<td>40</td>
<td>100</td>
</tr>
<tr>
<td>Nephrology</td>
<td>30</td>
<td>15</td>
<td>45</td>
<td>30</td>
<td>80</td>
</tr>
<tr>
<td>Neurology</td>
<td>20</td>
<td>10</td>
<td>45</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>30</td>
<td>15</td>
<td>60</td>
<td>40</td>
<td>100</td>
</tr>
<tr>
<td>Oncology - Medical, Surg</td>
<td>20</td>
<td>10</td>
<td>45</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Oncology - Radiation/Rad</td>
<td>30</td>
<td>15</td>
<td>60</td>
<td>40</td>
<td>100</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>20</td>
<td>10</td>
<td>30</td>
<td>20</td>
<td>50</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>20</td>
<td>10</td>
<td>30</td>
<td>20</td>
<td>50</td>
</tr>
<tr>
<td>Physical, Rehabilitative Medicine</td>
<td>30</td>
<td>15</td>
<td>45</td>
<td>30</td>
<td>80</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>30</td>
<td>15</td>
<td>60</td>
<td>40</td>
<td>100</td>
</tr>
<tr>
<td>Podiatry</td>
<td>20</td>
<td>10</td>
<td>45</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>20</td>
<td>10</td>
<td>45</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Pulmonology</td>
<td>20</td>
<td>10</td>
<td>45</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>30</td>
<td>15</td>
<td>60</td>
<td>40</td>
<td>100</td>
</tr>
<tr>
<td>Urology</td>
<td>20</td>
<td>10</td>
<td>45</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>30</td>
<td>15</td>
<td>60</td>
<td>40</td>
<td>100</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>30</td>
<td>15</td>
<td>60</td>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>
## Provider Availability Standards for Medicare Advantage Products (cont’d.)

### Provider Minimum Number Requirements

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Large Metro</th>
<th>Metro</th>
<th>Micro</th>
<th>Rural</th>
<th>CEAC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>1.67</td>
<td>1.67</td>
<td>1.42</td>
<td>1.42</td>
<td>1.42</td>
</tr>
<tr>
<td>Allergy and Immunology</td>
<td>0.05</td>
<td>0.05</td>
<td>0.04</td>
<td>0.04</td>
<td>0.04</td>
</tr>
<tr>
<td>Cardiology</td>
<td>0.27</td>
<td>0.27</td>
<td>0.23</td>
<td>0.23</td>
<td>0.23</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>0.10</td>
<td>0.10</td>
<td>0.09</td>
<td>0.09</td>
<td>0.09</td>
</tr>
<tr>
<td>Dermatology</td>
<td>0.16</td>
<td>0.16</td>
<td>0.14</td>
<td>0.14</td>
<td>0.14</td>
</tr>
<tr>
<td>Endocrinology</td>
<td>0.04</td>
<td>0.04</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
</tr>
<tr>
<td>ENT/Otolaryngology</td>
<td>0.06</td>
<td>0.06</td>
<td>0.05</td>
<td>0.05</td>
<td>0.05</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>0.12</td>
<td>0.12</td>
<td>0.10</td>
<td>0.10</td>
<td>0.10</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
</tr>
<tr>
<td>Nephrology</td>
<td>0.09</td>
<td>0.09</td>
<td>0.08</td>
<td>0.08</td>
<td>0.08</td>
</tr>
<tr>
<td>Neurology</td>
<td>0.12</td>
<td>0.12</td>
<td>0.10</td>
<td>0.10</td>
<td>0.10</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>0.01</td>
<td>0.01</td>
<td>0.01</td>
<td>0.01</td>
<td>0.01</td>
</tr>
<tr>
<td>Oncology - Medical, Surgical</td>
<td>0.19</td>
<td>0.19</td>
<td>0.16</td>
<td>0.16</td>
<td>0.16</td>
</tr>
<tr>
<td>Oncology - Radiation/Radiation Oncology</td>
<td>0.06</td>
<td>0.06</td>
<td>0.05</td>
<td>0.05</td>
<td>0.05</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>0.24</td>
<td>0.24</td>
<td>0.20</td>
<td>0.20</td>
<td>0.20</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>0.20</td>
<td>0.20</td>
<td>0.17</td>
<td>0.17</td>
<td>0.17</td>
</tr>
<tr>
<td>Physiatry, Rehabilitative Medicine</td>
<td>0.04</td>
<td>0.04</td>
<td>0.03</td>
<td>0.03</td>
<td>0.03</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>0.01</td>
<td>0.01</td>
<td>0.01</td>
<td>0.01</td>
<td>0.01</td>
</tr>
<tr>
<td>Podiatry</td>
<td>0.19</td>
<td>0.19</td>
<td>0.16</td>
<td>0.16</td>
<td>0.16</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>0.14</td>
<td>0.14</td>
<td>0.12</td>
<td>0.12</td>
<td>0.12</td>
</tr>
<tr>
<td>Pulmonology</td>
<td>0.13</td>
<td>0.13</td>
<td>0.11</td>
<td>0.11</td>
<td>0.11</td>
</tr>
<tr>
<td>Rheumatology</td>
<td>0.07</td>
<td>0.07</td>
<td>0.06</td>
<td>0.06</td>
<td>0.06</td>
</tr>
<tr>
<td>Urology</td>
<td>0.12</td>
<td>0.12</td>
<td>0.10</td>
<td>0.10</td>
<td>0.10</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>0.02</td>
<td>0.02</td>
<td>0.02</td>
<td>0.02</td>
<td>0.02</td>
</tr>
<tr>
<td>Cardiothoracic Surgery</td>
<td>0.01</td>
<td>0.01</td>
<td>0.01</td>
<td>0.01</td>
<td>0.01</td>
</tr>
</tbody>
</table>

*Minimum number of providers required is based upon the (minimum provider to beneficiary ratio) multiplied by the (95th percentile of the average health plan market share times the total Medicare beneficiaries residing in a county)*
### Behavioral Health Requirements – FEP PPO and ASO

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>ACCESS STANDARD</th>
<th>COMPLIANCE TARGET</th>
</tr>
</thead>
</table>
| **Geographic Distribution of Behavioral Health Individual Practitioners including:**  
  - Psychologists  
  - Psychiatrists  
  - MFCC                                                 | Urban: 1 within 10 miles of each member  
  Suburban: 1 within 20 miles of each member  
  Rural: 1 within 30 miles of each member                  | Urban: 90%  
  Suburban: 85%  
  Rural: 75%                                      |
| **Geographic Distribution of Behavioral Health facilities including:**  
  - Inpatient Psychiatric Hospital  
  - Residential & OP Treatment Facility                 | Urban: 1 within 15 miles of each member  
  Suburban: 1 within 30 miles of each member  
  Rural: 1 within 60 miles of each member                  | Urban: 90%  
  Suburban: 85%  
  Rural: 75%                                      |
| **Behavioral Health Member Ratio including:**  
  - Top 3 HVS Substance Abuse practitioner              | 1 provider: 20,000 members                                                        | 100%               |

#### Linguistic and Cultural Requirement

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>STANDARD</th>
<th>COMPLIANCE TARGET</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnic/ Cultural and Language Needs</td>
<td>1 PCP speaking a threshold language to 1,000 members speaking a threshold languages</td>
<td>100%</td>
</tr>
</tbody>
</table>
### Additional Measurements for Multidimensional Analysis

<table>
<thead>
<tr>
<th>METRICS</th>
<th>PRODUCT</th>
<th>STANDARD</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access related member complaints and grievances</td>
<td>HMO/POS PPO-CDI</td>
<td>Rate of complaints and grievances 1.00 PTMPY</td>
<td>Semi-Annual</td>
</tr>
<tr>
<td>Access related member complaints and grievances</td>
<td>IFP PPO</td>
<td>1.00 PTMPY</td>
<td>Quarterly</td>
</tr>
<tr>
<td>PCP Turnover</td>
<td>HMO</td>
<td>14%</td>
<td>Semi-Annual</td>
</tr>
<tr>
<td>PCP, Specialist, and Hospital Network Change Analysis</td>
<td>IFP ePPO</td>
<td>10% (Net change)</td>
<td>Quarterly</td>
</tr>
<tr>
<td>PCP to Member Ratio</td>
<td>IFP PPO</td>
<td>1:2000</td>
<td>Quarterly</td>
</tr>
<tr>
<td>Top 10 HVS Turnover</td>
<td>HMO/PPO/CDI/SHOP HMO/PPO</td>
<td>10%</td>
<td>Semi-Annual</td>
</tr>
<tr>
<td>Hospital Turnover</td>
<td>HMO/PPO/CDI</td>
<td>5%</td>
<td>Semi-Annual</td>
</tr>
<tr>
<td>Average Enrollment per PCP</td>
<td>HMO/POS</td>
<td>&lt; 1,200</td>
<td>Semi-Annual</td>
</tr>
<tr>
<td>Open PCP Panel</td>
<td>HMO/POS DCHMO</td>
<td>85%</td>
<td>Semi-Annual</td>
</tr>
<tr>
<td>Member Satisfaction</td>
<td>HMO/POS PPO - DMHC</td>
<td>HMO – Patient Assessment Survey at IPA/MG level HMP/PPO – CAHPS at Health Plan level</td>
<td>Annual</td>
</tr>
</tbody>
</table>
Section 2: Provider Responsibilities

Language Assistance for Persons with Limited English Proficiency (LEP)

This section summarizes Blue Shield’s Language Assistance Program (LAP) and specifies the roles and responsibilities of Blue Shield and its contracted providers in supporting the program.

Blue Shield’s Threshold Languages

Blue Shield’s threshold languages for 2019 are:

- Spanish
- Chinese – Traditional
- Vietnamese

A threshold language is a language other than English that Blue Shield will use to translate vital documents. Threshold languages are determined based on the language preferences of the largest number of plan enrollees, excluding Medi-Cal, Medicare and Administrative Services Only enrollees.

Blue Shield’s Language Assistance Program

Blue Shield is committed to providing quality health care services to all enrollees regardless of their ability to speak English. Access to timely language services is provided through competent, trained interpreters and translators.

Blue Shield and its contracted providers must offer timely language assistance services to its LEP enrollees at all points of contact where the need for such services can be reasonably anticipated, and at no charge to the enrollee, even when the enrollee is accompanied by a family member or friend who can interpret.

Identifying LEP Enrollees at Points of Contact

When an enrollee communicates his or her language preference to Blue Shield, it is added to the enrollee’s profile and printed on his or her member identification card if it is a language other than English.

Providers must inform Blue Shield LEP members who have a language preference other than English that they have access to interpretation services at no cost to them.

Providing Interpretation Services

Blue Shield provides the following interpretation services when contacted by an enrollee:

- Offers trained bilingual representatives who speak Spanish and can assist Spanish-speaking LEP enrollees who call, using the telephone number listed on the enrollee’s identification card. Additionally, our representatives have access to telephonic interpretation services to provide timely interpretive services in other languages.
- Identifies providers who are bilingual or who employ bilingual staff. Providers who can offer personal bilingual capabilities or staff with bilingual capabilities within their practices are indicated in our provider directory, which can be accessed by calling Member Services or by logging on to blueshieldca.com.
Language Assistance for Persons with Limited English Proficiency (LEP) (cont’d.)

Blue Shield provides the following interpretation resources to our contracted providers for assisting our enrollees:

- Access to telephonic interpretation services through Provider Customer Services at (800) 541-6652. The provider will be guided by Voice Response Unit (VRU) menu prompts to request access to spoken interpretation services for a member over the phone (in almost any language) or hear information on how to obtain vital document translation (available in Blue Shield’s threshold languages only – Spanish, Chinese - Traditional, and Vietnamese) on behalf of a member.

  The VRU will also aid in the verification of the enrollee’s membership status.

- In-person interpretation services for a member at a provider site. To arrange for in-person interpretation services, the provider must call the Provider Customer Service number at (800) 541-6652 and speak to a Provider Customer Services Agent.

Please refer to the section below on “Timeliness Standards” for information on Blue Shield’s response time and expectations from providers who are requesting services on behalf of a member.

Contracted providers complete a Provider Enrollment Application (PEA) at the onset of their relationship with Blue Shield. The PEA allows the provider to indicate additional language capability within their practice. Language capability information is included in the provider directory to allow LEP members to select a provider who can speak to them in their preferred language, contingent on the availability of a provider that speaks that language. Providers can update their language capability listing by calling the Provider Information & Enrollment at (800) 258-3091. Blue Shield will update its provider directories accordingly and expect updates from providers regarding changes.

If a provider chooses to provide interpretation services to their patients (and Blue Shield members) using their bilingual doctors or staff members, the Language Assistance regulations and Blue Shield’s interpreter standards require the bilingual providers and/or bilingual staff meet the following requirements:

- A documented and demonstrated proficiency in both English and the other language(s);
- A fundamental knowledge in both languages of health care terminology and concepts relevant to health care delivery systems (or health plan context);
- Education and training in interpreting ethics, conduct and confidentiality.

The Healthcare Industry Collaborative Effort (ICE) has developed a self-assessment tool that can assist providers in identifying language skills and resources existing in their health care setting. This simple tool will provide a basic and subjective idea of the bilingual capabilities of the staff. Once bilingual staff members have been identified, they should be referred to professional assessment agencies to evaluate the level of proficiency. There are many sources that will help assess the bilingual capacity of the staff.

If the provider does not meet these requirements, they should inform the patient that Blue Shield will make an interpreter available to the patient at no charge and inform the patient that he/she can choose to use the bilingual office staff, if they choose, however, if the patient chooses to use the bilingual staff, then the provider should note that decision in the patient’s record.

Blue Shield may perform quality assurance audits of its contracted providers to confirm and document the accuracy of provider language capability disclosure forms and attestations of their language capability.
Language Assistance for Persons with Limited English Proficiency (LEP) (cont’d.)

Timeliness Standards for Interpretation Services at Points of Contact

For purposes of this subsection, “timely” means in a manner appropriate for the situation in which language assistance is needed. Interpretation services are not timely if they delay results in the effective denial of the service, benefit, or right at issue. Quality assurance standards for timely delivery of language assistance services for emergency, urgent and routine health care services, including standards for coordinating interpretation services with appointment scheduling, are:

- **Over-the-Phone Interpretation (OPI):** Immediate – no more than 10 minutes, from time of connection with the interpretation vendor to the time that the interpreter (who speaks the enrollee’s language) is present on the telephone line.
  
  Used for administrative points of contact with Blue Shield, and routine, urgent and emergent services with contracted providers.

- **In-Person Interpretation (IPI), or Face-to-Face Routine Visit:** Five (5) business days with advanced notice from the enrollee is preferred in order to make best efforts to accommodate the request for face-to-face interpreters. At the time of the appointment, if a face-to-face interpreter has been scheduled and the interpreter does not show after a 15-minute wait time, the provider shall offer the enrollee the choice of using a telephone interpreter or the opportunity to reschedule the appointment.

- **For appointments made within 48 hours/Emergency** (same or next day access for routine or urgent care): Provide services telephonically (see Over-the-Phone Interpretation above).

These standards also apply when the enrollee contacts Blue Shield to arrange for an interpreter.

Documenting Enrollee Refusal of Language Assistance

If the enrollee refuses language assistance services offered when contacting Blue Shield, it will be documented in the enrollee’s record. If the enrollee declines language assistance services offered by a Blue Shield contracted provider, the provider is required to document the refusal in the enrollee’s medical record.

Documenting that a patient has refused interpretive services in the medical record is a way to protect providers. It will ensure consistency when medical records are monitored through site reviews or audits. If the patient insists on using a family member or friend to interpret, providers must also note that in the medical record. It is especially important to document if the interpreter used is a minor. Consider offering a professional telephonic interpreter through the telephonic interpretation service, in addition to a patient’s chosen family member or friend, to ensure accuracy of the interpretation.

In emergency situations, a minor may be used as an interpreter if the following conditions are met:

(A) The minor demonstrates the ability to interpret complex medical information in an emergency/critical situation; and,

(B) The insured is fully informed in his or her primary/preferred spoken language that a qualified interpreter is available at no charge to the insured. If the insured refuses the offer of the qualified interpreter, the offer of a qualified interpreter and the insured’s decision to use the minor as the interpreter shall be documented in the medical record file.
Section 2: Provider Responsibilities

Language Assistance for Persons with Limited English Proficiency (LEP) (cont’d.)

Documenting Enrollee Refusal of Language Assistance (cont’d.)

It is required that providers document in the patient’s medical record an LEP patient’s preferred language. Additionally, it is recommended the medical record also contain the name and contact information of any professionally-trained interpreter whose services were used for a medical visit.

Informing Enrollees of their Right to Appeal

Blue Shield provides enrollees with written notices in their language, provided that it is one of Blue Shield’s threshold languages, informing them about their right to file an appeal with the plan or seek independent medical review (IMR).

These notices are available for providers on Provider Connection at blueshieldca.com/provider under Guidelines & Resources, Patient Care Resources, and then Language Assistance Program Resources. Members may access appeal and IMR information in their Evidence of Coverage or Certificate of Insurance, and at blueshieldca.com, as well as the DMHC website at www.dmhc.ca.gov or on the CDI website at www.insurance.ca.gov. Hard copies of the DMHC notice may also be requested by submitting a written request to: Department of Managed Health Care, Attention: HMO Help Notices, 980 9th Street, Suite 500, Sacramento, CA 95814.

Providing Translation Services

Vital Documents

Vital documents are materials deemed critical to accessing the health plan and its benefits. Vital documents may be produced by the plan, a contracted health care service provider, or contracted administrative services provider.

The following documents are the “vital documents” produced by Blue Shield. This category includes documents produced or distributed to enrollees by a delegated IPA or medical group:

- Applications
- Consent forms, including any form by which a member authorizes or consents to any action by Blue Shield
- Letters containing important information regarding eligibility and participation criteria
- Notices pertaining to the denial, reduction, modification, or termination of services and benefits, and the right to file a grievance or appeal
- Notices advising LEP enrollees of the availability of language assistance at no cost and other outreach materials that are provided to enrollees
- Blue Shield’s and delegated IPA/medical group explanation of benefits or similar claim processing information that is sent to an enrollee if the document requires a response from the enrollee
- Enrollee disclosures (Benefit Matrix or Patient Charge Schedules).
Vital documents are divided into two categories:

- **Standard Vital Documents**
  Most standard documents are translated up front, while other standard vital documents such as Summary of Benefits Coverage, benefit summaries and benefit matrices will be translated upon request by LEP enrollees.

- **Non-Standard Vital Documents**
  Non-standard vital documents contain enrollee-specific information. These documents are not translated into threshold languages. Blue Shield will include with any non-standard vital documents distributed to enrollees the appropriate DMHC/CDI-approved written notice of the availability of interpretation and translation services. If translation or interpretation of any non-standard vital document is requested by the enrollee, Blue Shield will provide the requested translation within 21 calendar days of that request, with the exception of expedited grievances, as noted below.

**Blue Shield’s Standard Vital Documents**
Blue Shield has identified its standard vital documents (i.e., documents that do not contain enrollee-specific information) and has translated these documents into its threshold languages. Examples of standard vital documents include:

- Applications, consent forms
- Notices of the right to file a grievance or appeal
- Notice of language assistance at no cost

**Blue Shield’s Non-standard Vital Documents (those containing enrollee-specific information) include:**

- Letters containing important information regarding eligibility and participation criteria;
- Notices pertaining to the denial, reduction, modification, or termination of services and benefits.
Language Assistance for Persons with Limited English Proficiency (LEP) (cont’d.)

Notice of the Availability of Language Assistance Services

Blue Shield issues non-standard vital documents to all enrollees and includes brief, alternate instructions in English and our threshold languages (Spanish, Chinese -Traditional, and Vietnamese), as follows:

- English: For assistance in English at no cost, call 1-866-346-7198.
- Navajo (Dine): Diní kʼehji doo bágh ilínígo shíka’ ał’ooowol ninizingo, kwįį’ hodíi níih 1-866-346-7198.
- Vietnamese (Tiếng Việt): Để được hỗ trợ miễn phí tiếng Việt, vui lòng gọi điện số 1-866-346-7198.
- Armenian (Հայերեն): Հայերենը մեկնարկեցրեներին հաճախ կիրառվող երկրներում 1-866-346-7198.
- Russian (Русский): Если нужна бесплатная помощь на русском языке, то позвоните 1-866-346-7198.
- Japanese (日本語): 日本語支援が必要な場合 1-866-346-7198 に電話をかけてください。
- Persian (فارسی): برای دریافت کمک رایگان زبان فارسی، لطفاً به شماره تلفن 1-866-346-7198 نامبگردید (فارسی)
- Punjabi (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵਿੱਚ ਫੈਲਣ ਅਨੁਸਾਰ ਸੰਖਿਤ ਸਨਮਾਨਤਾ ਦਿੱਤੀ ਸੀ। 1-866-346-7198 ਤੋਂ ਕਲ ਕਰੋ: (ਪੰਜਾਬੀ)
- Hmong (Hmoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-866-346-7198.
- Hindi (हिंदी): हिंदीमें ख्यात वेबसाइट वेबसाइट के लिए, 1-866-346-7198 पर कॉल करें।
- Thai (ไทย): สำหรับภาษาไทยในภาษาไทยไม่สามารถใช้ในประเทศไทย 1-866-346-7198.
Language Assistance for Persons with Limited English Proficiency (LEP) (cont’d.)

Notice of the Availability of Language Assistance Services (cont’d.)

Blue Shield’s Notice of Availability of Language Assistance (that includes both DMHC- and CDI-approved language) is available on Provider Connection at blueshieldca.com/provider under Guidelines & Resources, Patient Care Resources, and then Language Assistance Program Resources.

The notice states the following in English and in Blue Shield’s threshold languages and non-threshold languages:

- The notice in threshold languages (Blue Shield’s threshold languages are Spanish, Chinese - Traditional, and Vietnamese):
  
  “No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-346-7198. For more help call the CA Dept. of Insurance at 1-800-927-4357.”

- The notice in non-threshold languages:
  
  “No Cost Language Services. You can get an interpreter and get documents read to you in [language]. For help, call us at the Member/Customer Service number listed on the back of your ID card or 866-346-7198. For more help call the CA Dept. of Insurance at 1-800-927-4357.”

Enrollees requiring help to read a Blue Shield-generated non-standard vital document are instructed to call the toll-free telephone number on the back of their member ID card for at no cost interpretation or translation into the plan’s threshold languages. When translation of the non-standard vital document is requested, Blue Shield provides the translation within twenty-one (21) calendar days of the request.

Request for Translation

Providers are not delegated to provide translation of non-standard vital documents and must forward such requests received from Blue Shield enrollees to Blue Shield.

A provider who receives a request for a vital document translation should forward it to Blue Shield within one business day if it is urgent or within two business days if it is not urgent.

To forward the vital document to Blue Shield:

- Complete Blue Shield’s “Language Assistance Form” available at Provider Connection at blueshieldca.com/provider under Guidelines & Resources, Patient Care Resources, and then Language Assistance Program Resources;

- Attach a copy of the document to be translated;

- Fax the request to (209) 371-5838.
### Language Assistance for Persons with Limited English Proficiency (LEP) (cont’d.)

#### Timeliness Standards for Standard and Non-Standard Vital Documents

The following timeliness standards apply for standard and non-standard vital documents:

<table>
<thead>
<tr>
<th>Element</th>
<th>Type of Request</th>
<th>Timeliness Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Urgent:</td>
<td>Provider receives a request for translation of a provider’s non-standardized vital document from a Blue Shield enrollee</td>
</tr>
<tr>
<td></td>
<td>Non-Urgent:</td>
<td>Response within two business days</td>
</tr>
<tr>
<td>Blue Shield requests a provider’s non-standardized vital document</td>
<td>Urgent:</td>
<td>Within one business day</td>
</tr>
<tr>
<td></td>
<td>Non-Urgent:</td>
<td>Within two business days</td>
</tr>
<tr>
<td>Blue Shield member requests a Blue Shield standard vital document from provider.</td>
<td>All:</td>
<td>Within one business day</td>
</tr>
</tbody>
</table>
Language Assistance for Persons with Limited English Proficiency (LEP) (cont’d.)

Language Assistance at Contracted Facilities

Hospitals are required to provide interpretation services. Therefore, when Blue Shield enrollees request assistance directly from hospital staff, the hospital is responsible for making such arrangements. Regulations require that Blue Shield monitor contracted facilities for deficiencies in the delivery of interpretation services.

Training and Education

Providers are expected to ensure that all contracted or employed providers and their staffs who are in contact with LEP members receive education and training regarding Blue Shield’s LAP through formal or informal processes.

For additional information on Blue Shield’s Language Assistance Program, go to Provider Connection at blueshieldca.com/provider under Guidelines & Resources, Patient Care Resources, and then Language Assistance Program Resources.

Monitoring Compliance

Blue Shield’s LAP annual compliance audit includes:

1. Monitoring internal Blue Shield organizations, contractors, contracted health care providers, and network compliance with regulatory standards for the LAP, including the availability, quality and utilization of language assistance services.
2. Tracking grievances and complaints related to its LAP.
3. Documenting actions taken to correct problems.

References

Several websites provide guidance, tools and information that may be of help to provider offices in treating diverse populations. The following websites will provide you with resources to comply with the requirements of the LAP:

- American Academy of Family Physicians Cultural Proficiency Resources
- American Medical Association: Improving Communication-Improving Care
  http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/the-ethical-force-program/patient-centered-communication.page
- Graduate School of AMA Eliminating Health Disparities
- The Georgetown University Center for Child and Human Development – National Center for Cultural Competence Curricula Enhancement Module Series www.necccurricula.info/sitemap.html
- The Manager’s Electronic Resource Center: The Provider’s Guide to Quality & Culture
  http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English
  www.thinkculturalhealth.org
Section 3: Medical Care Solutions
This page intentionally left blank.
## Table of Contents

Medical Care Solutions Program Overview ......................................................................................................... 1  
Practice Guidelines ............................................................................................................................................... 3  
Mental Health and Substance Use Disorder Clinical Management Program for Self-Insured Accounts (ASO) 3  
  Program Activities ............................................................................................................................................. 4  
Wellness Assessments .......................................................................................................................................... 6  
Blue Shield Medical & Medication Policies .......................................................................................................... 8  
  Medical Policy .................................................................................................................................................. 8  
  Medication Policy .............................................................................................................................................. 8  
Use of Free-Standing Urgent Care Centers ......................................................................................................... 9  
Use of Non-Preferred/Non-Participating Providers .......................................................................................... 9  
Referral to Non-Preferred/Non-Participating Providers .................................................................................... 10  
Billing Members for Durable Medical Equipment (DME) ............................................................................. 10  
Continuity of Care for Members by Non-Contracted Providers ..................................................................... 11  
Prior Authorizations .......................................................................................................................................... 11  
  Prior Authorization Response Times ............................................................................................................... 12  
  Specialty Drug Prior Authorization for the Medical Benefit ....................................................................... 13  
Prior Authorization List for Network Providers .............................................................................................. 14  
Organ and Bone Marrow Transplants ............................................................................................................. 18  
  Transplant Authorization ................................................................................................................................... 19  
Drug Formulary ................................................................................................................................................. 20  
  Mandatory Generic Drug Policy ..................................................................................................................... 22  
  Mail Service Prescriptions .............................................................................................................................. 22  
  Specialty Drugs ............................................................................................................................................... 22
Section 3: Medical Care Solutions

Medical Care Solutions Program Overview

The Medical Care Solutions Department within Blue Shield’s Health Care Services (HCS) division is established to provide oversight of the delivery of care to members. The Blue Shield Medical Care Solutions professional staff includes California-licensed physicians, and nurses who monitor healthcare services delivered by contracted-physicians and providers for timeliness, appropriateness, and quality of care.

The Blue Shield Medical Care Solutions program consists of active ongoing coordination and evaluation of requested or provided health services to promote delivery of medically necessary, appropriate health care services and quality, and cost-effective clinical outcomes. The Medical Care Solutions Program is designed to assist Blue Shield contracted physicians, providers, and hospitals in ensuring that medical services are:

- Covered under the member’s health plan benefits;
- Appropriate and medically necessary and that such determination is made by qualified licensed health care professionals. Medically necessary services include only those services that have been established as safe and effective and are furnished in accordance with generally accepted professional standards to treat an illness, injury, or medical condition, and which, as determined by Blue Shield, are consistent with Blue Shield’s Medical Policy, evidence-based criteria, approved nationally recognized medical necessity criteria, and federal and state regulations;
- Consistent with the symptoms or diagnosis;
- Not furnished primarily for the convenience of the patient, the attending physician, or other provider; and
- Provided at the most appropriate level and can be provided safely and effectively to the patient.

If there are two or more medically necessary services that may be provided for the illness, injury, or medical condition, Blue Shield will provide benefits based on the most cost-effective service.

The goal of the Blue Shield Medical Care Solutions Program is to promote the efficient and appropriate utilization of medical services and to monitor the quality of care given to members. To accomplish this goal, the program requires systematic monitoring and evaluation of the medical necessity and level of care of the services requested and provided. Blue Shield determines medical necessity and the appropriateness of the level of care through the prospective review of care requested and the concurrent and retrospective review of care provided. These reviews are conducted by Blue Shield nurse reviewers, medical directors, pharmacists, peer review committees, physician peer reviewers and other consultants.

Blue Shield may also delegate UM activities to subcontracted entities. Blue Shield approval of the delegated entity’s UM program is based on a review of its policies and procedures, demonstration of compliance with stated policies and procedures, and the ability to provide services to our members in keeping with various accreditation and regulatory requirements. All delegated activities are monitored and evaluated by the Blue Shield Healthcare Services teams and the appropriate oversight committee to assist the delegated entity in improving its processes. Blue Shield retains the authority and responsibility for the final determination in UM medical necessity decisions and ensures appeals related to utilization issues are handled in a timely and efficient manner.
Blue Shield members generally expected to benefit from Medical Care Solutions support include those with potential long-term, complex, or exceptional care needs, resulting from the following conditions:

- AIDS/HIV
- Cancer
- Chronic and disabling pulmonary diseases (e.g., asthma, emphysema)
- Cardiovascular disease
- Cerebral vascular accident
- Head/spinal cord injury
- Total joint replacement
- High-risk pregnancy
- Diabetes Mellitus
- Transplant (Solid Organ or Bone Marrow Transplant (BMT))
- End stage renal disease
- Members with complex conditions
- Members with coexisting medical and behavioral health conditions

In conjunction with Blue Shield Medical Care Solutions, the member, attending physician, and ancillary care providers participate in the member’s plan of care. Blue Shield’s Medical Care Solutions Department will contact the requesting provider(s) within 72 hours for urgent requests to inform them of the status of their request for care or services. The Blue Shield Medical Care Solutions staff will follow the Blue Shield Timeliness Standards for all other non-urgent requests for services. Blue Shield will also send written notification to the member and providers to confirm the request determination. Blue Shield licensed nurses engage with members to ensure care needs are coordinated prior to, during, and after a hospital confinement.

Members may self-refer or be referred for Medical Care Solutions through a variety of sources, including their physician, Social Services, family members, employers, etc.
Practice Guidelines

Blue Shield is committed to improving health with optimal outcomes. Clinical practice and preventive health guidelines assist physicians by providing a summary of evidence-based recommendations for the evaluation and treatment of preventive aspects and select common acute and chronic conditions.

Blue Shield’s Clinical Practice Guidelines focus on important aspects of care with recognized and measurable best practices for high-volume diagnoses. The basis of the Guidelines includes a variety of sources that are nationally recognized, or evidence-based, or are expert consensus documents. Additional points have been included where medical literature and expert opinion are noted. Network physician involvement is a crucial part of the guideline development, as well as adoption for the organization after approval by Blue Shield Committees.

Refer to Appendix 3-A for a listing of the current Clinical Practice Guidelines, including references to appropriate source documents. Guidelines are also available on Provider Connection at blueshieldca.com/provider under Guidelines & Resources, then Guidelines and Standards.

Mental Health and Substance Use Disorder Clinical Management Program for Self-Insured Accounts (ASO)

Self-insured accounts (as listed in Appendix 5-B: Other Payor Summary List) have the following two options for clinical management of mental health and substance use disorder services:

1. **Standard Clinical Management** provided by Blue Shield Medical Care Solutions or,

2. **Expanded Clinical Management** provided by Blue Shield’s mental health service administrator (MHSA), Human Affairs International of California (HAI-CA), a Magellan Health Services company. Expanded Clinical Management allows for more intensive management of mental health and substance use disorder services in the inpatient and outpatient settings. Members of self-insured accounts who have chosen the Expanded Clinical Management benefit are identified by the following message on the back of their ID cards:

   “(800) 378-1109 Mental Health Prior Authorization”

Members who have the Expanded Clinical Management benefit receive services from directly contracted Blue Shield network providers. All claims for these members should be submitted to Blue Shield for payment.
Program Activities

Prior Authorization Requirements

1. **Standard Clinical Management:** Prior authorization is required for inpatient services, residential, partial hospitalization, intensive outpatient services, and services billed with the following CPT and HCPCS Codes. Authorization can be obtained by calling Blue Shield Medical Care Solutions at (800) 541-6652, Option 6 or by faxing in a request for prior authorization to (844) 807-8997. In addition, providers have the option to complete, submit, attach documentation, track status and receive determinations for medical and pharmacy prior authorizations via AuthAccel, Blue Shield’s online authorization tool. Registered users may access the tool in the *Authorizations* section after logging into Provider Connection at [www.blueshieldca.com/provider](http://www.blueshieldca.com/provider).

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90899</td>
<td>Unlisted Procedure</td>
</tr>
<tr>
<td>90867</td>
<td>Therapeutic repetitive transcranial magnetic stimulation treatment; initial; planning including cortical mapping, motor threshold determination, delivery and management</td>
</tr>
<tr>
<td>90868</td>
<td>Therapeutic repetitive transcranial magnetic stimulation treatment; subsequent delivery and management, per session</td>
</tr>
<tr>
<td>90869</td>
<td>Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management</td>
</tr>
<tr>
<td>90901</td>
<td>Bio-Feedback</td>
</tr>
<tr>
<td>96116</td>
<td>Neurobehavioral Status Exam</td>
</tr>
<tr>
<td>96118</td>
<td>Neuropsychological Testing</td>
</tr>
<tr>
<td>96119</td>
<td>Neuropsychological Testing</td>
</tr>
<tr>
<td>96120</td>
<td>Neuropsychological Testing</td>
</tr>
<tr>
<td>H0031</td>
<td>Functional assessment and treatment plan developed for Applied Behavior Analysis (ABA), hourly increments</td>
</tr>
<tr>
<td>H0032</td>
<td>Case oversight and management of treatment team by licensed MH professional or certified BCBA, per 15 min</td>
</tr>
<tr>
<td>G9012</td>
<td>Case oversight and management of treatment team by licensed MH professional or certified BCBA, per 15 min</td>
</tr>
<tr>
<td>H2019</td>
<td>Direct Applied Behavior Analysis (ABA) services by a paraprofessional or Board-Certified Behavior Analyst (BCBA) provider, per 15 min</td>
</tr>
<tr>
<td>H2014</td>
<td>Skills training and development, social skills group, per 15 min</td>
</tr>
<tr>
<td>S5110</td>
<td>Home care training, family, per 15 min</td>
</tr>
<tr>
<td>S5108</td>
<td>Home care training to home care client, per 15 min</td>
</tr>
<tr>
<td>H0001</td>
<td>Methadone Induction Phase</td>
</tr>
<tr>
<td>H0020</td>
<td>Methadone Treatment</td>
</tr>
</tbody>
</table>
Prior Authorization Requirements (cont’d.)

2. **Expanded Clinical Management:** Prior authorization is required for inpatient services, residential, partial hospitalization, intensive outpatient services, and services billed with the following CPT and HCPCS Codes. Authorization can be obtained by calling Blue Shield’s MHSA at (800) 378-1109.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>90870</td>
<td>ECT</td>
</tr>
<tr>
<td>90899</td>
<td>Unlisted Procedure</td>
</tr>
<tr>
<td>90867</td>
<td>Therapeutic repetitive transcranial magnetic stimulation treatment; initial; planning including cortical mapping, motor threshold determination, delivery and management</td>
</tr>
<tr>
<td>90868</td>
<td>Therapeutic repetitive transcranial magnetic stimulation treatment; subsequent delivery and management, per session</td>
</tr>
<tr>
<td>90869</td>
<td>Therapeutic repetitive transcranial magnetic stimulation (TMS) treatment; subsequent motor threshold re-determination with delivery and management</td>
</tr>
<tr>
<td>90901</td>
<td>Bio-Feedback</td>
</tr>
<tr>
<td>96101</td>
<td>Psych Testing</td>
</tr>
<tr>
<td>96102</td>
<td>Psych Testing</td>
</tr>
<tr>
<td>96103</td>
<td>Psych Testing</td>
</tr>
<tr>
<td>96116</td>
<td>Neurobehavioral Status Exam</td>
</tr>
<tr>
<td>96118</td>
<td>Neuropsychological Testing</td>
</tr>
<tr>
<td>96119</td>
<td>Neuro psychological Testing</td>
</tr>
<tr>
<td>96120</td>
<td>Neuropsychological Testing</td>
</tr>
<tr>
<td>H0031</td>
<td>Functional assessment and treatment plan developed for Applied Behavior Analysis (ABA), hourly increments</td>
</tr>
<tr>
<td>H0032</td>
<td>Case oversight and management of treatment team by licensed MH professional or certified BCBA, per 15 min</td>
</tr>
<tr>
<td>G9012</td>
<td>Case oversight and management of treatment team by licensed MH professional or certified BCBA, per 15 min</td>
</tr>
<tr>
<td>H2019</td>
<td>Direct Applied Behavior Analysis (ABA) services by a paraprofessional or Board-Certified Behavior Analyst (BCBA) provider, per 15 min</td>
</tr>
<tr>
<td>H2014</td>
<td>Skills training and development, social skills group, per 15 min</td>
</tr>
<tr>
<td>S5110</td>
<td>Home care training, family, per 15 min</td>
</tr>
<tr>
<td>S5108</td>
<td>Home care training to home care client, per 15 min</td>
</tr>
<tr>
<td>H0001</td>
<td>Methadone Induction Phase</td>
</tr>
<tr>
<td>H0020</td>
<td>Methadone Treatment</td>
</tr>
</tbody>
</table>

There is no change in the claims submission process. Providers should submit all claims for mental health and substance use disorder services to Blue Shield. Providers are required to submit claims electronically to Blue Shield that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected.

**Note:** If provider fails to obtain authorization prior to providing covered services to a member, as required, or if provider provides services outside of the scope of the authorization obtained, then Blue Shield, or its delegate, shall have no obligation to compensate provider for such services; provider will be deemed to have waived payment for such services and shall not seek payment from Blue Shield, its delegate, or the member.
Mental Health and Substance Use Disorder Clinical Management Program for Self-Insured Accounts (ASO) (cont’d.)

Wellness Assessments

Expanded Clinical Management activities are supported by the use of the Consumer Health Inventory™ (CHI) and the Consumer Health Inventory-Children’s Version™ (CHI-C), described below.

Consumer Health Inventory™ (CHI)

The Consumer Health Inventory™ (CHI) measures functional health and well-being as well as behavioral symptoms and distress from the patient’s point of view. It is a practical, reliable, and valid measure of physical and mental health that can be completed in five to ten minutes. The CHI is designed for adults and youth 14 years and older. It is recommended that the CHI be administered at patient intake, every 30-45 days, and at discharge.

The CHI is based on the SF-12® Health Survey which is nationally recognized as a leading health assessment tool for measuring changes in physical functioning and mental well-being. The CHI expands the scope of the SF-12® assessment tool, including new, evidence-based assessment questions that address the following:

- Presence and impact of behavioral health symptoms
- Substance use patterns
- Personal strengths
- Work place productivity
- Key attributes of the CHI™ include:
  - Free to members and providers
  - Easy-to-use and administer
  - Available in English and Spanish
  - Completed by the member
  - Produces immediate dashboard reports for both the member and provider
Mental Health and Substance Use Disorder Clinical Management Program for Self-Insured Accounts (ASO) (cont’d.)

Wellness Assessments (cont’d.)

Consumer Health Inventory—Children’s Version™ (CHI-C)

The Consumer Health Inventory—Children’s Version™ (CHI-C) is the child/adolescent version of the CHI. It is completed by the parent or primary caregiver for children up to age 17. The CHI-C is based on the SF-10™ Health Survey for Children. Like the CHI, it measures key functional indicators and is available in English and Spanish versions. It is recommended that the CHI-C be administered at patient intake, every 30-45 days, and at discharge.

The CHI-C provides an assessment of a child’s physical and psychosocial health status from his or her caretaker’s perspective. The CHI-C measures key functional indicators:

- Physical health
- Psychosocial health
- School participation
- Distress symptoms
- Strength

Examples of the Consumer Health Inventory forms are available on Blue Shield’s MHSA website at http://www.magellanprovider.com along with CHI resources such as provider guides, sample assessment surveys, instructions, and member materials, under Education, then Outcomes Library.
Blue Shield Medical & Medication Policies

Medical and medication policies are general statements of coverage for Blue Shield as a company. Unless a specific regulatory requirement (state or federal) or a plan-specific benefit or limitation applies, medical and medication policies are applied to individuals covered by Blue Shield.

The emergence of new technologies and pharmaceuticals (or new uses for existing technologies and pharmaceuticals) is monitored on an ongoing-basis to ensure timely availability of appropriate policies.

Medical Policy

The Blue Shield Medical Policy Committee reviews technologies (devices and/or procedures) for medical and behavioral health indications that are new or emerging, and new applications for existing technologies. The Committee meets at least four times per year. Experts are consulted and invited on an as-needed basis to the Committee.

The primary sources of the technology evaluations are derived from the Blue Cross Blue Shield Association Technology Evaluation Center (BCBSA TEC), the Blue Cross Blue Shield Association Medical Policy Reference Panel (BCBSA MPP), and the California Technology Assessment Forum (CTAF).

For a recommended technology to be considered eligible for coverage, that technology must meet all of the Technology Assessment (TA) Criteria:

1. The medical technology must have final approval from the appropriate government regulatory bodies.
2. The scientific evidence must permit conclusions concerning the effectiveness of the technology on health outcomes.
3. The technology must improve the net health outcome.
4. The technology must be as beneficial as established alternatives.
5. The improvement must be attainable outside investigational settings.

Medication Policy

The Blue Shield Pharmacy and Therapeutics (P&T) Committee reviews pharmaceuticals.

Pharmaceutical reviews are conducted using the available scientific evidence, including randomized controlled trials, cohort studies, systemic reviews, and the clinical trial data submitted to the FDA to support a new drug, abbreviated drug, or biologic license application (NDA, ANDA, BLA).

For a pharmaceutical to be considered eligible for coverage, the drug product must meet the following criteria:

1. The pharmaceutical product is approved by the U.S. Food and Drug Administration for marketing in the U.S.
2. The scientific evidence must permit conclusions concerning efficacy and safety of the pharmaceutical product on health outcomes.
3. The available scientific evidence demonstrates improved net health outcomes, and the beneficial effects outweigh the harmful effects on health outcomes.
4. The established alternatives improve net health outcomes as much as, or more than the established alternatives.
5. The health outcome improvements are attainable outside of investigational settings.
Blue Shield Medical & Medication Policies (cont’d.)

Only when sufficient credible evidence (such as clinical studies and trials, peer review scientific data, journal literature) has demonstrated safety and efficacy, will a technology or pharmaceutical be considered eligible for coverage, based on medical necessity.

Note: Benefit and eligibility criteria supersede medical necessity determinations.

Medical or medication policy information is available through Provider Connection at www.blueshieldca.com/provider under Authorizations, Clinical Policies and Guidelines or by contacting Provider Information & Enrollment at (800) 258-3091.

For information concerning Blue Shield’s member grievance process, refer to Section 1.

Use of Free-Standing Urgent Care Centers

Generally, Blue Shield urgent care physicians are not located in an acute hospital setting and are required to offer extended hours of operation, including weekends, and provide services to members without appointments.

Members should be referred to these physicians, rather than hospital emergency rooms, when appropriate and available for the level of service and care indicated. A list of currently contracted urgent care physicians may be found on blueshieldca.com/provider and in the Blue Shield provider directories.

Use of Non-Preferred/Non-Participating Providers

Blue Shield members should be referred to a preferred/participating provider for services whenever possible to maximize the benefits available to them under their benefit plans and to provide those benefits at the lowest possible cost to the members. A provider type includes, but is not limited to, the provider types listed in Section 1 of this manual. Examples of other provider types include hospitals, ambulatory surgery centers, and DME vendors.

To assist members in making informed choices, Blue Shield requires providers to discuss the option of utilizing a preferred/participating provider when making a referral to a non-preferred/non-participating provider for non-emergent services. This policy is not intended to dissuade members from utilizing their non-preferred benefits, but instead is intended to help them understand the impact of their decisions. Often the use of a non-preferred/non-participating provider results in reduced benefits and/or higher out-of-pocket costs to the member.

If, after discussing the options available, the member chooses to receive services from a non-preferred/non-participating provider, the referring physician and the member must complete the Member Advance Notice Form - Referral to Non-Preferred Provider, available on blueshield.com/provider in the Guidelines & Resources section, then Forms section, and then select the Patient Care Forms link. The original completed form must be filed in the member’s medical record and be made available to Blue Shield within five (5) business days from the date of the request by Blue Shield.
Referral to Non-Preferred/Non-Participating Providers

If Blue Shield confirms that it is not able to ensure reasonable access to care, providers will be able to request and obtain authorization for out-of-network provider services. Blue Shield will pay/price these services at the member’s preferred in-network benefit level.

Since members incur higher copayments and deductibles when non-participating health care professionals are used, every effort must be made to ensure referrals are made to participating health care professionals and facilities. When there are no Blue Shield network health care professionals (for specialty, acute care, ancillary care, etc.) available in the member’s service area, the member or provider may request a referral to a non-participating provider. Providers requesting a referral to a non-participating provider must call Blue Shield at (800) 541-6652 Option 6 or complete and fax the Out of Network Referral Request Form to (855) 895-3506. The Out of Network Referral Request Form is available on blueshield.com/provider in the Guidelines & Resources section, then Forms section, and then select the Patient Care Forms link. Requests for referrals to non-participating providers must be made prior to services being rendered. Blue Shield will review the referral request. When a request is approved for an out-of-network referral, the member is covered at their preferred in-network benefit level.

If, for some reason, a primary care physician, other health care professional specialty, acute care facility, or other provider is not available or accessible to a member whose benefit plan is affiliated with a narrow network, then Blue Shield will refer the member to the required professional or institution from its larger PPO Network to ensure member access to care. If, for some reason, the professional or institution is not available within Blue Shield’s larger PPO Network, the Out of Network Referral Request Form must be generated for the member and the associated claim(s) is/are paid/priced at preferred in-network benefit levels. Examples of situations prompting a request for a referral to a non-preferred/non-participating provider include:

- There are no providers in the network who are accepting new patients.
- Participating providers are too far away for the member to see per approved access and availability standards.
- The member requires specific treatments that do not exist in-network.
- The participating providers or specialists are unable to perform a medically necessary service.
- The participating providers or specialists are unable to admit the member to a participating facility due to timing, capacity, etc.
- The participating providers or specialists are unable to offer the member an appointment that meets regulatory timely access standards (e.g., within 10 business days of appointment request for non-urgent primary care, and within 15 business days of appointment request for non-urgent specialty care).

Billing Members for Durable Medical Equipment (DME)

Providers are not allowed to bill members for covered durable medical equipment (DME), and/or retrieve equipment that has been determined to be medically necessary by delegated entities. If, at any point during DME rental periods the member exhibits behavior that is not consistent with Blue Shield Medical Policy, the provider shall contact the delegated entity, inform them of the member’s documented non-compliance with Blue Shield Medical Policy, and request their determination on continued use of the prescribed DME. Until a notice of non-coverage is received from the applicable delegated entity, the provider shall submit claims to Blue Shield for reimbursement. If the delegated entity issues a notice of non-coverage, the provider shall inform the member of their financial responsibility at that point, in writing, and/or retrieve the DME, as appropriate.
Continuity of Care for Members by Non-Contracted Providers

Newly covered members who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; or who are children from birth to 36 months of age; or who have received authorization from a provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a non-contracted provider who was providing services to the member at the time the member’s coverage became effective under their Blue Shield plan.

Existing Blue Shield members who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; or who are children from birth to 36 months of age; or who have received authorization from a provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a non-contracted provider who was providing services to the member at the time the provider’s contract with Blue Shield terminated.

A member can request continuity of care services by completing Blue Shield’s Request for Continuity of Care Services form, available by calling Blue Shield Member Services or downloading from blueshieldca.com, then either mailing or faxing the completed form for review to the address or fax number listed on the form at least thirty (30) days before the health plan takes effect or as soon as the member becomes aware of the need for continuity of care services.

Prior Authorizations

The term “prior authorization” means that approval for coverage requires prior submission of a request for non-urgent services (there is no prior authorization requirement for emergency services). Prior authorization is required for all non-emergent acute care hospitalizations and for certain procedures, drugs, place of care, or equipment. In addition, all non-emergent Blue Shield-managed behavioral health inpatient, residential, partial hospitalizations, intensive outpatient and non-routine outpatient services require prior authorization.

For urgent or emergent admissions, Blue Shield must be notified within one business day following admission. In addition, there are selected services and procedures which may be done in an ambulatory care setting or inpatient facility for non-emergent care that require mandatory prior authorization review for medical necessity, along with the prior authorization needed for an inpatient admission. Requests may be submitted to Blue Shield Medical Care Solutions via telephone, fax, or U.S. mail. In addition, providers have the option to complete, submit, attach documentation, track status and receive determinations for medical and pharmacy prior authorizations via AuthAccel, Blue Shield’s online authorization tool. Registered users may access the tool in the Authorizations section after logging into Provider Connection at www.blueshieldca.com/provider.

In most cases, providers may refer to in-network specialists without prior authorization. Medical necessity review by Blue Shield Medical Care Solutions may be required in certain geographic areas.

Note: If provider fails to obtain authorization prior to providing covered services to a member, as required, or if provider provides services outside of the scope of the authorization obtained, then Blue Shield, or its delegate, shall have no obligation to compensate provider for such services; provider will be deemed to have waived payment for such services and shall not seek payment from Blue Shield, its delegate, or the member.
Prior Authorizations (cont’d.)

Prior Authorization Response Times

Medical Services
Non-urgent: Within five business days after receipt of request.
Urgent: Within 72 hours after receipt of request if “urgent” criteria definition is met.

Medications
Non-urgent: Within 72 hours after receipt of request.
Urgent: Within 24 hours after receipt of request if “urgent” criteria definition is met.

“Urgent” is defined as an imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision making might seriously jeopardize the life or health of the member. Scheduling issues do not meet the definition of “Urgent.”

Certain self-funded employers have established agreements with independent review organizations other than Blue Shield. In such cases, the requesting provider should contact this review organization per the instructions on the member’s identification card. Refer to the exhibit on the following page for a list of services requiring prior authorization.

Effective January 1, 2008, §1371.8 of the Health & Safety Code and §796.04 of the Insurance Code were amended to clarify 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. 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, providers 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.
Prior Authorizations (cont’d.)

Specialty Drug Prior Authorization for the Medical Benefit

Specialty drugs covered in the members’ medical benefit may require prior authorization to establish medical necessity and appropriate place of care. “Place of Care” is defined as the options for physical location of infusion administration. Places of care include the physician’s office, outpatient facility, ambulatory infusion center, or home health/home infusion. Certain specialty drugs covered in the members’ medical benefit may require prior authorization to establish medical necessity and approval to administer the drug at an outpatient facility.

The Specialty Drug Prior Authorization requirements apply to all participating physicians, health care professionals, facilities, and ancillary providers (“Providers”) that order or render certain specialty drugs.

Note: Failure to follow the Specialty Drug Prior Authorization process may result in administrative denial. Claims denied for failure to request prior authorization may not be billed to the member.

Failure to meet medication policy criteria will result in a denial for lack of medical necessity in accordance with the member’s benefit document for the specialty drug and/or place of service (i.e., outpatient hospital facility). Upon issuance of the denial, the member and provider will receive a denial notice with the appeal process outlined.

A complete list of medications and their authorization requirements for coverage in the medical benefit can be found on Provider Connection at www.blueshieldca.com/provider under Authorizations, Clinical Policies and Guidelines, Medication Policy, then Medication Policy List.

The provider ordering the specialty drug is responsible for obtaining a prior authorization number prior to any rendering of the specialty drug and provide the rendering provider’s contact information if different from ordering provider. A provider may request a prior authorization by contacting Blue Shield Medical Care Solutions at (800) 541-6652 Option 6 or complete and fax the California Prescription Drug Prior Authorization or Step Therapy Exception Request Form 61-211 (Revised 12/2016) to (844) 262-5611. In addition, providers have the option to complete, submit, attach documentation, track status and receive determinations for medical prior authorizations via AuthAccel, Blue Shield’s online authorization tool. Registered users may access the tool in the Authorizations section after logging into Provider Connection at www.blueshieldca.com/provider.

A prior authorization number will be issued to the ordering provider when the prior authorization process is completed, and a determination has been reached.

Medications

Non-urgent: Within 72 hours after receipt of request.
Urgent: Within 24 hours after receipt of request if “urgent” criteria definition is met.

“Urgent” is defined as an imminent and serious threat to the health of the enrollee; including but not limited to, severe pain, potential loss of life, limb or major bodily function and a delay in decision making might seriously jeopardize the life or health of the member. Scheduling issues do not meet the definition of “Urgent.”

The determination will be communicated to the provider in writing and by phone/fax once the final determination has been made. If the rendering provider is different from the ordering provider, to help ensure proper payment, the prior authorization number should be obtained and communicated by the ordering provider to the rendering provider scheduled to render the specialty drug.
Prior Authorizations (cont’d.)

Specialty Drug Prior Authorization for the Medical Benefit (cont’d.)

Please note that receipt of a coverage authorization means that the service met our criteria for medical necessity and/or met coverage and drug policy criteria, and place of care. It does not guarantee or authorize payment. If a place of care is not indicated by the ordering provider, Blue Shield of California will select a place of care for the member. Medication infusions at an outpatient hospital facility may be required for select specialty drugs.

Payment of covered services is contingent upon the member being eligible for services on the date of service, the provider being eligible for payment, any claim processing requirements, and the provider participation agreement with Blue Shield of California. The length of time for which a prior authorization will be valid will vary by request.

Prior Authorization List for Network Providers

Contact Blue Shield Medical Care Solutions unless otherwise indicated at:

blueshieldca.com/provider
(800) 541-6652 Option 6
Fax: (844) 807-8997

In addition, providers have the option to complete, submit, attach documentation, track status and receive determinations for medical prior authorizations via AuthAccel, Blue Shield’s online authorization tool. Registered users may access the tool in the Authorizations section after logging into Provider Connection at www.blueshieldca.com/provider.

<table>
<thead>
<tr>
<th>ALL INPATIENT ADMISSIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Require Prior Authorization</td>
</tr>
</tbody>
</table>

All electively scheduled admissions require prior authorization at least five business days prior to admission to the following facilities:

- Acute Inpatient
- Skilled Nursing
- Sub-Acute Care
- Hospice
- Psychiatric
- Chemical Dependency
- Acute Rehabilitation

Urgent / Emergent admissions require notification within 24 hours of admission.

<table>
<thead>
<tr>
<th>OUTPATIENT PROCEDURES / EQUIPMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior Authorization/Pre-service Review Required</td>
</tr>
</tbody>
</table>

A complete list of procedures and their authorization requirements for coverage can be found on Provider Connection at www.blueshieldca.com/provider under Authorizations, Prior Authorization Forms and List.

For Direct Contracting HMO: All outpatient surgical procedures performed in an acute hospital or free-standing Ambulatory Surgery Center setting require prior authorization.
### Prior Authorization List for Network Providers (cont’d.)

<table>
<thead>
<tr>
<th>TYPE OF SERVICE / PROCEDURE</th>
<th>PPO AND DIRECT CONTRACT HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Ambulance Service</strong></td>
<td>Go to Provider Connection at blueshieldca.com/provider and click on Ancillary Providers in the Helpful Resources section on the right to view a list of contracted ambulance providers or call Provider Information &amp; Enrollment at (800) 258-3091 for information on contracted options.</td>
</tr>
<tr>
<td><strong>Non-Emergency:</strong> Blue Shield covers non-emergency ambulance services/air ambulance. Under specific situations, prior authorization may be required by Blue Shield Medical Care Solutions. Non-emergency ambulance services may include transferring a member from a non-contracted facility to a contracted facility, or between contracted facilities, in connection with an authorized confinement/admission, and under other circumstances as necessary, if medical treatment or observation is required. <strong>Note:</strong> Non-Emergency services provided solely for the convenience of the patient or physician would not be covered.</td>
<td></td>
</tr>
<tr>
<td><strong>All Homecare, Home Hospice, and Home IV</strong></td>
<td>Prior authorization required</td>
</tr>
<tr>
<td><strong>Home-based Palliative Care Services Not Included in the Program Case Rate</strong></td>
<td>Prior authorization required</td>
</tr>
<tr>
<td><strong>Note:</strong> Patients newly enrolled in the program are eligible for expedited authorization of certain covered services (e.g., supplies, durable medical equipment (DME), oxygen, medications). Attach documentation that clearly states the member is in the Palliative Care Program and indicate that the request should be expedited. If you need additional help in this area, email <a href="mailto:BSCPalliativeCare@blueshieldca.com">BSCPalliativeCare@blueshieldca.com</a>.</td>
<td>(800) 541-6652 Option 6 Fax: (844) 807-8997 or Submit online with attached documentation, track and receive determinations for medical authorizations via AuthAccel, at blueshieldca.com/provider in the Authorizations section.</td>
</tr>
<tr>
<td><strong>Laboratory Services</strong></td>
<td>No prior authorization is required</td>
</tr>
<tr>
<td>Laboratory services for a given geographic area may be directed to specific providers. The process may differ depending upon the network structure in an individual geographic area.</td>
<td></td>
</tr>
</tbody>
</table>
**Prior Authorization List for Network Providers (cont’d.)**

<table>
<thead>
<tr>
<th>TYPE OF SERVICE / PROCEDURE</th>
<th>PPO AND DIRECT CONTRACT HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health and Substance Use Disorder</td>
<td>Contact MHSA (877) 263-9952</td>
</tr>
<tr>
<td>For HMO &amp; PPO members managed by Blue Shield’s mental health service administrator (MHSA)</td>
<td>Contact MHSA (800) 378-1109</td>
</tr>
<tr>
<td>For Self-Insured Accounts with Expanded Clinical Management (ASO)</td>
<td>Contact Blue Shield Medical Care Solutions (800) 541-6652 Option 6</td>
</tr>
<tr>
<td>Prior authorization for Self-Insured Accounts with Standard Clinical Management is required for:</td>
<td>Fax: (844) 807-8997</td>
</tr>
<tr>
<td>• Inpatient admissions</td>
<td>or Submit online with attached documentation, track and</td>
</tr>
<tr>
<td>• Residential Treatment</td>
<td>receive determinations for medical authorizations via</td>
</tr>
<tr>
<td>• Partial hospitalization programs</td>
<td>AuthAccel, at blueshieldca.com/provider in the</td>
</tr>
<tr>
<td>• Intensive outpatient programs</td>
<td>Authorizations section.</td>
</tr>
<tr>
<td>• Non-routine Outpatient</td>
<td>Contact MHSA (800) 985-2398</td>
</tr>
<tr>
<td>For Blue Shield 65 Plus Group Members- managed by Blue Shield’s mental health service administrator (MHSA)</td>
<td>Contact Blue Shield Medical Care Solutions (800) 786-7474</td>
</tr>
<tr>
<td>For Blue Shield 65 Plus IFP Members, prior authorization is required for:</td>
<td>Fax: (844) 696-0975</td>
</tr>
<tr>
<td>• Inpatient admissions</td>
<td>or Submit online with attached documentation, track and</td>
</tr>
<tr>
<td>• Residential Treatment</td>
<td>receive determinations for medical authorizations via</td>
</tr>
<tr>
<td>• Partial hospitalization programs</td>
<td>AuthAccel, at blueshieldca.com/provider in the</td>
</tr>
<tr>
<td>• Intensive outpatient program</td>
<td>Authorizations section.</td>
</tr>
<tr>
<td>• Non-routine Outpatient</td>
<td>Contact Blue Shield Medical Care Solutions (800) 633-4581 or (800) 995-2800</td>
</tr>
<tr>
<td>For FEP members, prior authorization is required for:</td>
<td>or Submit online with attached documentation, track and</td>
</tr>
<tr>
<td>• Outpatient Counseling or Therapy</td>
<td>receive determinations for medical authorizations via</td>
</tr>
<tr>
<td>• Intensive Outpatient Programs and Partial Hospitalization Programs</td>
<td>AuthAccel, at blueshieldca.com/provider in the</td>
</tr>
<tr>
<td>• Behavioral Health Case Management</td>
<td>Authorizations section.</td>
</tr>
</tbody>
</table>
### Prior Authorization List for Network Providers (cont'd.)

<table>
<thead>
<tr>
<th>TYPE OF SERVICE / PROCEDURE</th>
<th>PPO AND DIRECT CONTRACT HMO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FDA-approved prescription pharmaceuticals/drugs</strong> provided as part of a medical service and administered in the physician office, outpatient facility, ambulatory infusion center, or through home health/home infusion. (does not apply to drugs or products that are excluded from the member’s benefit)</td>
<td>A complete list of medications and their authorization requirements for coverage in the medical benefit, including place of care, can be found on Provider Connection at blueshieldca.com/provider under Authorizations, Clinical Policies and Guidelines, Medication Policy, and then Medication Policy List. Faxed requests must be submitted on the California Prescription Drug Prior Authorization or Step Therapy Exception Request Form 61-211 (Revised 12/2016). Providers may also submit prior authorization requests online at blueshieldca.com/provider under Authorizations then Request Pharmacy Prior Authorization. An additional link to the Medication Policies User Guide is available on the Medication Policy homepage. Contact Blue Shield Medical Care Solutions (800) 541-6652 Option 6 Fax: (844) 262-5611</td>
</tr>
<tr>
<td><strong>Radiology</strong> The following radiologic procedures are managed by National Imaging Associates, Inc. (NIA)</td>
<td>Prior authorization required Submit authorization requests online at <a href="http://www.RadMD.com">www.RadMD.com</a> or contact NIA at (888) 642-2583</td>
</tr>
<tr>
<td>• CT, all examinations</td>
<td></td>
</tr>
<tr>
<td>• MRI/MRA, all examinations</td>
<td></td>
</tr>
<tr>
<td>• Nuclear Cardiology Imaging</td>
<td></td>
</tr>
<tr>
<td>• PET (Positron Emission Tomography)</td>
<td></td>
</tr>
<tr>
<td><strong>Transplants</strong> Solid Organ and Bone Marrow Transplants</td>
<td>Prior authorization required Kidney / Cornea / Skin Transplants (800) 541-6652 Option 6 SOT and BMT Transplants (800) 637-2066 ext. 841-1130 Fax: (916) 350-8865</td>
</tr>
</tbody>
</table>
Organ and Bone Marrow Transplants

Members referred for major organ and bone marrow transplants (excludes cornea, kidney only and skin) are evaluated within the Blue Shield Major Organ/Bone Marrow Transplant Network. Certain transplants are eligible for coverage within Blue Shield’s transplant network but only if specific criteria are met and prior written authorization is obtained from Blue Shield’s Medical Care Solutions Transplant Team. Only the human organ and bone marrow transplants listed below are covered. For commercial HMO and PPO members, donor costs for a member are only covered when the recipient is also a Blue Shield member. Donor costs are paid in accordance with Medicare coverage guidelines for Blue Shield 65 Plus members.

All transplant referrals must be to a California network transplant facility for benefits to be paid. Please contact the Blue Shield Transplant Team at (916) 841-1130 for the listing of institutions selected to participate in this network and for coordination of referrals for evaluation. Members who are in a transplant treatment continuum must be cleared by the Blue Shield Medical Care Solutions Transplant Team for change of IPA. All requests should be sent to the Transplant Medical Care Solutions Department in Rancho Cordova. For members living in California, referrals to an out-of-state transplant facility must be at the referral of a Blue Shield’s Major Organ/Bone Marrow Transplant Network facility approved for the specified type of transplant based upon medical necessity. For coverage, all referrals for medical necessity to an out-of-state provider must be pre-authorized by a Blue Shield Medical Director.

Blue Shield 65 Plus – Prior authorization for all Blue Shield 65 Plus evaluations and transplants is required and coverage subject to applicable Medicare coverage guidelines. These services must be performed at a Medicare-approved transplant facility for the specific transplant in question. The evaluation for Blue Shield 65 members requires authorization by the IPA/medical group only.

Note: Charges incurred as a result of cadaver organ donor evaluation, donor maintenance, or organ recovery is directly reimbursable by the Organ Procurement Organization (OPO) according to federal law and therefore is not paid by Blue Shield. These charges may include but are not limited to: extended hospital stay beyond the second death note, lab studies, ultrasound maintaining oxygenation and circulation to vital organs, and the recovery surgery. Blue Shield will pay the appropriate organ acquisition fee at the time the organ is transplanted. For Blue Shield 65 Plus transplants, Blue Shield will pay in accordance with contractual or Medicare fee schedules in accordance with Medicare coverage guidelines.

Commercial HMO and PPO – Both the transplant evaluation and actual transplant procedure require prior authorization. The evaluation for HMO members requires authorization by the IPA/medical group or as otherwise specified. No self-referrals for transplant evaluations will be approved under the POS. For PPO members, the evaluation requires notification only. All Blue Shield members are entitled to transplant evaluations at any Blue Shield transplant network facility approved for the specified organ or transplant type, whether or not that facility has a contractual relationship with the IPA/medical group.
Organ and Bone Marrow Transplants (cont’d.)

Transplant Authorization

When the evaluation is completed, the transplant coordinator at the transplant facility will send the transplant request to Blue Shield’s Medical Care Solutions Transplant Team for medical necessity review and authorization.

Authorizations for transplants are required from Blue Shield Transplant Team for the following major organ and bone marrow transplant types:

- Bone marrow
- Stem cell
- Cord blood
- Kidney and pancreas or kidney with another solid organ (for kidney only, see below)
- Heart
- Heart/lung
- Lung
- Liver
- Pancreas
- Small bowel with or without liver
- Multi-organ transplants (including kidney plus other organs)

The following transplants are also eligible for coverage but are handled as routine inpatient services by the designated Medical Care Solutions Prior Authorization Department for all members. No special centers are required as long as a Blue Shield of California contracted facility is used, and, for kidney transplants, the facility is Medicare-certified.

- Corneal
- Kidney only
- Skin

Requests for transplants must include the following:

- Subscriber ID, requesting MD, CPT/ICD-9/ICD-10-CM & ICD-10-PCS code(s)
- Letter of request, including protocol reference
- Patient Selection/Bone Marrow Transplant (BMT) Committee Minutes/Tumor Board Recommendation
- Transplant Consult (from diagnosis to current/chemosensitivity/lab/staging)
- Synopsis of psycho-social and caregiver evaluation
- Comprehensive psychiatric evaluation (history of serious/prolonged mental illness)
- Documented completion of substance use disorder program (current history of substance use disorder)
- Complete Transplant evaluation and workup

Fax the information to (916) 350-8865, Attn: Transplant.
Drug Formulary

The Blue Shield of California Drug Formulary (formulary), maintained by the Blue Shield of California Pharmacy and Therapeutics (P&T) Committee, is designed to assist physicians in prescribing medically-appropriate, cost-effective drug therapy.

The formulary contains medications approved by the Food & Drug Administration (FDA) which have been reviewed for safety, efficacy, bio-equivalency, and cost. The P&T Committee is the governing committee responsible for oversight and approval of policies and procedures pertaining to formulary management, drug utilization, pharmacy-related quality improvement, educational programs and utilization management programs, and other drug issues related to patient care. The committee determines clinical drug preference for formulary inclusion, medication coverage policies and clinical coverage requirements based on the medical evidence for comparative safety, efficacy and cost when safety and efficacy are similar. The voting members of the P&T Committee are practicing physicians and pharmacists in the Blue Shield network who are not employees of Blue Shield. The P&T Committee reviews drugs on a quarterly basis.

The formulary applies to members with outpatient prescription drug benefits through Blue Shield. Some drugs require prior authorization to determine medical necessity or to ensure safe use of a drug. Providers are encouraged to use the formulary to optimize drug benefits for our members, and to help them minimize their out-of-pocket expenses.

Blue Shield offers different types of outpatient prescription drug benefits. Drugs are placed into formulary drug tiers and member cost-share (copayment or coinsurance) for covered medications varies by tier.

For drugs that require prior authorization or an exception to benefit or coverage rules, coverage decisions are based on the medication coverage policies defined by Blue Shield’s P&T Committee and the following will be considered during the review for coverage:

1. The requested drug, dose, and/or quantity are safe and medically necessary for the specified use.
2. Prior use of formulary alternative(s) has not achieved therapeutic goals or are inappropriate for the specific member’s situation.
3. Treatment is stable and a change to an alternative may cause clinical decompensation or immediate harm.
4. Relevant clinical information provided with the authorization request supports the use of the requested medication over formulary drug alternatives.
Drug Formulary (cont’d.)

Commercial Plans:

**Pharmacy Benefit Medications.** Providers have the option to complete and fax the California Prescription Drug Prior Authorization or Step Therapy Exception Request Form 61-211 (Revised 12/2016) to (888) 697-8122. This form is available on blueshieldca.com/provider under Authorizations, Prior Authorization Forms and List, Prior Authorization Forms, under the Oral/Topical Drugs link. Providers may also submit prior authorization requests online by going to blueshieldca.com/provider under Authorizations then Request Pharmacy Prior Authorization.

**Outpatient Medical Benefit Medications.** Providers have the option to complete and fax the California Prescription Drug Prior Authorization or Step Therapy Exception Request Form 61-211 (Revised 12/2016) to (844)-265-5611. This form is available on blueshieldca.com/provider under Authorizations, Prior Authorization Forms and List, Prior Authorization Forms, under the Office Drugs link.

**Medicare Plans:** The Centers for Medicare & Medicaid Services (CMS) is eliminating the prescriber and provider enrollment requirement for Part C and Part D, and instead is compiling a “Preclusion List” of prescribers, individuals, and entities that fall within either of the following categories: (a) are currently revoked from Medicare, are under an active reenrollment bar, and CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or (b) have engaged in behavior for which CMS could have revoked the prescriber, individual, or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. CMS will make the Preclusion List available to Part D prescription drug plans and Medicare Advantage plans. Plans are required to deny payment for claims submitted by, or associated with, prescriptions written by prescribers and providers on the list. Full enforcement of the Part C and D prescriber exclusion list requirement will begin on January 1, 2019.

Providers also have the option to request a prior authorization or exception request by faxing a Prescription Drug Prior Authorization Request Form (available at blueshieldca.com/provider) to (888) 697-8122 or via phone to (800) 535-9481 Monday through Friday, 8:00 a.m. until 6:00 p.m. PST, excluding holidays. Providers may also submit prior authorization requests online by going to blueshieldca.com/provider under Authorizations then Request Pharmacy Prior Authorization.

Once all required supporting information is received, a coverage decision, based upon medical necessity, is provided within the following timelines:

- Commercial plans within 24 hours for urgent requests and 72 hours for standard requests.
- Medicare Part D plans within 24 hours for an expedited review and 72 hours for standard requests.
- Specialty Drugs are covered at a copayment or coinsurance and most require prior authorization for coverage. Specialty Drugs are available through a Blue Shield Network Specialty.

The most current version of Blue Shield formularies and other information about Blue Shield prescription drug benefits and pharmacies can be accessed on blueshieldca.com in the Provider Connection or Pharmacy sections or by calling (800) 535-9481.

*Note: Different drug formularies apply depending on the member’s plan.*
Drug Formulary (cont’d.)

Mandatory Generic Drug Policy

In general, generic drugs should be prescribed whenever possible to help keep the member’s out-of-pocket costs low. We recommend that physicians indicate or write Generic Substitution Permitted/OK on the prescription to inform the pharmacist to fill with a generic equivalent if available. Even when there is no generic equivalent for a brand-name drug, consider prescribing an alternative drug in the same class that is available as a generic. Most FDA-approved generic drugs are covered on the formulary. Transmitting a prescription using e-Prescribing technology provides the best method for determining and prescribing available generic equivalents and alternatives covered on the drug formulary.

If a brand name drug is dispensed when a generic is available upon request of the member or prescriber, the member may be responsible for paying the difference between the cost of the brand name drug and its generic equivalent, in addition to the Tier 1 copayment. Exceptions may be granted to cover the brand name drug at a plan copayment if medically necessary and use of the generic equivalent is not clinically appropriate for the individual patient.

Information about covered generic drugs on the formulary can be accessed on blueshieldca.com in the Provider Connection or Pharmacy sections.

Mail Service Prescriptions

Members may have their prescriptions for medications taken on an ongoing, regular basis to maintain health filled by Blue Shield’s mail service pharmacy and delivered to the location of their choice for convenience and to optimize their copayment. Prescriptions for mail service must be prescribed for a quantity to cover up to a 90-day supply. Prescriptions can be sent electronically, by phone, or by fax.

Information about contacting Blue Shield’s mail service provider can be accessed on blueshieldca.com/provider in the Guidelines & Resources section.

Specialty Drugs

Specialty drugs are drugs that may require special handling or manufacturing processes, coordination of care, close monitoring, or extensive patient training for safe self-administration that generally cannot be met by a retail pharmacy and are available at a Network Specialty Pharmacy. Specialty drugs may also be drugs restricted by the FDA or drug manufacturer to prescribing by certain physicians or dispensing at certain pharmacies.

New prescriptions for specialty drugs should be sent to a Network Specialty Pharmacy who will provide Specialty Drugs by mail or, upon a member’s request, at an associated retail pharmacy for pickup.

The list of specialty drugs and information about Network Specialty Pharmacies may be accessed at blueshieldca.com.
Section 4: Billing
# Section 4: Billing

## Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview</td>
<td>1</td>
</tr>
<tr>
<td>Claims Processing</td>
<td>1</td>
</tr>
<tr>
<td>Electronic Claims Submission</td>
<td>1</td>
</tr>
<tr>
<td>Encounter Submission</td>
<td>2</td>
</tr>
<tr>
<td>Paper Claim Forms (Using the CMS 1500 Claim Form)</td>
<td>2</td>
</tr>
<tr>
<td>Provider Identification</td>
<td>3</td>
</tr>
<tr>
<td>Providers Without a Blue Shield Contract</td>
<td>3</td>
</tr>
<tr>
<td>Filing “Clean” Claims</td>
<td>4</td>
</tr>
<tr>
<td>Encounters “Splitting” to Payable Injectable Claims</td>
<td>4</td>
</tr>
<tr>
<td>Instructions for Claim Form Fields Requiring Special Attention</td>
<td>4</td>
</tr>
<tr>
<td>Timeliness Requirement</td>
<td>4</td>
</tr>
<tr>
<td>Medicare Crossover</td>
<td>5</td>
</tr>
<tr>
<td>Claims Review Monitoring Program</td>
<td>6</td>
</tr>
<tr>
<td>Prepayment Claim Review</td>
<td>6</td>
</tr>
<tr>
<td>Retrospective Review</td>
<td>6</td>
</tr>
<tr>
<td>Provider on Review</td>
<td>6</td>
</tr>
<tr>
<td>Provider Payment</td>
<td>7</td>
</tr>
<tr>
<td>Blue Shield Provider Allowances</td>
<td>7</td>
</tr>
<tr>
<td>Electronic Remittance Advice (ERA)</td>
<td>9</td>
</tr>
<tr>
<td>Third Party Liability (TPL)</td>
<td>10</td>
</tr>
<tr>
<td>Coordination of Benefits</td>
<td>11</td>
</tr>
<tr>
<td>Determining the Order of Payment</td>
<td>11</td>
</tr>
<tr>
<td>When Blue Shield is the Primary Plan</td>
<td>12</td>
</tr>
<tr>
<td>When Blue Shield is the Secondary Plan</td>
<td>12</td>
</tr>
<tr>
<td>References</td>
<td>12</td>
</tr>
<tr>
<td>BlueCard® Program Claims</td>
<td>13</td>
</tr>
<tr>
<td>Limitations for Duplicate Coverage (Commercial)</td>
<td>13</td>
</tr>
<tr>
<td>Veterans Administration (VA)</td>
<td>13</td>
</tr>
<tr>
<td>Department of Defense (DOD), TRICARE/CHAMPVA</td>
<td>14</td>
</tr>
<tr>
<td>Medi-Cal</td>
<td>14</td>
</tr>
<tr>
<td>Medicare Eligible Members</td>
<td>14</td>
</tr>
<tr>
<td>Special Billing Situations</td>
<td>15</td>
</tr>
<tr>
<td>Ancillary Claims Filing Requirements</td>
<td>15</td>
</tr>
<tr>
<td>Billing of Exchange-Purchased Plans</td>
<td>15</td>
</tr>
<tr>
<td>CRNA Billing</td>
<td>15</td>
</tr>
<tr>
<td>Hospice Billing (Commercial)</td>
<td>16</td>
</tr>
<tr>
<td>Hospice Billing (Medicare)</td>
<td>17</td>
</tr>
<tr>
<td>Major Organ Transplant (MOT) Billing</td>
<td>19</td>
</tr>
<tr>
<td>Office-Administered Injectable Medications</td>
<td>19</td>
</tr>
<tr>
<td>Office-Based Ambulatory Procedures</td>
<td>20</td>
</tr>
<tr>
<td>Claim Inquiries and Corrected Claims</td>
<td>20</td>
</tr>
<tr>
<td>Resubmissions or Corrected Claims</td>
<td>20</td>
</tr>
<tr>
<td>Overpayments</td>
<td>21</td>
</tr>
<tr>
<td>Provider Inquiries</td>
<td>21</td>
</tr>
<tr>
<td>Provider Appeals and Dispute Resolution</td>
<td>22</td>
</tr>
<tr>
<td>Definitions</td>
<td>22</td>
</tr>
<tr>
<td>Unfair Billing and Payment Patterns</td>
<td>24</td>
</tr>
</tbody>
</table>
Section 4: Billing

Capitated Entity (IPA/MG/Capitated Hospital) Appeal Resolution Requirements ............................................ 31
Provider Appeals of Medicare Advantage Claims.............................................................................................. 32
  Contracted.................................................................................................................................................... 32
  Non-Contracted............................................................................................................................................ 34
Overview

This section outlines Blue Shield’s billing procedures and requirements for submitting claims. It describes Blue Shield claims payment policies for specific situations, such as Coordination of Benefits (COB) and major organ transplant billing. It also explains Blue Shield’s process for resolving billing issues. Following these procedures and guidelines will help assure error-free processing and timely payments of your claims.

*Note: In many instances, Blue Shield’s billing procedures and guidelines are identical to those for Medicare. However, it is important for you to become familiar with Blue Shield’s unique billing requirements to assure correct and timely payment.*

Claims Processing

All Blue Shield-contracted providers are required to submit claims electronically that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected.

If you do not submit a complete claim in one of these two formats, it may not be accepted or may possibly be denied, and you will need to resubmit the claim in an acceptable format.

Electronic Claims Submission

Providers have several data transfer options for submitting claims electronically to Blue Shield. Blue Shield has contracted with several vendors for providers to submit claims at no cost. Electronic claims can also be submitted directly to Blue Shield via secure file transfer protocol (SFTP) using one of their own dedicated static IP addresses.

To enroll in electronic claim submission, providers can use any approved clearinghouse listed on Provider Connection. Providers can submit claim at no charge using vendors Office Ally, TriZetto Provider Solutions or Ability Network. These vendors can be contacted at www.blueshieldca.com/provider in the Claims section under How to Submit Claims or by contacting the EDI Department at (800) 480-1221.

The many benefits to the provider for using electronic submission include: reporting/acknowledgment of receipts, faster payment, improved accuracy, no claim forms, no postage and handling, and the ability to submit to a single location.

Blue Shield pays all transaction fees for selected Electronic Data Interchange (EDI) vendors. Call the EDI Help Desk at (800) 480-1221 to obtain a connection or go to Provider Connection at www.blueshieldca.com/provider and click on the Claims tab for more information about the options listed above. You can also send an email to the EDI Department directly at EDI_BSC@blueshieldca.com.

Blue Shield, in accordance with HIPAA regulation, accepts electronic claims submitted in the ANSI format version 5010. Most electronic claim software packages follow the CMS 1500 format. The special billing guidelines and procedures instructions in Appendix 4-A apply to both the identified “block” on the CMS 1500 and the related “field” on the electronic record, unless otherwise indicated. Your electronic claims software may have additional specific requirements. Follow the system documentation provided by your software vendor.
Section 4: Billing

Claims Processing (cont’d.)

Encounter Submission

Providers are required to submit all encounter data to Blue Shield. Encounter data submissions may be made directly to Blue Shield or through a vendor. Regardless of the route of submission, providers may request the professional and facility encounter data specifications and procedures from Blue Shield using the contact information below. Encounter data must be submitted in HIPAA compliant ANSI 837P and 837I formats.

Commercial and Medicare Encounter Data

EDI Operations: (800) 480-1221 – EDI questions only

For encounter processing questions, call the Customer Service number on back of the member’s card.

EDI Clearinghouse Vendors

A list of approved Clearinghouse Vendors can be found on Provider Connection at www.blueshieldca.com/provider. Click on Claims, Manage Electronic Transactions, then Enroll in Electronic Data Interchange. You may also contact the EDI Help Desk at (800) 480-1221.

Paper Claim Forms (Using the CMS 1500 Claim Form)

All Blue Shield-contracted providers are required to submit claims electronically that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. As required by AB1455, electronically submitted claims will be acknowledged within 2 days and paper claims will be acknowledged within 15 days.

When paper claims forms are used with medical records attached, we require accurately completed CMS 1500 (or successor) forms to process claims quickly and efficiently. Blue Shield utilizes Optical Character Recognition (OCR) which allows paper claims to be scanned and data interpreted with minimal data entry. Claims submitted on photocopied claim forms prevent the OCR process from working properly, necessitating manual data entry of the claim, which can slow processing and payment. To facilitate the efficient and accurate claims processing of paper forms, original red claim forms are required. Also, ensure that:

- Data entered onto the claim form is done in Arial font, point size 10–12
- Only black ink is used
- Data is entered in CAPITAL letters
- Dot matrix printers are not used. Laser printers are recommended.
- No italics, red ink, stickers or rubber stamps are used
- No handwritten descriptions are placed on the claim
- No narrative descriptions of procedure, modifier or diagnosis are on the claim.
  The CPT, Modifier, ICD-10-CM, and ICD-10-PCS codes are sufficient. For drug codes, the CPT and NDC are required for consideration of payment.
- No white correction fluid is used
- Data is not touching box edges
- No special characters are used (e.g., dollar signs, punctuation marks, parentheses)
Claims Processing (cont’d.)

Provider Identification

Correct and complete provider identification on the billing provider, as well as on the rendering provider, is crucial to timely claims processing. Claims that do not identify the rendering provider may not be accepted or may possibly be denied payment and require resubmission with this information. For ancillary claims (independent clinical labs, DME/HME, and specialty pharmacy), the referring/ordering physician NPI is required in block 17B.

Refer to the CMS 1500 general instructions in Appendix 4 for information on provider identification, as well as to Appendix 4-A Special Billing Guidelines and Procedures for required rendering provider information in Block 24J and Block 33 of the claim form.

Providers Without a Blue Shield Contract

If you are a non-contracted provider, you must indicate your taxonomy code in the top box of 24J and your NPI in the lower block of the CMS 1500 when billing for services. If you do not have an NPI number, enter your California State License or Certificate number in Block 24J of the CMS 1500 when billing for services. Do not use the taxonomy or NPI of the supervising physician.

*Note: Hospitals that act as the billing agent for hospital-based physicians (emergency room physicians, clinic physicians, anesthesiologists, radiologists, pathologists, etc.) and allied health professionals must obtain a separate nine-digit Blue Shield NPI for both group and individual providers to bill for these services.*

*Claims for these services must be submitted on a CMS 1500 claim form or transmitted electronically and must include not only the billing agent NPI but also the NPI of the provider who performs the service.*

*If you have questions regarding the provider identification process, please call Provider Information & Enrollment at (800) 258-3091.*
Claims Processing (cont’d.)

Filing “Clean” Claims

“Clean” claims are claims that have been completed correctly with all the necessary information to make a benefit coverage decision and identify the rendering provider. Filing “clean” claims allows Blue Shield to pay them quickly and accurately.

Providers should follow the most recently updated Current Procedural Terminology (CPT) coding guidelines (published annually by the American Medical Association), National Drug Code (NDC) for drugs as well as the HCFA Common Procedure Coding System (HCPCS), ICD-10-CM, ICD-10-PCS, and coding guidelines published annually by the Centers for Medicare & Medicaid Services (CMS).

Blue Shield removes deleted HCPCS and CPT codes from its claims payment system. To ensure timely payment, providers are encouraged to only submit currently valid and recognized CPT and HCPCS codes. For drug codes, the CPT and NDC are required for consideration of payment.

Encounters “Splitting” to Payable Injectable Claims

Claim payment is automated to process injectable claims that are exceptions to capitation and to reimburse the IPA/medical group directly. Claims for qualifying immunizations and injectable services that are payable exceptions to the capitated lines of service(s) submitted electronically will be split off from the encounter and processed accordingly.

Instructions for Claim Form Fields Requiring Special Attention

Some claim form fields cause the most common claims processing problems/denials and payment delays because of incomplete or invalid information. Please refer to Appendix 4-A Special Billing Guidelines and Procedures for instructions on completing claim form fields requiring special attention.

Timeliness Requirement

When you provide covered services to a Blue Shield member, you must submit your claims to Blue Shield within 12 months of the date of service(s) unless otherwise stated by contract. At Blue Shield's discretion, claims submitted after 12 months, without an accompanying explanation of reasons for the delay, may be denied. Subscribers are not responsible for charges denied for late filing.
Claims Processing (cont’d.)

Medicare Crossover

Claims for Blue Shield Medicare Supplement plans are automatically sent to Blue Shield by the Medicare carrier. Providers do not need to submit these claims to Blue Shield for supplemental coverage processing.

When Blue Shield is the patient’s secondary carrier, submit claims electronically using the process below or contact your clearinghouse or billing system vendors for EDI secondary submission. If EDI secondary is not available, attach proof of the primary carrier’s payment or denial and a copy of the other carrier’s identification card. See Section 4.4, Paper Submission for more detail.

Instructions for Medicare COB Electronic Submission

837 Professional COB Claims -- Secondary/Tertiary Electronic Claims to Blue Shield

• Claim level information can be submitted, Blue Shield requires line level on professional claims.
• Standard list refers to HIPAA compliant codes established by CMS and other government entities.
• Both 2430 segments must equal original total charge in CLM02 in order to balance.

Claim Information (2300)
CLM*TERT837PDLLRSNDTST*1000***23>>&1*Y*A*Y*Y*B~

837 Institutional COB Claims -- Secondary/Tertiary Electronic Claims to Blue Shield

• Claim level information needs to be submitted, Blue Shield may also receive line level on COB institutional claims.
• Standard list refers to HIPAA compliant codes established by CMS and other government entities.
• Both 2430 segments must equal original total charge in CLM02 in order to balance.

Claim information (2300)
CLM*COBSECTERTST*11751.32***11A>1*Y**Y*Y********Y~

Call the EDI Help Desk at (800) 480-1221 with any questions about Medicare supplemental claims that should have been forwarded, but were not. Questions about the amount paid on the supplemental claim should be directed to the appropriate Blue Shield Customer Service department.
Claims Review Monitoring Program

Prepayment Claim Review

Blue Shield providers are expected to adhere to the highest standard of integrity in their billing practices. Blue Shield is committed to high quality, cost-effective care and monitors the coding and billing patterns of health care providers. Our monitoring program is designed to detect billing irregularities, including “unbundling” of services, incorrect modifier usage, and procedure coding inconsistent with current AMA and CMS guidelines.

Blue Shield strives to make its clinical payment and health plan specific policies transparent to providers. We have implemented claims editing software systems that are primarily based on industry standard correct coding rules, in order to pay professional providers accurately, consistently, and in a standardized manner.

Retrospective Review

Blue Shield’s Medical Care Solutions provides accurate and timely retrospective review of complex professional and institutional claims to determine medical necessity, utilization, and appropriateness of treatment. Providers may receive requests for medical records to augment the retrospective review process. Retrospective claims are reviewed per the contract language.

Provider on Review

Providers who consistently demonstrate questionable billing patterns may be placed on prepayment claims review and may be required to submit appropriate medical records for medical review before Blue Shield will pay claims.

The following are some examples of common billing irregularities that may result in prepayment review:

- Billing CPT codes at higher levels than supported by medical records (e.g., upcoding)
- Failure to include NDC and CPT for drugs
- Repeated itemized billing of paneled laboratory tests or unbundling services
- Falsifying medical/billing records
- Misrepresentation of providers of service
- Billing "consultations" for visits that are clearly patient-initiated
- Billing for services that aren’t documented as having been performed in the medical record

Note: The above situations fall under our administrative compliance program and/or our Special Investigations Unit. Situations in which Blue Shield has identified aberrant billing pattern by a provider who does not follow Blue Shield’s recommendations for corrective action may result in a referral to the Provider Compliance Review Committee for further action up to and including administrative termination.
Provider Payment

Blue Shield Provider Allowances

“Blue Shield Provider Allowances” is the term used to describe the compensation schedules for providers who render medical, surgical, or other services to Blue Shield members. Providers are contractually obligated to accept the current Blue Shield Provider Allowances, including the member’s applicable copayment, as payment in full.

Blue Shield Provider Allowances compensate physicians and other healthcare professionals appropriately for medical services they render by capturing actual time, skill, training, and costs associated with providing the service. Blue Shield Provider Allowances are reviewed annually, apart from drug and immunization allowances which are reviewed quarterly, as new CPT-4 and HCPCS Level II Codes are added or existing codes change, per the American Medical Association. For drug codes, the CPT and NDC are required for compensation.

Blue Shield uses a variety of methodologies and factors when determining physician and other healthcare professional allowances to closely align payments with actual resources used by providers in rendering professional services. Reimbursement rates vary by region, of which Blue Shield has 24. Blue Shield also considers facility-based pricing for some procedures when establishing allowances.

Except for Blue Shield Provider Allowances for drugs and immunizations, Blue Shield will give providers at least 45 working days’ notice of changes to the Blue Shield Provider Allowances. Blue Shield Provider Allowances for drugs and immunizations reimbursed using Average Sales Price (ASP) or Average Wholesale Price (AWP) methodologies are reviewed quarterly and adjustments may be made without notification. NDC is required for payment consideration. Providers may terminate their participation with Blue Shield if they do not accept any changes to Blue Shield Provider Allowances.

Providers may obtain CPT code-specific allowances from Blue Shield in one of the following ways:

- Logging onto Provider Connection at www.blueshieldca.com/provider and navigating to the Professional Fee Schedule link under the Claims tab. Tier A and Tier B allowances are available. Tier A are professional fees provided in an office setting while Tier B are professional services provided in a facility setting.

- Calling Blue Shield Provider Information & Enrollment at (800) 258-3091

EOBs will also clearly state the Blue Shield Provider Allowance in effect on the date of service for each billed code.

A summary of Blue Shield Provider Allowances is provided below. Please also refer to the Blue Shield Payment Processing Logic document in Appendix 4-G which provides an overview of common Blue Shield claims adjudication processes. Blue Shield’s Payment Policies are available on Provider Connection at www.blueshieldca.com/provider under the Claims tab; Medical Policies are found on Provider Connection under the Authorizations tab.
Provider Payment (cont’d.)

Blue Shield Provider Allowances (cont’d.)

Summary of Blue Shield Provider Allowances

- The majority of J Code allowances are determined using an Average Sales Price (ASP) plus reimbursement methodology, which promotes the use of value-based, cost-effective therapies by paying a greater percentage above ASP for generic and multi-source therapies as compared to single-source branded therapies. Allowances are reviewed quarterly using drug pricing data submitted to CMS by drug manufacturers and may be adjusted without notification to reflect changes in ASP. This reimbursement approach provides a reasonable margin over the acquisition cost for the drugs. Allowances for drugs without a published ASP, or billed using an “unclassified” HCPCS Code (such as J3490 or J9999), will be based on an Average Wholesale Price (AWP) less methodology, which are also reviewed quarterly.

- Immunization allowances are AWP-based.

- For drugs, CPT and NDC are required for payment regardless of reimbursement methodology.

- Anesthesia allowances are determined using the American Society of Anesthesiologists (ASA) codes utilizing coefficients tied to a geographic locality. For obstetric anesthesia, Blue Shield follows ASA methodology, which allows the base units, plus time units plus modifier units. However, reimbursement is subject to a cap of 23 total units.

- The following services are reimbursed on a statewide fee schedule:
  - Behavioral Health services (benefits may be administered through a specialty carve-out network).
  - DME, including orthotics and prosthetics.
  - Home health and home infusion services.
  - Selected maternity codes.

Note: The summary of Blue Shield provider allowances is subject to change upon proper notification.
Electronic Remittance Advice (ERA)

ERA is an electronic version of an explanation of medical payment in HIPAA-compliant files. Providers are required to receive ERA files or view Explanation of Payment (EOP) using the Blue Shield’s Provider Connection site at www.blueshieldca.com/provider. The ERA files are transmitted to vendors or providers in the ASC X12 835 5010 format.

The ERA replaces the paper Explanation of Payment. To enroll for the ERA, providers must complete an enrollment form found on Provider Connection at www.blueshieldca.com/provider in the Claims section under Enroll in Electronic Data Interchange or by contacting the EDI Department at (800) 480-1221.

An ERA or EOP is also issued if a claim is denied for any reason, or if additional information is needed from the provider. A denial letter is sent when services to a Medicare member are denied.

ERAs or EOPs may be generated by other payors. For example, payments for services rendered to some national account subscribers may not be issued by Blue Shield. Payment for provider services that are covered under your Blue Shield contract are based on our allowances.

Tools at Provider Connection at www.blueshieldca.com/provider allow registered billing providers to execute their claims payment or processing status (updated nightly), execute multiple claims payment status inquiries (up to 10 members at once), and generate claims reports. The EOP information displayed on the claims details section of the website is the same information as the printed EOB. Providers can download a copy of the EOP from Provider Connection.

For questions regarding the ERA/EFT enrollment process, please call the EDI Help Desk at (800) 480-1221.

Note: When enrolling in the ERA/EFT program, you must register your National Provider Identifier (NPI) with Blue Shield of California.
Third Party Liability (TPL)

If a member is injured or becomes ill due to the act or omission of another person (a “third party”), Blue Shield and the provider will provide the necessary treatment according to plan benefits. If the member receives a related monetary award or settlement from the third party, third party insurer or from uninsured or underinsured motorist coverage, Blue Shield and the provider have the right to recover the cost of benefits paid for treatment of the injury or illness. The total amount of recovery will be calculated according to California Civil Code Section 3040.

The member is required to:

1. Notify Blue Shield and the provider in writing of any claims or legal action brought against the third party as a result of their role in the injury or illness within 30 days of submitting the claim or filing the legal action against the third party; and

2. Agree to fully cooperate and complete any forms or documents needed to pursue recovery from the third party;

3. Agree, in writing, to reimburse Blue Shield for benefits paid from any recovery received from the third party;

4. Provide a lien calculated according to California Civil Code Section 3040. The lien may be filed with the third party, the third party’s agent or attorney, or the court, unless otherwise prohibited by law; and,

5. Respond to information requests regarding the claim against the third party, and notify Blue Shield and the provider in writing within ten (10) days of any recovery obtained.

If this plan is part of an Employee Welfare Benefit Plan subject to the Employee Retirement Income Security Act (ERISA), the member is also required to do the following:

1. Ensure that any monetary recovery is kept separate from the member’s other assets and agree in writing that the amount necessary to satisfy the lien is held in trust for Blue Shield; and,

2. Instruct legal counsel retained by the member to hold the portion of the recovery to which Blue Shield is entitled in trust for Blue Shield.
Coordination of Benefits

Coordination of Benefits (COB) is utilized when a member is covered by more than one group health plan. Payments for “allowable expenses” will be coordinated between the plans up to the maximum benefit value or amount payable by each plan separately.

COB ensures that benefits paid by multiple group health plans do not exceed 100% of eligible expenses and the plans follow a consistent order of payment.

Determining the Order of Payment

When a plan does not have a COB provision, that plan will provide its benefits first. Otherwise, the plan covering the person as an employee will provide its benefits before the plan covering the person as a dependent.

The following applies to coverage for dependent children:

- When the parents are not divorced or separated, the group health plan of the parent, whose date of birth (month and day) occurs earlier in the year is primary. If either parent’s plan does not have a COB provision regarding dependents, this rule does not apply. The rule established by the plan without a COB provision determines the order of benefits.

- When the parents are divorced or separated and the specific terms of the court decree state that one of the parents is responsible for the health care expenses of the child, that parent’s group health plan is primary. The group health plan of the other parent is secondary.

- When the parents are not married, or are divorced or separated and there is no court order which would otherwise establish coverage for the child, primary responsibility is determined in the following order:
  - The group health plan of the custodial parent.
  - The group health plan of the spouse of the custodial parent.
  - The group health plan of the non-custodial parent.

- When the parents are divorced or separated and there is a court decree that the parents share joint custody, without specifying which parent is responsible for the health care expenses of the child, the group health plan of the parent whose date of birth (month and day) occurs earlier in the year is primary.

If the above rules do not apply, the plan that has covered the person for the longer period of time is the primary plan provided that:

- The group health plan covering the person, or the dependent of such person, as an active employee provides benefits before the group health plan that covers the person, or the dependent of such person, as a laid-off or retired employee. If either plan does not have a COB provision regarding laid-off or retired employees, this rule does not apply.
Section 4: Billing

Coordination of Benefits (cont’d.)

When Blue Shield is the Primary Plan

The provider will provide Blue Shield Plan benefits without considering the existence of any other group health plan.

Upon request, the provider will provide the member or the secondary group health plan with a statement documenting copayments paid by the member or services denied so the member may collect the reasonable cash value of those services from the secondary group health plan. It is not necessary to provide the member with an itemized billing.

When Blue Shield is the Secondary Plan

If, as the secondary plan, the provider covers a service that would otherwise be the primary group health plan’s liability, the provider may collect the reasonable cash value of that service from the primary group health plan.

When a disagreement exists as to which group health plan is secondary, or the primary group health plan has not paid within a reasonable period of time, Blue Shield will provide benefits as if it were the primary group health plan, provided the member:

- Assigns to Blue Shield the right to receive benefits from the other group health plan;
- Agrees to cooperate with Blue Shield in obtaining payment from the other group health plan; and
- Allows Blue Shield to verify benefits have not been provided by the other group health plan.

References

Additional information regarding COB is available through the following references:

- California Code of Regulations, Title 28, Section 1300.67.13
- The member’s Evidence of Coverage
- Coordination of Benefit Handbook, Thompson Publishing Group: www.thompson.com

*Note: for information on determining the order of payment when the patient is also covered by Medicare, refer to Limitations for Duplicate Coverage - Medicare in this section.*
BlueCard® Program Claims

The BlueCard® Program is a national program that enables Blue Cross and Blue Shield (BCBS) Plan members to obtain healthcare services while traveling or living in another Blue Cross and/or Blue Shield Plan’s service area. The program links participating healthcare providers with all independent Blue Cross and Blue Shield Plans across the country through a single electronic network for claims processing and reimbursement. Additionally, the program links providers in more than 200 countries and territories worldwide.

The program allows professional providers to conveniently submit claims for patients from out-of-state Blue Plans, either domestic or international, to Blue Shield of California. Blue Shield is your primary contact for BlueCard claims processing, provider correspondence and inquiries.

Providers are required to submit BlueCard claims electronically to Blue Shield that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected.

Mail hard-copy BlueCard claims that require medical records to:

Blue Shield of California  
BlueCard Program  
P. O. Box 1505  
Red Bluff, CA  96080-1505

For more detailed information about the BlueCard Program claims process, refer to Appendix 5-A of this manual or access the BlueCard Program web page at www.blueshieldca.com/bluecard.

Limitations for Duplicate Coverage (Commercial)

Veterans Administration (VA)

If the member is a qualified veteran who is not on active duty, the member’s primary plan is required to pay the Veterans Administration (VA) for medically necessary plan benefits provided to the member who is a qualified veteran at a VA facility for a condition unrelated to military service (based on the reasonable value or Blue Shield’s allowable amount). VA claims cannot be denied solely because the member failed to obtain a referral or authorization.

If an issue arises as to whether an illness or injury is related to military service, the VA determination prevails. While the VA determination is not subject to review, the VA will, upon request, provide documentation to substantiate its decision.

If the member is treated by the VA, the VA notifies Blue Shield by sending a copy of an assignment of benefits and will cooperate with requests for medical records. The VA will accept payment equal to what would ordinarily be paid to other providers in its geographic area. Regular administrative procedures should be followed, as if the VA were part of the member’s IPA/medical group.
Limitations for Duplicate Coverage (Commercial) *(cont’d.)*

Department of Defense (DOD), TRICARE/CHAMPVA

Blue Shield is always the primary payor for covered services, even if provided for conditions related to military service, delivered at a Department of Defense (DOD) facility when the member is a qualified veteran who is not on active duty. Payment is based on the reasonable value or Blue Shield’s allowable amount. TRICARE - CHAMPVA will not provide payment if the services are a benefit through Blue Shield but were not paid because the member did not comply with service delivery rules (e.g., non-authorized, out-of-network, non-emergency/urgent services). TRICARE - CHAMPVA may cover other services excluded.

Medi-Cal

Medi-Cal is considered a payor of last resort.

Medicare Eligible Members

1. Blue Shield will provide benefits before Medicare in the following situations:
   a. When the Member is eligible for Medicare due to age, if the subscriber is actively working for a group that employs 20 or more employees (as defined by Medicare Secondary Payor laws).
   
   b. When the Member is eligible for Medicare due to disability, if the subscriber is covered by a group that employs 100 or more employees (as defined by Medicare Secondary Payor laws).
   
   c. When the Member is eligible for Medicare solely due to end stage renal disease during the first 30 months that the Member is eligible to receive benefits for end-stage renal disease from Medicare.

2. Blue Shield will provide benefits after Medicare in the following situations:
   a. When the Member is eligible for Medicare due to age, if the subscriber is actively working for a group that employs less than 20 employees (as defined by Medicare Secondary Payor laws).
   
   b. When the Member is eligible for Medicare due to disability, if the subscriber is covered by a group that employs less than 100 employees (as defined by Medicare Secondary Payor laws).
   
   c. When the Member is eligible for Medicare solely due to end stage renal disease after the first 30 months that the Member is eligible to receive benefits for end-stage renal disease from Medicare.
   
   d. When the Member is retired and age 65 years or older.

When Blue Shield provides benefits after Medicare, the combined benefits from Medicare and the Blue Shield group plan may be lower but will not exceed the Medicare Allowed charges. The Blue Shield group plan Deductible and Copayments or Coinsurance will be waived.
Special Billing Situations

Ancillary Claims Filing Requirements

Health care providers should file claims for their Blue Cross and/or Blue Shield patients to the local Blue Plan, as traditionally defined. However, there are a few circumstances in which claims filing directions will differ, based on the type of provider and service. For these circumstances, the local Blue Plan is identified differently.

For ancillary services, the local Blue Plan is defined as follows:

- **Independent Clinical Labs:** All claims for clinical laboratory services provided to Blue Plan members must be submitted to the Blue Plan located in the state or service area where the specimen was drawn, regardless of where the specimen is analyzed.

- **Durable/Home Medical Equipment (DME) and Supplies:** All claims for DME provided to Blue Plan members must be submitted to the Blue Plan located in the state or service area to which the DME is shipped, or in which it is purchased at a retail store.

- **Specialty Pharmacy:** All claims for specialty pharmacy services provided to Blue Plan members must be submitted to the Blue Plan located in the state or service area where the ordering physician is located.

  Note: Claims will be paid based on the provider’s participation status with the local Plan as defined above, regardless of the provider’s status with Blue Shield.

For more detailed information about the Ancillary Claims Filing Requirements for independent clinical labs, DME providers and specialty pharmacy providers, log onto [www.blueshieldca.com/provider](http://www.blueshieldca.com/provider), click on the **Ancillary Providers** link under **Helpful Resources**, and then select the **Ancillary Claims Filing Requirements** box at the bottom of the web page.

For questions about filing ancillary claims under these requirements, call our BlueCard Claims Unit at (800) 622-0632.

Billing of Exchange-Purchased Plans

Under California and federal law, subscribers receiving subsidies for Exchange-purchased individual plans that are delinquent in premium payments have a three-month grace period to pay all outstanding premiums due. During the first month of this grace period, Blue Shield will continue to process all appropriate claims for services rendered to the subscriber and any dependents. During the 2nd and 3rd months of the grace period, coverage for the subscriber and dependents is suspended until all outstanding premiums are paid to Blue Shield. When premiums become delinquent and the member is in the 2nd or 3rd month of the grace period, Blue Shield will provide written notification to providers advising them that the member’s eligibility has been suspended. In the event that premiums are not received by the end of the subscriber’s three-month grace period, claims will be denied.

CRNA Billing

All CRNA claims must be billed with one of the Modifiers QS, QX or QZ, noted in the payment policy for “Anesthesia Services” located on Provider Connection, or the claim will be denied.
Special Billing Situations (cont’d.)

Hospice Billing (Commercial)

Hospice is a type of care that focuses on the palliative care of a terminally ill patient's pain and symptoms. Terminal illness is defined as a medical condition resulting in a prognosis of life of one year or less if the disease follows its natural course.

Authorization

All hospice care services require prior authorization.

- HMO Plans – Authorization through the delegated IPA or medical group.
  - Direct Contracting IPA – Authorization through Blue Shield’s Medical Care Solutions Department.
- PPO Plans – Authorization through Blue Shield’s Medical Care Solutions Department.

Billing of Covered Services

Hospice claims should be submitted to Blue Shield by the hospice provider. Services must be billed on the UB04 (or successor) claim form with the appropriate Revenue Code, Type of Bill, CPT/HCPCS Codes and modifiers in order to receive payment for services rendered.

When billing for hospice care, claims should have Type of Bill (TOB) 81x or 82x and the following revenue codes:

- 0651 – Routine home care
- 0652 – Continuous home care
- 0655 – Inpatient respite care
- 0656 – General inpatient care
- 0657 – Physician care

For hospice-arranged services, the provider of service will bill the hospice and the hospice will reimburse the provider. The hospice will then include those services in the billing to Blue Shield. Blue Shield will reimburse the hospice for all covered services based on the contracted rates.

Consultation Visit Prior to Hospice Care

The hospice will bill a consultation visit prior to hospice care services commencing using HCPCS G0337 – Hospice Evaluation and Counseling Services, Pre-election.

Please call the Provider Information & Enrollment at (800) 258-3091 for additional information or for answers to questions not addressed above.
Special Billing Situations (cont’d.)

Hospice Billing (Medicare)

CMS issued Program Memorandum Intermediaries/Carriers – AB-02-015 (2/7/02) CMS Pub.60AB
Clarification of Payment Responsibilities of Fee-for-Service Contractors as it Relates to Hospice Members
Enrolled in Managed Care Organizations (MCOs) and Claims Processing Instructions for Processing
Rejected Claims to clarify regulations regarding payment responsibility for hospice patients enrolled in
managed care plans, as well as provide specific claims processing requirements to ensure payment for such
claims. The information below is reprinted from that program memorandum:

Covered Services

While a hospice election is in effect, certain types of claims may be submitted by either a hospice provider, a
provider treating an illness not related to the terminal condition, or an MCO to a fee-for-service contractor of
CMS, subject to the usual Medicare rules of payment, but only for the following services:

1. Hospice services covered under the Medicare hospice benefit if billed by a Medicare hospice;
2. Services of the enrollee's attending physician if the physician is not employed by or under contract to
   the enrollee's hospice;
3. Services not related to the treatment of the terminal condition while the beneficiary has elected
   hospice; or
4. Services furnished after the revocation or expiration of the enrollee's hospice election until the full
   monthly capitation payments begin again. Monthly capitation payments will begin on the first day of
   the month after the beneficiary has revoked their hospice election.

Billing of Covered Services

Medicare hospices will bill the RHII for Medicare beneficiaries who have coverage through managed care
just as they do for beneficiaries with fee-for-service coverage, beginning with a notice of election for an initial
hospice benefit period, and followed by claims with types of bill 81x and 82x. If the beneficiary later revokes
election of the hospice benefit, a final claim indicating revocation, through use of occurrence code 42, should
be submitted as soon as possible so that the beneficiary's medical care and payment are not disrupted. The
HMO may directly bill for attending physician services, as listed above, to Medicare carriers in keeping with
existing processes.

Medicare physicians may also bill such service directly to carriers as long as all current requirements for
billing for hospice beneficiaries are met. Revised requirements for such billing were set forth in Transmittal
1728, Change Request 1910 of the Medicare Carriers Manual (MCM), Part 3 and specifies use of Modifiers
GW and GV. When these modifiers are used, carriers are instructed to use an override code to assure such
claims have been reviewed and should be approved for payment by the Common Working File (CWF) in
Medicare claims processing systems.

For medical services for a condition not related to the terminal condition for which the beneficiary elected
hospice, a claim must be submitted to the intermediary using the condition code 07. If physician services are
billed to carriers, the instructions in Transmittal 1728, Change Request 1910 of the MCM should be followed
and should specify the use of Modifier GW.
Special Billing Situations (cont’d.)

Hospice Billing (Medicare) (cont’d.)

Billing of Covered Services (cont’d.)

As specified above, by regulation, the duration of payment responsibility by fee-for-service contractors extends through the remainder of the month in which hospice is revoked by hospice beneficiaries. Managed care enrollees who have elected hospice may revoke hospice election at any time, but claims will continue to be paid by fee-for-service contractors as if the beneficiary were a fee-for-service beneficiary until the first day of the month following the month in which hospice is revoked.

Timely Filing

These instructions apply to all contractors for claims filed in the timely filing period for managed care enrollees who have elected hospice. The timely filing period extends from the date of service to the end of the calendar year after the year service was rendered. However, if a service was provided in the fourth quarter of a calendar year, the claim will be timely to the end of the second year after the year in which the service was rendered. Since there have been allegations of lack of compliance with the regulatory requirements for Medicare fee-for-service contractors to process hospice claims for managed care beneficiaries, exceptions to timely filing will be considered on a case-by-case basis. Exceptions to the timely filing requirements will be determined by Medicare contractors on a case-by-case basis in accordance with applicable CMS guidelines.

Physician Billing Instructions for Non-Hospice Services

CMS has specific coverage rules that apply when an individual is covered under a Medicare hospice program. Treatment for the specific hospice related condition is covered under the scope of the Hospice benefit. Treatment for non-hospice related services must be specifically billed to denote the following:

1. Services not related to the specific terminal illness covered through hospice. For example, the hospice related illness is congestive heart failure.

2. A separate medical condition not related to treatment for hospice is eligible for payment under Medicare Part B, provided the billing is done properly with the specific codes designated by Medicare (e.g., GW modifiers) and are utilized when billing. A separate medical condition not related to treatment for congestive heart failure is eligible for payment under Medicare Part B, provided that the medical documentation regarding the separate medical condition is included.

3. Separate, non-hospice related treatment for things such as renal failure or related red blood cell production issues that meet Medicare criteria for Procrit injections would be distinct from the CHF condition being treated under the hospice program. As such they are eligible for coverage under Medicare Part B.

4. The billing should be done with a Modifier GW and should denote that the treatment is not for the CHF condition, which is coded as covered under hospice.

Resources: Medicare Hospice Manual; Chapter 11 Medicare Managed Care Manual, discussion with the hospice staff confirming that the Renal Failure and Red Blood cell production issues are not part of the scope of the hospice treatment for CHF; Frank Abrahamian at US Government Services; and conversations with CMS staff and NHIC staff; DHHS Program Memorandum.
Special Billing Situations (cont’d.)

Major Organ Transplant (MOT) Billing

Payment for professional services for major organ transplants (bone marrow, stem cell, liver, lung, heart, heart/lung, kidney/pancreas, small bowel with liver, and multi-organ) will be paid by the in-network facility where the transplant was performed. Blue Shield has contracted with selected transplant facilities to pay a global case rate for this procedure. If the physician receives the following denial message from Blue Shield: “Payment for these services are included in the global case rate paid to the facility,” along with an Explanation of Benefits (EOB), payment for the professional service can be secured by submitting a copy of the claim and the EOB to the facility where the transplant was performed.

Questions about the global transplant case period may be directed to Provider Information & Enrollment at (800) 258-3091.

Office-Administered Injectable Medications

Pharmaceutical supplies, including but not limited to, the drugs required to provide members with office-administered injectables are the responsibility of the physician and will be reimbursed by Blue Shield according to established allowed amounts for the services rendered to Blue Shield members. In addition, select medications are available for Drop Ship from a Blue Shield preferred pharmacy. Drop Ship is a voluntary program, in addition to the buy-and-bill method, for providers to procure office administered medications. The drop ship option will only be available for select drugs and does NOT replace buy and bill. Under this program, physician offices order medications from a Blue Shield preferred pharmacy on an individual patient basis. The pharmacy delivers the drug to the physician office and bills Blue Shield for the cost of the drug. After the member receives treatment, the physician only bills Blue Shield for the administration costs. Physician offices will continue to be required to procure medications through the buy-and-bill method for drugs not available through the Drop Ship program. A list of the Drop Ship medications and preferred pharmacies can be found on Provider Connection at www.blueshieldca.com/provider. For questions regarding billing of office administered injectable medications, please call Provider Information & Enrollment at (800) 258-3091.

Additionally, Blue Shield Physician members are required to:

- Provide Covered Services they are licensed to provide and seek payment only from Blue Shield for those services.
- Provide all necessary supplies and materials required to administer injectables in the office. Physicians should not instruct Blue Shield members to obtain injectable drugs from the pharmacy prior to an office visit for the purposes of administrating such drug(s) in the office.
- Note: Instructing members to obtain drugs prior to an office visit is a violation of the Independent Physician Agreement and the Knox-Keene Act, which could result in contract termination.
- Submit the appropriate billing for services rendered to Blue Shield and collect only the authorized copayment from the member.

A complete list of infused and office administered medications, which include appropriate procedure codes for billing and their authorization requirements for coverage in the medical benefit, can be found on Provider Connection at www.blueshieldca.com/provider under Authorizations, Clinical Policies and Guidelines, Medication Policy, and then Medication Policy List.
Section 4: Billing

Special Billing Situations (cont’d.)

Office-Based Ambulatory Procedures

Office-based ambulatory procedures should be performed in a physician office setting, unless it is medically necessary that they be performed in a facility setting on either an outpatient or inpatient basis.

The list of office-based ambulatory procedures is provided in Appendix 4-H List of Office-Based Ambulatory Procedures.

Claim Inquiries and Corrected Claims

Blue Shield utilizes Optical Character Recognition (OCR), which allows paper claims to be scanned and data interpreted with minimal data entry. It is important that all claims have no comments, writings, or descriptions other than those outlined in the processes below.

Resubmissions or Corrected Claims

Resubmission

If a claim needs to be re-submitted because you have not received notice of adjudication, use the following steps:

- Confirm that the claim has not been received by accessing Provider Connection at www.blueshieldca.com/provider.
- Transmit a 276 electronic claim status transaction.
- If the original claim was not received, re-submit the claim electronically.

Corrected Claims

Corrected claims that do not have a medical record attached must be submitted electronically. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. Please wait for the original claim to finalize before sending a corrected claim to avoid denial as a duplicate.

Once the initial claim has finalized in our system, re-submit the corrected claim with the appropriate adjustment bill type. You will also need to include the following EDI segments on the adjusted claim:

- Send "F8" in REF01 (Loop 2300)
- Send the 12 digit claim number from the incorrect original claim in REF02 (Loop 2300).
  
Sample: REF*F8*12345678912345~

Note: 12345678912345 should be replaced with the original claim number. Obtain the Blue Shield claim number via the claim status option on Provider Connection, from the explanation of benefits (EOB), or from the electronic remittance advice (ERA).
Claim Inquiries and Corrected Claims (cont’d.)

Corrected Claims (cont’d.)

- Ensure the request is within the timely filing period as specified in the contract.

  Note: Send corrected claims originally processed by a Foundation for Medical Care directly to that Foundation.

- Corrected billings submitted with no documentation clearly describing the correction being made may be processed as a raw claim or returned with a request for additional information regarding the change(s).

Overpayments

Blue Shield’s process and procedures for notification of overpayments and offset shall be in accordance with the regulations at 28 California Code of Regulations Section 1300.71. In the event you disagree or contest Blue Shield’s notice, you should notify us, in writing, within thirty (30) working days of receipt. Please refer to Provider Appeals and Dispute Resolution, within this section, for additional information.

If you do not contest or object a notice of overpayment, you should reimburse Blue Shield within 30 working days of receipt. In the event you fail to reimburse Blue Shield, you authorize Blue Shield to offset such uncontested overpayments from your current claim submissions.

Provider Inquiries

A provider inquiry is a telephonic or written request to explain the rationale for a decision to reduce, delay, or deny services or benefits. An inquiry may also include questions or clarifications regarding proposed services or treatments, administrative procedures or claims payment. Issues or questions may be resolved at the inquiry level. An inquiry may or may not alter the original decision.

Providers may initiate inquiries regarding a decision by Blue Shield, including but not limited to a claims processing determination.

Inquires may focus upon areas such as:

- Payment Methodology
- Multiple Surgeries
- Corrected Billings
- Medical Policy
- Coordination of Benefits (COB)
- Third Party Liability (TPL)
- Utilization Denials

Inquiries can be generated by either a telephone call or written correspondence to the member’s appropriate Customer Service Department. For claims with dates of service less than 30 days old, visit Provider Connection at www.blueshieldca.com/provider where this information is readily accessible. Information about the Provider Appeals and Dispute Resolution Process and where to direct an inquiry can be found in this manual or by contacting the member’s Customer Service Department.
Section 4: Billing

Provider Appeals and Dispute Resolution

Blue Shield has established fair, fast and cost-effective procedures to process and resolve provider appeals. Blue Shield’s Provider Appeals and Dispute Resolution Process is accessible to both contracting and non-contracting providers.

Definitions

**Appeal**

A written notice to Blue Shield, submitted to the designated provider appeal address, challenging, appealing or requesting reconsideration of a claim that has been denied, adjusted (paid at less than billed charges), or contested, or requesting resolution of billing determinations, such as bundling/unbundling of claims/procedures codes or allowances, or disputing a request for reimbursement of an overpayment of a claim; and a written notice to Blue Shield, submitted to the designated provider appeal address, disputing administrative policies and procedures, administrative terminations, retro-active contracting, or any other contract issue.

**Bundled Appeal**

A written notice to Blue Shield, submitted to the designated provider appeal address, identifying a group of substantially similar multiple claims challenging, appealing, or requesting reconsideration of claims that have been previously denied, adjusted (paid at less than billed charges), or contested, that are individually numbered using the Blue Shield assigned claim number to identify each claim contained in the bundled appeal; or a written notice, submitted to the designated provider appeal address, identifying a group of substantially similar contractual appeals that are individually numbered using the section of the contract and sequential numbers that are cross-referenced to a document or spreadsheet. (For example, Section I A #1, Section I A #2, etc.)

**Provider Inquiry**

A telephone or written request for information, or question regarding claim status, submission of corrected claims, member eligibility, payment methodology rules (bundling/unbundling logic, multiple surgery rules), Medical Policy, coordination of benefits, or third party liability/workers compensation issues submitted by a provider to Blue Shield, or a telephone discussion or written statement questioning with the way Blue Shield processed a claim (i.e. wrong units of service, wrong date of service, clarification of payment calculation).

**Receipt Date**

The working day when the provider appeal, whether by physical or electronic means, is first delivered to the designated provider appeal office or post office box.

**Appeal Determination Date**

The working day when the written provider dispute determination or amended provider dispute determination is delivered by physical or electronic means.
Provider Appeals and Dispute Resolution (cont’d.)

Definitions (cont’d.)

Date of Contest, Denial, Notice, or Payment

The date Blue Shield's claim decision, or payment, is electronically transmitted (835) or deposited in the U.S. mail (Explanation of Benefits).

Unjust or Unfair Payment Pattern

Any practice, policy, or procedure that results in repeated delays in the processing and/or correct reimbursement of claims as defined by applicable regulations.

Unfair Billing Pattern

Engaging in a demonstrable and unjust pattern of bundling/unbundling or up-coding of claims, and/or other demonstrable and unjustified billing patterns.

Good Cause for Untimely Submission of Claims

Circumstances reasonably beyond the control of the provider that prevented the timely submission of a claim would be considered “good cause.”

Examples of circumstances beyond the control of the provider, include, but are not limited to:

- Patient gave incorrect health coverage/insurance information (copy of an incorrect ID card);
- Patient was unable to provide health coverage/insurance information (patient was comatose, the patient expired before the information could be obtained, etc.);
- Natural disaster/acts of nature (fire, flood, earthquake, etc.);
- Acts of war/terrorism;
- System wide loss of computer data (system crash);
- BlueCard claims sent to the wrong Blue Plan.

Examples of Circumstances That Do Not Constitute “good cause”:

- Claim was sent to the wrong carrier (Blue Cross instead of Blue Shield), but the provider had the correct health coverage/insurance information for Blue Shield of California membership.
- The claim was submitted timely, but Blue Shield was unable to process because the claim was not a complete claim (did not contain the minimum data elements to enter the claim into the system, i.e., missing a subscriber number).

Providers have an obligation to be responsible for appropriate timely billing practices. Provider requests to review a claim timely filing denial because the provider believes there was good cause for the delay, will be handled as a provider appeal.
Provider Appeals and Dispute Resolution (cont’d.)

Unfair Billing and Payment Patterns

Reporting Unfair Billing Patterns

Blue Shield may report providers Blue Shield believes are engaging in unjust billing patterns to the DMHC.

Toll-free provider line (877) 525-1295
Email: plans-providers@dmhc.ca.gov

Providers may report instances in which the provider believes a plan is engaging in an unfair payment pattern to the DMHC’s Office of Plan and Provider Relations.

Toll-free provider line (877) 525-1295
Email: plans-providers@dmhc.ca.gov

Unfair Payment Patterns

Unjust payment patterns include:

- Imposing a claims filing deadline on three or more claims over the course of any three-month period, or less than 90 days for contracting providers; 180 days for non-contracting provider; 90 days from the primary payors determination, when paying as a secondary/tertiary payor
- Failing to forward at least 95% of misdirected, capitated claims to the appropriate capitated entity within 10 working days of receipt, over the course of any three-month period
- Failing to accept at least 95% of late claim submissions, over the course of any three-month period, when the provider submits proof of Good Cause
- Failing to notify providers at least 95% of the time, in writing and within 365 days of the payment date, of intent to recover an overpayment, over the course of any three-month period
- Failing to notify providers, at least 9% of the time over the course of any three-month period, of the claim, name of the patient, date of service and a clear explanation of the basis upon which an overpayment was made.
- Failing to allow providers 30 working days, at least 95% of the time over the course of any three-month period, of their right to appeal a request to recover an overpayment
- Failing to acknowledge at least 95% of claims within 2 working days for electronic submissions, or 15 working days for paper submissions
- Failing to provide an accurate and clear written explanation of the specific reasons for denying, adjusting or contesting a claim at least 95% of the time over any three-month period
- Including provider contract provision inconsistent with any of the applicable regulations of the Health and Safety Code or CCR, title 28 on three (3) or more occasions over the course of any three-month period
- Requesting medical records on more than 3% of claims, excluding professional emergency services and care claims, over the course of any 12-month period
Provider Appeals and Dispute Resolution (cont’d.)

Unfair Billing and Payment Patterns (cont’d.)

Unfair Payment Patterns (cont’d.)

- Requesting medical records on professional emergency services and care claims on more than 20% of the claims, over the course of any 12-month period
- Failing to process PPO and POS II, III claims within 30 working days or HMO and POS I claims within 45 working days at least 95% of the time over the course of any three-month period
- Failing to automatically pay interest penalties when processing exceeds the specified time frames at least 95% of the time over the course of any three-month period
- Failing to notify providers of the appeal process when a claim is denied, adjusted or contested at least 95% of the time over the course of any three-month period
- Failing to acknowledge initial provider appeals within 15 working days of receipt at least 95% of the time over the course of any three-month period
- Failing to resolve and provide written determination of initial provider appeals within 45 working days of receipt
- Rescinding or modifying an authorization for health care services after the provider has rendered the service on three or more occasions over the course of any three-month period

Provider Contracts

Blue Shield informs contracting providers and capitated entities, initially upon contracting, or upon change of the Provider Appeal Resolution Process, of the procedures for submitting a provider appeal, including:

- Identity of the office responsible for receiving and resolving provider appeals
- Mailing address
- Telephone number
- Directions for filing an appeal
- Directions for filing bundled appeal
- The timeframe in which Blue Shield will acknowledge receipt of the appeal. The disclosures are made in contracts, in the various provider manuals and on Provider Connection at www.blueshieldca.com/provider

Explanation of Benefits

An Explanation of Benefits (EOB) informs providers of the availability of Blue Shield's Provider Appeal Resolution Process and provide instructions for filing a provider appeal. An EOB is sent each time Blue Shield processes a provider submitted claim unless a provider is enrolled with Electronic Remittance Advice (ERA). Providers can retrieve a copy of the EOB from Provider Connection at www.blueshieldca.com/provider. The provider appeal resolution information is printed on page two of the provider's EOB. EOBs are issued to both contracted and non-contracted providers.
Provider Appeals and Dispute Resolution (cont’d.)

Online Access

The Provider Appeal Resolution Process is available to registered users on Provider Connection at www.blueshieldca.com/provider.

Provider Manuals


Blue Shield's Appeal Process

The following information outlines the process Blue Shield has established to allow providers and capitated entities to submit appeals.

Blue Shield's Senior Management is responsible for:

- The maintenance of the Provider Appeal Resolution Process;
- Review of the Provider Appeal Resolution operations;
- Noting any emerging patterns to improve administrative capacity, Blue Shield Provider Relations, claim payment procedures and patient care; and
- Preparing the required reports and disclosures.

Provider Appeals – Reports

Blue Shield will track each provider appeal and will report the following information in the Annual Plan Claims Payment and Dispute Resolution Mechanism Report:

- Information on the number and type of provider appeals received.
- A summary of the disposition of all provider appeals, including a description of the types, terms and resolution.

Internally, Blue Shield will review the provider appeal data to identify emerging patterns and trends, and initiate the appropriate action.
Provider Appeals and Dispute Resolution *(cont’d.)*

Unfair Billing and Payment Patterns *(cont’d.)*

Levels

Blue Shield's Provider Appeal Resolution Process consists of two levels: Initial and Final.

CCR, title 28, Section 1300.71.38 requires health plans to offer an appeal process. State law does not require health plans to offer two levels.

**Address For Submission of an Initial Appeal**

Initial Appeals must be submitted in writing to the following address:

Blue Shield Initial Appeal Resolution Office  
P.O. Box 272620  
Chico, CA 95927-2620

Initial appeals regarding facility contract exception(s) must be submitted in writing to the following address:

Blue Shield Initial Appeal Resolution Office  
Attention: Hospital Exception and Transplant Team  
P.O. Box 629010  
El Dorado Hills, CA 95762-9010

**Required Information/Appeal**

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

- The provider's name
- The provider's identification number and/or the provider's tax identification number
- Contact information - mailing address and phone number
- Blue Shield's claim number, when applicable
- The patient's name, when applicable
- The patient's Blue Shield subscriber number, when applicable
- The date of service, when applicable
- A clear explanation of issue the provider believes to be incorrect, including supporting medical records when applicable

As applicable, bundled appeals must identify individually each item by using either the claim number or the section of the contract and sequential numbers that are cross-referenced to a document or spreadsheet.
Section 4: Billing

Provider Appeals and Dispute Resolution (cont’d.)

Unfair Billing and Payment Patterns (cont’d.)

Appeals Submitted With Incomplete Information

Appeals that are lacking the required information will be returned to the provider or capitated entity.

Blue Shield will return the appeal and notify the provider or capitated entity of the missing information necessary to categorize the submission as a provider appeal.

The original appeal, along with the additional information identified by Blue Shield, should be resubmitted to Blue Shield within 30 working days of the provider's receipt of the notice requesting the missing information.

Blue Shield will not require the provider to resubmit claim information or supporting documentation that has been previously received as part of the claims adjudication process.

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.

In the event the appeal is regarding the lack of a decision, the appeal must be submitted within 365 days, or the time specified in the provider's contract, whichever is greater, after the time for contesting or denying a claim has expired.

Appeals alleging a demonstrable and unfair payment pattern by Blue Shield must be submitted within the timeframes indicated above, based on the date of the most recent action or inaction by Blue Shield.

Timely Filing of Appeals

If a contracted provider or capitated entity fails to submit an initial appeal or final 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 specified 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.
Provider Appeals and Dispute Resolution (cont’d.)

Unfair Billing and Payment Patterns (cont’d.)

Timeframe for Providers to Contest Blue Shield's Request to Refund an Overpayment

Providers must submit notice contesting Blue Shield's refund request within 30 working days of the receipt of the notice of overpayment.

The provider's notice contesting Blue Shield's refund request must include the required information for submitting an appeal as well as a clear statement indicating why the provider believes that the claim was not over paid. A provider's notice that it is contesting Blue Shield's refund request will be identified as an appeal and handled in accordance with Blue Shield's Provider Appeal Resolution Process.

Timeframe for Acknowledgement of Appeals

Blue Shield will acknowledge the receipt of each paper appeal within 15 working days of the receipt of the written appeal.

Timeframe for Resolving Appeals

Blue Shield will resolve appeals within 45 working days of the receipt of the appeal.

In the event the original appeal was returned to the provider due to missing information, the amended appeal will be resolved within 45 working days of the receipt of the amended appeal.

If the resolution of the appeal results in additional monies due to the provider, Blue Shield will issue payment, including interest when applicable, within 5 working days of the date of the written response notifying the provider of the appeal resolution.

Resolution

Blue Shield will provide a written determination to each appeal, stating the pertinent facts and explaining the reason(s) for the determination.

The written determination of an initial appeal will notify providers and capitated entities of their right to file a final appeal.

Submitting Appeals on a Member's Behalf

Appeals submitted on a member's behalf will be treated as a member grievance and handled within the member grievance process.

Blue Shield will verify with the member that the provider has been authorized to submit an appeal (member grievance) on the member's behalf.
Section 4: Billing

Provider Appeals and Dispute Resolution (cont’d.)

Unfair Billing and Payment Patterns (cont’d.)

Final Appeals

Provider or capitated entities that disagree with Blue Shield's written determination may pursue the matter further by initiating a final appeal.

To initiate a final appeal, providers and capitated entities must, within 65 working days of Blue Shield's initial determination, or the time specified in the provider's contract, whichever is greater, submit a written request to the following address:

Blue Shield
Final Provider Appeal and Resolution Process
P.O. Box 629011
El Dorado Hills, CA 95762-9011

Commercial Appeals regarding facility contract exception(s) must be submitted to:

Blue Shield Initial Appeal Resolution Office
Attention: Hospital Exception and Transplant Team
P.O. Box 629010
El Dorado Hills, CA 95762-9010

The final appeal must be submitted in accordance with the required information for an appeal.

Blue Shield will, within 45 working days of receipt, review the final appeal and respond in writing, stating the pertinent facts and explaining the reason(s) for the determination.

Arbitration

If, after participating in the initial and final levels of the Provider Appeal Resolution Process, the provider or capitated entity continues to disagree with Blue Shield's payment or determination, the provider or capitated entity may submit the matter to binding arbitration as applicable and outlined in the provider's contract.
Capitated Entity (IPA/MG/Capitated Hospital) Appeal Resolution Requirements

IPA/Medical Group Responsibilities

In accordance with state law, IPA/medical groups are required to establish a fair, fast, cost-effective provider dispute resolution process.

In the event an IPA/medical group fails to resolve provider disputes in a timely manner, and consistent with state law, Blue Shield may assume responsibility for the administration of the IPA/medical group’s dispute resolution mechanism.

Blue Shield Contracts

Blue Shield contracts require the IPA/medical group to establish and maintain a fair, fast and cost-effective dispute resolution to process and resolve provider appeals.

The IPA/medical group's dispute resolution process must be in accordance with sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36 1371.37 1371.38, 1371.4, and 1371.5 of the Health and Safety Code, and sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4 of the CCR, title 28.

Quarterly Reports

IPAs, medical groups and capitated hospitals are required to create and retain for audit a tabulated report of each provider dispute received and/or reported. The report must be categorized by receipt date, and include the identification of the provider, type of appeal, disposition and outcome of the appeal and number of work days to resolve the appeal. A summary statistical report will be submitted quarterly in accordance with ICE-standardized formats.

Each individual appeal in a bundled appeal is reported separately.

Provider Appeal Documentation

Upon request, the IPA/medical group will make available to Blue Shield, or the DMHC, all records, notes and documents regarding their provider dispute resolution mechanism and the resolution of provider appeals.

Medical Necessity Denials

Blue Shield’s Provider Appeal Resolution Process includes a process to allow any provider submitting a claim dispute to the IPA/medical group’s dispute resolution mechanism involving an issue of medical necessity or utilization review and unconditional right of appeal for that claim dispute.

Providers must submit their requests to Blue Shield within 60 working days from the date they received the IPA/medical group determination.
Provider Appeals of Medicare Advantage Claims

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).
Provider Appeals of Medicare Advantage Claims (cont’d.)

Contracted (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 specified 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 Appeals Resolution letter or the Remittance advice with either additional payment or an explanation for upholding the original claim determination.

The provider 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.
Non-Contracted

CMS requires Medicare Advantage Organizations (MAOs) 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 what 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.

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
Section 5: Blue Shield Benefit Plans and Programs
# Section 5: Blue Shield Benefit Plans and Programs

## Table of Contents

**Blue Shield Benefit Plans**

- Blue Shield HMO Plans ................................................................. 1
- Access+ SpecialistSM Feature ....................................................... 2
- Blue Shield 65 PlusSM (HMO)(Medicare Advantage) .................. 3
- Medicare Part D ............................................................................. 4
- Part D Eligibility .......................................................................... 4
- Fraud, Waste, and Abuse Requirements and Training .................. 4
- Exclusion Lists ............................................................................. 5
- Medicare Part D Prescriber Preclusion List .................................... 5
- Medication Therapy Management Program (MTMP) .................... 6
- Blue Shield PPO Plans ................................................................. 7
- PPO Primary Care Physician Requirement for IFP PPO Members .... 7
- Point-of-Service (POS) Plans ......................................................... 8
- Point of Service (POS) Options .................................................... 8
- Federal Employee Program (FEP) ................................................. 9
  - About the BlueCross and BlueShield Service Benefit Plan .......... 9
  - Precertification for Inpatient Hospital Admissions ..................... 10
  - Mental Health, Substance Abuse, and Behavioral Health Services for FEP ............................................... 10
  - Required Prior Authorization .................................................. 10
  - Integrated Care Management Program for FEP ....................... 13
  - Transitions of Care Program for FEP ....................................... 14
- Medicare Supplement Plans ......................................................... 15
  - Claims Assignment ..................................................................... 15
- The BlueCard® Program ............................................................... 16
- Other Payers ................................................................................. 16
- Mental Health Services ............................................................... 17
  - Psychiatric Care ....................................................................... 17
  - Member Self-Referral Number .................................................. 17
  - Primary Care Physician Consultation Line ............................... 17
  - PCP Behavioral Health Toolkit .................................................. 17
  - Telebehavioral Health Online Appointments ............................. 17
  - Blue Shield MHSA Covered Services for PPO Commercial Plan Members ................................................ 18
  - Mental Health Services for Self-Funded Accounts (ASO) and the Federal Employee Program (FEP) .......... 18

**Blue Shield Benefit Programs**

- Care Management ........................................................................ 19
- Additional Care Management Programs ..................................... 21
- Home-Based Palliative Care Program ......................................... 22
  - Eligibility/Referral .................................................................... 22
- Wellness and Prevention Programs ............................................. 23
  - CareTips Clinical Messaging ...................................................... 23
  - Daily Challenge ......................................................................... 23
  - Diabetes Prevention Program (DPP) .......................................... 23
  - LifeReferrals 24/7SM .................................................................. 24
  - NurseHelp 24/7SM ................................................................... 25
  - Preventive Health Guidelines .................................................... 25
  - Preventive Health Services Policy ............................................ 26
  - QuitNet ....................................................................................... 26
  - Walkadoo .................................................................................. 26
  - Wellness Discount Programs .................................................... 27
- Patient Ally .................................................................................. 27
Section 5: Blue Shield Benefit Plans and Programs

This page intentionally left blank.
Blue Shield Benefit Plans

Blue Shield offers a variety of benefit plans representing a cross section of financing and delivery systems to meet the various health care needs and budgets for subscribers of both group plans and individual plans.

This section gives a brief description of the following Blue Shield plans. More detailed plan information, including plan networks, can be found on blueshieldca.com/provider.

- HMO Plans
- PPO Plans
- Point of Service (POS) Plans
- Federal Employee Program (FEP)
- Medicare Supplement Plans
- The BlueCard® Program
- Other Payors

Blue Shield HMO Plans

Blue Shield offers the Access+ HMO® Plan and Local Access+ HMO Plan to Small Business and Core Account groups. Point-of-service (POS) and SaveNet HMO plans are included in the Core HMO family of products. Blue Shield offers Trio HMO plans to Small Business, Core, and individual and family plans (IFP) (on-exchange and mirrored only).

Blue Shield Access+ HMO is Blue Shield’s commercial HMO plan, which includes a unique direct access feature called Access+ Specialist™, which allows a member to access a specialist within his or her assigned medical group or IPA.

Custom employer groups may choose not to offer this direct access feature. The member’s identification card will designate if the member has the Access+ direct access feature. An "A+" appearing next to the network name on the card indicates that the subscriber has the Access+ Specialist feature.
Blue Shield HMO Plans (cont’d.)

Access+ SpecialistSM Feature

Access+ HMO members with the Access+Specialist feature can self-refer directly to any primary care physician (PCP) or specialist (M.D. or D.O.) for a consultation, as long as that physician is in the same IPA/medical group as the member’s PCP.

The members simply present their ID card at the specialist’s office and pay their Access+ office visit copayment, which is generally higher than the standard office visit copayment.

After the consultation, if additional services or procedures are recommended, the specialist coordinates care with the member’s PCP and follows Blue Shield’s authorization process. If Blue Shield authorizes additional services/procedures, the HMO member may go back to the specialist for the authorized services and pay the usual office visit copayment.

An Access+Specialist visit does not include:

- Any services which are not covered, or which are not medically necessary
- Services provided by a non-Access+ provider (such as podiatry and physical therapy), except for the X-ray and laboratory services described above
- Allergy testing
- Endoscopic procedures
- Any diagnostic imaging, including CT, MRI or bone density measurements
- Injectables, chemotherapy or other infusion drugs, other than vaccines and antibiotics
- Infertility services
- Emergency services
- Urgent services
- Inpatient services, or any services which result in a facility charge, except for routine X-ray and laboratory services
- Services for which the IPA/medical group routinely allows the member to self-refer without authorization from the primary care physician
- OB/GYN services by an obstetrician/gynecologist or family practice physician within the same IPA/medical group as the member’s PCP
Blue Shield 65 Plus<sup>SM</sup> (HMO) (Medicare Advantage)

Blue Shield 65 Plus<sup>SM</sup> (HMO)<sup>1</sup> is Blue Shield’s Medicare Advantage-Prescription Drug (MA-PD) plans. These plans are open to all Medicare beneficiaries, including those under age 65 who are entitled to Medicare on the basis of Social Security disability benefits, who meet all of the applicable eligibility requirements for membership, have voluntarily elected to enroll in Blue Shield 65 Plus, have paid any premiums required for initial enrollment to be valid, and whose enrollment in Blue Shield 65 Plus, has been confirmed by the Centers for Medicare & Medicaid Services (CMS). Blue Shield 65 Plus is offered to individual Medicare beneficiaries and to group Medicare beneficiaries retired from employer groups/Unions who have selected the product as an option.

To be eligible for enrollment in the Blue Shield 65 Plus program, the member must have both Medicare Part A and Medicare Part B and live within the CMS-approved Blue Shield 65 Plus service area. Patients diagnosed with End Stage Renal Disease (ESRD) prior to signing an enrollment application, who have ongoing dialysis, are not eligible to join Blue Shield 65 Plus, unless they are already a Blue Shield commercial plan member and within their 30-month coordination period or were previously enrolled with another Medicare Advantage HMO that has subsequently withdrawn from their county. Once a kidney transplant has occurred and the individual no longer needs dialysis, he or she is eligible to enroll in Blue Shield 65 Plus. All other pre-existing conditions are covered without a waiting period.

The Blue Shield 65 Plus plan provides comprehensive coordinated medical services to members on a prepaid basis through an established provider network. Members must choose a primary care physician (PCP) and have all care coordinated through this physician. The Blue Shield 65 Plus (HMO) plan is regulated by the Centers for Medicare & Medicaid Services (CMS), the same federal agency that administers Medicare. Please contact Blue Shield 65 Plus Medicare Member Services (877) 654-6500 (for Providers), (800) 776-4466 (for Members), if you have questions about benefit information, eligibility, claims, and/or billing.

---

<sup>1</sup> When the manual references Blue Shield 65 Plus, it refers to Blue Shield’s Medicare Advantage-Prescription Drug plans: Blue Shield 65 Plus (HMO), Blue Shield 65 Plus Choice Plan (HMO), and Blue Shield Trio Medicare (HMO).
Medicare Part D

The Medicare Prescription Drug Improvement and Modernization Act (MMA) introduced the Medicare Advantage Program and the Prescription Drug Benefit. The prescription drug benefit, as well as an employer subsidy for qualified retiree health plans, is referred to as Medicare Part D. Coverage for the drug benefit is being provided by private prescription drug plans (PDPs) that offer drug-only coverage, or through Medicare Advantage plans that offer both prescription drug and health care coverage (known as Medicare Advantage – Prescriptions Drug Plans (MA-PD)).

Part D Eligibility

In general, an individual is eligible to enroll in a Medicare prescription drug plan (PDP) if:

1. The individual is entitled to Medicare Part A and/or enrolled in Part B, provided that he/she will be entitled to receive services under Medicare Part A and/or Part B as of the effective date of coverage under the plan; and

2. The individual permanently resides in the service area of a PDP.

Other eligibility requirements and exclusions include:

- An individual who is living abroad or is incarcerated is not eligible for Part D.
- For individuals whose Medicare entitlement determination is made retroactively, Part D eligibility begins with the month the individual receives the notice of the Medicare entitlement determination.
- A PDP sponsor may not deny enrollment to otherwise eligible individuals covered under an employee benefit plan. If the individual enrolls in a PDP and continues to be enrolled in his/her employers or spouse’s health benefits plan, then coordination of benefits (COB) rules will apply.
- A Part D eligible individual may not be enrolled in more than one Part D plan at the same time.

Fraud, Waste, and Abuse Requirements and Training

Blue Shield has a comprehensive program in place to detect, prevent and control Part D Fraud, Waste, and Abuse (FWA) as part of the General Compliance Plan Requirements (42 C.F.R. § 423.504(b)(4)(vi)(H)).

The Medicare Part D FWA training is a requirement under CMS for anyone who works with Medicare Part D. Blue Shield’s Medicare Part D Compliance training is for contracted pharmacies to ensure these providers have a thorough understanding of federal and state regulations around Medicare Part D. Successful completion is required of anyone involved with the administration or delivery of the Part D benefit. The training focuses on how to detect, correct, and prevent fraud, waste, and abuse surrounding Medicare Part D. To access the online training, please go to https://www.blueshieldca.com/provider/about-this-site/announcements/medicare-compliance-training.sp.

A statement of attestation is required annually by all network pharmacies contracted with Blue Shield for the Medicare Prescription Drug Plans. The compliance statement of attestation indicates that the pharmacy staff completed the Medicare Part D Fraud, Waste, and Abuse Compliance training.
Medicare Part D (cont’d.)

Exclusion Lists

The Office of the Inspector General (OIG) excludes individuals and entities from participation in Medicare, Medicaid, the State Children’s Health Insurance Program (SCHIP), and all Federal health care programs (as defined in section 1128B(f) of the Social Security Act (the Act)) based on the authority contained in various sections of the Act, including sections 1128, 1128A, 1156, and 1892. The OIG and the General Services Administration (GSA) maintain a sanction lists that identifies those individuals and entities found guilty of fraudulent billing, misrepresentation of credentials, etc.

Therefore, CMS prohibits any employee, provider, contractor, or subcontractor from performing any activity related to Medicare Part D or other federal programs if they are listed in the General Services Administration (GSA) database of excluded individuals/entities or the Office of Inspector General’s (OIG) database of excluded individuals or entities. Below are links to these databases:

- [https://oig.hhs.gov/exclusions/index.asp](https://oig.hhs.gov/exclusions/index.asp)
- [https://www.sam.gov/portal/SAM](https://www.sam.gov/portal/SAM)

CMS requires that all entities review the lists prior to hiring or contracting of anyone and monthly thereafter to ensure that its employees, consultants, volunteers, board members, officers, first tier entities, downstream entities, or related entities that assist in the administration or delivery of Part D benefits are not included on such lists. If the first-tier entities, downstream entities, or related entities are on such lists, the entity’s policies shall require the immediate removal of such employees, board members, first tier entities, downstream entities, or related entities from any work related directly or indirectly on all Federal health care programs and take appropriate corrective actions. Upon audit, entities and providers must provide evidence that these monthly validation checks have been conducted.

Medicare Part D Prescriber Preclusion List

The Centers for Medicare & Medicaid Services (CMS) is eliminating the prescriber and provider enrollment requirement for Part C and Part D and instead is compiling a “Preclusion List” of prescribers, individuals, and entities that fall within either of the following categories: (a) are currently revoked from Medicare, are under an active reenrollment bar, and CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or (b) have engaged in behavior for which CMS could have revoked the prescriber, individual, or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. CMS will make the Preclusion List available to Part D prescription drug plans and Medicare Advantage plans. Plans are required to deny payment for claims submitted by, or associated with, prescriptions written by prescribers and providers on the list. Full enforcement of the Part C and D prescriber exclusion list requirement will begin on January 1, 2019.

Additionally, the added provisions require organizations offering Part D to cover a three-month provisional supply of the drug and provide beneficiaries with individualized written notice before denying a Part D claim or beneficiary request for reimbursement on the basis of a prescriber’s being neither enrolled in an approved status nor validly opted out. The three-month provisional supply is intended to give the prescriber time to enroll in Medicare or opt-out and ensure beneficiary access to prescribed medication.
Medicare Part D (cont’d.)

Medication Therapy Management Program (MTMP)

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:
  - Respiratory Disease-Chronic Lung Disorders
  - Chronic Heart Failure (CHF)
  - Diabetes
  - Hypertension
  - Osteoporosis
- Receive seven or more different covered Part D prescriptions monthly
- Likely to incur an annual cost threshold established by CMS each calendar year for Medicare covered prescriptions

Members meeting these criteria will be automatically enrolled in the MTMP at no additional cost relating to the program and they may opt-out if they desire.

Members have the option to speak with a designated pharmacist to discuss their medication therapy issues. The pharmacist consultations are designed to improve member health while controlling out-of-pocket costs and may include topics such as:

- Drug adverse reactions
- Drug side-effects
- Drug-drug interactions
- Drug-disease interactions
- Medication non-compliance and non-adherence
- Duplicate therapy
- Dosing that can be consolidated
- Non-prescription drug use

A written summary of the consultation with relevant assessments and recommendations will be provided to the member. The member’s prescribing physician or primary care physician may be contacted by the pharmacist to coordinate care or recommend therapy changes when necessary.
Blue Shield PPO Plans

Under a Blue Shield PPO plan, members may self-refer to any provider. The highest benefits level (i.e., lowest out-of-pocket costs) will be paid when a Blue Shield Preferred Provider is used.

A member’s copayments and deductible amounts for covered services will vary depending on whether he or she selects a preferred hospital provider or a non-network hospital provider. Therefore, there is a financial incentive for members to use Blue Shield preferred hospital providers.

If a member chooses to go to a non-network hospital provider, Blue Shield’s payment for a service by that non-network hospital provider may be substantially less than the amount billed. The member is responsible for the difference between the amount Blue Shield pays and the amount billed by non-network hospital provider. It is therefore to the member’s advantage to obtain medical and hospital services from preferred hospital providers.

Our PPO Savings Plans (PSP) are PPO plans with a choice of deductibles, designed to allow qualified individuals to establish a tax advantaged account under federal guidelines. Most services provided by a preferred hospital provider require a percentage copayment.

All PSP plans function very differently than regular PPO plans. All benefits (including pharmacy) must accrue to the deductible. The only benefits that can be paid by Blue Shield prior to the deductible being met is preventive care. If a member chooses to go to a non-network hospital provider, Blue Shield’s payment for a service by that non-network hospital provider may be substantially less than the amount billed. The member is responsible for the difference between the amount Blue Shield pays and the amount billed by non-network hospital provider. It is therefore to the member’s advantage to obtain medical and hospital services from preferred hospital providers.

PPO Primary Care Physician Requirement for IFP PPO Members

Beginning in 2017, all individual and family plan (IFP) PPO benefit plan members, with the exception of IFP PPO grandfathered plan members, will be required to have a primary care physician (PCP) of record. This requirement is intended to encourage support and close collaboration between PPO patients and their primary care physicians, and to provide consistent partnership in maintaining preventive care and making informed decisions about specialty care when it is needed. The requirement for an assigned PPO PCP has been implemented by Covered California for all PPO individual and family plans offered through the Exchange. Blue Shield agrees with this approach and will apply the requirement to all IFP PPO plans, with the exception of grandfathered plans.

Blue Shield will assign a participating physician in the Exclusive PPO Network to each IFP PPO member. Physicians may opt out of eligibility to be assigned as a PCP.

The following criteria will be used to help determine which physicians are eligible for assignment:

- IFP PPO members who have already established an ongoing primary care relationship with an eligible PCP will be matched to that physician and appear in Blue Shield’s records as that member’s PCP.

- In order to be eligible for matching, an Exclusive PPO Network physician must practice within the specialties of Family Practice, Internal Medicine or Pediatrics. In addition, Blue Shield will apply other business rules to determine a physician’s eligibility to be assigned as a PCP to an IFP PPO member. For example, a physician practicing solely in an urgent care clinic or emergency room would not be among those eligible to be matched with a Blue Shield IFP PPO member as their PCP.
Blue Shield PPO Plans (cont’d.)

PPO Primary Care Physician Requirement for IFP PPO Members (cont’d.)

- A physician who does not wish to be assigned as a PCP to an IFP PPO member may opt out of eligibility for assignment by providing a written notification to Blue Shield, using one of the following methods:

<table>
<thead>
<tr>
<th>Method</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Email</td>
<td><a href="mailto:BSCPrvdrInformationEnrollment@blueshieldca.com">BSCPrvdrInformationEnrollment@blueshieldca.com</a></td>
</tr>
<tr>
<td>FAX</td>
<td>Provider Information and Enrollment (916) 350-8860</td>
</tr>
<tr>
<td>Postal mail</td>
<td>Provider Information and Enrollment</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 629017</td>
</tr>
<tr>
<td></td>
<td>El Dorado Hills, CA 95762-9017</td>
</tr>
</tbody>
</table>

Point-of-Service (POS) Plans

The POS plans combine both HMO and PPO service delivery features. At the time services are needed, or at the point of service, the member may choose to receive benefits under the HMO network or PPO network option. Under the latter option, the member may receive covered services from either a Blue Shield preferred hospital provider or non-network hospital provider. The choice determines the member’s level of financial responsibility.

Point of Service (POS) Options

<table>
<thead>
<tr>
<th>Network</th>
<th>How Care is Accessed</th>
<th>Financial Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO Network</td>
<td>Member’s care is coordinated through the primary care physician who makes any necessary specialist referrals.</td>
<td>Physician and hospital services: Applicable HMO office visits and other copayments apply. No deductible unless the plan has a facility deductible which would be applied for applicable inpatient admissions.</td>
</tr>
<tr>
<td>PPO In-network</td>
<td>Member self-refers to a Blue Shield Preferred Provider.</td>
<td>Applicable PPO copayment and deductible applies.</td>
</tr>
<tr>
<td>Non-Network PPO</td>
<td>Member self-refers to a non-network provider.</td>
<td>Applicable PPO copayment and deductible applies. Member may be balance-billed.</td>
</tr>
<tr>
<td>(non-preferred or non-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>participating)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Upon enrollment in the POS Plan, all members must select a primary care physician (PCP). Services rendered by the PCP or specialist and facility care authorized by the PCP are deemed to be provided under the HMO option. Facility claims for such HMO options should be submitted on a UB 04 (or successor) form.

Services provided on a “self-referred” basis – either by a physician who is not the member's PCP, by a specialist, or other provider without a referral from the member's PCP – will be paid according to the provider’s agreement with Blue Shield.

When hospital services are provided under the PPO option, the facility should use the UB 04 (or successor) form for submitting a claim, mark it "self-referred" and send it to the appropriate Service Center. Blue Shield physicians should admit patients to a select or preferred hospital and follow the PPO pre-admission guidelines (refer to Section 3: Medical Care Solutions).
Federal Employee Program (FEP)

About the BlueCross and BlueShield Service Benefit Plan

The local BlueCross and BlueShield Plans underwrite and administer the BlueCross and BlueShield Service Benefit Plan, the largest privately underwritten health insurance contract under the Federal Employee Health Benefits (FEHB) Program. Sixty-four percent of all federal employees and retirees who receive their health care benefits through the government’s FEHB Program are members of the Service Benefit Plan.

Federal Employee Program (FEP) Preferred Providers include Blue Shield’s Preferred Physicians and Blue Cross’ Preferred Hospitals. FEP members may select the Basic Option or Standard Option benefit level. Under the Standard Option, members can seek care from any covered provider they want, however, in some cases, they must get advance approval of care from Blue Shield. The Blue Cross Blue Shield Service Benefit Plan Brochure is located at FEPBlue.org as well as medical and medication policies. Important FEP phone numbers are as follows:

- Blue Shield of California FEP Customer Service (800) 824-8839.
- Blue Shield of California FEP Integrated Care Management (800) 995-2800
- Blue Shield of California FEP Utilization Management ad Prior Authorization (800) 633-4581
- Anthem Blue Cross FEP Customer Service (800) 322-7319

Under the Basic Option, members must use Preferred providers in order to receive benefits, except under the following special circumstances:

- Medical emergency or accidental injury care in a hospital emergency room and related ambulance transport as described in Section 5(d) Emergency services and accidents
- Professional care provided at preferred facilities by non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians, and assistant surgeons
- Laboratory and pathology services, X-rays and diagnostic tests billed by non-preferred laboratories, radiologists and outpatient facilities
- Services of assistant surgeons
- Special provider access situations
- Care received outside the United States and Puerto Rico

Unless otherwise noted above, when services of non-preferred providers are covered in a special exception, benefits will be provided based on the plan allowance. Members are responsible for the applicable coinsurance or copayment and may be responsible for any difference between Blue Shield’s allowance and the billed amount.

Note: Please refer to Section 3 of the Blue Cross and Blue Shield Service Benefit Plan Contract Brochure for more information on special circumstances.
Precertification for Inpatient Hospital Admissions

Preferred providers are responsible for obtaining pre-certification for all inpatient admissions to preferred hospitals. Pre-certification requires notification prior to scheduled admissions or within two business days after an emergency admission, even if the member has been discharged from the hospital within those 2 days. The member will be subject to the $500 benefit reduction if admitted to a preferred hospital and pre-certification is not obtained. The member is ultimately responsible for ensuring that pre-certification has been completed. If the pre-certification is not obtained, the member’s inpatient hospital benefit for covered services will be reduced by $500. (For specific rules, please refer to Section 3 the Blue Cross and Blue Shield Service Benefit Plan Contract Brochure located at Fepblue.org). Pre-certification is not needed for a maternity admission for pre-certification of additional days for the baby. The subscriber must add the baby to the plan before certification for services to be provided.

Mental Health, Substance Abuse, and Behavioral Health Services for FEP

It is important to follow these policies to help ensure your patient’s needs for mental health services are met efficiently. Please use the following information to request assistance:

- For any services that are to be rendered in a residential treatment center (RTC), please call (800) 995-2800 before services are rendered. Services in an RTC are a covered benefit, when medically necessary, for members who are enrolled and actively participating in the integrated care management program at Blue Shield. A case manager will be able to assist you and the member to develop a plan that meets the member’s needs.

- For Behavioral Health Inpatient Hospitalizations call (800) 633-4581. If the admission is emergent due to a condition that puts the member’s life in danger or could cause serious damage to bodily function, the member, the member’s representative, the physician, or the hospital must telephone us within two business days following the day of the emergency admission, even if the member has been discharged from the hospital. If we are not telephoned within two business days, a $500 penalty may apply.

No prior authorization is required for outpatient professional services, including individual or group therapy, outpatient partial hospitalizations, intensive outpatient programs, office and home visits for FEP PPO members. If you should have any questions regarding coverage, please call FEP Customer Service at (800) 824-8839. If you have questions regarding prior authorization call FEP Prior Authorization department at (800) 633-4581.

Required Prior Authorization

Members must obtain prior approval for these services under both the Standard and Basic Option. Precertification is also required if the service or procedure requires an inpatient hospital admission. Contact Blue Shield at the prior authorization number at (800) 633-4581 before receiving these types of services. Find more information about the services below in the BCBSA Service Benefit Plan (SBP) Brochure at www.fepblue.org/benefit-plans/benefit-plans-brochures-and-forms.
**Prior Approval is required for:** | **Additional Information**
--- | ---
Outpatient sleep studies performed outside the home | Prior approval is required for sleep studies performed in any other location that is not the member’s home.

Applied behavior analysis (ABA) | Prior approval is required for ABA and all related services, including assessments, evaluations, and treatments.

Gender reassignment surgery | Prior to surgical treatment of gender dysphoria, the provider must submit a treatment plan including all surgeries planned and the estimated date each will be performed. A new prior approval must be obtained if the treatment plan is approved and is later modified. Modification can be to the type of treatment, date, time or location of the service/surgery to be provided.

BRCA testing and testing for large genomic rearrangements in the BRCA1 and BRCA2 genes | Prior approval is required for BRCA testing and testing for large genomic rearrangements in the BRCA1 and BRCA2 genes whether performed for preventive or diagnostic reasons.  
*Note:* Genetic counseling and evaluation services are required before preventive BRCA testing is performed.

Surgical services | Morbid Obesity- See the 2018 Service Benefit Plan Brochure for requirements.  
Surgical correction of congenital anomalies (see definition in the Service Benefit Plan Booklet); and surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth (see definition in the Service Benefit Plan Brochure).  
Separate Inpatient (IP) Authorization is needed for all IP admissions.

Hospice care | Prior approval is required for home hospice, continuous home hospice, or inpatient hospice care services. Blue Shield will advise you which home hospice care agencies we have approved. Please contact FEP Care Management at (800) 995-2800.

Organ/tissue transplants – Prior approval is required for both the procedure and the facility | Covered Organ/tissue Transplants - See the list of covered transplant services in the 2018 Service Benefit Plan Brochure.  
If you travel to a Blue Distinction Center for Transplants, prior approval is also required for travel benefits.  
The organ transplant procedures must be performed in a facility with a Medicare-Approved Transplant Program. If Medicare does not offer an approved program for a certain type of organ transplant procedure, this requirement does not apply, and you may use any covered facility that performs the procedure.  
The blood or marrow stem cell transplants listed must be performed in a facility with a transplant program accredited by the Foundation for the Accreditation of Cellular Therapy (FACT), or in a facility designated as a Blue Distinction Center for Transplants or as a Cancer Research Facility.  
Clinical trials for certain blood or marrow stem cell transplants – See the list of conditions covered only in clinical trials in the 2018 Service Benefit Plan Brochure.
### Prior Approval is required for:

<table>
<thead>
<tr>
<th>Drug Category</th>
<th>Additional Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription drugs and supplies</td>
<td>Contact CVS Caremark, our Pharmacy Program administrator, at (800) 624-5060 (TTY: 800-624-5077 for the hearing impaired) or visit the FEP CareMark website at: <a href="https://www.caremark.com/wps/portal/WEBSUPPORT_FAQS?cms=CMS-PWCM-2034779">https://www.caremark.com/wps/portal/WEBSUPPORT_FAQS?cms=CMS-PWCM-2034779</a> to request prior approval, or to obtain a list of drugs and supplies that require prior approval. Please note that updates to the list of drugs and supplies requiring prior approval are made periodically during the year. New drugs and supplies may be added to the list and prior approval criteria may change.</td>
</tr>
<tr>
<td>Mail Order Prescription Drug Program</td>
<td>Standard Option members may use our Mail Service Prescription Drug Program to fill their prescriptions. Basic Option members with primary Medicare Part B coverage also may use this program once prior approval is obtained.</td>
</tr>
<tr>
<td>Medical foods covered under the pharmacy benefit</td>
<td>Contact CVS Caremark, our Pharmacy Program administrator, at (800) 624-5060 (TTY: 800-624-5077 for the hearing impaired) to request prior approval.</td>
</tr>
</tbody>
</table>
Federal Employee Program (FEP) (cont’d.)

Integrated Care Management Program for FEP

Nurses who are licensed and familiar with California resources will be assisting your patients with obtaining the resources they require to maintain their optimum health. The referral phone number is (800) 995-2800.

Our Integrated Case Management program offers a systematic application of processes and shared information to optimize the design and coordination of benefits and care for members identified with acute or complex conditions. Through comprehensive, high-touch, coordinated care management delivered in partnership with providers, clients, and members, the program promotes improved health outcomes, quality of life, and member satisfaction.

Conditions managed through our Integrated Case Management Program include:

- **Acute Catastrophic** – Includes members with immediate needs relating to an acute episode of care for conditions such as stroke, sepsis, spinal cord injury, trauma, amputation, open wounds, newly diagnosed cancer, or complications from surgeries characterized by readmission to the hospital.

- **Disease Management** – Blue Shield provides disease management services to our members identified with chronic medical conditions, such as; Asthma, Diabetes, CHF, Chronic Obstructive Pulmonary Disease (COPD) and Coronary Artery Disease (CAD). Chronic diseases, including cardiovascular disease and diabetes, are the leading causes of death in California and are among the most common, costly and often preventable of health problems. Disease management is an approach to reach members with chronic conditions and provide them with the necessary tools to minimize the impact of their condition.

- **Post-neonatal Intensive Care Unit (NICU)/Pediatrics** – Focuses on premature or medically complex neonates being discharged home from the hospital after birth, as well as pediatric members with special needs.

- **Behavioral Health** – Assists members with Mental Health and Chemical Dependency diagnosis. Participates in discharge planning for all inpatient psychiatric and substance abuse admissions, including detoxification.

- **Oncology** – Focuses on members with cancer diagnoses to manage them through the health care continuum.

- **Palliative Care** – Provides a care management option for patients that includes symptom control in addition to curative therapy. A combination of palliative care while curative care is ongoing has been shown to improve quality of life, reduce inpatient stays, increase choice of hospice and the results have been demonstrated in both a care delivery locus and in a health plan setting. The intent of the program is to permit the use of palliative care, for severe chronic conditions one year in advance of the patient’s likely end of life.
Federal Employee Program (FEP) (cont’d.)

Transitions of Care Program for FEP

Blue Shield’s Transitions of Care program focuses on members and caregivers who need guidance on the transition to and from hospital and home. Unplanned readmissions are prevented by completing a safety risk assessment with the member, discussing follow-up plans, medication reconciliation, and facilitating adherence to the prescribed treatment plan. Length of hospital stay is decreased by preparing member for hospital stay and development of a discharge plan. The referral phone number is (800) 995-2800.

The Transitions of Care program has four primary components:

- A telephone call to the member by a Transitions of Care Nurse (TCN) to discuss the surgery/acute condition, what to expect, what to ask their physician, and how to prepare for the return home.

- A complimentary Guided Imagery Toolkit mailed to members prior to or following surgery that contains an instructional letter and an audio tape or compact disc of recordings that weave together inspirational music, healing images, and positive statements to help add to a member’s sense of safety and comfort prior to and following surgery.

- A recovery guide that provides members with useful information regarding what to ask their physician such as pre- and post-operative testing and preparation, expected post-operative recovery milestones, and information regarding return to work.

- A post-hospitalization call to identified patients who are urgently or emergently admitted to an acute care hospital. The TCN will discuss adherence to the discharge plan, provide medication reconciliation, and conduct a needs assessment for any unmet needs the patient may have post discharge. Additionally, the TCN may engage in care coordination efforts with the member when any unmet needs that have been identified that may need further intervention.
Medicare Supplement Plans

Claims Assignment

For physician providers who accept assignment, Blue Shield pays contract benefits up to Medicare's approved amounts. Patients are responsible for payment of services not approved by Medicare. For physician providers who do not accept assignment, Blue Shield will pay according to the following structure for Medicare Supplement Plans and Group plans:

<table>
<thead>
<tr>
<th>Plan and Group Numbers</th>
<th>Medicare Unassigned Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Benefit Plan A, B, C, D, H, K</td>
<td></td>
</tr>
<tr>
<td>Group #s SAS, SBS, SCS, SDS, SHS, SHR, SKS</td>
<td>Blue Shield pays contract benefits. Patients pay balance of billed charges (limiting charge).*</td>
</tr>
<tr>
<td>Benefit Plan F, I, J</td>
<td></td>
</tr>
<tr>
<td>SFS, SIS, SIR, SJS</td>
<td>Blue Shield pays 100% of the difference between Medicare's payment and billed charges.</td>
</tr>
<tr>
<td>Benefit Plan G</td>
<td></td>
</tr>
<tr>
<td>Group #s SGS</td>
<td>Blue Shield pays 80% of the difference between Medicare's payment and billed charges. Patients pay balance of billed charges.*</td>
</tr>
<tr>
<td>Golden Coronet Senior</td>
<td></td>
</tr>
<tr>
<td>500915-500918, 520915-520918</td>
<td>Blue Shield pays 80% of the difference between Medicare's payment and billed charges. Patients pay balance of billed charges.*</td>
</tr>
<tr>
<td>Coronet Major Medicare</td>
<td></td>
</tr>
<tr>
<td>500921-500922, 500923-500924</td>
<td>Blue Shield pays contract benefits. Patients pay balance of billed charges.*</td>
</tr>
<tr>
<td>Coronet Senior</td>
<td></td>
</tr>
<tr>
<td>500913-500914, 520913-520914, 500927-500928, 520927-520928, 550913-550914, 550927</td>
<td>Blue Shield pays contract benefits. Patients pay balance of billed charges.*</td>
</tr>
<tr>
<td>Preferred Senior</td>
<td></td>
</tr>
<tr>
<td>PS2901, PS2902, PS2911, PS2912</td>
<td>Blue Shield pays contract benefits. Patients pay balance of billed charges.*</td>
</tr>
</tbody>
</table>

*Not to exceed the Medicare limiting charge or billed charge, whichever is less.

Note: Preferred Senior contracting physicians agree to accept Medicare assignment for Preferred Senior Plan members. Contracting Preferred Senior Anesthesiologists bill the Preferred Senior Plan directly under the Advance Pay System.
The BlueCard® Program

The BlueCard® Program is a national program that enables Blue Cross and Blue Shield (BCBS) Plan members to obtain healthcare services while traveling or living in another Blue Cross and/or Blue Shield Plan’s service area. The program links participating healthcare providers with all the independent Blue Cross and Blue Shield Plans across the country through a single electronic network for claims processing and reimbursement. Additionally, the program links providers in more than 200 countries and territories worldwide.

The BlueCard Program allows providers to conveniently submit claims for members from out-of-state Blue Plans, including international Blue Plans, directly to Blue Shield of California. Blue Shield offers you a one-payer solution for submitting your BlueCard claims, and a point of contact for your claims-related questions, through the convenience of Blue Shield.

For more detailed information about the BlueCard Program, refer to Appendix 5-A of this manual or access the BlueCard Program web page at www.blueshieldca.com/bluecard.

Other Payors

Blue Shield and its affiliates may contract with employers, insurance companies, associations, health plans, health and welfare trusts or organizations, other payors, and administrators (collectively, “Other Payors”) to provide administrative services for plans provided by those entities which are not underwritten by Blue Shield. Such administrative services may include offering access to the physician and provider networks under contract to Blue Shield or its affiliates. In general, Other Payors must meet financial and administrative criteria established by Blue Shield, and their health programs must encourage the use of contracting providers. In the event that Blue Shield is not the underwriter of the health plan, the Other Payor shall be responsible for payment or covered services. Refer to Appendix 5-B for the Other Payor Summary list.

Blue Shield or its affiliates may adopt the policies and procedures of the Other Payors for services rendered for these members. Claims for Other Payors’ members should be sent according to the manuals or the member ID cards, which will generally identify where claims are to be submitted. Providers must look solely to the Other Payor for payment for covered services rendered to Other Payors’ members (except for copays, coinsurance and deductibles which may be collected from members). Payments and allowances will be clearly shown on the Other Payors’ Explanation of Benefits (EOBs).
Mental Health Services

Psychiatric Care

The diagnosis and medically necessary treatment of mental health conditions are a covered benefit for all Blue Shield plans. Severe mental illness and serious emotional disturbances of a child for all commercial members are covered under the same terms and conditions as any medical condition. Blue Shield’s mental health service administrator (MHSA) for commercial PPO members is Human Affairs International of California (HAI-CA). Other psychiatric conditions are also covered through the MHSA.

Members must utilize the Blue Shield MHSA provider network to access psychiatric covered services and receive authorization for these services from the MHSA.

Commercial PPO members should use the Member Self-Referral phone number below to contact Blue Shield’s MHSA to access behavioral health care.

Member Self-Referral Number

Blue Shield members can self-refer to the MHSA by calling the Member Self-Referral Number at (877) 263-9952 to obtain a referral to an appropriate mental health provider and receive an authorization for services and/or crisis intervention services. This phone number is available 24 hours/day; 7 days per week, 365 days a year.

Primary Care Physician Consultation Line

The Blue Shield MHSA offers a Primary Care Physician Consultation Line at (877) 263-9870 to facilitate Personal Care Physician discussion with a Board-Certified psychiatrist regarding mental health and substance abuse issues, prescribing of psychotropic medication and coordination of care issues.

PCP Behavioral Health Toolkit

Primary care physicians and their staff members can access Blue Shield’s new online PCP Behavioral Health Toolkit at any time by visiting blueshieldca.com/provider, selecting the Guidelines & Resources tab, then clicking PCP Behavioral Toolkit under the Patient Care Resources section. The website includes clinical consultation contacts, referral information, screening tools, patient education resources and more to help primary care physicians manage or refer patients to meet behavioral health care needs.

Telebehavioral Health Online Appointments

The Blue Shield MHSA offers real-time, two-way communication via online virtual appointments with a mental health or substance use disorder provider. Appointments are available for counseling services, psychotherapy, and medication management with participating therapists and psychiatrists contracted with Blue Shield’s mental health service administrator (MHSA). To access Telebehavioral health providers, members can visit Find a Doctor on blueshieldca.com. Once on Find a Doctor, click on Mental Health to be directed to Blue Shield’s MHSA website. Enter the required search criteria, hit search and on the next screen click on More Filters, then select Telebehavioral Health from the Specialties drop down list.
Mental Health Services (cont’d.)

Blue Shield MHSA Covered Services for PPO Commercial Plan Members

Blue Shield’s MHSA is responsible for authorizing services and paying claims for the following services:

- In-network professional and institutional psychiatric services.
- Pre-surgical Psychiatric/Psychological evaluations requested by the surgeon.
- Outpatient services for the treatment of mental health diagnoses when provided by a MHSA contracted clinician.
- Electro-convulsive Therapy (ECT) and associated anesthesia.
- Behavioral Health Treatment (BHT) including Applied Behavior Analysis (ABA).
- Inter-facility transports authorized by the MHSA.
- Psychological testing for a psychiatric condition.

For the following other services, please see member’s health plan benefits:

- Outpatient radiology, laboratory, speech therapy, occupational therapy, and physical therapy services associated with a psychiatric diagnosis.
- Medical consultations requested by the MHSA.
- Structured Pain Management Program.
- Nutritional counseling.
- Experimental or investigational treatments.
- Outpatient prescription medications.

Mental Health Services for Self-Funded Accounts (ASO) and the Federal Employee Program (FEP)

Self-Funded Accounts (ASO) and the Federal Employee Program (FEP) use Blue Shield of California’s network of contracted mental health providers. Claims are billed to Blue Shield.

For additional mental health information for ASO and FEP accounts, see the following sections within this manual:

Section 2: Behavioral Health Requirements – FEP PPO and ASO
Section 3: Mental Health and Substance Use Disorder Clinical Management Program for Self-Insured Accounts (ASO)
Section 5: Federal Employee Program (FEP); Mental Health, Substance Abuse, and Behavioral Health Services for FEP
Blue Shield Benefit Programs

Care Management

Shield Support is Blue Shield’s comprehensive, integrated care management program that includes member-focused clinical interventions to optimize health and quality of life. The program offers a personalized, coordinated approach to care, encouraging members to be active participants in the management and improvement of their own health. Through shared decision making and a whole-person approach, the goal is for each member to receive care that is customized to their specific needs and preferences.

The Shield Support experienced care teams include registered nurses, behavioral health clinicians, social workers, dietitians, physicians and pharmacists who provide long and short-term support, including:

- **Case management** for acute, long-term, and high-risk conditions, designed to help members live better with illness, recover from acute conditions, and develop self-management skills
- **Care coordination** services to help members navigate the healthcare system and access care, and to facilitate information sharing among the healthcare team involved in the member’s care

Through skilled interviewing, the care team empowers members to take action and choose their own health goals. A personalized care plan is developed to help ensure that member needs and preferences are known and communicated. The care team maintains frequent contact with members, their caregivers, and providers in order to help assure the provision of safe, appropriate and effective care and provides support by coordinating the wide range of specialized care from numerous providers to help prevent duplicate or unnecessary treatments and tests. The care team also provides coaching on medical conditions as well as behavioral health support and lifestyle modifications for an optimal quality of life.

The Shield Support care team works to prevent readmissions by completing safety risk assessments, discussing follow-up care plans, reconciling medication and facilitating adherence to prescribed treatment plans. Shield Support prepares members in advance for hospital stays, including guided imagery recordings to assist members in preparing for surgery or dealing with other health issues. The program is supported by medical directors who provide clinical direction and oversight to the care team.

Shield Support is designed to allow the member to better manage their medical treatment, their health conditions, and the many related issues that may impact their quality of life.

Member identification for Shield Support is based on our customized predictive risk score. This predictive risk score was developed to optimize outreach to those members who are likely to become high risk and are most likely to benefit from care management support. Additionally, condition specific triggers and utilization patterns are used to identify members for Shield Support.
Care Management (cont’d.)

Members may also be identified from an acute event or hospital admission or discharge. Shield Support encompasses a broad spectrum of interventions for short-term care coordination as well as ongoing complex case management for members with the following conditions or utilization:

- Behavioral health
- Cancer
- Cardiovascular, e.g., Coronary Artery Disease, Heart Failure
- Catastrophic injury
- Diabetes
- Musculoskeletal
- Chronic Pain
- Respiratory, e.g., Asthma, COPD
- End-stage renal disease
- Stroke
- Transgender
- Transplant (solid organ and bone marrow)
- Pre-term infants in the Neonatal Intensive Care Unit (NICU) and post NICU
- Plus: ER utilization, post-discharge from hospital, opioid use, high cost and direct referrals

The following services are offered through the Shield Support program:

- Telephonic coaching from nurses, behavioral health clinicians, social workers and pharmacists
- Home visits (as needed)
- Biometric home monitoring (for some members with diabetes, coronary artery disease, COPD, and heart failure)
- In-person self-management community workshops (for members 18+ years of age)
- Virtual health coaching and cognitive behavioral therapy modules
- Online self-management workshops and educational materials (for members 18+ years of age)

Physician referrals are an important component of Blue Shield’s Care Management Programs and may allow for identification of a member more quickly. Blue Shield providers may refer Blue Shield members to our Care Management Programs by submitting the referral form via secure email to bscliaison@optum.com or fax to (877) 280-0179. To download an electronic copy of the referral form, please visit www.blueshieldca.com/provider/guidelines-resources/patient-care/programs.sp. Each referral will be evaluated for eligibility and appropriateness.
Section 5: Blue Shield Benefit Plans and Programs

Care Management (cont’d.)

In addition to Shield Support, the following discrete Prenatal case management program is offered:

- **Prenatal Program.** This program is designed to improve the quality of care received before and during pregnancy and to reduce the costs associated with high-risk pregnancies, while helping women have healthy pregnancies and healthy babies.

Additional Care Management Programs

The following programs are available to certain Blue Shield members depending on their plan design:

- **Shield Advocate.** The Shield Advocate program provides a designated team of registered nurses to a client's membership to provide a proactive, member-focused approach to navigate the healthcare system, resolve problems, answer health and treatment related questions, provide health counseling, and support coordination of care.

- **Shield Concierge.** Shield Concierge is an integrated service designed to provide a customer-specific, personalized service experience for members covered by Blue Shield. This program strives to improve and expand the member experience by resolving more inquiries during the first contact with the member and proactively identifying services specifically beneficial to the member. A team of professionals consisting of Shield Concierge representatives, registered nurses, social workers, health coaches, pharmacy technicians, and pharmacists provide information to a member regarding benefits, doctors and specialists, coordination of care, case management, and questions on formulary and drug authorizations.

- **Expanded Managed Behavioral Health.** Administered by Blue Shield’s Mental Health Service Administrator (MHSA), the Expanded Managed Behavioral Health program provides a sophisticated approach to managing inpatient and outpatient behavioral health services. The program employs specially trained behavioral health clinicians to assess a member’s situation and direct him/her to the most appropriate care setting.

- **Landmark Home-Based Care.** The Landmark program offers participating chronically ill members 24/7 access to medical professionals and in-home urgent care. Community-based, physician-led medical teams specializing in house calls and home-based care deliver medically needed services to chronically ill patients. Landmark does not replace patients’ primary care providers but rather supports the work of patients’ existing providers. Landmark clinicians communicate and collaborate with the patients’ PCPs and specialists to reinforce the PCP’s in-office care plan and provide the attention and care that chronically ill patients with complex health needs may require. Blue Shield identifies eligible members for the Landmark program based on their health and the number and type of chronic conditions they have.
Home-Based Palliative Care Program

Blue Shield offers a home-based palliative care program that uses an interdisciplinary team to provide tightly integrated, longitudinal in-home palliative care services as well as the assessment and provision of medical care aligned with the patient’s goals. The program incorporates:

- treatment decision support,
- care plan development and shared decision-making, and
- pain and symptom management.

Services provided under the program include, but are not limited to:

- comprehensive in-home, palliative care needs assessment,
- care plan development aligned with the member’s goals,
- nurse case manager assignment to coordinate medical care,
- home-based palliative care visits - either in person or via videoconferencing,
- medication management and reconciliation,
- psychosocial support for mental, emotional, social and spiritual well-being,
- 24/7 telephonic support,
- caregiver support, and
- transition assistance across care settings (Note: A member remains enrolled in the program during admission to and discharge from any facilities where the member seeks care).

Members do not need to be terminal nor forego curative treatment to qualify for the program. Members most likely to benefit from the program include those in remission, recovering from serious illness or in the late stage of illness; those experiencing documented gaps in care including a decline in health status and/or function; and those using the hospital and/or the emergency room to manage illness/late-stage disease.

Eligibility/Referral

The home-based palliative care program is available to all Blue Shield members except for those covered under a PPO Federal Employee Plan (FEP), a Blue Shield Medicare supplemental insurance plan (Medigap), or those currently enrolled in hospice or who have an illness that is primarily a psychiatric or substance use disorder. Members with one of the following diagnosis categories, among others, are appropriate for the program: cancer, organ failure, stroke, neurodegenerative disease, HIV/AIDS, dementia/Alzheimer’s, frailty or advance age, and/or multiple comorbidities.

Referral to the program can be made in one of three ways: (1) members can self-refer to the program by contacting Blue Shield Member Customer Service at the phone number located on the back of the member ID card, (2) medical care providers can refer members to the program by contacting Blue Shield Provider Customer Service at (800) 541-6652, or (3) Blue Shield case managers can refer members to the program.

Once a referral is made, the member will be screened to determine whether or not the criteria outlined in the Palliative Care Patient Eligibility Screening Tool (see Appendix 2) is met, then the member can decide whether or not to participate in the program. Enrollment in the program does not eliminate nor reduce any covered benefits or services, including home health services.
Wellness and Prevention Programs

Blue Shield offers member-directed health improvement programs. Our mission is to support a member’s access to high quality care and facilitate participation in managing his or her own health. Blue Shield actively encourages providers to become familiar with these programs so they can assist members in learning about and taking advantage of these services. Blue Shield offers the following preventive health and wellness initiatives:

**CareTips Clinical Messaging**

CareTips is a clinical messaging program designed to help improve quality of care and yield cost-of-healthcare savings. Members receive CareTips communications that are based on nationally-recognized clinical practice guidelines and focus on quality improvement topics, many of which are drawn from HEDIS clinical measures. CareTips messages are derived from a systematic analysis of Blue Shield’s medical, pharmacy, and lab claims that identifies potential gaps in care and medication-related issues.

The messages are intended to encourage preventive care and support improvement in treatment outcomes for patients with chronic conditions. We encourage members to bring these communications to their provider for further discussion and possible coaching and follow up.

**Daily Challenge**

Members can take a small step each day on the path to better health with our engaging interactive program, Daily Challenge. Signing up is easy at www.mywellvolution.com. Every day members get an email to perform one simple wellness-related task. The Daily Challenge is mobile; users can receive their challenges via email, SMS text, mobile app, or the web platform. They can earn points, connect with others, and build a support network with friends and family as they explore techniques to improve all areas of their well-being. Taking a confidential Well Being Assessment is easy and helps members focus in the areas of their well-being that they most want to improve.

**Diabetes Prevention Program (DPP)**

The Diabetes Prevention Program helps members who are at risk of type 2 diabetes lose weight and adopt healthy habits. The program includes 16 weekly sessions over the span of six months followed by monthly maintenance sessions during which members learn new ways to eat healthier, increase activity, and manage challenges with help from a personal health coach and small support group. The program is digital or in-person. Members can get started by pre-qualifying at www.solera4me.com/shield.
Wellness and Prevention Programs (cont’d.)

LifeReferrals 24/7SM

A phone call connects members with a team of advisers who can help them with personal, family, and work issues. They’ll be guided to the appropriate professional, depending on their needs. Some of the services offered are:

- **Legal and financial** – Members can connect with a financial adviser on money matters or an attorney on a variety of legal services. Members may be eligible to receive a 60-minute consult at no cost to them.

- **Personal challenges including relationship problems or coping with grief** – Members can talk to a referrals specialist and set up face-to-face sessions with licensed therapists at no cost to them.

- **Work/life resources** – Members can consult with a specialist who can provide useful information and referrals to a wide range of resources, such as educational programs, day care, meal programs, transportation, and more.

The LifeReferrals 24/7 team is available to discuss your patients’ concerns and guide them to possible solutions anytime, day or night, at (800) 985-2405. All of the services and referrals to resources are treated confidentially.

Blue Shield offers information on a broad range of services that help members manage the impact of home, health and career. These include:

- **Adult and Elder Support Services** – Help with aging parents and family, including in-home and long-term care, transportation, and housing.

- **Child and Parenting Support Services** – Resources for meeting parenting challenges, day care, tutoring, pregnancy, adoption, and child development.

- **Family and Relationship Services** – Information to help deal with parent-child conflicts, single parent challenges, and better communication.

- **Lifelong Learning** – Information about schools, classes, and other opportunities for growth.

- **Financial Assistance** – Consultations with financial advisers on money matters.

- **Legal Assistance** – Consultations and discounts on a variety of legal services.

- **Domestic Relocation** – Resources and support for members moving into a new community.
Wellness and Prevention Programs (cont’d.)

NurseHelp 24/7℠

Members can access a registered nurse anytime, day or night, seven days a week, 365 days a year at no cost by phone at (877) 304-0504 or online, www.blueshieldca.com. Experienced nurses are ready to answer questions, listen, and provide members with information that can help them choose the most appropriate level of care for their situation. The nurses are trained to offer callers:

- **Health information** – Better understanding of health concerns and chronic conditions, education about possible treatment options to help patients make informed decisions and suggestions for preparing for doctor appointments.

- **Healthcare assistance** – Guidance in understanding and choosing the most appropriate types of health care such as hospital, urgent care center, doctor visit, or home treatment. Assistance with questions about medical tests, medications and living with chronic conditions.

- **Preventive and self-care measures** – Helpful tips for taking care of minor injuries at home, such as a twisted ankle or a common illness like a cold or the flu.

- **Online nurse help** – One-on-one personal Internet dialogue with a registered nurse 24 hours a day, seven days a week. Members get immediate answers to their general health questions and research assistance. The online nurses can also refer members to health information, resources and member programs on blueshieldca.com.

LifeReferrals 24/7 and NurseHelp 24/7 are designed to complement, not replace, the care you provide to your patients.

**Preventive Health Guidelines**

Blue Shield’s Preventive Health Guidelines are based on nationally recommended guidelines for screening examinations, immunizations, and counseling topics for healthy individuals, as well as for individuals at risk for disease. These guidelines are updated and distributed annually to members via blueshieldca.com. Clinical reference sources include the US Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services, American Academy of Pediatrics, the Advisory Committee on Immunization Practice, and the Health Resources and Services Administration Women’s Preventive Services Guidelines.

Guidelines available in both English and Spanish are located on Provider Connection at blueshieldca.com/provider under Eligibility & Benefits, then Preventive Health Guidelines.
Wellness and Prevention Programs (cont’d.)

Preventive Health Services Policy

Blue Shield has developed a Preventive Health Services Policy as a result of the Affordable Care Act (ACA) of the health reform legislation, adopting United States (US) Preventive Services Task Force (USPSTF) recommendations; the US Department of Health and Human Services, Health Resources and Services Administration (HRSA) recommendations for infants, children, adolescents, and women; immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC); American Academy of Pediatrics/Bright Futures/Recommendations for Pediatric Preventive Healthcare; and additional requirements mandated by the state of California. This policy applies to new and renewing members.

These services, when criteria are met and the primary reason for the visit is preventive care, will be provided under the preventive care services benefits with no cost-sharing to the member when applicable procedure and diagnosis codes are billed together. When a preventive service is provided during a non-preventive visit, the entire visit will be provided under the medical benefit of the member’s plan, and cost-sharing may apply per member benefits.

The Preventive Health Services Policies are located on Provider Connection at blueshieldca.com/provider under Eligibility & Benefits, Preventive Health Guidelines, and then Preventive Benefit Policies.

QuitNet

QuitNet utilizes digital coaching, access to California quit line telephonic counselors, online community support, and complimentary doorstep delivery of nicotine replacement therapy for smokers looking to kick the habit. Member access is available via native app or website and participants are prompted daily via app, text, or email to engage with the platform, community and/or coaches. A number of clinical trials have been published documenting QuitNet’s clinical efficacy.

Walkadoo

Walkadoo provides daily personalized physical activity recommendations via app, text, or email. Utilizing third party fitness trackers (e.g., Fitbit, Jawbone, Misfit) or smartphone step tracking functionality allows Walkadoo to offer customized steps/day prescriptions based upon an individual’s actual physical activity patterns. A recently published trial reflected a significant improvement in steps/day among Walkadoo users compared to controls with particular impact among the high-risk sedentary and low-active populations.
Wellness and Prevention Programs (cont’d.)

Wellness Discount Programs

To make it easier for members to take care of themselves, Blue Shield offers a wide range of member discounts on popular programs that can help them save money while they get healthier, including:

- Weight Watchers – Discounts on monthly subscriptions and at-home kits.
- 24-Hour Fitness – Waived enrollment, processing, and initiation fees, as well as discounted monthly dues.
- ClubSport, and Renaissance ClubSport – Discounts on enrollment and complimentary personal training sessions.
- Alternative Care Discount Program – 25% savings on acupuncture, chiropractic services, and therapeutic massage services from practitioners participating with the ChooseHealthy® program. The program also allows you to get discounts up to 57% on popular products from health and fitness vendors. In addition, members can learn from evidence-based, online health classes and articles offered at no cost.
- LASIK surgery – Discounts on LASIK surgery through QualSight LASIK, and LASIK and PRK surgery through NVISION, Inc.
- Discount Vision Program – Discounts on vision exams, frames and lenses, contacts lenses, and more.

Patient Ally

Patient Ally at http://www.patientally.com is an Internet portal developed by Office Ally that lets Blue Shield providers and members view lab results, order prescription refills, request and schedule appointments, and more.

Providers can easily add this online communication tool to their practice in order to achieve greater levels of efficiency and patient satisfaction. Patient Ally is designed to work easily into providers' daily routines. For more information or to register, visit http://www.officeally.com or call (888) 747-4255.
This page intentionally left blank.
Section 6: Supplemental Direct Contracting HMO
Administrative Procedures and Responsibilities
This page intentionally left blank.
Table of Contents

Overview ........................................................................................................................................................... 1
HMO Practitioner Responsibilities ................................................................................................................... 2
  Role of the Primary Care Physician (PCP) ....................................................................................................... 2
  Prior Authorizations and Referrals .............................................................................................................. 2
  Role of the HMO Specialist .......................................................................................................................... 3
  Standing Specialist Referrals ....................................................................................................................... 3
  Access-to-Care Monitoring for HMO Members ......................................................................................... 3
  Office Review for HMO Providers ................................................................................................................ 4
HMO Member-Related Issues ........................................................................................................................... 5
  Member-Initiated Primary Care Physician Change ...................................................................................... 5
  Provider Requests to Disenroll HMO Members ........................................................................................... 5
Provider Status Changes ................................................................................................................................... 7
  Primary Care Physician Termination Notification Requirements ............................................................. 7
  Specialist/Specialty Group Termination Notification Requirements ....................................................... 8
HMO Claims Submission and Processing ......................................................................................................... 9
  Specialist Claims ........................................................................................................................................... 9
  Access+ SpecialistSM Claims Processing .................................................................................................. 9
This page intentionally left blank.
Overview

The Blue Shield administrative procedures and responsibilities in this section apply specifically to physicians who have contracted directly with Blue Shield HMO for the delivery of care to Blue Shield Access+ HMO® members, Blue Shield Trio HMO members, Blue Shield 65 PlusSM (HMO) members, Added Advantage POS® members (under the HMO option), and other Blue Shield HMO members.

Pursuant to the Blue Shield agreement, providers may be required to provide services directly to HMO members, in the absence of a Blue Shield-contracted HMO IPA or medical group. In the event such services are directly provided, reimbursement for medically-necessary HMO-covered services will be paid on a fee-for-service basis. Blue Shield will make payment at the allowances in effect at the time of service, based on Blue Shield’s medical review allowance policies, as applicable. Blue Shield will notify providers when such a situation occurs.

*Note:* Providers affiliated with a Blue Shield-contracted IPA or medical group, please contact the IPA or medical group administrator for information regarding its internal policies and your responsibilities as a Blue Shield HMO provider. Blue Shield’s HMO IPA/Medical Group Procedures Manual outlines expectations of Blue Shield contracted IPA or medical group network providers.

The Medical Care Solutions Department within Blue Shield’s Health Care Quality and Affordability (HCQA) division is established to provide oversight of the delivery of care to members. The Blue Shield Medical Care Solutions professional staff includes California-licensed physicians and nurses who monitor healthcare services delivered by contracted physicians and providers for timeliness, appropriateness, and quality of care.

Blue Shield’s Medical Care Solutions Department is structured to ensure utilization management (UM) decision-making is based only on the appropriateness of care and service and existence of benefit coverage. The Medical Care Solutions Program ensures that contracting physicians are not penalized for authorizing appropriate medical care. Blue Shield does not specifically reward practitioners or providers or other individuals for issuing denials of coverage or service of care. Medical decisions are made by qualified individuals, without undue influence from management concerned with Blue Shield's fiscal operations. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.
HMO Practitioner Responsibilities

Role of the Primary Care Physician (PCP)

A primary care physician (PCP) is defined as a general practitioner or a board-certified family practitioner, internist, obstetrician/gynecologist or pediatrician. A physician who is not board-certified will be listed as a general practitioner.

For the HMO plan, the PCP plays a critical role in managing and coordinating the care of the member. If a provider is selected as a PCP by a Blue Shield HMO member, the provider must understand the administrative responsibilities providers are required to follow, as well as the specific Blue Shield HMO procedures that apply to and affect HMO members.

Prior Authorizations and Referrals

In the absence of a Blue Shield-contracted IPA or medical group, the primary care physician works directly with Blue Shield’s Medical Care Solutions Department to request prior authorization for specific services (refer to Section 3: Medical Care Solutions for prior authorization details). Providers can submit requests for authorization directly to Blue Shield for inpatient services, outpatient services, home health care/home infusion services, and DME/orthotic services. Simply go to Provider Connection at blueshieldca.com/provider and click on Authorizations. Enter necessary information and a response will appear in the message center advising providers of the status of the authorization request.

Except self-referrals to an OB/GYN or for Access+ Specialist visits, HMO members must obtain a specialty referral from their PCP for all specialty and ancillary services. PCPs may refer to in-network specialists without prior authorization in most cases. Medical necessity review by Blue Shield Medical Care Solutions may be required in certain geographic areas. For a referral to a specialist, the PCP should complete the prior authorization/referral form (see copy in Appendix 6-A). Referrals to specialists not listed in the Blue Shield HMO provider directory require prior authorization.

Note: Blue Shield HMO Provider Directories may be obtained by calling Provider Information & Enrollment, Member Services, or online at blueshieldca.com under Find a Doctor.

An HMO member may self-refer directly to OB/GYN or family practice providers within the same Blue Shield defined network area as her PCP without a referral. However, services provided by an OB/GYN or family practice physician outside of the defined network area will not be covered under the plan.
HMO Provider Responsibilities (cont’d.)

Role of the HMO Specialist

The Blue Shield HMO specialist provides care in coordination with the member’s primary care physician, except in those circumstances in which the HMO member is allowed to directly access a specialist (e.g., the Access+Specialist feature). Refer to Section 5 for details about this feature.

Generally, however, the member requires a referral from his or her PCP to receive care from a specialist.

Standing Specialist Referrals

Blue Shield maintains policies and procedures for standing referrals to specialists for members with a condition or disease, including but not limited to HIV and AIDS that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling. (Standing referral involves more than one appointment with a medical specialist.)

The Department of Managed Health Care (DMHC) issued a definition of an HIV/AIDS specialist which can be accessed at www.dmhc.ca.gov.

This law requires that patients receive a standing referral to an HIV/AIDS specialist when continued care is needed for the patient’s HIV/AIDS condition. When authorizing a standing referral to a specialist for the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, the primary care physician must refer the enrollee to an HIV/AIDS specialist.

Access-to-Care Monitoring for HMO Members

Blue Shield requires that Direct Contracted HMO providers provide access to health care services according to the applicable standards established by Blue Shield, Title 28 CCR 1300.67.2.2, and stipulated under Section 2 of this manual, Service Accessibility Standards.
HMO Provider Responsibilities (cont’d.)

Office Review for HMO Providers

Site Evaluations

In adhering to accreditation standards for quality, Blue Shield requires that the offices of all physicians providing services to HMO members meet office site standards. A site visit that reviews the quality of the office(s) where patient care will be provided is conducted when Blue Shield receives member complaints. Blue Shield staff or a Blue Shield-contracted vendor performs these office site evaluations. Some of the areas covered in the evaluation are physical accessibility (e.g., parking, handicap access), appearance, space adequacy (e.g., seating), medical record organization, record confidentiality (i.e., evidence that records are secured), and appointment availability (by type of care). Follow-up visits at least every six months will be conducted until deficient offices meet office site standards.

Medical Records Keeping Practices for HMO Providers

In alignment with regulatory and accrediting agencies, Blue Shield requires that providers maintain a centralized medical record for each member seen in his or her office and to comply with all applicable confidentiality requirements imposed by both federal and state law. Providers have an obligation to produce medical records to Blue Shield when requested for survey processes, quality improvement, and other provider relations activities.

A medical record keeping practices review, which may be conducted by Blue Shield or a Blue Shield-contracted vendor, looks at the quality, content, organization, and completeness of documentation. To ensure member confidentiality, Blue Shield may review “blinded” medical records or a model instead of the actual record. The review of medical record keeping practices does not have to include clinical elements.
HMO Member-Related Issues

Member-Initiated Primary Care Physician Change

Commercial HMO members may change their primary care physician or designated IPA/medical group by calling Blue Shield’s Member Services Department. These changes are generally effective on the first day of the month following approval of the change by Blue Shield. Members receive an updated Blue Shield identification card that reflects the PCP or designated IPA/medical group change.

Once the PCP or designated IPA/medical group change is effective, all care must be provided or referred by the new PCP or designated IPA/medical group, except for the following:

1. Obstetrician/gynecologist (OB/GYN) services provided to a female member by an OB/GYN or family practice physician in the same IPA/medical group as the new PCP.

2. Services under the self-referral provisions of the Blue Shield Access+ Specialist benefit.

Voluntary IPA/medical group changes are not permitted during the third trimester of pregnancy or while admitted to a hospital. The effective date of the new IPA/medical group will be the first of the month following discharge from the hospital, or when pregnant, following the completion of post-partum care.

Additionally, changing primary care physicians or designating a new IPA/medical group during the course of treatment may interrupt the quality and continuity of care. For this reason, the effective date of the transfer when requested during the course of treatment or during an inpatient hospital stay will be the first of the month following the date it is medically appropriate to transfer the member’s care to the new PCP or designated IPA/medical group, as determined by Blue Shield.

Note: Exceptions must be approved by the Blue Shield HMO Medical Director.

Blue Shield 65 Plus members may change their PCP by calling Blue Shield’s 65 Plus Member Services Department. If they call by the 15th day of the month, the transfer will usually be effective on the first day of the following month.

Provider Requests to Disenroll HMO Members

Blue Shield has established procedures for Blue Shield providers requesting to end their relationship with an HMO member for cause such as disruptive behavior or failure to follow treatment recommendations. Providers may not end a relationship with a member because of the member’s medical condition or the cost and type of care that is required for treatment.

Before requesting disenrollment for cause, providers must counsel the member in writing (via certified mail) about the problem. If the problem persists, providers may request disenrollment by sending all documentation, including the initial counseling letter, to Blue Shield’s Member Services Department.

Note: For Provider requests to transfer or disenroll Blue Shield 65 Plus members, refer to Section 1 of this manual.
HMO Member-Related Issues (cont’d.)

Provider Requests to Disenroll HMO Members (cont’d.)

Upon receipt of the documentation, Blue Shield will review the case and may:

- Decide not to disenroll the member
- Send a second counseling letter to the member
- Transfer the member to another provider
- Disenroll the member from the HMO with 31 days written notice

Providers will receive a written notice of Blue Shield’s decision. When a member is transferred to another provider, the former provider must supply patient records, reports, and other documentation at no charge to Blue Shield, the new provider, or the member.

Providers are required to coordinate care for these members until their request for disenrollment has been reviewed and granted.

Blue Shield retains sole and final authority to review and act upon the requests from providers to transfer or terminate a member. Members will not be transferred against their will or terminated until Blue Shield has carefully reviewed the matter, determined that transfer or termination is appropriate, and confirms that Blue Shield’s internal procedures have been followed.
Provider Status Changes

Primary Care Physician Termination Notification Requirements

If a primary care physician terminates from Blue Shield Commercial HMO, Blue Shield will notify the PCP’s members and reassign them to other PCPs within the Blue Shield Direct Network, or to PCPs who belong to other IPAs or Medical Groups. Blue Shield reserves the right to assign members to primary care physicians with the members' best interests in mind.

Blue Shield has established procedures for providers to ensure that our HMO members (Commercial and Medicare) are provided timely written notification in the event that a Blue Shield HMO primary care physician terminates. This policy and procedure is specific to individual PCP terminations only. The following are requirements for Primary Care Physician Termination Notification:

1. Primary care physicians must provide at least 90 days’ advance written notice of a termination in accordance with Blue Shield’s contractual requirements and the 1997 Balanced Budget Act (for Medicare Advantage members). Notification should include the termination date, reason for termination, terminating PCP’s California license number, and the name and ID number of the PCP you wish the members to be transferred to. Blue Shield will not be able to process the termination request if the required information is not included. Incomplete requests may be returned to the IPA/medical group.

2. Blue Shield provides affected members at least 30 calendar days’ advance written notice of their primary care physician’s termination which aligns with accreditation and regulatory requirements. The letter to the member includes notification of the PCP’s termination, the termination date, their new PCP, and the procedures for selecting another primary care physician by calling Member Services toll-free number.

3. In very limited circumstances (see number 4 below) the primary care physician may be unable to provide advance notice of termination. In such circumstances, Blue Shield must notify the impacted member to expedite a transfer to a new primary care physician.

4. The limited circumstances or exceptions referenced above include:

   - Death
   - Revocation of medical license or Medicare sanction and debarment
   - “Grossly unprofessional conduct, which includes any criminal or fraudulent acts (e.g., allegations of molestation or abuse). This requires investigation by Blue Shield’s Credentialing and Legal Departments before making a final determination.
   - Physician relocation out of the area without adequate notice.
   - The physician is an employee of a medical group and quits effective immediately. As a result, the physician does not have an office available where he/she may treat patients.
   - The physician is an employee of a group and their employment is terminated effective immediately.
Provider Status Changes (cont’d.)

Primary Care Physician Termination Notification Requirements (cont’d.)

5. If a primary care physician is unable to provide Blue Shield with the required 90-day notice of termination due to one of the limited circumstances listed in number 4 above, Provider Relations will provide Blue Shield's Commercial Member Services department with the specific PCP and effective date for automatic assignment of all affected members. Blue Shield's Commercial Membership Department will immediately notify each affected member, in writing, of their PCP’s termination as well as their new PCP assignment and will send the member a new ID card. In instances where a member must access a PCP prior to receiving written notification from Blue Shield of his or her newly assigned PCP, the member is entitled to seek care by self-referring to a PCP within Blue Shield's HMO network (see number 3 of the policy). This does not apply to Blue Shield 65 Plus (HMO) (Medicare Advantage) members.

6. In instances when a Medicare primary care physician terminates immediately, Medicare Member Services or Medicare Membership will attempt to contact each affected member via telephone (if possible) and/or via a member letter using a CMS-approved letter template to explain the situation and facilitate the member’s assignment to a new PCP. During these calls, if any issues are identified that involve continuity of care (e.g., pending referrals, hospitalization, necessary immediate PCP visits, etc.), Medical Care Solutions will be notified. Blue Shield will send the member a new ID card and contact the IPA/medical group to facilitate transfer of all medical records.

Specialist/Specialty Group Termination Notification Requirements

Blue Shield recognizes the importance of timely member notification prior to the termination of a regularly seen specialist or specialty group. In accordance with accreditation standards of the National Committee for Quality Accreditation (NCQA), Blue Shield members are required to receive at least 30 days prior notice of an upcoming physician termination, including specialist or specialty group termination. Blue Shield does not assign members to specialist physicians/specialty groups, but members who have seen specialist still need to be notified of upcoming specialist terminations. The responsibility to notify the member of upcoming specialist terminations rests with Blue Shield and is based on the following requirements:

1. Blue Shield will notify members seen regularly by a specialist or specialty group whose contract is terminated at least 30 days prior to the effective termination date.

2. Ways Blue Shield identifies members seen regularly by a specialist or specialty group may include but are not limited to:
   - Number of visits within a specified time period such as two or more cardiac follow-up visits within one year.
   - Repeated referrals for the same type of care over a specified time period such as four referrals for the treatment of diabetes over a two-year period.
   - Receipt of periodic preventive care by the same specialist or specialty group such as a woman receiving an annual well woman exam by the same OB/GYN.
HMO Claims Submission and Processing

Physicians (primary care physicians and specialists) and other providers who are contracted and notified by Blue Shield to provide services directly to HMO members (i.e., no affiliated IPA/medical group involved) must submit their claims to the appropriate address listed in Appendix 4-F.

Refer to Section 4: Billing for complete instructions on submitting Blue Shield claims.

Specialist Claims

Specialists must receive a referral from the member’s primary care physician to provide services, unless he/she is providing them under the Access+ Specialist feature or other circumstances in which a referral is not required (e.g., self-referral for OB/GYN care by a physician in the same defined network as the PCP).

When submitting a claim, specialists must include the primary care physician name in the referring physician’s box (Form Locator 17a) of the CMS 1500 claim form.

Access+ SpecialistSM Claims Processing

If you have rendered services as an Access+Specialist (refer to Section 5: Blue Shield Health Plans for details about this feature), submit paper claims to Blue Shield at the address below, along with a copy of the Access+ Specialist card (if available), for reimbursement. Also write “Access+” on the claim and indicate that the $30.00 copayment has been collected.

Blue Shield of California
Capitated Services Team
P.O. Box 629012
El Dorado Hills CA 95762-9012
This page intentionally left blank.
Table of Contents

A. Glossary

B. Acknowledgement of Financial Responsibility Form
Access+ Provider Group

A medical group or IPA that participates in the Access+ HMO program. The features of the Access+ Program include Access+ Satisfaction and Access+ Specialist.

Access+ Satisfaction®

A feature of the Access+ HMO program that allows HMO members to provide feedback regarding services received from HMO network physicians and their office staff.

Access+ Specialist℠

A feature of the Access+ HMO program that allows HMO members to self-refer, for an increased copayment, to a specialist within their IPA/medical group for Access+ Specialist services without a referral from their primary care physician.

Access+ Specialist Services

Services covered under the Access+ Specialist option of the Access+ HMO Program.

Activities of Daily Living

Mobility skills required for independence in normal everyday living. Recreational, leisure, or sports activities are not included.

Acute Care

Care rendered in the course of treating an illness, injury or condition that is marked by a sudden onset or abrupt change of status requiring prompt attention. It may include hospitalization, but of limited duration and not expected to last indefinitely. Acute care is in contrast to chronic care. See Chronic Care.

Administrative Services Only (ASO)

ASO accounts are self-funded, where the local plan administers claims on behalf of the account but does not fully underwrite the claims. ASO accounts may have benefit or claims processing requirements that may differ from non-ASO accounts. There may be specific requirements that affect; medical benefits, submission of medical records, Coordination of Benefits or timely filing limitations.

Blue Shield of California receives and prices all local claims, handles all interactions with providers, with the exception of Utilization Management interactions, and makes payment to the local provider.

Advance Directives

Documents signed by a member that explain the member’s wishes concerning a given course of medical care should a situation arise where he/she is unable to make these wishes known. Advance directives must be documented in a prominent place in the medical record for all Blue Shield members 18 years and older.
Glossary

Affordable Care Act

The comprehensive healthcare reform law enacted in March 2010. The law was enacted in two parts. The Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law.

Allowed Amount

The adjudicated claim cost for covered benefits at the contracted rate, including the member’s copayment/co-insurance portion.

Alternate Care Services Provider

Home health care agencies, pharmacy home infusion suppliers, home infusion suppliers and home medical equipment suppliers.

Ambulatory Surgery Center (ASC)

Any ambulatory surgical center that is certified to participate in the Medicare program under Title XVII (42 U.S.C. Sec. 1395 et seq.) of the federal Social Security Act, or any surgical clinic accredited by an accrediting agency as approved by the Licensing Division of the Medical Board of California pursuant to Health and Safety Code Sections 1248.15 and 1248.4. It is also known as a “surgicenter.”

Ancillary Services

Ancillary services are defined as independent clinical laboratory services, durable/home medical equipment and supply services and specialty pharmacy services.

Appeal, Member

A request for Blue Shield’s or Blue Shield’s Life’s reconsideration of an initial determination (either verbal or written) which resulted in the following:

- Complete denial of service, benefit or claim
- Reduction of benefits or claim payment
- Redirection of service or benefits
- Delay of prospective authorization for service or benefits
- Underwriting Investigation Unit (UIU) cancellation of coverage or enrollee underwriting denials

Appeal, Provider

A written statement from a provider disputing the decision to reduce, delay, or deny services or benefits, requesting the original decision is altered or overturned.
AuthAccel

An online authorization request tool available via Blue Shield’s Provider Connection website at www.blueshieldca.com/provider. In addition to options for faxing, calling or requesting authorizations by U.S. mail, AuthAccel presents an option for providers to complete, submit, track status, and receive determinations for medical and pharmacy prior authorizations. Registered users may access the tool in the Authorizations section, after logging into Provider Connection.

When providers submit pharmacy authorization requests via AuthAccel, it is not necessary for them to complete a separate California Prescription Drug Prior Authorization or Step Therapy Exception Request Form (61-211), as the same information is built into the tool.

Authorization

A process required for certain services (e.g., approval to receive care from a provider other than the member’s primary care physician) in order to determine medical necessity. Services without an authorization that require an authorization will be denied.

Balanced Budget Act of 1997 (BBA)

Legislation signed into law by President Clinton in August 1997. This legislation enacts the most significant changes to the Medicare program since its inception 30 years ago.

bcbs.com

Blue Cross and Blue Shield Association’s website, which contains useful information for providers.

Benefits

Covered health care services pursuant to the terms of the member’s health services contract.

Benefit Period (Blue Shield 65 Plus (HMO) Only)

A way of measuring the use of services under Medicare Part A. A benefit period begins on the first day of a Medicare-covered inpatient hospital stay and ends when a member has been out of the hospital (or other facility that primarily provides skilled nursing or rehabilitative services) for 60 consecutive days, including the day of discharge.

BlueCard Access®

A toll-free number – (800) 810-BLUE – for you and members to use to locate healthcare providers in another Blue Plan’s area. This number is useful when you need to refer the patient to a physician or healthcare facility in another location.

BlueCard Eligibility®

A toll-free number – (800) 676-BLUE – for you to verify eligibility, benefits coverage share of cost information, and prior authorizations on patients from other Blue Plans.
Glossary

BlueCard National Doctor and Hospital Finder

http://www.bcbs.com/healthtravel/finder.html

A website you can use to locate healthcare providers in another Blue Cross and/or Blue Shield Plan’s area. This is useful when you need to refer the patient to a physician or healthcare facility in another location. If you find that any information about you, as a provider, is incorrect on the website, please contact Blue Shield Provider Information & Enrollment at (800) 258-3091.

BlueCard PPO

A national program that offers members traveling or living outside of their Blue Cross and/or Blue Shield Plan’s area the PPO level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO provider.

BlueCard PPO Basic

A national program that offers members traveling or living outside of their Blue Cross and/or Blue Shield Plan’s service area the PPO basic level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO Basic provider.

When you see the “PPOB” in a suitcase logo on the front of the member’s Blue Plan ID card, it means the member has selected a PPO plan product from a Blue Cross Blue Shield plan. Since Blue Shield of California does not have a BlueCard PPO Basic network, providers will be reimbursed for covered services in accordance with your PPO contract with Blue Shield of California.

BlueCard PPO Member

A Blue plan patient who carries an ID card with a suitcase symbol containing “PPO” in it. Only members with this identifier can access the benefits of the BlueCard PPO.

BlueCard PPO Network

The network comprising those physicians, hospitals and other healthcare providers PPO members may elect to use to obtain the highest level of PPO benefits.

BlueCard PPO Provider

A doctor, hospital or other healthcare entity enrolled in a network of designated PPO providers.

BlueCard Routing Logic

A streamlined IT solution that Blue Shield of California developed that integrates with a provider’s clearinghouse and/or eligibility and benefits verification vendor’s system to simplify and automate selecting the correct California Blue plan for processing BlueCard claims. The BlueCard routing logic is an alternative to using our Claims Routing Tool on the Blue Shield Provider Connection website.
BlueCard Traditional

A national program that offers members traveling or living outside of their Blue plan’s service area the traditional, or indemnity, level of benefits when they obtain services from a physician or hospital outside of their Blue plan’s service area. These members will carry an ID card featuring an “empty” suitcase logo.

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 throughout this manual.

Blue Shield 65 Plus (HMO) Member

An individual who meets all of the applicable eligibility requirements for membership, has voluntarily elected to enroll in Blue Shield 65 Plus (HMO), has paid any premiums required for initial enrollment to be valid, and whose enrollment in Blue Shield 65 Plus (HMO) has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Blue Shield 65 Plus (HMO) Network

A group of physicians, hospitals, and other healthcare providers that contracts with Blue Shield to provide medical and facility based care to Blue Shield 65 Plus (HMO) members. When the member selects a Primary Care Physician (PCP), he or she is also choosing the hospital and specialty network associated with his/her PCP. This is different than the Access + HMO network.

Blue Shield Global Core®

A program that allows Blue Plan members traveling or living abroad to receive nearly cashless access to covered inpatient hospital care, as well as access to outpatient hospital care and professional services from healthcare providers worldwide. The program also allows members of international Blue Cross and/or Blue Shield Plans to access domestic (U.S.) Blue provider networks.

California Children’s Services (CCS)

California Children’s Services (CCS), formally known as the Crippled Children’s Services, was introduced by the California Legislature in 1927. This program was developed to provide medical treatment and rehabilitation to children who suffer from catastrophic medical conditions. CCS is funded through county, state and federal tax dollars, as well as through some fees paid by the families receiving care. CCS is not a Medi-Cal or Medicare program.

Capitation

A prepaid monthly fee paid to the IPA/medical group for each Blue Shield member in exchange for the provision of comprehensive health care services.

Case Rate

The all-inclusive rate paid, in accordance with the hospital contract Exhibit C, for specified types of care that are paid regardless of the type or defined duration of services provided by the hospital. For specified care/diagnoses, Blue Shield pays the stated Case Rate in lieu of the Per Diem rate.
**Glossary**

**Centers for Medicare & Medicaid Services (CMS)**

An agency within the U.S. Department of Health and Human Services which administers the Medicare Program and with whom Blue Shield has entered into a contract to provide healthcare and Medicare prescription drug coverage to Medicare beneficiaries.

**Chronic Care**

Care (different from acute care) furnished to treat an illness, injury, or condition, which does not require hospitalization (although confinement in a lesser facility might be appropriate), that may be expected to be of long duration without any reasonably predictable date of termination, and which may be marked by a recurrence requiring continuous or periodic care as necessary. See *Acute care*.

**COBRA**

Consolidated Omnibus Budget Reconciliation Act. It provides for the continuation of group health benefits for certain employees and their dependents (applies to groups of 20 or more employees). A member may elect to continue coverage under COBRA if coverage would continue as a result of a “qualifying event”. (A qualifying event may be termination of employment or reduction of hours, etc.)

**Coinsurance**

The percentage amount that a member is required to pay for covered services after meeting any applicable Deductible. Specific coinsurance information is provided in the member’s *Summary of Benefits*.

**Coinsurance (Blue Shield 65 Plus (HMO) Only)**

The percentage of the Blue Shield 65 Plus (HMO) contracted payment rate or Medicare payment rate that a member must pay for certain services.

**Commercial Plans or Programs**

All plans other than Medicare Advantage plans, including, but not limited to, Blue Shield Preferred Plans, Access+ HMO group benefit plans, Access+ HMO Plan for Individuals and Families, HMO POS plans, BlueCard, and government-sponsored programs (i.e., Healthy Families and Major Risk Medical Insurance).

**Consumer Directed Healthcare/Health Plans (CDHC/CDHP)**

Consumer Directed Healthcare (CDHC) is a broad umbrella term that refers to a movement in the healthcare industry to empower members, reduce employer costs and change consumer healthcare purchasing behavior. CDHC plans provide the member with additional information to make an informed and appropriate healthcare decision through the use of member support tools, provider and network information and financial incentives.

**Contracted Provider**

A credentialed health care professional or facility that has a contract with Blue Shield to provide services to members.
Contract Year (Blue Shield 65 Plus (HMO) Only)

The contract year for Medicare beneficiaries begins on April 1st and continues for a 12-month period. Note: the contract year for Group MA-PD members could begin at varying times of the year (for example July 1st or October 1st) and continues for a 12-month period.

Coordination of Benefits (COB)

A term used to describe a process to determine carrier responsibility when a member is covered by two or more group health plans. One of the carriers is considered the primary carrier and its benefits are paid first. Any balance is then processed by the secondary carrier, up to the limit of its contractual liability.

Copayment

The fixed dollar amount that a member is required to pay for covered services after meeting any applicable deductible. Specific copayment information is provided in the member’s Evidence of Coverage or Summary of Benefits.

Cosmetic Procedure

Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic within the broad range of normal, but which is considered unpleasing or unsightly.

Covered Services

Those services provided to a member pursuant to the terms of a group or individual health services contract and noted in the member’s Evidence of Coverage. Medically necessary health care services, which a member is entitled to receive pursuant to the Health Services Contract and Evidence of Coverage applicable to the member. Except as otherwise noted in the member’s Health Services Contract and Evidence of Coverage, covered services must generally be referred and authorized in conformity with Blue Shield’s Utilization Management programs.

Credentialing

The process in which Blue Shield verifies the evidence of a physician’s education, residency training, clinical capabilities, licenses, references, board certification, state and federal disciplinary sanctions and other components of the physician’s professional abilities and history.

Custodial Care

Care furnished in the home primarily for supervisory care or supportive services, or in a facility primarily to provide room and board (which may or may not include nursing care, training in personal hygiene and other forms of self-care and/or supervisory care by a physician); or care furnished to a member who is mentally or physically disabled, and who is not under specific medical, surgical or psychiatric treatment to reduce the disability to the extent necessary to enable the patient to live outside an institution providing such care; or when despite such treatment, there is no reasonably likelihood that the disability will be so reduced.

Delegation

The process by which Blue Shield allows the IPA/medical group to perform certain functions that are considered the responsibility of Blue Shield for the purpose of providing appropriate and timely care for Blue Shield members.
**Dependent (Commercial Only)**

A dependent is an individual who is enrolled and maintains coverage in the Plan, and who meets one of the following eligibility requirements, as:

1. A dependent spouse is an individual who is legally married to the Subscriber, and who is not legally separated from the Subscriber.

2. A Dependent Domestic Partner is an individual who meets the definition of Domestic Partner in the member’s plan.

3. A Dependent child is a child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner, and who is not covered as a Subscriber. A child includes any stepchild, child placed for adoption, or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction. A child is an individual less than 26 years of age (or less than 18 years of age if the child has been enrolled as a result of a court-ordered non-temporary legal guardianship. A child does not include any children of a Dependent child (i.e., grandchildren of the Subscriber, spouse, or Domestic Partner) unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.

4. If coverage for a Dependent child would be terminated because of the attainment of age 26, and the Dependent child is disabled and incapable of self-sustaining employment, benefits for such Dependent child will be continued upon the following conditions:
   
   a. the child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance;
   
   b. the Subscriber, spouse, or Domestic Partner must submit to Blue Shield a Physician's written certification of disability within 60 days from the date of the Employer's or Blue Shield's request; and thereafter, certification of continuing disability and dependency from a physician must be submitted to Blue Shield on the following schedule:
      
      i. within 24 months after the month when the Dependent child’s coverage would otherwise have been terminated; and
      
      ii. annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage for any reason other than attained age.

**Direct Contract**

An executed agreement between Blue Shield and an individual or group of individual providers for the purpose of providing health care services to Blue Shield enrollees.

**Domestic Partner (California Family Code)**

An individual who is personally related to the Subscriber by a registered domestic partnership. Both persons must have filed a Declaration of Domestic Partnership with the California Secretary of State. California state registration is limited to same sex domestic partners and only those opposite sex partners where one partner is at least 62 and eligible for Social Security based on age. The domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State.
Downstream Entity

All participating providers or other entities contracted or subcontracted with the IPA/medical group, including but not limited to individual physicians, ancillary providers, subcontracted administrative services vendors, third party administrators or management companies, as defined by CMS and the Medicare Advantage regulations.

Durable Medical Equipment (DME) 

Equipment designed for repeated use, which is Medically Necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient’s medical condition. Durable Medical Equipment includes wheelchairs, hospital beds, respirators, and other items that the Plan determines are Durable Medical Equipment such as oxygen ostomy and medical supplies.

Durable Power of Attorney

See Advance Directives.

Electronic Claim Submission

Electronic claim submission is the paperless submission of claims generated by computer software that is transmitted electronically to Blue Shield. Claim files are submitted to Blue Shield in the ASC X12 835 5010 format.

Electronic Data Interchange (EDI)

A computer-to-computer exchange of information between businesses. Use of electronic data interchange is considered an industry best-practice to optimize administrative efficiency, lower cost and reduce overall revenue cycle time.

Electronic Funds Transfer (EFT)

EFT is the electronic transfer of claim payments into a designated bank account based on information submitted by the provider. The EFT process is set up to ensure privacy in addition to being quick and efficient.

Electronic Provider Access (EPA)

Electronic Provider Access (EPA) is an online tool giving providers the ability to access out-of-area member’s Blue plan provider websites to request medical authorization and pre-service review. To access the EPA tool, log into Provider Connection at blueshieldca.com/provider and click on Pre-Service Review for Out-of-Area Members within Authorizations section. Choose the Electronic Provider Access option and you will be connected directly to the Blue plan within a secured routing mechanism to begin your request.

Electronic Remittance Advice (ERA)

ERA is an electronic version of an explanation of medical payment in HIPAA-compliant files. ERA files are transmitted to vendors or providers in the ASC X12 835 5010 format.

Eligibility Report

A report of members determined by Blue Shield to be eligible for benefits and for whom Blue Shield providers are compensated.
Emergency Services

Services necessary to screen and stabilize members in cases where an enrollee reasonably believed he/she had an emergency medical or psychiatric condition given the enrollee’s age, personality, education, background and other similar factors.

Employer Group

The organization, firm, or other entity that has at least two employees and who contracts with Blue Shield to arrange health care services for its employees and their dependents.

Essential Community Providers

Healthcare providers that serve predominately low-income, high-risk, special needs and medically-underserved individuals. The Department of Health and Human Services (HHS) proposes to define essential community providers as including only those groups suggested in the ACA, namely those named in section 340B(a)(4) of the Public Health Service Act and in section 197(c)(1)(D)(i)(IV) of the Social Security Act.

Evidence of Coverage and Disclosure

A summary of the Plan’s coverage and general provisions under the health services contract. The Evidence of Coverage includes a description of covered benefits, member cost-sharing, limitations and exclusion.

Exclusions

An item or service that is not covered by Blue Shield as defined in the Evidence of Coverage and Disclosure.

Exclusive Provider Organization (EPO)

An Exclusive Provider Organization (EPO) is a health benefits program in which the member receives no benefits for care obtained outside the network except emergency care and does not include a Primary Care Physician selection. EPO benefit coverage may be delivered via BlueCard PPO and is restricted to services provided by BlueCard PPO providers.

Expedited Appeals

A member, a member representative, or a physician on behalf of the member may request an expedited appeal of a denied prior authorization request because a member is experiencing severe pain or a member’s health or ability to function could be seriously harmed by waiting for a standard appeal decision. Blue Shield will make a decision on an expedited appeal as soon as possible to accommodate the patient’s condition not to exceed 72 hours from receipt of the request.

A request for a 72-hour/fast appeal consideration of a prior authorization request denial in which the health plan determines a member’s health or ability to function could be seriously harmed by waiting for a standard appeal decision. A member, member representative, or physician on behalf of the member may request an expedited appeal.

Expedited Initial Determination

When Blue Shield’s routine decision making process might pose an imminent or serious threat to a member’s health, including, but not limited to severe pain, potential loss of life, limb, or major bodily function, Blue Shield will make a decision on prior authorization requests relating to admissions, continued stays, or other healthcare services, as soon as medically indicated but no longer than 72 hours.
Expedited Review or Decision

The Knox Keene Act requires and provides for an expedited review (initial determination) and appeal process. When a member believes that his/her health and ability to function could be seriously harmed by waiting the 30 days for a standard appeal, he/she may request an expedited review (initial determination) or appeal. NCQA CMS requirements, standards, and Blue Shield require that this request be processed within 72 hours. This request may be filed by the member, his/her representative or his/her physician on behalf of the member.

Experimental/Investigational Treatments

- Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies that are not recognized, in accordance with generally accepted professional medical standards, as being safe and effective for use in the treatment of an illness, injury, or condition

- Any service that requires federal or state agency approval prior to its use, where such approval has not been granted at the time the service or supply was provided

- Services or supplies which themselves are not approved or recognized, in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients

Explanation of Benefits (EOB)

A written statement to members identifying which services rendered are covered and not covered under their health plan. Services that are not covered are the member’s financial responsibility.

External Independent Medical Review (Blue Shield 65 Plus (HMO) Only)

For Blue Shield 65 Plus (HMO) members, CMS has contracted with a national independent review body, MAXIMUS Federal Services, Inc. MAXIMUS Federal Services, Inc. is an independent CMS contractor that reviews appeals by members of Medicare managed care plans, including Blue Shield 65 Plus (HMO).

External Review

An option provided to commercial members for consideration of:

- A medical necessity decision following an appeal;

- An appeal under the Friedman/Knowles Experimental Treatment Act in which care for a member with a terminal illness has been denied on the grounds that the treatment is experimental;

- Where the case is sent to an independent, external review organization for an opinion, which is binding on Blue Shield.
Glossary

Fee-for-Service

A payment system by Medicare. Fee-for-service doctors, hospitals, and other providers are paid for each service performed. For Blue Shield 65 Plus (HMO), this is also known as traditional or original Medicare.

FEP

The Federal Employee Program.

Formulary

A continually updated list of prescription medications that Blue Shield maintains for use under the Outpatient Prescription Drug program. The list is based on evidence-based review of drugs by members of the Blue Shield Pharmacy & Therapeutics Committee. This committee is made up of physicians and pharmacists, including practicing network physicians and pharmacists who are not employees of Blue Shield, many of whom are providers and experts in the diagnosis and treatment of disease. The formulary contains both brand-name, generic and biologic drugs.

Fraud, Waste and Abuse (FWA)

Comprehensive program to detect, correct and prevent fraud, waste and abuse in the Part D benefit.

Grievance

An expression of dissatisfaction by a member, member representative or provider on the member’s behalf, and categorized as a potential quality issue, appeal (see Appeals) or complaint.

Health Maintenance Organization (HMO)

A health care service plan that requires its members to use the services of designated physicians, hospitals or other providers of medical care except in a medical emergency. HMOs have a greater control of utilization and typically use a capitation payment system.

Health Services Contract

The employer group or individual contract that establishes the benefits that subscribers and dependents are entitled to receive.

HIPAA (The Health Insurance Portability and Accountability Act of 1996)

HIPAA is the 1996 federal legislation that changes health coverage requirements in the group and individual markets. It contains provisions regarding portability of health coverage, Administrative Simplification, Medical Savings Accounts (MSAs), and fraud and abuse. The Centers for Medicare & Medicaid Services (CMS), formerly the main regulatory agency responsible for implementing the provisions of HIPAA. The provisions relating to Administrative Simplification were effective in 2002 and 2003. Administrative Simplification is intended to reduce the costs and administrative burdens of health care by establishing national standards (including security) and procedures for electronic storage and transmission of health care information. Administrative Simplification affects health plans, health care providers, and clearinghouses that transmit or collect health information electronically.
HIPAA EDI Validation Report

Blue Shield validates inbound electronic claim files for HIPAA compliance, and produces a report to providers submitting electronic claims. Blue Shield utilizes Edifecs as its HIPAA validator.

Hold Harmless

An agreement with a healthcare provider not to bill the member for any difference between billed charges for covered services (excluding coinsurance) and the amount the healthcare provider has contractually agreed with a Blue plan as full payment for these services.

Home Health Care (HHC)

A comprehensive, medially necessary range of health services provided by a recognized provider organization to a patient at home, usually under the supervision of a physician.

Hospice Care

Care and services provided in a home or facility by a licensed or certified provider that is:

- Designed to be palliative and supportive care to individuals who are terminally ill, and
- Directed and coordinated by medical professionals authorized by the Plan

Hospital

- A licensed and accredited health facility engaged primarily in providing (for compensation from patients) medical, diagnostic, and surgical facilities for the care and treatment of sick and injured members on an inpatient basis, and that provides such facilities under the supervision of a staff of physicians and 24-hour a day nursing services by registered nurses (not including facilities that are principally rest homes, nursing homes, or homes for the aged),
- A psychiatric hospital licensed as a health facility and accredited by the Joint Commission on Accreditation of Healthcare Organizations, or
- A “psychiatric health facility” as defined in Section 1250.2 of the Health and Safety Code.

Hospitalist

A physician who specializes in the care of patients who are hospitalized.

In Area

Refers to services performed within the Blue Shield service area.

Independent Physician and Provider Agreement

A contract between Blue Shield and an individual physician or provider, or a group of individual physicians or providers for the provision of health care services to Blue Shield members.
Glossary

Individual Family Plan (IFP)

A health plan purchased to cover an individual or family, as opposed to a group plan. It differs from a group plan in the following respects: (1) the individual applying for IFP coverage is the contract-holder rather than the employer, (2) underwriting evaluation of a health statement ordinarily is required for everyone to be covered under an IFP contract, and (3) choice of plans is restricted to predetermined benefits.

Infertility

The member who has a current diagnosis of infertility and who is actively trying to conceive and has either:

1) The presence of a demonstrated bodily malfunction recognized by a licensed Doctor of Medicine as a cause of not being able to conceive; or

2) For women age 35 and less, failure to achieve a successful pregnancy (live birth) after 12 months or more of regular unprotected intercourse; or

3) For women over age 35, failure to achieve a successful pregnancy (live birth) after 6 months or more of regular unprotected intercourse; or

4) Failure to achieve a successful pregnancy (live birth) after six cycles of artificial insemination supervised by a physician (The initial six cycles of artificial insemination are not a benefit of this plan); or

5) Three or more pregnancy losses.

Initial Decision/Initial Determination

When a physician group, hospital or Blue Shield makes an initial determination for a requested service or a claim for services rendered.

Inpatient

An individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician.

Interchange Acknowledgment (TA1)

For providers submitting electronic claims, Blue Shield provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Limitations

Refers to services that are covered by Blue Shield but only under certain conditions.
**Lock-In**

A provision for an HMO that requires the member to obtain all medical care through Blue Shield except in the following situations:

- Emergency services, anywhere
- Urgently needed services outside of the service area and (under limited circumstances) inside the service area
- Referrals to non-plan providers or Away-from-Home care

Members that use non-plan providers, except under the conditions mentioned, will be obligated to pay for these services. Neither Blue Shield nor Medicare will pay for these services.

**Marketplace Exchange**

For purposes of this document, the term Marketplace/Exchange refers to the public exchange as established pursuant to the Affordable Care Act (ACA): A transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Affordable Insurance Marketplaces will offer a choice of health plans that meet certain benefits and cost standards.

The ACA allows the opportunity for each state to establish a State-based Marketplace. Recognizing that not all states may elect to establish a State-based Marketplace, the ACA directs the Secretary of HHS to establish and operate a federally-facilitated Marketplace in any state that does not do so, or will not have an operable Marketplace for the 2014 coverage year, as determined in 2013. MAXIMUS Federal Services, Inc. (Blue Shield 65 Plus (HMO) Only).

**MAXIMUS Federal Services, Inc. (Blue Shield 65 Plus (HMO) Only)**

An independent Centers for Medicare & Medicaid Services (CMS) contractor that reviews appeals by members of Medicare managed care plans, including Blue Shield 65 Plus (HMO).

**Maximum Enrollee Out-of-Pocket Costs (Blue Shield 65 Plus (HMO) Only)**

For Blue Shield 65 Plus (HMO) members, the maximum out-of-pocket (MOOP) amount is the most that they will pay during the calendar year for in-network covered Medicare Part A and Part B services. Amounts paid for plan premiums, Medicare Part A and Part B premiums, and prescription drugs do not count toward the maximum out-of-pocket amount. If a Blue Shield 65 Plus (HMO) member reaches this amount, they will not have to pay any out-of-pocket costs for the remainder of the year for covered in-network Part A and Part B services. For specific guidelines on how to submit claims for MOOP electronically, contact the EDI Help Desk at (800) 480-1221.

**Medicaid**

A program designed to assist low-income families in providing healthcare for themselves and their children. It also covers certain individuals who fall below the federal poverty level. Other people who are eligible for Medicaid include low-income children under age 6 and low-income pregnant women. Medicaid is governed by overall Federal guidelines in terms of eligibility, procedures, payment level etc., but states have a broad range of options within those guidelines to customize the program to their needs and/or can apply for specific waivers. State Medicaid programs must be approved by CMS; their daily operations are overseen by the State Department of Health (or similar state agency).
Medically Necessary

Benefits are provided for covered services that are medically necessary. Medically necessary services include only those which have been established as safe and effective and are furnished in accordance with generally accepted professional standards to treat an illness or injury and which, as determined by Blue Shield, are:

- Consistent with Blue Shield medical policy; and,
- Consistent with the symptoms or diagnosis; and,
- Not furnished primarily for the convenience of the patient, the attending physician or other provider; and,
- Furnished at the most appropriate level that can be provided safely and effectively to the patient.

If there are two or more medically necessary services that may provide for the illness, injury, or medical condition, Blue Shield will provide benefits based on the most cost-effective services.

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, the 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 in the following cases:

- For diagnostic studies that could have been provided on an outpatient basis;
- For medical observation or evaluation;
- For personal comfort;
- In a pain management center to treat or cure chronic pain; or
- For 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.

Medicare Advantage Organization (MAO)

A public or private entity that contracts with CMS to offer a Medicare Advantage plan. Blue Shield of California is an MAO that offers Blue Shield 65 Plus (HMO), an MA-PD plan.

Medicare Advantage (MA) Program

Section 4001 of the BBA created the MA Program as a new Part C of Title XVIII of the Social Security Act. On June 19, 1998, the Centers for Medicare & Medicaid Services (CMS), issued the regulation implementing the MA Program required by the BBA. Under this program, eligible individuals may elect to receive Medicare benefits through enrollment in one of an array of private health plan choices beyond the original Medicare program or the plans now available through managed care organizations.

Medicare-Covered Charges

The maximum amounts Medicare will pay for Medicare-covered services.

Medicare Crossover

The Crossover program was established to allow Medicare to transfer Medicare Summary Notice (MSN) information directly to a payor with Medicare’s supplemental insurance company.
Medicare Guidelines

The rules and regulations used by CMS to determine the services that Medicare covers under Part A (Hospital Insurance protection) and Part B (Medical Insurance protection).

Medicare Part D Covered Drug

A Part D covered drug is available only by prescription, approved by the Food and Drug Administration (FDA) (or is a drug described under section 1927(k)(2)(A)(ii) or (iii) of the Act), used and sold in the United States, and used for a medically accepted indication (as defined in section 1927(k)(6) of the Act). A covered Part D drug includes prescription drugs, biological products, insulin as described in specified paragraphs of section 1927(k) of the Act, and vaccines licensed under section 351 of the Public Health Service Act. The definition of a covered Part D drug excludes any drug, biological product, insulin, or vaccine for which as prescribed and dispensed or administered to an individual, payments would be available under Parts A or B of Medicare for that individual. In addition, the definition of a covered Part D drug specifically excludes drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2) of the Act. Medicare Part D excludes fees for drug administration, except for administration fees associated with the administration of a Part D vaccine.

Under Medicare guidelines, some drugs may be covered under Medicare Part B or Medicare Part D depending upon the characteristics of the beneficiary and/or medical use of the drug. Unless otherwise indicated in the Division of Financial Responsibilities, Medicare Part B Covered Services are Group responsibility and Medicare Part D Covered Services are Blue Shield responsibility. Group is delegated for authorization of Medicare Part B drugs. If a drug does not meet LCD Medicare Part B coverage guidelines, Blue Shield will review for potential coverage under Part D, using the LCD Medicare guidelines and Blue Shield prior authorization coverage criteria. An LCD, as established by Section 522 of the Benefits Improvement and Protection Act, is a decision by a fiscal intermediary or carrier whether to cover a particular service on an intermediary-wide or carrier-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the service is reasonable and necessary).

Medicare Supplemental (Medigap)

Medicare Supplemental (Medigap) pays for expenses not covered by Medicare. Medigap is a term for a health insurance policy sold by private insurance companies to fill the “gaps” in original Medicare Plan coverage. Medigap policies help pay some of the healthcare costs that the original Medicare Plan doesn’t cover.

Medigap policies are regulated under federal and state laws and are “standardized.” There may be up to 12 different standardized Medigap policies (Medigap Plans A through L). Each plan, A through L, has a different set of basic and extra benefits. The benefits in any Medigap Plan A through L are the same for any insurance company. Each insurance company decides which Medigap policies it wants to sell.

Most of the Medigap claims are submitted electronically directly from the Medicare intermediary to the member’s Home Plan via Medicare Crossover process.

Medigap does not include Medicare Advantage products, which are a separate program under the Centers for Medicare & Medicaid Services (CMS). Members who have a Medicare Advantage Plan do not typically have a Medigap policy because under Medicare Advantage these policies do not pay any deductibles, copayments or other cost-sharing.
Glossary

Member
An individual, either a subscriber or eligible dependent, who is enrolled and maintains coverage in a Blue Shield Plan under the health services contract. This term also applies to Medicare beneficiaries enrolled in the Blue Shield Medicare Advantage plan or a Blue Shield Medicare prescription drug plan.

National Account
An employer group with employee and/or retiree locations in more than one Blue Plan’s service area.

National Provider Identifier (NPI)
The NPI is a unique 10 digit numeric identification number. The NPI will be issued by CMS to all eligible health care individual practitioners, groups and facilities. The NPI is required on all HIPAA compliant standard electronic transactions.

Non-Covered Services
Health care services that are not benefits under the subscriber’s Evidence of Coverage/Disclosure Form.

Opt-Out
The act of a member seeking care without a referral from the primary care physician. Depending upon with type of HMO plan involved, opt-outs might or might not be covered. If covered, members who opt out are responsible for higher out-of-pocket costs. Also called "self-referral."

Other Party Liability (OPL)
A cost containment program that ensure Blue plans meet their responsibilities efficiently without assuming the monetary obligations of others and without allowing members to profit from illness or accident. OPL includes coordination of benefits, Medicare, Workers’ Compensation, subrogation and no-fault auto insurance.

Out-of-Area Follow-up Care
Out-of-area services which are non-emergent and medically necessary in nature to establish the member’s progress following an initial emergency or urgent service.

Out-of-Pocket Maximum
The highest deductible, copayment and coinsurance amount an individual or family is required to pay for designated covered services each year as indicated in the Summary of Benefits. Charges for services that are not covered and charges in excess of the allowable amount or contracted rate do not accrue to the out-of-pocket maximum.

Note: Members are financially responsible for any services which are not covered by the Plan. This may result in total member payments in excess of the out-of-pocket maximum.

Outpatient
An individual receiving services under the direction of a plan provider but not requiring hospital admission.

Note: For Blue Shield Preferred Plans, a length of stay past midnight is considered an inpatient admission.
Outpatient Facility

A licensed facility, not a physician’s office or a hospital, that provides medical and/or surgical services on an outpatient basis.

Part B Premium (Blue Shield 65 Plus (HMO) Only)

A monthly premium paid (usually deducted from a person’s Social Security check) to cover Part B Premiums for Original Medicare fee-for-service. Members of Blue Shield 65 Plus (HMO) must continue to pay this premium by themselves, Medicaid, or another third party, to receive full coverage and be eligible to join and stay in Blue Shield 65 Plus (HMO).

Part D Premium (Blue Shield 65 Plus (HMO) Only)

Referred to as the Income Related Medicare Adjustment Amount (IRMAA). Beginning in 2011, the Affordable Care Act requires Part D enrollees whose incomes exceed certain thresholds, pay a monthly adjustment amount. This new premium applies to all Medicare beneficiaries, both group and individual, who fall into higher income levels. Like Part B, the premium will usually be deducted from the person’s Social Security check.

Participating Provider

A provider who has contracted with Blue Shield to accept Blue Shield’s payment, plus any applicable Member Deductible, Copayment, Coinsurance, or amounts in excess of specified Benefit maximums, as payment in full for Covered Services provided to Members enrolled in a designated Plan. This definition does not include providers who contract with Blue Shield’s mental health service administrator (MHSA) to provide covered mental health or substance abuse services.

Payor

The entity that accepts the financial risk for the provision of health care services.

Peer Review

A physician review for the purposes of determining the existence of an actual or potential quality of care issue. This review process includes a review of the clinical and administrative information available. It is the evaluation or review of the performance of colleagues by professionals with similar types and degrees of expertise.

Percent of Billed Charges

A payment arrangement under which a provider is reimbursed at a previously agreed upon percentage of the total billed amount, not to include non-benefit items or items previously excepted from the payment arrangement.

Per Diem Rate

A negotiated rate per day for payment of all covered inpatient services provided to a patient in a preferred hospital.
Glossary

**Physician Advisor Review**

A physician review of a utilization management request for prospective, concurrent and/or retrospective reviews for the purpose of determining medical necessity and/or appropriateness of care or services.

**Plan**

The member’s health care service plan, e.g. HMO, PPO, EPO, and POS.

**Plan Hospital**

A hospital licensed under applicable state law contracting with Blue Shield specifically to provide HMO Plan benefits to members.

**Plan Provider**

A provider who has an agreement with Blue Shield to provide covered services to HMO members.

**Plan Specialist**

A physician (M.D. or D.O.) other than a primary care physician, who has an agreement with Blue Shield to provide covered services to HMO members according to an authorized referral by a primary care physician, or according to the Access+ Specialist program, or during a well-woman examination.

**Point-of-Service (POS)**

A type of managed care plan whereby members have the option of choosing to obtain covered medical services from the provider of their choice from a provider within Blue Shield network or from an out-of-network provider, or through their primary care physician who manages their care and refers members to participating hospitals, physicians, and other providers within a select HMO network. POS members who obtain their medical care through their primary care physician receive HMO level benefits. Members who self-refer to in-network or out-of-network providers are subject to applicable deductibles, copayments and coinsurance. Care received from out-of-network providers is covered at the lowest benefit level. When members receive services from out-of-network providers they are financially responsible for the difference between the amount Blue Shield allows for those services and the amount billed by the out-of-network provider. Mental health and substance abuse services are provided at the HMO and PPO non-participating levels of care.

**Pre-Existing Condition**

Any physical and/or mental illness, injury or condition or conditions that existed during the 12 months prior to the effective date of coverage if, during that time, (1) any professional advice or treatment, or any medical supply (including but not limited to prescription drugs or medicines) was obtained for that disability, or (2) there was the existence of symptoms that would cause an ordinarily prudent person to seek diagnosis, care or treatment.

**Preferred Provider Organization (PPO)**

A network of providers (usually physicians, hospitals, and allied health care professionals) that contract with a payor to deliver services to the enrollees of a designated health care service plan. These providers agree to accept the payor’s allowances plus any enrollee coinsurance, copayment, or deductible as payment in full.
Preferred Provider Organization, Basic (PPOB)

A health benefit program that provides a significant financial incentive to members when they obtain services from any physician or hospital designated as a PPO provider and that does not require a primary care physician gatekeeper/referral to access PPO providers. Similar to BlueCard PPO/EPO, this network includes providers specializing in numerous types of care, as well as other provider types, such as Essential Community and Indian Health Service providers where they are available.

Prefix

Three characters preceding the subscriber identification number on the Blue Plan ID cards. The prefix identifies the member’s Blue Plan or national account and is required for routing claims.

Prescription Drug Plan (PDP)

Medicare Part D prescription drug coverage that is offered under a policy, contract or plan that has been approved by the Centers for Medicare & Medicaid Services (CMS) as specified in 42 C.F.R. § 423.272 to offer qualified prescription drug coverage.

Primary Care Physician (PCP)

A general practitioner, board-certified (if not board certified, must at least have completed a two-year residency program) eligible family practitioner, internist, obstetrician/gynecologist or pediatrician who has contracted with Blue Shield to provide Covered Services to members in accordance with their health services contract and the Plan service delivery guidelines.

Primary Care Physician (PCP) Behavioral Health Toolkit

Blue Shield’s new online toolkit designed specifically for primary care providers to help them manage or coordinate their patients’ behavioral health needs. Providers can log into www.blueshieldca.com/provider, select the Guidelines & Resources tab, then click PCP Behavioral Health Toolkit in the Patient Care Resources section to find information for managing a behavioral health condition or making a referral to a behavioral health provider, as well as consultation contact information, patient educational materials, and more.

Provider/Practitioner

A credentialed health care professional or facility that has an agreement with Blue Shield to provide services to members.

Provider Connection


Provider Inquiry

A telephoned or written request from a provider to explain the rationale for a decision to reduce, delay, or deny services or benefits. This inquiry may or may not alter the original decision.
Glossary

Provider Manual

The Blue Shield *Independent Physician and Provider Manual*, which sets forth the operational rules and procedures applicable to Blue Shield physicians and providers and which is amended and updated by Blue Shield at least annually. The Provider Manual shall include the Bylaws and rules, regulations or policies adopted by Blue Shield, including Blue Shield’s payment and medical policies, which may, from time to time, be communicated to physicians and providers.

Prudent Layperson

A non-medically trained individual using reasonable judgement under the circumstances. For emergency services, coverage is provided when a prudent layperson would believe that an emergency situation exists.

Psychiatric Emergency Medical Condition

A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

A) An immediate danger to himself or to herself, or to others.

B) Immediately unable to provide for, or utilize, food, shelter, or clothing due to the mental disorder.

Qualified Health Plan (QHP)

Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.

Quality Improvement Organization (QIO)

A group of health quality experts, clinicians, and consumers organized to improve the care delivered to people with Medicare. QIOs work under the direction of the Centers for Medicare & Medicaid Services (CMS) to assist Medicare providers with quality improvement and to review quality concerns for the protection of beneficiaries and the Medicare Trust Fund. Formerly known as a Peer Review Organization (PRO). Health Services Advisory Group (HSAG) is the QIO for California.

Referral

The process by which a provider refers a member to another provider for covered services.

Referred Services

A covered health service, performed by a referred-to provider, that is:

- Authorized in advance by the primary care physician and/or the IPA/medical group
- Limited in scope, duration or number of services, as authorized

Referred-To Provider

A provider to whom a member is referred for services.
Rehabilitation Service

Inpatient or outpatient care furnished to an individual disabled by injury or illness, including Severe Mental Illness and Severe Emotional Disturbances of a Child, to restore an individual’s ability to function to the maximum extent practical. Rehabilitation services may consist of Physical Therapy, Occupational Therapy, and/or Respiratory Therapy.

Residential Care

Mental Health or Substance Abuse services provided in a facility or a free-standing residential treatment center that provides overnight/extended-stay services for members who do not require acute inpatient care.

Secure File Transfer Protocol (SFTP)

A service (communication protocol) specially designed to establish a connection to a particular computer, so that files can be securely transferred between computers. This protocol encrypts the data transferred to the receiving computer and prevents unauthorized access during the operation.

Service Area (Blue Shield 65 Plus (HMO))

The geographic area in which a person must permanently reside in to be able to become or remain a member of a Blue Shield 65 Plus plan. Blue Shield 65 Plus has multiple service areas within California. The specific service area in which the member permanently resides determines the Medicare Advantage plan(s) in which they may enroll. More than one Blue Shield Medicare Advantage plan may be offered in a service area.

Service Area (HMO)

The geographic area as defined in the Blue Shield HMO contract generally considered to be located within a 30-mile radius from the IPA/medical group’s primary care physician facilities.

If members receive care outside their primary care physician’s service area, it must be for an urgent or emergency condition or authorized by their primary care physician. When processing claims and encounters, the zip code of the attending physician (for professional claims) or the billing provider (for facility claims) is compared to the IPA/medical group’s table of zip codes stored in Blue Shield’s system to determine if the claim is for out-of-area services.

Shared Savings Services

Covered services paid by Blue Shield from a budget that is subject to a periodic settlement. Any surplus or deficit from this budget is shared between the IPA/medical group and Blue Shield.

Skilled Nursing Facility (SNF)

A facility with a valid license issued by the California Department of Public Health as a “Skilled Nursing Facility” or any similar institution licensed under the laws of any other state, territory, or foreign country. Also included is a Skilled Nursing Unit within a Hospital.
State Children’s Health Insurance Program (SCHIP)

SCHIP is a public program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children. The program was designed with the intent to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid. States are given flexibility in designing their SCHIP eligibility requirements and policies within broad federal guidelines. Some states have received authority through waivers of statutory provisions to use SCHIP funds to cover the parents of children receiving benefits from both SCHIP and Medicaid, pregnant women, and other adults.

Stop-Loss

A contractual agreement with day or dollar threshold criteria that allows payment beyond the normal case or per-diem rate.

Sub-Acute Care

Skilled nursing or skilled rehabilitative care provided in a hospital or skilled nursing facility to patients who require skilled care such as nursing services; physical, occupational, or speech therapy; a coordinated program of multiple therapies; or who have medical needs that require daily monitoring by a registered nurse. A facility that is primarily a rest home, convalescent facility or home for the aged is not included in this definition.

Subscriber

A group employee or individual who is enrolled in and maintains coverage under the health services contract.

Third Party Liability

A provision of the health services contract that allows recovery of reasonable costs from a third party when a member is injured through the act or omission of a third party.

Traditional Coverage

Traditional coverage is a health benefit plan that provides basic and/or supplemental hospital and medical/surgical benefits (e.g., basic, major medical and add-on riders) designed to cover various services. Such products generally include cost sharing features, such as deductibles, coinsurance or copayments.

Urgent Services (HMO/POS Members)

Those covered services rendered outside of the primary care physician’s service area (other than Emergency Services) which are medically necessary to prevent serious deterioration of a member's health resulting from unforeseen illness, injury or complications of an existing medical condition, for which treatment cannot reasonably be delayed until the member returns to the primary care physician’s service area.

Validation Reports

Blue Shield generates a validation report for electronic submitters of claims and encounters summarizing the number of claims and encounters that have been received and processed.

Waivered Condition

A condition that is excluded from coverage for charges and expenses incurred during the six (6) month period beginning as of the effective date of coverage. A Waivered Condition applies only to a condition for which medical advice, diagnosis, care, or treatment, including prescription drugs, was recommended or received from a licensed health practitioner during the six (6) months immediately preceding the effective date of coverage.
**Member Acknowledgement of Financial Responsibility**

**Provider**, please check one of the following:

- □ Blue Shield has indicated that the services listed are not covered under your benefit plan.
- □ Your benefits have not been verified. In the event that Blue Shield determines that the services listed are not covered under your benefit plan, you will be responsible for the cost of that service.

**Provider:** This form must be used for Blue Shield members who wish to receive healthcare services from you that may not be covered by their Blue Shield Benefit Plan. Acknowledgement of responsibility must include specific information regarding date of service, services provided and billed amounts.

**Member:** Your signature on this form acknowledges that you agree to bear full financial responsibility for all services provided as listed below if:

- The services are not covered under your Blue Shield Benefit Plan, or
- The services have not been otherwise approved for payment by Blue Shield.

**Service Description:**

(Any service not described as a covered benefit in the member’s Evidence of Coverage.)

---

**Date of Service:**

**Billed Amount:**

**Member or Member’s Legal Representative Name (Please Print)**

**Member or Member’s Legal Representative Signature**

**Date**

**Provider or Provider’s Representative Name (Please Print)**

**Provider or Provider’s Representative Signature**

**Date**

**QUESTIONS?**

Blue Shield Provider Customer Service: **(800) 541-6652**

Blue Shield Provider Information & Enrollment: **(800) 258-3091**
# Table of Contents

A. Blue Shield Bylaws  
B. Blue Shield Home Care Referral Form  
C. NCP Guidelines for Palliative Care  
D. Palliative Care Patient Eligibility Screening Tool
CALIFORNIA PHYSICIANS' SERVICE

Blue Shield of California

bylaws

revised January 1, 2016
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Preamble</td>
<td>1</td>
</tr>
<tr>
<td>CHAPTER 1. PURPOSES</td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>CHAPTER 2. MEMBERSHIP</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Section 1. Classification of Members</td>
<td>2</td>
</tr>
<tr>
<td>CHAPTER 3. PHYSICIAN MEMBERS</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Section 1. Physician Members</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Section 2. Termination of Physician Member</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Section 3. Fair Procedure</td>
<td>3</td>
</tr>
<tr>
<td>CHAPTER 4. BENEFICIARY MEMBERS</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Section 1. Beneficiary Members</td>
<td>3</td>
</tr>
<tr>
<td>CHAPTER 5. BOARD OF DIRECTORS</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Section 1. Corporate Powers Vested in Board of Directors</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Section 2. Terms of Office</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Section 3. Nomination and Election of Directors</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Section 4. Vacancies</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Section 5. Removal From Office</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Section 6. Powers of the Board</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Section 7. Duties of the Board</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Section 8. Fees and Compensation</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Section 9. Meetings of the Board</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Section 10. Physician Directors</td>
<td>5</td>
</tr>
<tr>
<td>CHAPTER 6. OFFICERS AND TECHNICAL ADVISORS</td>
<td></td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Section 1. Officers</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Section 2. Election of Officers</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Section 3. Vacancies</td>
<td>6</td>
</tr>
</tbody>
</table>
CHAPTER 7. DUTIES OF OFFICERS ........................................................................................................ 6
  Section 1. Chairperson of the Board ....................................................................................... 6
  Section 2. Chief Executive Officer ....................................................................................... 7

CHAPTER 8. EXECUTIVE AND OTHER COMMITTEES ESTABLISHED .......................................... 8
  Section 1. Executive Committee .......................................................................................... 8
  Section 2. Nominating and Corporate Governance Committee ............................................ 8
  Section 3. Other Committees ............................................................................................. 8
  Section 4. Committee Chair ............................................................................................... 8

CHAPTER 9. ARRANGEMENTS FOR SUBSCRIBERS AND ENROLLEES, AND PUBLIC POLICY PARTICIPATION ........................................... 8
  Section 1. Definitions .......................................................................................................... 8
  Section 2. Entering Agreements ......................................................................................... 9
  Section 3. Public Policy Participation ............................................................................... 9

CHAPTER 10. PAYMENT FOR SERVICES OF PHYSICIAN MEMBERS AND OTHERS ..................... 9
  Section 1. Payment to Physician Members ....................................................................... 9
  Section 2. Compensation .................................................................................................... 9
  Section 3. Surcharges Prohibited ...................................................................................... 10
  Section 4. Continuation of Services ............................................................................... 10
  Section 5. Compliance ...................................................................................................... 10

CHAPTER 11. FUNDS .................................................................................................................. 10
  Section 1. Investment of Funds ......................................................................................... 10

CHAPTER 12. MISCELLANEOUS ................................................................................................. 10
  Section 1. Business to be Conducted Without Profit ......................................................... 10
  Section 2. Use of Income: Salaries May Be Paid to Officers and Employees .................... 11
  Section 3. Distribution of Assets on Dissolution ................................................................. 11
  Section 4. Principal Offices ............................................................................................... 11
  Section 5. Other Offices ................................................................................................... 11
  Section 6. Seal ................................................................................................................... 11
  Section 7. Indemnification ................................................................................................. 11
CHAPTER 13. AMENDMENTS

Section 1. Power of the Board.
Preamble

California Physicians’ Service was established as a non-profit corporation on February 2, 1939, to provide not only leadership in the maintenance of high standards of medical service, but also in the means of distribution of that service so that all who need care may receive it. Recognizing that the very advances made by modern science have greatly increased the cost of good health care services and will continue to increase that cost as new methods and equipment for diagnosis and treatment are discovered and perfected; and, therefore, that the cost of always unpredictable injury or illness is a financial catastrophe too great to be borne by the few citizens of California thus always inflicted at any given time, although the total cost over any period is within the means of the total group; this corporation was established as a method to distribute this cost of medical service so as to relieve the intolerable financial burden heretofore falling on the unfortunate few in any given period of time. This voluntary medical service plan was established to enable the people of the State of California to obtain prompt and adequate health care services whenever needed on a periodic budgeting basis without injury to the standards of medical service, without disruption of the proper physician-patient relation and without profit to any agency, assuring that all payments made by patients except administrative costs will be utilized for health care services and not otherwise, in an efficient, coordinated and organized service which can, upon the same fundamental basis, be the means which governmental agencies -- federal, state, and local -- may use to provide, at the lowest possible cost to the taxpayer, good health care services.

CHAPTER 1. PURPOSES

The purposes of this corporation are:

1. The establishment and maintenance of a fund obtained by means of periodic payments on behalf of its beneficiary members, to be used to defray the costs of medical services, hospital care and other health services and facilities or medical service and hospital care alone or in conjunction with other health services and facilities.

2. To furnish and supply to those persons eligible for and admitted to beneficiary membership herein, hospital and nursing service at the lowest cost consistent with due and adequate care on a periodic payment plan, in hospitals now or hereafter organized or established in the State of California, whose organization and management evidence that they are qualified to render and are actually rendering economic and efficient hospital care to the sick and injured.
3. To enter into, make, perform and carry out contracts for the performance of medical services or for the furnishing of hospital care or both medical services and hospital care or for any other lawful object or purpose with any public or municipal corporation, body politic, the State of California, or any political subdivision of said state, any instrumentality, commission, board, bureau, or other administrative agency of said state, the United States of America, or any department, bureau, commission or other administrative agency thereof, or any corporation incorporated under the laws of the United States or any foreign state.

4. To build, acquire, operate, equip, maintain, lease as lessee or lessor, mortgage, deed in trust, sell, and otherwise dispose of hospitals, laboratories, drugs, medicines, medical and surgical apparatus, instruments and supplies and all other physical means and facilities for the relief, care and treatment of sick and injured persons.

5. And in aid and furtherance of the foregoing purposes, to exercise all powers afforded or permissible under the laws governing this corporation.

CHAPTER 2. MEMBERSHIP

Section 1. Classification of Members. The corporation has no members within the meaning of Section 5056 of the California Corporations Code. The corporation may refer to persons associated with it as "members" even though such persons are not members within the meaning of Section 5056.

CHAPTER 3. PHYSICIAN MEMBERS

Section 1. Physician Members. Physician Members shall be those licensed physicians who, pursuant to written agreement with this corporation, have the privilege of rendering medical services to subscribers or enrollees when chosen to do so by subscribers or enrollees, and who have the right of receiving payment for such services from available funds of the corporation. The term "Physician Member" shall include individuals entering into such written agreements, and individuals who are partners, officers, members or employees of each Physician Group entering into such agreement, including persons affiliating with said Physician Group subsequent to the making of such agreement, when consistent with the terms thereof. Each Physician Member shall be bound by the Bylaws, schedules of compensation for services rendered, and rules and regulations of the corporatons, together with any amendments to such Bylaws, schedules or rules and regulations.
Section 2. Termination of Physician Membership. Physician Membership shall automatically terminate in the event of any suspension or revocation of licensure as a physician in California or for disciplinary cause in any other state, whether or not stayed subject to probation, or a conviction of a felony or other criminal offense relating to practice or fitness as a physician; or in the event of action taken by any federal or state agency administering a program providing health benefits, terminating or restricting the physician's right to participate therein for reasons relating to the physician's professional competence, professional conduct, or for the commission of fraud or criminal conduct. Further, Physician Membership may be terminated, suspended, or restricted in accordance with the provisions of the corporation's written agreement authorizing the Physician Member to provide care to subscribers and enrollees, or for other good cause as the corporation may determine.

Section 3. Fair Procedure. Except when termination of Physician Membership is required pursuant to Section 2 above, the termination, suspension or restriction of Physician Membership for cause relating to the Physician Member's professional competence or professional conduct shall not become final until the corporation has afforded the Physician Member a fair procedure, including notice of the reasons for such action, and a reasonable opportunity to respond thereto. The Corporation nonetheless shall be entitled to take summary action reasonably intended for the protection of subscribers and enrollees.

CHAPTER 4. BENEFICIARY MEMBERS

Section 1. Beneficiary Members. Beneficiary members are the persons enrolled to receive services pursuant to medical service certificate or contract, and are herein otherwise referred to as "enrollees," which may include subscribers. No beneficiary member shall have the right to vote or acquire or hold or possess any property right, or right, title or interest in or to any property or assets of the corporation, nor shall any beneficiary member have any rights or privileges other than as are provided herein.

CHAPTER 5. BOARD OF DIRECTORS

Section 1. Corporate Powers Vested in Board of Directors. The corporate powers of this corporation shall be vested in a board ("the Board") of not more than fifteen (15) nor less than ten (10) Trustees (referred to herein as "Directors"), comprised primarily of persons who reside in the State of California. A majority of the Board shall constitute a quorum for the transaction of business. One Director shall be the Chief Executive Officer of the Corporation while holding office as Chief Executive Officer. One director may be the Chief Operating Officer of the Corporation while holding office as Chief Operating Officer. A majority of the Directors shall be Subscribers who are not physicians or other providers of health care services. The remaining Directors shall be Physician Members, except that two of the remaining Directors may be other providers of health care services.
Section 2. Terms of Office. The Directors elected by the Board at the regular meeting of the Board preceding the annual meeting shall hold office for three years commencing on the first day of the month in which the annual meeting is held, and ending on the last day of the month preceding the month in which the annual meeting is held three years later, unless removed as provided in these Bylaws, and until their successors are elected and/or appointed or the Board elects not to fill such office pursuant to Section 3 hereof. Directors other than the Chief Executive Officer and Chief Operating Officer are ineligible for election to the Board for more than four full terms. A Director elected to serve four full terms shall not be eligible to serve as a Director in the future.

Section 3. Nomination and Election of Directors. At the regular meeting of the Board preceding the annual meeting, the Board shall by resolution fix the exact number of Directors within the maximum and minimum number of directors authorized by these Bylaws, and shall elect a Director to fill each vacancy then existing on the Board. The Board may elect Directors from the slate of nominees presented by the Nominating and Corporate Governance Committee, or nominees presented by other Directors.

At any time other than the regular meeting of the Board preceding the annual meeting, the Board may elect up to two (2) additional Directors who shall hold office commencing upon election and ending on the last day of the month preceding the month in which the next annual meeting is held, unless removed as provided in these Bylaws, and until their successors are elected and/or appointed. Such term shall not be considered a full term for purposes of Section 2 hereof. The size of the Board shall be increased automatically to accommodate any Directors so elected.

Section 4. Vacancies. Vacancies in the Board may be filled by a majority of the remaining Directors, though less than a quorum, or by a sole remaining Director, at any time other than the regular meeting of the Board preceding the annual meeting and each Director so elected shall hold office for the remainder of such term.

Section 5. Removal From Office. Any Director may be removed from office as such by the affirmative vote of three-fourths of the Board at any regular or special meeting of the Board on written notice, setting forth the reasons and grounds therefore, mailed to such Director at his or her last known address at least ten days prior to the date of such meetings. A Director who is absent from three consecutive regular meetings of the Board, without cause, shall automatically forfeit the office of Director. "Cause" includes illness, absence from the state and other grounds acceptable to the Chairperson of the Board.

Section 6. Powers of the Board. The Board shall have full power to control and manage the property and conduct the affairs and business of this corporation and to make rules not inconsistent with the laws of the State of California and these Bylaws for the guidance of the officers and management of the affairs of the corporation.
Section 7. Duties of the Board. It shall be the duty of the Board, in addition to the other duties imposed on them by the law and these Bylaws, to cause to be kept a complete record for all their minutes and acts; to supervise all committees, officers, representatives, agents and employees; to arrange, handle, conduct and maintain all property and assets of the corporation; to invest and re-invest all money, funds and securities of the corporation and to create and conserve a reserve fund for the purpose of protecting the interests of this corporation. The Board shall, in accordance with the exclusive purpose of this corporation to promote social welfare, endeavor to extend services to the fullest extent consistent with prudent management.

Section 8. Fees and Compensation. Directors shall not receive any stated salary for their services as Directors but, by resolution of the Board, expenses of attendance at each meeting, plus a fixed fee for the time devoted to any meeting, may be allowed.

Section 9. Meetings of the Board.

(a) Annual Meeting: The annual meeting of the Board shall be held in the month of November of each year, or at such other time and place as the Board, by resolution, may determine.

(b) Regular and Special Meetings: In addition to the organization meeting, the Board shall meet at the call of the Chairperson of the Board, or in his or her absence, any three Directors, but not less than four times each year.

(c) Notice and Place of Meeting: Regular meetings of the Board may be held at any place within the State of California without notice if the time and place of such meetings are fixed by the Board. Special meetings of the Board shall be held upon four days' notice by first class mail or by forty-eight hours' notice delivered personally or by telephone or telegraph.

(d) Written Consent and Waivers of Notice: When all of the Directors are present at any Directors' meeting, however called or noticed, and sign a written consent thereto on the record of such meeting, or if a majority of the Directors are present, and if those not present sign in writing a waiver of notice of such meeting, whether prior to or after the holding of such meeting, which waiver shall be filed with the Secretary, the transactions of such meeting are as valid as if had at a meeting regularly called and noticed.

Section 10. Physician Directors. No person licensed in the State of California as a physician and surgeon shall be eligible to take office as a Director of this corporation unless such person is a Physician Member of this corporation, and in the event that said membership is terminated for any reason, said person shall automatically forfeit the office of Director.
CHAPTER 6. OFFICERS AND TECHNICAL ADVISORS

Section 1. Officers. The officers of the corporation shall be a Chairperson of the Board, President, two or more Vice Presidents, Secretary, Chief Financial Officer, and such other officers as may be deemed necessary. When the duties do not conflict, one person may hold more than one of these offices except those of President and Secretary.

Section 2. Election of Officers. The Board shall elect a Chairperson of the Board, President, two or more Vice Presidents, Secretary, Chief Financial Officer, and such other officers as may be deemed necessary. The Chairperson of the Board shall be elected at the regular meeting of the Board preceding the annual meeting, for a term of two years with the right of re-election and until his or her successor is elected and appointed unless sooner removed, provided, however, that the Chairperson of the Board shall be eligible to serve for a maximum of two terms. All officers, with the exception of the Chairperson of the Board, shall hold office for one year with the right of re-election, and until their successors are elected and appointed unless sooner removed. Prior to the election of the Chairperson of the Board, the Nominating and Corporate Governance Committee shall seek suggestions for nominees from all Directors for that position. The Committee shall then meet to select one or more nominees for that position. The Board shall elect the Chairperson of the Board from these nominations, and any additional nominees from Board members. The Chairperson of the Board must be a member of the Board, and the other officers may, but need not, be members of the Board. The Board may also appoint such other officers, technical advisors, representatives and agents as it may deem proper. Furthermore, the Chief Executive Officer, or if there is none, the President, may appoint such other officers at or below the level of Vice President, technical advisors, representatives and agents as he or she deems proper. The Board may at any time, and with or without assigning any cause therefore, remove any officer, technical advisor, representative, agent or employee elected or appointed by it or by the Chief Executive Officer or President. The Chief Executive Officer or President may at any time, and with or without assigning any cause therefore, remove any officer, technical advisor, representative, agent or employee appointed by him or her.

Section 3. Vacancies. If the office of any officer becomes vacant, the Board may elect a successor who shall hold office at the pleasure of the Board.

CHAPTER 7. DUTIES OF OFFICERS

Section 1. Chairperson of the Board. The Chairperson of the Board provides leadership to the Board to ensure the full discharge of the Board’s responsibilities, and performs the following specific duties:

1. Chairs meetings of the Board (references in this section to meetings of the Board include regular and special meetings, and executive sessions);
2. Chairs meetings of the Executive Committee;

3. Oversees the scheduling of Board meetings, and works with committee chairs to coordinate the schedule of committee meetings;

4. Takes primary responsibility for creating the agenda for Board meetings, based on input from Directors, and in collaboration with the CEO;

5. Ensures proper flow of information to the Board, reviewing the adequacy and timing of documents prepared by management;

6. Ensures adequate lead time for effective study and discussion by the Board of business under consideration;

7. Helps the Board fulfill the Board’s goals by assigning specific tasks to Board members, as needed;

8. Facilitates discussion among the independent Directors on key issues, both in executive sessions of the Board and outside of Board meetings, as needed;

9. Identifies guidelines for the conduct of the Directors, and ensures that each Director is making a significant contribution;

10. Communicates to each Director the results of that Director’s individual Board performance evaluation;

11. Acts as liaison between the Board and management, including facilitating communication between the CEO and the Board to provide the CEO with useful perspective and insight into Board considerations;

12. Provides a “sounding board” for the CEO and actively assists in the CEO’s leadership and personal development;

13. Provides advice and makes recommendations to the Chair of the Compensation Committee regarding the annual evaluation of the CEO’s performance and establishment of the CEO’s compensation, and communicates the Committee’s decisions on these matters to the CEO;

14. Working with the Nominating and Corporate Governance Committee, ensures proper committee structure, including assignment of members and committee chairs; and

15. Carries out other duties as requested by the Board, depending on need and circumstances
Section 2. Chief Executive Officer. The Chief Executive Officer shall, subject to the control of the Board, have general supervision, direction and control of the business and offices of the corporation. The Chief Executive Officer may, but need not, be the President. The Chief Executive Officer shall be ex-officio a member of all standing committees including the Executive Committee, except the Audit, Executive Compensation, and Nominating and Corporate Governance Committees, shall have the general powers and duties of management usually vested in the Office of Chief Executive Officer of a corporation, and shall have such other powers and duties as may be prescribed by the Board or these Bylaws.

CHAPTER 8. EXECUTIVE AND OTHER COMMITTEES ESTABLISHED

Section 1. Executive Committee. The Board shall appoint an Executive Committee which shall consist of the Chairperson of the Board plus such other members of the Board as it shall determine. Subject to all actions and instructions of the Board, the Executive Committee shall be vested with all the powers of the Board when it is not in session.

Section 2. Nominating and Corporate Governance Committee. The Board shall appoint a Nominating and Corporate Governance Committee composed exclusively of persons who are outside directors. The Nominating and Corporate Governance Committee shall be responsible for advising the Board on corporate governance matters, advising the Board on potential conflicts of interest concerning Directors, developing policies on the size and composition of the Board, developing Board selection criteria, reviewing possible candidates for Board membership, performing Board evaluations, and recommending a slate of nominees for Directors and Officers, and such additional or different responsibilities as the Board may establish by resolution from time to time.

Section 3. Other Committees. The Board may from time to time create other standing and special committees, appoint the members thereof and vest therein such powers and duties as it may deem desirable. If the Board shall create either a Medical Policy Committee or a Finance Committee, the membership thereof shall be not less than three. The Chairperson of the Board may attend and participate in the meetings of any standing or special committee whether or not he or she is a member of the committee (without vote if he or she is not a member of the committee).

Section 4. Committee Chairs. The Board shall appoint the Chairs of all standing and special committees other than the Executive Committee, which shall be chaired by the Chairperson of the Board. Except for the Chair of the Executive Committee, committee Chairs shall serve for a term of one year with the right of re-election, provided, however, that they shall be eligible to serve for a maximum of four terms.
CHAPTER 9. ARRANGEMENTS FOR SUBSCRIBERS AND ENROLLEES, AND PUBLIC POLICY PARTICIPATION

Section 1. (a) "Subscriber" means the person who is responsible for payment to the Corporation for beneficiary membership or whose employment or other status, except for family dependency, is the basis for eligibility for such membership.

(b) "Enrollee" means a person (who may also be a Subscriber) enrolled to be a recipient of services under any agreement by this Corporation to provide such services.

Section 2. The corporation may enter into such arrangements for the provision of health care services to Subscribers and Enrollees as are deemed appropriate, and the privileges and obligations of subscribers and enrollees shall be consistent with the written agreements pertaining thereto.

Section 3. Public Policy Participation. Subscribers and enrollees may participate in establishing corporation public policy affecting their comfort, dignity, and convenience in the receipt of health care services by submitting written recommendations, suggestions or comments identifying the policy issue, together with relevant information. Such policy issues will be included as agenda items for consideration by the Board at least quarterly. The disposition of each such item shall be reflected in the minutes, and the person submitting such item for consideration shall be informed of the Board's action within ten business days following approval of the minutes. The Corporation shall take appropriate measures to advise subscribers and enrollees as to the manner in which they may participate in the development of public policy. Such procedures are not intended for the resolution of individual inquiries or complaints, and shall not substitute for appeal procedures or other contractual provisions governing such inquiries and complaints.

CHAPTER 10. PAYMENT FOR SERVICES OF PHYSICIAN MEMBERS AND OTHERS

Section 1. Payment to Physician Members. In accordance with schedules or provisions for compensation adopted by the Corporation, Physician Members shall be paid for medical or surgical services rendered to Subscribers or Enrollees. In the event that available funds of the corporation are insufficient to pay in full for such services, the corporation may withhold from such payments by assessment such amounts as are required for the corporation's solvency and compliance with statutory requisites, until such time as funds are again available to return such monies to the Physician Members. To the extent that this corporation has, by medical service certification or contract, agreed to pay for such medical or surgical services, subscriber members shall not be liable on account thereof to Physician Members. To provide against contingencies, increased demands for services and other unforeseeable burdens, the Board shall withhold a portion of available funds and place same in a Stabilization Reserve.
Section 2. Compensation. Compensation for rendering medical, surgical, or other services shall be determined by the corporation. Schedules or provisions for compensation adopted from time to time by the corporation shall be binding upon all Physician Members, and Physician Members shall have no right, claim or demand against this corporation or Subscribers or Enrollees for any further or additional compensation beyond the sums payable pursuant to the applicable schedule.

Section 3. Surcharges Prohibited. No Physician Member and no participating health care provider shall make any surcharge for covered services, and the levying of any surcharge shall be cause for suspension or expulsion pursuant to Chapter 3, Section 2, or other appropriate action by the corporation.

Section 4. Continuation of Services. In the event that any person ceases to be a Physician Member or participating health care provider, such person shall look solely to this corporation for payment for covered services then being rendered by such person to Subscribers and Enrollees under such person's care, until services then being rendered are completed, so long as it is not reasonable and medically appropriate to obtain such services from a Physician Member or participating health care provider.

Section 5. Compliance. Each Physician Member or other participating provider shall license or register all equipment required to be licensed or registered by law, and all operating personnel for such equipment shall be licensed or certified as required by law. Further, as to the employment and utilization of allied health manpower by Physician Members and other participating providers, employment and utilization shall be consistent with the Knox-Keene Act and good medical practice.¹ Physician Members and all participating providers of health care contracting with this corporation shall maintain such records and provide such information to the corporation or to the Commissioner of Corporations as may be necessary for compliance by the corporation with the provisions of the Knox-Keene Act and the rules thereunder, such records to be retained and to remain available for at least two years regardless of any termination of membership or participating agreement, whether by rescission or otherwise.²

CHAPTER 11. FUNDS

Section 1. Investment of Funds. All funds of this corporation shall be invested in accordance with investment policies adopted from time to time by the Board of Directors or its duly authorized committee. Such investment policies shall be consistent with all applicable laws and regulations.

¹ (Formerly Chapter I, Section 5.)
² (Formerly Chapter XI, Section 8.)
CHAPTER 12. MISCELLANEOUS

Section 1. Business to be Conducted Without Profit. This corporation shall conduct and carry on its business without profit to any of its members. No member of this corporation shall, by reason of membership herein, be or become entitled at any time to receive any assets, property, income or earnings from the corporation or to profit therefrom in any manner. The exclusive purpose of this corporation is the promotion of social welfare with respect to the costs of illness or injury.

Section 2. Use of Income: Salaries May Be Paid to Officers and Employees. All of the income, revenue and earnings of the corporation, unless otherwise limited, shall be held, used, managed, devoted, expended and applied in the discretion and judgment of the Board to carry out the objects and purposes of the corporation and without profit directly or indirectly to any member of the corporation as such; provided, however, that (a) officers, agents and representatives of the corporation who may be selected and appointed from the members or Directors or otherwise may be paid such reasonable salaries or compensation for work done or services performed for the corporation as the Board shall from time to time determine; and (b) Physician Members may receive compensation as hereinbefore provided for medical or surgical services actually rendered to Subscribers or Enrollees.

Section 3. Distribution of Assets on Dissolution. In the event of the dissolution of this corporation, all of its assets and property, after payment and satisfaction and discharge of all claims and demands against and liabilities of the corporation, including claims of beneficiary members for the amount of dues then prepaid and unearned by the corporation, shall first be applied to the repayment of any assessments or monies withheld from Physician Members as yet unpaid, and if the assets and property remaining are insufficient for return in full, a pro rata distribution shall be made. Any assets or property then remaining shall be distributed to the beneficiary members in proportion to the amount of dues contributed by each thereof.

Section 4. Principal Offices. The principal offices for the transaction of the business of the corporation are hereby fixed and located in the City and County of San Francisco, and in the City of Los Angeles, State of California. The Board is hereby granted full power and authority to change said principal offices from one location to another in said counties.

Section 5. Other Offices. Branch or substitute offices may at any time be established by the Board at any place or places where the corporation is qualified to do business.

Section 6. Seal. The corporation shall have a common seal consisting of two concentric circles with the words and figures "CALIFORNIA PHYSICIANS' SERVICE, CALIFORNIA, FEBRUARY 2, 1939" and the caduceus engraved thereon.

Section 7. Indemnification. From and after the adoption of this section (9 September 1959) each Director and officer now or hereafter serving the corporation
(and said person's heirs, executors and administrators), and each person serving on a committee of this corporation and each person serving on the California Physicians' Service Review Committee established by any county medical society in California, shall be indemnified and held harmless by this corporation from and against all costs and expenses which may be imposed upon or reasonably incurred by said person in connection with or resulting from any claim, action, suit or proceeding in which said person may be involved by reason of being or having been a Director or officer or committee member of this corporation or committee member of any such California Physicians' Service Review Committee.

As used herein, the term "costs and expenses" includes but is not limited to attorneys' fees, court costs, and amounts of judgments against and amount paid in settlement by any such Director, officer, committee member or member of any such California Physicians' Service Review Committee, other than amounts paid by the corporation itself.

No one shall be indemnified hereunder with respect to any matter in which it is finally adjudged that the Director, officer or committee member, or member of any California Physicians' Service Review Committee, is liable for misconduct in the performance of his or her duties.

This section shall also apply to medical advisors or consultants retained by the corporation on a full- or part-time basis, and members of the review committees of other professional organizations, while performing claims review functions for and at the request of this corporation.

CHAPTER 13. AMENDMENTS

Section 1. Power of the Board. Any Bylaw may be adopted or these Bylaws may be amended or repealed by the vote or written assent of a majority of the Board.
# Home Care Referral Form

**Date:**

**Recommended program (Click link to access vendor referral email below):**

- Palliative Care
- Meal
- Partners in Care Foundation (PICF)
- Personal Care Services

**Referral Information**

- **Referral Title:**
  - CM Nurse
  - UM Nurse
  - Other
- **First name:**
- **Last name:**
- **Prefix:**
- **Phone number:**
- **Contact Name (if different from referring person):**
- **Email (of referring contact):**

**Member Information**

- **Last Name:**
- **First Name:**
- **Middle Initial:**
- **Gender:**
  - M
  - F
- **Date of Birth (mm/dd/yyyy):**
- **Age:**
- **Member ID:**
- **City:**
- **State:**
- **Zip Code:**
- **Home Phone:**
- **Cell Phone:**
- **Service Facility (if applicable):**
- **Bus Phone:**

**Member Consent (if applicable):**

- **Preferred Language:**
  - English
  - Spanish
  - Chinese
  - Vietnamese
  - Korean
  - Other
- **Power of Attorney (POA):**
  - Yes
  - No

**Care Giver / Alternate Contact Information:**

- **Name:**
- **Relationship:**
- **Cell Phone Number:**
- **Preferred Phone Number:**

**Primary Care Physician Information**

- **Name:**
- **Street Address:**
- **City:**
- **State:**
- **Zip Code:**
- **Bus Phone:**
- **Fax Number:**

**RSC Requesting:**

- **1) Home Visit (Indicate Vendor Program Above):**
  - Post Discharge (All LOBs)
  - All Other (All LOBs)
- **2) Evidence-Based Self-Management Program:**
- **3) Inpatient Facility Visit (In patient at the facilities listed below):**
  - UCLA Ronald Reagan
  - UCLA Santa Monica
  - Other

**Diagnosis Criteria (Check all that apply):**

- Chronic Illness: CHF, DM, COPD
- Acute Illness: Pneumonia, MI, CVA, CAD
- Mental Health: Depression, Substance Abuse
- Cancer
- Dementia - Alzheimer’s
- Post Surgical Procedure
- End Stage Renal Disease (ESRD), Dialysis
- Other

**Other Risk Factors (Check all that apply):**

- LOS > 7 days for most recent admission
- Limited caregiver support / Lives alone
- 2+ hospitalizations or ED visits in past 4 months
- 5-9 medications
- Radiation / chemotherapy / immunotherapy
- Cognitive impairment (Dependent Question below)
- Level of Impairment: □ Mid, □ Moderate, □ Severe
- □ > 2 psychosocial needs
- □ Home safety
- □ Extensive DME needs

**Greatest Need (brief synopsis of request):**
National Consensus Project (NCP) Clinical Practice Guidelines for Quality Palliative Care

Domain 1: Structure and Processes of Care

Guideline 1.1 Criteria

1. Assessment and its documentation are interdisciplinary and coordinated.

2. The interdisciplinary team (IDT) completes an initial comprehensive assessment and subsequent reevaluation through patient and family interviews, review of medical and other available records, discussion with other providers, physical examination and assessment, along with relevant laboratory and/or diagnostic tests or procedures.

3. An initial evaluation includes: the patient’s current medical status; adequacy of diagnosis and treatment consistent with review of past history; diagnosis and treatment; and responses to past treatments.

4. Assessment includes documentation of disease status: diagnoses and prognosis; comorbid medical and psychiatric disorders; physical and psychological symptoms; functional status; social, cultural, and spiritual strengths, values, practices, concerns, and goals; advance care planning concerns, preferences, and documents; and appropriateness of hospice referral. (To view Domains 3-8, visit the National Coalition for Hospice and Palliative Care’s National Consensus Project page.)

5. Assessment of neonates, children and adolescents must be conducted with consideration of age and stage of neurocognitive development.

6. The IDT documents assessment of the patient and family perception and understanding of the serious or life-limiting illness including: patient and family expectations of treatment, goals for care, quality of life, as well as preferences for the type and site of care.

7. Comprehensive assessment identifies the elements of the quality of life. Quality of life is defined by four domains: physical, psychological, social, and spiritual aspects of care. Interventions are focused to alleviate distress in one or any of these domains.

8. The comprehensive assessment recurs on a regular basis and in subsequent intervals, or in response to significant changes in the patient’s status or the patient and family’s goals.
This page intentionally left blank.
Blue Shield members are deemed “Program eligible” when they meet the criteria outlined in this tool.

### Step 1: Chart review (Patient must fulfill all criteria)

<table>
<thead>
<tr>
<th>Patient has an advanced disease/disorder/condition that is known to be life-limiting:</th>
<th>□ Cancer: Locally advanced or metastatic cancer; leukemia or lymphoma</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>□ Congestive heart failure</td>
</tr>
<tr>
<td></td>
<td>□ Chronic obstructive pulmonary disease</td>
</tr>
<tr>
<td></td>
<td>□ Cerebral vascular accident/stroke: Inability to take oral nutrition, change in mental status, history of aspiration or aspiration pneumonia</td>
</tr>
<tr>
<td></td>
<td>□ Chronic kidney disease (CKD) or End Stage Renal Disease (ESRD)</td>
</tr>
<tr>
<td></td>
<td>□ End-stage liver disease (ESLD)</td>
</tr>
<tr>
<td></td>
<td>□ Severe Dementia or Alzheimer’s Disease</td>
</tr>
<tr>
<td></td>
<td>□ Other (fill in): __________________________</td>
</tr>
</tbody>
</table>

The patient meets at least one of four criteria:

| □ One or more ER visits within past 12 months |
| □ One or more hospitalizations within past 12 months |
| □ Hospital readmission within past 30 days |
| □ Current referral prompted by: |
| | o Uncontrolled symptoms related to underlying disease (e.g., pain, shortness of breath, vomiting) AND/OR |
| | o Inadequate home, social, family support |

If above criteria are met, contact (email or phone) the patient’s primary medical providers for coordination on patient, then proceed to Step 2.

### Step 2: Clinical Screening (Patient must fulfill all criteria)

The patient’s PPS rating is <=70%

Click the link to access the Palliative Performance Scale (PPS) tool [npcrc.org/files/news/palliative_performance_scale_PPSv2.pdf](https://npcrc.org/files/news/palliative_performance_scale_PPSv2.pdf)

The patient meets at least two of six criteria:

| □ Decline in function, feeding intolerance, frequent falls, or unintended decline in weight (a.k.a. FTT) |
| □ Complex care requirements: dependent on one or more ADLs, complex home support for ventilator/antibiotics/feedings |
| □ High-risk factors: low health literacy, medication non-adherence, a frequent no-show to outpatient appointments, cognitive impairment |
| □ Would you be surprised if this patient died within one year? |
| □ Patient declined hospice enrollment |
| □ Complex goals of care: conflict among patient/family regarding GOC, patient refusing to engage in GOC/ACP activities |

The patient meets ALL criteria:

| □ The primary diagnosis explaining the above is NOT psychiatric in nature |
| □ The patient is not currently enrolled in hospice |
Table of Contents

A. Clinical Practice Guidelines
Appendix for Section 3

This page intentionally left blank.
Guideline Source Documents

Acute Respiratory Tract Infections

Blue Shield of California has adopted Clinical Practice Guidelines by Alliance Working for Antibiotic Resistance Education (AWARE) which are supplied by the California Medical Association (CMA) Foundation. To see any recent changes or to print copies of these guidelines, go to blueshieldca.com/provider and click on Guidelines & Resources, Guidelines and Standards, and then Clinical Practice Guidelines.

Asthma

Blue Shield of California has adopted Clinical Practice Guidelines supplied by the National Asthma Education and Prevention Program. To see any recent changes or to print copies of these guidelines, go to blueshieldca.com/provider and click on Guidelines & Resources, Guidelines and Standards, and then Clinical Practice Guidelines.

Chronic Obstructive Pulmonary Disease

Blue Shield of California has adopted Clinical Practice Guidelines supplied by GOLD, Global Initiative for Chronic Obstructive Pulmonary Disease. To see any recent changes or to print copies of these guidelines, go to blueshieldca.com/provider and click on Guidelines & Resources, Guidelines and Standards, and then Clinical Practice Guidelines.

Coronary Artery Disease

Blue Shield of California has adopted Clinical Practice Guidelines supplied by the American Heart Association/American and the American College of Cardiology Foundation. To see any recent changes or to print copies of these guidelines, go to blueshieldca.com/provider and click on Guidelines & Resources, Guidelines and Standards, and then Clinical Practice Guidelines.

Depression

Blue Shield of California has adopted Clinical Practice Guidelines supplied by the American Psychiatric Association. To see any recent changes or to print copies of these guidelines, go to blueshieldca.com/provider and click on Guidelines & Resources, Guidelines and Standards, and then Clinical Practice Guidelines.

Diabetes

Blue Shield of California has adopted Clinical Practice Guidelines supplied by the American Diabetes Association. To see any recent changes or to print copies of these guidelines, go to blueshieldca.com/provider and click on Guidelines & Resources, Guidelines and Standards, and then Clinical Practice Guidelines.

Heart Failure

Blue Shield of California has adopted Clinical Practice Guidelines supplied by American College of Cardiology, Heart Failure Society of America, and the American Heart Association. To see any recent changes or to print copies of these guidelines, go to blueshieldca.com/provider and click on Guidelines & Resources, Guidelines and Standards, and then Clinical Practice Guidelines.
Guideline Source Documents (cont’d.)

Preventive Health

Blue Shield of California has adopted Clinical Practice Guidelines supplied by the U.S. Preventive Services Task Force (USPSTF), Advisory Committee on Immunization Practices, Centers for Disease Control and Prevention, and Agency for Healthcare Research and Quality (AHRQ). To see any recent changes or to print copies of these guidelines, go to blueshieldca.com/provider and click on Guidelines & Resources, Guidelines and Standards, and then Clinical Practice Guidelines.

Substance Abuse

Blue Shield of California has adopted Clinical Practice Guidelines supplied by the American Psychiatric Association. To see any recent changes or to print copies of these guidelines, go to blueshieldca.com/provider and click on Guidelines & Resources, Guidelines and Standards, and then Clinical Practice Guidelines.
Table of Contents

A. Special Billing Guidelines and Procedures
B. Electronic Claims Submission
C. Sample CMS 1500 Form
D. CMS 1500 General Instructions
E. Guidelines for Successful ICR Processing
F. Where to Send Claims
G. Blue Shield Payment Processing Logic
H. List of Office-Based Ambulatory Procedures
The following instructions generally apply to both the indicated “Block” on the CMS 1500 claim form and the related “field” of the electronic claim record. If the electronic claim completion procedure differs, it will be explained and marked with a ☐. If you have questions with electronic claim submission, please call or email the Electronic Data Interchange (EDI) Help Desk at (800) 480-1221 or access www.blueshieldca.com/provider/claims/electronic-transactions/submit-edi-inquiry.sp to open an EDI inquiry. You may also visit Provider Connection at blueshieldca.com/provider and click on the Claims section under Enroll in Electronic Data Interchange.

**Block 1 - 8 – Patient Information**

**la. Insured’s ID number.**

Enter the insured subscriber's ID number exactly as it is shown on the Blue Shield Identification (ID) card.

Always include the three-letter alpha-prefix that precedes the identification number on the patient or subscriber's ID card. This will ensure proper eligibility identification of the patient and enable Blue Shield to route out-of-state subscriber claims to the appropriate Blue Cross/Blue Shield Plan.

☐ Consult the system documentation provided by your software vendor to ensure your system can accept and transmit the three-letter alpha prefix in your electronic claims submissions.

**Blocks 9 - 9d – If Blue Shield is the Secondary Payor**

In addition to the information in Blocks 9 – 9d, the following primary insurance information is required for both paper and electronic claims:

- Amount Allowed
- Amount Applied to Deductible, and/or
- Amount Paid.

☐ Blue Shield can accept claims electronically when Blue Shield is the secondary payor. Consult your software documentation or vendor to determine if your software package can support submitting secondary insurance claims.

**Block 10a - 10c – Patient Condition**

☐ Auto or Other Accident (injury) indicator must contain the correct field value in order for Blue Shield to correctly move the Date of Injury from the electronic claim record onto our claims processing system. Consult your software vendor, billing service or clearinghouse to verify they have correctly identified the value for the electronic claim.

**Block 14 – Date of Current Illness, Injury or Pregnancy**

☐ Date of illness, injury or pregnancy is always a required field on your electronic claim record. However, Blue Shield will move the date information from the electronic record to our claims processing system only if the value(s) in Block 10b or 10c indicate the equivalent of "Y" to Auto or Other Accident. If you are experiencing problems in which Blue Shield is requesting the date of injury on your electronic claim, check with your software vendor, billing service or clearinghouse to verify that they correctly identified these values.
Special Billing Guidelines and Procedures

Block 17 – 17b - Referring or Ordering Physician

17. Name of Referring or Ordering Physician or Other Source

Enter as last name, first name.

Note: Physicians rendering services to a Blue Shield POS member who has self-referred must enter the words "self-referral" in this Block for Blue Shield to accurately identify and process the claim under the PPO benefit plan coverage.

Electronic claim record of Referring Physician:
- Last Name Field (Claim Header Record) - Enter “Self-referral”
- First Name Field (Claim Header Record) - Leave Blank

17b. National Provider Identifier (NPI) Number of Referring/Ordering Physician

When possible, enter in this block the NPI of the referring physician. If the NPI is not known, please leave this field blank.

Block 21 - Diagnosis, Sign and Symptom

Enter the diagnosis/condition of the patient by using a current ICD-10-CM code number. Enter up to four 5-digit codes in priority order. The primary diagnosis code must be in the #1 position of Block 21. The secondary diagnosis code must be in the #2 position of Block 21. If more than four codes are listed on a requisition, submit no more than the top four codes.

DO NOT:

1. Use verbal descriptions instead of codes.
2. Truncate ICD-10-CM codes; all codes must be used at their highest level of specificity (assign the fourth or fifth digit sub. classification where it exists to ensure accurate processing).
3. Code in the decimal point.
Blocks 24a - 24j – Detail of Services. Items Rendered

24a. Dates of Service

Enter the month, day and year for each procedure, using the format “MMDDYY.” For non-DME and radiation treatment leave “to” date blank - no date ranging.

**Durable Medical Equipment & Radiation Treatment Dates:** Enter the month, day and year for each procedure, using the format “MMDDYY.” Report all services provided on the same day for the same patient using only one claim form to ensure correct benefit coverage. Date spans on a single line should not cross months. Date spans on a single claim should not cross years.

24d. Procedure, Service or Supply.

Enter the procedure, service, or supply using the most recently published AMA Current Procedural Terminology (CPT) Code or HCFA Common Procedure Coding System (HCPCS) Code. When applicable, also enter the CPT or HCPCS Modifiers and National Drug Code (NDC). Block 24d contains space for up to four modifiers. When more than four modifiers apply, enter Modifier 99 (for multiple modifiers), and then use the "Comments" field (Block 19) to explain the modifiers. When an unlisted procedure is billed (e.g. 43499), a description of the actual service must be provided in Block 19 if electronically-submitted; or, if paper-submitted, the operative report (or radiology, etc.) must be included.

To report bi-lateral procedures the services must be billed on two lines of the submitted claim. For example:

- 19368
- 19368-50

Report anesthesia services using the five-digit American Society of Anesthesiologists (ASA) Coding System, plus the Status Modifier Code (PI through P6). Also submit Anesthesia time in minutes, standard time in Box 24g.

24i. Qualifier for Performing/Rendering Physician and National Provider Identifier (NPI)

Use the shaded area to enter the appropriate qualifier for the non-NPI reported in the shaded area of 24j.

24j. Performing/Rendering Physician Taxonomy Code and National Provider Identifier (NPI)

Enter the provider specialty taxonomy code (in the shaded area) and NPI (in the non-shaded area) for the performing or rendering provider or supplier.

Provider organizations such as medical group practices or clinics must include the rendering provider taxonomy code and the NPI of the rendering provider. Providers who bill as individual practitioners should also include on their claims the rendering provider specialty taxonomy code and the rendering provider NPI.

*Note: Claims from group practices submitted without the performing or rendering taxonomy code in Block 24j will be rejected.*
Blocks 25 - 33 – Physician or Supplier Billing Information

25. Federal Tax ID Number, EIN or SSN

Enter the provider/supplier Federal Tax ID, Employer Identification Number or Social Security Number as it is shown on Blue Shield's Provider File for the PIN assigned to the physician/supplier of services.

31. Signature of Physician or Supplier Including Degrees or Credentials

Enter as last name, first name of treating physician.

32. Service Facility Location Information

Enter as the name and address of the location where services were rendered.

32a. Service Facility Location National Provider Identifier (NPI)

When possible, enter the service facility NPI.

33. Provider’s/Supplier's Billing Name, Address, Zip Code, and Phone Number

Enter the name, address and telephone number to identify the practice location from which the claim is submitted.

33a. Provider’s/Supplier's Billing Name National Provider Identifier (NPI)

Enter the billing provider/supplier’s NPI.

33b. Rendering Provider’s Specialty Taxonomy Code

Enter the taxonomy code of the rendering provider’s specialty.
Additional Claims Submission Pointers

To expedite the processing of your claims, here are some additional claims submission pointers:

- When billing for drugs, supplies and equipment, use HCPCS codes. Drug codes also require the NDC be submitted.
- Use the most current ICD-10-CM for coding all diagnoses, including mental disorders.
- Identify diagnoses as precisely as possible. To expedite claim processing, always use four-digit codes, unless there is none in the particular coding category, and add a fifth digit sub-classification code whenever one exists.
- To ensure proper eligibility, obtain a copy of the Subscriber's Blue Shield ID card to verify the correct subscriber name, number and employer group information. You may visit Provider Connection at blueshieldca.com/provider for up-to-date eligibility verification.
- For correct benefit consideration, report same-day services for the same patient on the same claim. If services exceed more than six detail lines, use separate forms. In order to ensure that multiple forms are processed as a single claim, enter “continued” or “Page 1 of 2” in the Total Charges field.
- Blue Shield's processing system allows up to a maximum of 20 detail lines per electronic professional claims.
- Hospitals must submit professional services by professional electronic claim format or on a CMS 1500 claim form. You may no longer bill these services under revenue codes using the hospital's facility NPI on a UB 04 (or successor) claim form. All Blue Shield hospitals must establish a professional NPI to bill for these services.
- Claims for ancillary services (clinical lab, specialty pharmacy and DME/HME) may require additional location information in order to determine the local plan.

For EDI claims:
- Loop 2310 837P Referring Provider segment with the NPI in the NM109
- Loop 2420E 837P Ordering Provider Segments with the NPI in the NM109 including the N3 and N4 address segments if applicable

For CMS 1500:
- Block 5 Enter patient’s complete current address and telephone number.
- Block 17-17a Enter name and NPI of the referring physician.
  
  Note: When submitting claims for a Blue Shield POS member who has self-referred, enter the words “self-referral.”
- Block 24b For DME/HME claims, address where the items were shipped, rented, or purchased at a retail store.
- Block 32 – 32a For clinical lab claims, enter the location where the specimen was drawn if different from the billing address. For DME/HME claims, address where the items were shipped, rented, or purchased at a retail store.
Additional Claims Submission Pointers (cont’d.)

Blue Shield may require additional documentation to complete the processing of a claim. The documentation should be complete and legible. Types of documentation may include but are not limited to:

1. Operative Reports
2. Emergency Room Reports
3. Consultant Reports
4. Test Records
5. Facility Records
6. NIA Authorization

On claims for which you normally include more detailed information on the claim line, please contact the EDI Help Desk at (800) 480-1221 to confirm where this information would go in the electronic format.

Ambulance Claims

Ambulance claims that do not have a medical record attached are required to be submitted electronically. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected.

Include the additional coding requirements from the ambulance claim guidelines below so claims can be processed accurately. For more information, complete EDI Companion Guides are available on Provider Connection at blueshieldca.com/provider in the Claims section. Call the EDI Help Desk at (800) 480-1221 or email EDI_BSC@blueshieldca.com with any questions.

<table>
<thead>
<tr>
<th>Page Number</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>170</td>
<td>2300</td>
<td>CLM</td>
<td>Claim Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>172</td>
<td>2300</td>
<td>CLM05</td>
<td>Health Care Service Location Indicator (Place of Service)</td>
<td>41 - land 42 - water</td>
<td>Use for ‘type of transport.’</td>
</tr>
<tr>
<td>227</td>
<td>2300</td>
<td>REF</td>
<td>Prior Authorization or Referral Number</td>
<td></td>
<td></td>
</tr>
<tr>
<td>227</td>
<td>2300</td>
<td>REF01</td>
<td>Reference Identification Qualifier</td>
<td>G1</td>
<td>Prior authorization qualifier</td>
</tr>
<tr>
<td></td>
<td>2300</td>
<td>REF02</td>
<td>Prior Authorization or Referral Number</td>
<td></td>
<td>911 plus any free form comments/ information up to 26 characters</td>
</tr>
<tr>
<td>246</td>
<td>2300</td>
<td>NTE02</td>
<td>Description</td>
<td></td>
<td>Report location to which patient was transported. Include facility name, city and zip code.</td>
</tr>
<tr>
<td>247</td>
<td>2300</td>
<td>NTE01</td>
<td>Note Reference Code</td>
<td>ADD</td>
<td>Use in conjunction with NTE02 to identify the purpose of the notes in NTE02</td>
</tr>
<tr>
<td>248</td>
<td>2300</td>
<td>CR</td>
<td>Ambulance Transport Information</td>
<td>I, R, T, X</td>
<td>Use for ‘transport information.’ All values are accepted.</td>
</tr>
<tr>
<td>249</td>
<td>2300</td>
<td>CR103</td>
<td>Ambulance Transport Code</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Page Number</td>
<td>Loop ID</td>
<td>Reference</td>
<td>Name</td>
<td>Codes</td>
<td>Notes/Comments</td>
</tr>
<tr>
<td>-------------</td>
<td>---------</td>
<td>-----------</td>
<td>-----------------------</td>
<td>-------</td>
<td>---------------------------------------------------------</td>
</tr>
<tr>
<td>250</td>
<td>2300</td>
<td>CR106</td>
<td>Quantity</td>
<td></td>
<td>Use to report transport distance.</td>
</tr>
<tr>
<td>250</td>
<td>2300</td>
<td>CR109</td>
<td>Description</td>
<td></td>
<td>Free format field. Use to clarify the purpose for the round-trip service.</td>
</tr>
<tr>
<td>250</td>
<td>2300</td>
<td>CR110</td>
<td>Description</td>
<td></td>
<td>Free format field. Use to clarify details regarding use of a stretcher during service.</td>
</tr>
<tr>
<td>303</td>
<td>2310D</td>
<td>NM1</td>
<td>Service facility location</td>
<td></td>
<td></td>
</tr>
<tr>
<td>304</td>
<td>2310D</td>
<td>NM101</td>
<td>Entity identifier code</td>
<td>77</td>
<td>Service location. Qualifies patient pick-up location.</td>
</tr>
<tr>
<td>304</td>
<td>2310D</td>
<td>NM102</td>
<td>Entity Type qualifier</td>
<td>2</td>
<td>Non-person entity qualifier</td>
</tr>
<tr>
<td>304</td>
<td>2310D</td>
<td>NM103</td>
<td>Organization name</td>
<td></td>
<td>Name of location where patient was picked-up, e.g., RESIDENCE (up to 35 characters).</td>
</tr>
<tr>
<td>307</td>
<td>2310D</td>
<td>N3</td>
<td>Service facility location address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>307</td>
<td>2310D</td>
<td>N301</td>
<td>Address Information</td>
<td></td>
<td>Address of location where patient was picked up</td>
</tr>
<tr>
<td>308</td>
<td>2310D</td>
<td>N4</td>
<td>Service facility location city/state/zip code</td>
<td></td>
<td></td>
</tr>
<tr>
<td>308</td>
<td>2310D</td>
<td>N401</td>
<td>City</td>
<td></td>
<td>City in which patient was picked up</td>
</tr>
<tr>
<td>309</td>
<td>2310D</td>
<td>N402</td>
<td>State</td>
<td></td>
<td>State in which patient was picked up</td>
</tr>
<tr>
<td>309</td>
<td>2310D</td>
<td>N403</td>
<td>Zip Code</td>
<td></td>
<td>Zip code of location where patient was picked up</td>
</tr>
<tr>
<td>400</td>
<td>2400</td>
<td>SV1</td>
<td>Professional Service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>404</td>
<td>2400</td>
<td>SV105</td>
<td>Place of Service</td>
<td></td>
<td>Line level place of service value</td>
</tr>
<tr>
<td>412</td>
<td>2400</td>
<td>CR1</td>
<td>Ambulance Transport Information</td>
<td></td>
<td></td>
</tr>
<tr>
<td>488</td>
<td>2400</td>
<td>NTE</td>
<td>Line Note</td>
<td></td>
<td></td>
</tr>
<tr>
<td>488</td>
<td>2400</td>
<td>NTE01</td>
<td>Note Reference Code</td>
<td>ADD</td>
<td>Use in conjunction with NTE02 to identify the purpose of the notes in NTE02.</td>
</tr>
<tr>
<td>488</td>
<td>2400</td>
<td>NTE02</td>
<td></td>
<td></td>
<td>Free format field. Use for any additional comments.</td>
</tr>
</tbody>
</table>
**Drug Requirements - 837 Professional Claims**

Home infusion services and drug claims that do not have a medical record attached are required to be submitted electronically. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected.

Please use the following guidelines:

- Report the appropriate J code in the service line of the claim (loop 2400 SV101-1).
- Report date of service in the service line (loop 2400 DTP03).
- Report name of drug in service line notes (loop 2400 NTE-2).
- Use qualifier “N4” for NDC format 5-4-2 (loop 2410 LIN02).
- Report the National Drug Code (Loop 2410 LIN03).
- If the price of the NDC drug reported in LIN03 is different from the charges reported in the SV102, create a CTP segment in loop 2410.

<table>
<thead>
<tr>
<th>Page Number</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>400</td>
<td>2400</td>
<td>SV101-1</td>
<td>Product/Service ID</td>
<td>HC</td>
<td></td>
</tr>
<tr>
<td>400</td>
<td>2400</td>
<td>SV101-2</td>
<td>Product/Service ID</td>
<td>HCPC</td>
<td>J codes for home infusion/drugs</td>
</tr>
<tr>
<td>435</td>
<td>2400</td>
<td>DTP01</td>
<td>Service line date</td>
<td>472</td>
<td>Service line date of service</td>
</tr>
<tr>
<td></td>
<td>2400</td>
<td>DTP03</td>
<td>Date time period</td>
<td>DATE</td>
<td>Date, a time, range of dates</td>
</tr>
<tr>
<td>472</td>
<td>2400</td>
<td>REF02</td>
<td>Line Item control</td>
<td></td>
<td>Providers submit these to assist posting the 835 sent back.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>number</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Provider control</td>
<td></td>
<td></td>
</tr>
<tr>
<td>488</td>
<td>2400</td>
<td>NTE01</td>
<td>Note reference code</td>
<td>“ADD”</td>
<td>Only “ADD” is acceptable for these claims.</td>
</tr>
<tr>
<td>488</td>
<td>2400</td>
<td>NTE02</td>
<td>Description</td>
<td></td>
<td>Name of drug and any pertinent information – up to 80 bytes</td>
</tr>
<tr>
<td>AD 73</td>
<td>2410</td>
<td>LIN02</td>
<td>Product/Service ID</td>
<td>“N4”</td>
<td>National drug format 5-4-2</td>
</tr>
<tr>
<td>AD 74</td>
<td>2410</td>
<td>LIN03</td>
<td>Product/Service ID</td>
<td></td>
<td>National drug code</td>
</tr>
<tr>
<td>AD 75</td>
<td>2410</td>
<td>CTP03</td>
<td>Drug unit price</td>
<td></td>
<td>Required only if price is different from how it appears in the SV102. Price per unit of product, service, commodity, etc.</td>
</tr>
<tr>
<td>AD 75</td>
<td>2410</td>
<td>CTP04</td>
<td>Quantity</td>
<td></td>
<td>National drug unit count</td>
</tr>
<tr>
<td>AD 75</td>
<td>2410</td>
<td>CTP05</td>
<td>Composite unit of</td>
<td></td>
<td>Unit or basis of measurement</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>measure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>AD 75</td>
<td>2410</td>
<td>CTP05-1</td>
<td>Unit or basis of</td>
<td>F2-</td>
<td>Include the appropriate qualifier.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>measurement code</td>
<td>International Unit</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>GR-Gram</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>ML-Milliliter</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>UN-Unit</td>
<td></td>
</tr>
<tr>
<td>AD 77</td>
<td>2410</td>
<td>REF02</td>
<td>Pharmacy prescription</td>
<td></td>
<td>Required if the drug has been dispensed with an assigned RX number.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>number</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Additional Claims Submission Pointers (cont’d.)

**837 Institutional Claims**

Home infusion services and drug claims that do not have a medical record attached are required to be submitted electronically. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected.

- Report name of the drug in the claim note (loop 2300 NTE02 – note: use “MED” in NTE01).
- Report description using up to 80 bytes, placed in order of the service lines (see example below).
- Report HCPC code of drug at the service line (loop 2400 SV202-2 (use “HC” in SV202-1).
- Report date of service in the service line (loop 2400 DTP03). Use “472” in DTP01.
- Use qualifier “N4” for NDC format 5-4-2 (loop 2410 LIN02).
- Report the national drug code (loop 2410 LIN03).
- If the price of the NDC drug reported in LIN03 is different from the charges reported in the SV203, create a CTP segment in loop 2410.
- Refer institutional addenda for reference (pages 38-39).
- Report the quantity of drug dispensed (loop 20140 CTP04).
- Report the appropriate drug unit quantity qualifier (loop 2010 CT05-1).

<table>
<thead>
<tr>
<th>Page Number</th>
<th>Loop ID</th>
<th>Reference</th>
<th>Name</th>
<th>Codes</th>
<th>Notes/Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>207</td>
<td>2300</td>
<td>NTE01</td>
<td>Note reference code</td>
<td>“MED”</td>
<td>Medications</td>
</tr>
<tr>
<td>207</td>
<td>2300</td>
<td>NTE02</td>
<td>Description</td>
<td></td>
<td></td>
</tr>
<tr>
<td>446</td>
<td>2400</td>
<td>SV202-1</td>
<td>Product/Service ID qualifier</td>
<td>“HC”</td>
<td>HCPC’s code qualifier</td>
</tr>
<tr>
<td>447</td>
<td>2400</td>
<td>SV202-2</td>
<td>Product/service</td>
<td></td>
<td>Service code</td>
</tr>
<tr>
<td>456</td>
<td>2400</td>
<td>DTP01</td>
<td>Service line date qualifier</td>
<td>“472”</td>
<td>Service line date of service</td>
</tr>
<tr>
<td>456</td>
<td>2400</td>
<td>DTP03</td>
<td>Date time period</td>
<td>Date, a time, or range of dates</td>
<td></td>
</tr>
<tr>
<td>AD37</td>
<td>2410</td>
<td>LIN02</td>
<td>Product/service ID qualifier</td>
<td>“N4”</td>
<td>National drug format 5-4-2</td>
</tr>
<tr>
<td>AD38</td>
<td>2410</td>
<td>CTP03</td>
<td>Unit price</td>
<td>Required only if the price is different from how it appears in SV102. Price per unit of product, service, commodity, etc.</td>
<td></td>
</tr>
<tr>
<td>AD38</td>
<td>2410</td>
<td>CP04</td>
<td>Quantity</td>
<td>National drug unit count</td>
<td></td>
</tr>
<tr>
<td>AD38</td>
<td>2410</td>
<td>CTP05</td>
<td>Composite unit of measure</td>
<td>Unit or basis of measurement</td>
<td></td>
</tr>
<tr>
<td>AD38</td>
<td>2410</td>
<td>CTP05-1</td>
<td>Unit or basis of measurement code</td>
<td>F2-Int’l Unit GR-Gram ML-Milliliter UN-Unit</td>
<td>Include the appropriate qualifier.</td>
</tr>
<tr>
<td>AD77</td>
<td>2410</td>
<td>REF02</td>
<td>Pharmacy prescription number</td>
<td>Required if the drug has been dispensed with an assigned RX number</td>
<td></td>
</tr>
</tbody>
</table>
Additional Claims Submission Pointers (cont’d.)

**HEDIS® Guidelines**

Each HEDIS measure identified below has criteria that is required for your patient’s chart or claims review to be considered valid towards HEDIS measurement. In addition to using CPT/HCPC codes, please use CPT Category II codes to help your office to meet criteria for HEDIS measures:

<table>
<thead>
<tr>
<th>Metabolic Monitoring for Children and Adolescents on Antipsychotics</th>
<th>CPT Category II Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test or Biometric Value</td>
<td></td>
</tr>
<tr>
<td>HbA1c Tests</td>
<td>3044F</td>
</tr>
<tr>
<td>HbA1c Tests</td>
<td>3045F</td>
</tr>
<tr>
<td>HbA1c Tests</td>
<td>3046F</td>
</tr>
<tr>
<td>LDL-C Tests</td>
<td>3048F</td>
</tr>
<tr>
<td>LDL-C Tests</td>
<td>3049F</td>
</tr>
<tr>
<td>LDL-C Tests</td>
<td>3050F</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Comprehensive Diabetes Care</th>
<th>CPT Category II Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test or Biometric Value</td>
<td></td>
</tr>
<tr>
<td>Diabetic Retinal Screening Negative</td>
<td>3072F</td>
</tr>
<tr>
<td>Diabetic Retinal Screening With Eye Care Professional</td>
<td>2022F</td>
</tr>
<tr>
<td>Diabetic Retinal Screening With Eye Care Professional</td>
<td>2024F</td>
</tr>
<tr>
<td>Diabetic Retinal Screening With Eye Care Professional</td>
<td>2026F</td>
</tr>
<tr>
<td>Diastolic 80-89</td>
<td>3079F</td>
</tr>
<tr>
<td>Diastolic Greater Than/Equal to 90</td>
<td>3080F</td>
</tr>
<tr>
<td>Diastolic Less Than 80</td>
<td>3078F</td>
</tr>
<tr>
<td>HbA1c Level 7.0-9.0</td>
<td>3045F</td>
</tr>
<tr>
<td>HbA1c Level Greater Than 9.0</td>
<td>3046F</td>
</tr>
<tr>
<td>HbA1c Level Less Than 7.0</td>
<td>3044F</td>
</tr>
<tr>
<td>HbA1c Tests</td>
<td>3044F</td>
</tr>
<tr>
<td>HbA1c Tests</td>
<td>3045F</td>
</tr>
<tr>
<td>HbA1c Tests</td>
<td>3046F</td>
</tr>
<tr>
<td>Nephropathy Treatment</td>
<td>3066F</td>
</tr>
<tr>
<td>Nephropathy Treatment</td>
<td>4010F</td>
</tr>
<tr>
<td>Systolic Greater Than/Equal to 140</td>
<td>3077F</td>
</tr>
<tr>
<td>Systolic Less Than 140</td>
<td>3074F</td>
</tr>
<tr>
<td>Systolic Less Than 140</td>
<td>3075F</td>
</tr>
<tr>
<td>Urine Protein Tests</td>
<td>3060F</td>
</tr>
<tr>
<td>Urine Protein Tests</td>
<td>3061F</td>
</tr>
<tr>
<td>Urine Protein Tests</td>
<td>3062F</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Care for Older Adults</th>
<th>CPT Category II Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Test or Biometric Value</td>
<td></td>
</tr>
<tr>
<td>Advance Care Planning</td>
<td>1157F</td>
</tr>
<tr>
<td>Advance Care Planning</td>
<td>1158F</td>
</tr>
<tr>
<td>Functional Status Assessment</td>
<td>1170F</td>
</tr>
<tr>
<td>Medication List</td>
<td>1159F</td>
</tr>
<tr>
<td>Medication Review</td>
<td>1160F</td>
</tr>
<tr>
<td>Pain Assessment</td>
<td>1125F</td>
</tr>
<tr>
<td>Pain Assessment</td>
<td>1126F</td>
</tr>
<tr>
<td>Test or Biometric Value</td>
<td>CPT Category II Code</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>Stand Alone Prenatal Visits</td>
<td>0500F</td>
</tr>
<tr>
<td>Stand Alone Prenatal Visits</td>
<td>0501F</td>
</tr>
<tr>
<td>Stand Alone Prenatal Visits</td>
<td>0502F</td>
</tr>
</tbody>
</table>

Medication Reconciliation Post-Discharge

<table>
<thead>
<tr>
<th>Test or Biometric Value</th>
<th>CPT Category II Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Reconciliation</td>
<td>1111F</td>
</tr>
<tr>
<td>Postpartum Visits</td>
<td>0503F</td>
</tr>
</tbody>
</table>

Prenatal and Postpartum Care

<table>
<thead>
<tr>
<th>Test or Biometric Value</th>
<th>CPT Category II Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stand Alone Prenatal Visits</td>
<td>0500F</td>
</tr>
<tr>
<td>Stand Alone Prenatal Visits</td>
<td>0501F</td>
</tr>
<tr>
<td>Stand Alone Prenatal Visits</td>
<td>0502F</td>
</tr>
</tbody>
</table>

Cardiovascular Monitoring for People With Cardiovascular Disease

<table>
<thead>
<tr>
<th>Test or Biometric Value</th>
<th>CPT Category II Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>LDL-C Tests</td>
<td>3048F</td>
</tr>
<tr>
<td>LDL-C Tests</td>
<td>3049F</td>
</tr>
<tr>
<td>LDL-C Tests</td>
<td>3050F</td>
</tr>
</tbody>
</table>

Diabetes Monitoring for People With Diabetes and Schizophrenia

<table>
<thead>
<tr>
<th>Test or Biometric Value</th>
<th>CPT Category II Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c Tests</td>
<td>3044F</td>
</tr>
<tr>
<td>HbA1c Tests</td>
<td>3045F</td>
</tr>
<tr>
<td>HbA1c Tests</td>
<td>3046F</td>
</tr>
<tr>
<td>LDL-C Tests</td>
<td>3048F</td>
</tr>
<tr>
<td>LDL-C Tests</td>
<td>3049F</td>
</tr>
<tr>
<td>LDL-C Tests</td>
<td>3050F</td>
</tr>
</tbody>
</table>

Diabetes Screening for People With Schizophrenia or Bipolar Disorder

<table>
<thead>
<tr>
<th>Test or Biometric Value</th>
<th>CPT Category II Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c Tests</td>
<td>3044F</td>
</tr>
<tr>
<td>HbA1c Tests</td>
<td>3045F</td>
</tr>
<tr>
<td>HbA1c Tests</td>
<td>3046F</td>
</tr>
</tbody>
</table>
Submitting Claims/Encounters Electronically and Electronic Payments

Blue Shield's Electronic Data Interchange (EDI) program enables the paperless exchange of information between Blue Shield, providers, and other business partners. All EDI transactions follow HIPAA-compliant guidelines for format and code. Improved cash flow through quicker receipt of claims, improved efficiencies through less paperwork, and enhanced accuracy of data are just a few of the benefits EDI offers.

Electronic Claim Submission – Providers are required to submit claims electronically that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected.

Electronic Funds Transfer (EFT) – Providers are required to receive claims payments electronically through direct deposit of funds into a designated bank account based on information submitted by the provider.

Electronic Remittance Advice (ERA) – Providers are required to receive ERA files or view Explanation of Payment (EOP) using Blue Shield’s Provider Connection website at blueshieldca.com/provider.

Electronically-transmitted claims and payments are more secure, efficient, and cost-effective than paper remittance; they help to reduce revenue cycle times and are environmentally friendly. Providers are required to have an internet connection for all electronic transactions.

EDI Claims (837)

- Reduce your accounts receivable days outstanding. EDI claims arrive the same day the data is transmitted and 99.1 percent process in less than 6 days
- Reduce errors and rebilling; more than 85 percent of EDI claims accepted require no human intervention to adjudicate
- Save money when you eliminate paper, postage and handling costs
- Tighten your revenue management using the quick-response alerts you’ll receive on rejected EDI claims

Claims are submitted in the ASC X12 837 5010 format. Blue Shield has contracted with several vendors for providers to submit claims at no cost.

To enroll in electronic claim submission, providers can use any approved clearinghouse listed on Provider Connection. Providers can submit claim at no charge using vendors Office Ally, TriZetto Provider Solutions or Ability Network. These vendors can be contacted at blueshieldca.com/provider in the Claims section under How to Submit Claims or by contacting the EDI Department at (800) 480-1221 or access www.blueshieldca.com/provider/claims/electronic-transactions/submit-edi-inquiry.sp to open an EDI inquiry.
Electronic Claims Submission

Submitting Claims/Encounters Electronically and Electronic Payments (cont’d.)

EDI Claims Status Inquiries (276)

Providers use the EDI Claim Status Inquiry transaction (EDI 276) to inquire about the status of a claim after it has been submitted to Blue Shield. The claim status response transaction (EDI 277) is then returned in response to a request inquiry about the status of a claim. The claim status response (EDI 277) indicates if a claim is pending or finalized. If finalized, it states the disposition of the claim – rejected, denied, approved for payment, or paid.

If the claim was approved or paid, payment date, amount, etc. may also be provided in the 277. If the claim was denied or rejected, the 277 includes an explanation, such as if the subscriber is not eligible.

Benefits of using EDI Claim Inquiry are:

- Increase efficiency by tracking claims in seconds eliminating unnecessary claims tracing
- Save administrative costs by decreasing outbound calls and unnecessary hold time
- Reduce accounts receivable days outstanding by receiving responses the next business day

To enroll for the EDI Claim Inquiries, providers must complete an enrollment form found on Provider Connection at blueshieldca.com/provider in the Claims section under Enroll in Electronic Data Interchange, contact the EDI Department at (800) 480-1221 or access www.blueshieldca.com/provider/claims/electronic-transactions/submit-edi-inquiry.sp to open an EDI inquiry

Improve Security of PHI and Financial Information

EDI Eligibility Inquiries (270/271)

The EDI Eligibility and Benefit inquiry (EDI 270/271) is used to verify information about the healthcare eligibility and benefits associated with a subscriber or dependent. The eligibility and benefit response (EDI 271):

- Checks member eligibility and benefits within seconds
- Provides correct member demographic information
- Verifies member liability and accumulated amounts including copays, deductibles, and out-of-pocket expenses
- Confirms member coordination of benefits (COB) information

Advantages of checking member eligibility and benefits are:

- Fewer rejected claims
- Save administrative costs by decreasing outbound calls and unnecessary hold time
- Reduce collection and billing costs

To enroll for the EDI Eligibility Inquiries, providers must complete an enrollment form found on Provider Connection at blueshieldca.com/provider in the Claims section under Enroll in Electronic Data Interchange or contact the EDI Department at (800) 480-1221.
Improve Security of PHI and Financial Information (cont’d.)

EDI Authorizations (278)

Blue Shield offers health care providers the ability to submit request for prior authorization, (e.g., preapproval, preauthorization, prior notification, etc.) review, and receive responses electronically.

This allows the provider to:

- Track records more easily when you receive documentation of authorization requests
- Save administrative costs by decreasing outbound calls and unnecessary hold time
- Reduce the potential for patient care delays associated with prior authorization

To enroll for EDI Authorizations, providers must complete an enrollment form found on Provider Connection at blueshieldca.com/provider in the Claims section under Enroll in Electronic Data Interchange or contact the EDI Department at (800) 480-1221.

Electronic Remittance Advice (ERA) 835

- Save administrative costs – automate the payment posting process
- Reconcile transactions more quickly
- Reduce payment posting errors
- Reduce paper handling and storage costs
- Convert paper remittance to a single electronic format for your account receivable system

ERA files are transmitted to vendors or providers in the ASC X12 835 5010 format. The ERA replaces the paper Explanation of Payment (EOP). To enroll for the ERA, providers must complete an enrollment form found on Provider Connection at blueshieldca.com/provider in the Claims section under Enroll in Electronic Data Interchange or by contacting the EDI Department at (800) 480-1221.

Electronic Funds Transfer (EFT)

- Get faster payment and reduce administrative time and cost with direct deposits into specified accounts
- Increase security of payments – eliminate lost checks
- Get more accurate banking audit results – consult with your financial institution regarding available options

EFT is the electronic transfer of claim payments into a designated bank account based on information submitted by the provider. Providers are required to receive claims payments electronically. The EFT process is set up to ensure privacy in addition to being quick and efficient. To enroll for EFT, providers must complete an enrollment form found on Provider Connection at blueshieldca.com/provider in the Claims section under Enroll in Electronic Data Interchange, contact the EDI Department at (800) 480-1221, or access www.blueshieldca.com/provider/claims/electronic-transactions/submit-edi-inquiry.sp to open an EDI inquiry.
Electronic Claims Submission

Methods for Direct Transmission of HIPAA-Compliant Transactions

Secure File Transfer Protocol (SFTP)

- Use it for all HIPAA transactions, claims/encounters, ERA, eligibility, claim status, authorizations
- Receive a detailed report the same or next business day
- Support unattended scripted file transfers
- Use robust data exchange capability for larger file size and faster data transfer

Real-time HTTP/s Connectivity

Blue Shield supports CORE Phase II HTTP/s open connectivity standards, HTTP MIME Multipart and SOAP+WSDL for EDI eligibility and claim inquiries.

Blue Shield, in accordance with HIPAA regulation, accepts electronic claims submitted in the ANSI format version 5010. The “Special Billing Guidelines and Procedures” instructions in Appendix 4 apply to both the identified “block” on the CMS 1500 and the related “field” on the electronic record, unless otherwise indicated. Your electronic claims software may have additional specific requirements. Follow the system documentation provided by your software vendor.

The creation of the National Provider Identifier (NPI) was mandated by HIPAA and is an attempt to ensure that all medical providers can be identified by a single identifier across all payor systems. To implement the NPI, Blue Shield cross-references the NPI to the correct provider records in our system. On the CMS 1500 Form, the National Provider Identifier would be noted in Box 33A. Providers should have applied for and received their type 1 and/or type 2 National Provider Identifier through the CMS NPPES website and be submitting that information on all claims. The NPI should also be registered with Blue Shield prior to submitting claims.

Special Billing Situations

Ambulance

Providers are required to submit ambulance claims electronically that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. By using the coding requirements for the ANSI format, you have the ability to provide Blue Shield with the required information normally obtained from trip notes and additional reports. Within the electronic format you will need to provide the information specific to emergency transports by using a variety of the fields available, including the notes section using the 2300 loop within the REF02 segment. The detailed billing requirements are available on Provider Connection at blueshieldca.com/provider.

Providers needing to schedule ambulance services should go to Provider Connection at blueshieldca.com/provider and click on Ancillary Providers in the Helpful Resources section on the right to view a list of contracted ambulance providers or call Provider Information & Enrollment at (800) 258-3091 for information on contracted options.
Special Billing Situations (cont’d.)

Ancillary Claims Filing Requirements

Submit ancillary claims electronically using instructions below. The referring/ordering physician is required to identify the local plan.

- Loop 2310 837P = Referring Provider segment with the NPI in the NM109.
- Loop 2420E 837P = Ordering Provider Segments with the NPI in the NM109 including the N3 and N4 address segments, if applicable.

Submit Self-Referred Claims Electronically

When Point of Service (POS) plan members self-refer to a specialist, use the instructions below to bill electronically. For questions, contact your clearinghouse or billing system vendor, contact the EDI Department at (800) 480-1221 or email EDI_BSC@blueshieldca.com.

Submitting Self-Referral for POS Professional & Institutional Claims

- Self-Referral for Professional is identified in Loop 2310A
- Self-Referral for Institutional is identified in Loop 2310F
- Insert SELRREFERRAL for NM103 but leave blank NM104
- Use generic NPI for NM109
  Sample: SELFREFERRAL
  NM1*DN*1*SELFREFERRAL*****xx*1002233777~

Reporting NDC Codes on X12N EDI

Professional and Institutional Claims and Encounters

Home Infusion Professional Claims

Home infusion services and drug claims that do not have a medical record attached must be submitted electronically. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. Use the following guidelines:

- Report name of the drug in the claim note (Loop 2300 NTE02). Use “MED” in NTE01.
- Report description using up to 80 bytes, placed in order of the service lines (See example below).
- Report date of service in the service line (Loop 2400 DTP03). Use “472” in DTP01.
- Use qualifier “N4” for NDC format 5-4-2 (Loop 2410 LIN02).
- Report the national drug code (Loop 2410 LIN03).
Electronic Claims Submission

Special Billing Situations (cont’d.)

Home Infusion Professional Claims (cont’d.)

Notes:

207 2300 NTE01 Note reference - “MED” is Medications.

207 2300 NTE02 Description - Name of drugs. Use up to 80 bytes, and show in order of service lines.

Example:

(NTE*MED*J9265 PACLITAXEL 30MG J1644 HEPARIN 1000UN J3490 CIMETIDINE 300MG–).

A new field is available in 5010 for description of services that can be used for drug specifics or any additional information needed for the claim. The NTE segment can also still be utilized.

Examples:

Professional Claim / SV102-7

SV1*HC>J3490>>>>>MULTITRACE-4 10ml Conc.*11.94*UN*1.000***1~

Submit Prior Authorization Numbers Electronically

For both Institutional and Professional EDI claims, report Prior Authorization Number in the REF02 segment in Loop 2300. Use the “G1” qualifier in the REF01 segment of Loop 2300.

REF01 = G1

REF02 = Authorization Number

Sample: REF*G1*12456789ABCD

Report the entity that approved the authorization (Blue Shield, IPA, NIA), authorization date, date range service approved, and approved days/units in NTE02 Loop 2300. For Professional claims, use the “Claim Note” and for Institutional claims, use the “Billing Note.” In both Professional and Institutional claims, use “ADD” as the value in NTE01.

Sample: NTE*ADD* BSC 20050719 20050719 20050722 4 DAYS

- The first field is either BSC, IPA, or NIA
- The second field is the date the authorization was given (use ccyymmddd format)
- The third field is the date range approved (use ccyymmddd format)
- The fourth field is either the amount of days approved or units

For additional information or specifics on billing claims electronically for secondary and tertiary insurance, drugs, or home infusion, please contact the EDI Department at (800) 480-1221 or access www.blueshieldca.com/provider/claims/electronic-transactions/submit-edi-inquiry.sp to open an EDI inquiry.
Special Billing Situations (cont’d.)

Submit Corrected Claims Electronically

Corrected claims that do not have a medical record attached must be submitted electronically. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. Please wait for the original claim to finalize before sending a corrected claim to avoid denial as a duplicate.

Once the initial has finalized in our system, re-submit the corrected claim with the appropriate adjustment bill type. You will also need to include the following EDI segments on your adjusted claim:

- Send "F8" in REF01 (Loop 2300)
- Send 12 or 14 digit number BSC ICN of incorrect original claim in REF02 (Loop 2300)
- Sample: REF*F8*12345678912345~

Note: 12345678912345 should be replaced with the original claim’s Blue Shield of California internal control number (ICN).

You can obtain the Blue Shield claim number using the claim status option on Provider Connection or from the explanation of benefits (EOB) or electronic remittance advice (ERA).

Additional Reports

For providers that are submitting to Blue Shield in the ANSI 5010 format they will also receive reports that are specific to the 837 claims transaction.

Interchange Acknowledgment – TA1 – Provides the capability for the receiving trading partner to notify the sending trading partner of problems that were encountered in the interchange control structure.

Functional Acknowledgment – 999 – Identifies the acceptance or rejection of the functional group, transaction sets or segments.

Unsolicited Claim Status Inquiry Report 277CA v 5010 – Blue Shield validates inbound electronic data interchange (EDI) for HIPAA compliance, advising only of HIPAA level rejections.
This page intentionally left blank.
## Instructions for Completing a CMS 1500 Form

<table>
<thead>
<tr>
<th>Block #</th>
<th>Instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Identify coverage by checking all appropriate boxes.</td>
</tr>
<tr>
<td>1a</td>
<td>Enter the subscriber's ID number exactly as on ID card, including the first three alpha characters.</td>
</tr>
<tr>
<td>2</td>
<td>Enter patient's full name in last name, first name, middle initial order.</td>
</tr>
<tr>
<td>3</td>
<td>Enter patient's date of birth (two-digit method, e.g., 05/07/42) and sex.</td>
</tr>
<tr>
<td>4</td>
<td>Enter name of insured subscriber exactly as it appears on the ID card.</td>
</tr>
<tr>
<td>5</td>
<td>Enter patient's complete current address and telephone number.</td>
</tr>
<tr>
<td>6</td>
<td>Enter patient's relationship to insured subscriber.</td>
</tr>
<tr>
<td>7</td>
<td>Enter insured subscriber's complete address and telephone number.</td>
</tr>
<tr>
<td>8</td>
<td>Check appropriate box.</td>
</tr>
<tr>
<td>9</td>
<td>If there is any other insurance company or insured party who may be responsible for any part of this bill, enter the insured person's name; and</td>
</tr>
<tr>
<td>9a</td>
<td>Policy and/or group number; and</td>
</tr>
<tr>
<td>9b</td>
<td>Date of birth and sex; and</td>
</tr>
<tr>
<td>9c</td>
<td>Employer's name, if applicable; and</td>
</tr>
<tr>
<td>9d</td>
<td>Insurance plan or program name.</td>
</tr>
<tr>
<td>10a-c</td>
<td>Check “Yes” or “No” to indicate whether employment, auto or other accident applies to one or more service described in Block 24.</td>
</tr>
<tr>
<td>11</td>
<td>Enter subscriber's group number exactly as it appears on ID card; and</td>
</tr>
<tr>
<td>11a</td>
<td>Insured's date of birth and sex; and</td>
</tr>
<tr>
<td>11b</td>
<td>Employer's name, if applicable; and</td>
</tr>
<tr>
<td>11c</td>
<td>Insurance plan or program code; and</td>
</tr>
<tr>
<td>11d</td>
<td>Indicate if there is another health benefit plan. If ‘Yes,’ complete fields 9-9d with other health benefit plan information.</td>
</tr>
<tr>
<td>12-13</td>
<td>Not applicable. Note: Blue Shield will only make payment directly to Physician Members and Participating Health Care Professionals.</td>
</tr>
<tr>
<td>14</td>
<td>Enter date of current illness, injury, or pregnancy.</td>
</tr>
<tr>
<td>15</td>
<td>Complete if applicable.</td>
</tr>
<tr>
<td>16</td>
<td>If applicable, enter dates patient is/has been unable to work. An entry in this field usually indicates workers' compensation related coverage.</td>
</tr>
<tr>
<td>17-17b</td>
<td>Enter name and NPI of the referring physician. Note: When submitting claims for a Blue Shield POS member who has self-referred, enter the words “self-referral.”</td>
</tr>
<tr>
<td>18</td>
<td>Complete these dates when a medical service is furnished as a result of, or subsequent to, a related hospitalization.</td>
</tr>
<tr>
<td>19</td>
<td>Enter taxonomy codes and appropriate qualifier (ZZ). Note: When you need to use more than four modifiers with a procedure code, enter the additional modifiers.</td>
</tr>
<tr>
<td>20</td>
<td>Enter “Yes” or “No” when billing diagnostic laboratory tests. “No” means the tests were performed by the billing physician/lab. “Yes” means the lab test was performed outside the physician’s office. (A lab billing for test performed by another affiliated lab should also check “Yes”). If “Yes”, you must enter purchase price for the test in the “Charges” portion of this block.</td>
</tr>
<tr>
<td></td>
<td>When lab procedures are performed by a party other than the billing physician/lab, identify procedures by adding the -90 modifier to the regular procedure code in Block 24D. Charges for these services cannot exceed the amount the outside laboratory charged.</td>
</tr>
<tr>
<td>21</td>
<td>Enter up to four 5-digit ICD-10 CM codes in priority order with the primary diagnosis in the #1 position. Do not add any diagnosis description.</td>
</tr>
<tr>
<td>22-23</td>
<td>Not applicable.</td>
</tr>
</tbody>
</table>
24 Itemize each service rendered using the appropriate codes. Report only one service per line. This area of the claim form may not contain more than six lines of service. If you need to report more lines for the same patient, do so on separate claims. Also, claims cannot be continued from one to another; each claim must be separate.

24a Enter the month, day, and year for each procedure, using the format “MMDDYY.” For non-DME and radiation treatment leave 'to' date blank - no date ranging. **Durable Medical Equipment & Radiation Treatment Dates:** Enter the month, day, and year for each procedure using the format “MMDDYY.” Report all services provided on the same day for the same patient using only one claim form to ensure correct benefit coverage. Date spans on a single line should not cross months. Date spans on a single claim should not cross years.

24b Enter the two-digit Place of Service code. For DME/HME claims, address where the items were shipped, rented, or purchased at a retail store.

Refer to the Medicare website www.cms.gov for current place of services.

24c Leave blank. Completion of this block is not required.

24d Enter procedure, service or supply using the appropriate HCPCS/CPT procedure code and up to four modifiers. For assistant at surgery or anesthesia, always be sure to include applicable modifiers. For Telehealth HIPAA compliant video services, use Modifier 95 in 24d and place of service 02 in 24b. **Note:** When you need to use more than four modifiers with a procedure code, enter Modifier 99 in Block 24D and list applicable modifiers in Block 19.

24e Enter diagnosis code reference pointer from Block 21 to relate date of service and procedures performed to appropriate diagnosis. A maximum of 4 diagnosis pointers may be referenced. Place commas between multiple diagnosis reference pointers on the same line.

24f Enter charge for the service performed. Do not enter dollar signs or decimal points. Always include cents.

24g When a charge is for more than one item or service, enter number of items or services. This field is most commonly used for number of miles, units of supplies, anesthesia minutes, or oxygen volume.

**Format:** This is a three-digit block. The rightmost digit represents tenths, and the leftmost 2 digits represent whole items or units.

**Example:**
- 1 Service - Enter 010
- 2.5 Services - Enter 025
- 14 Services - Enter 140

If you need to report more than 99 services, you must use two lines. **Example:** 100 Services billed. Enter first line as 990 and second line as 010.

For anesthesia services, show elapsed time in minutes. Do not use time 'units'. **Example:** 1 hour and 10 minutes = 70 minutes. Enter as 070 (70 minutes).

24h Not applicable.

24j Enter the provider specialty Taxonomy Code (in the shaded area) and NPI (in the non-shaded area) for the performing or rendering provider or supplier.

Provider organizations such as medical group practices or clinics must include the rendering provider taxonomy code and the NPI of the rendering provider. Providers who bill as individual practitioners should also include on their claims the rendering provider specialty taxonomy code and the rendering provider NPI.

**Note:** Claims from group practices submitted without the rendering specialty taxonomy code in Block 24j will be rejected.
Enter provider specialty taxonomy code and NPI of the rendering provider or supplier. Several different providers or suppliers may be involved in providing services billed on the claim. If several members of a group shown in Block 33 have furnished services, this item is used to distinguish them.

25 Show provider/supplier Federal Tax ID (Employer Identification Number) or Social Security Number.

26 Enter the patient’s account number.

27 Blue Shield will make direct payment to Physician Members and Participating Health Care Professional only, whether or not this box is completed.

28 Enter total charge for services indicated in Block 24F. Do not enter dollar signs or decimal points. Always include cents.

29 Enter total amount paid by patient on submitted charges in Block 28.

30 Enter the balance due (Block 28 less Block 29).

31 Show signature of provider/supplier or representative and the date form was signed.

32 – 32b Enter name and address of person, organization or facility performing services, if services were furnished in a hospital, clinic, laboratory or any facility other than patient's home or provider's office. Enter the NPI in box 32a. For clinical lab claims, enter the location where the specimen was drawn if different from the billing address. For DME/HME claims, address where the items were shipped, rented or purchased at a retail store.

33 – 33b Enter Provider’s/Supplier’s Billing name, address, telephone number for which bill is submitted. Enter the billing provider / supplier’s NPI in box 33a. Enter the Rendering Providers specialty taxonomy code in 33b.
This page intentionally left blank.
Guidelines for Successful ICR Processing

Follow the guidelines below to assure successful Intelligent Character Recognition (ICR) entry of CMS 1500 paper claims.

- Use only original CMS 1500 claim forms printed in "red dropout" ink. The ink used to print the form must not contain any carbon.

- Use the same font and the same entry method on the entire form. Use Pica, Arial 10, 11, or 12 font type; black ink; and input data in CAPITAL letters. Mixing entry methods (e.g., adding typewritten information to a claim already printed on a laser printer) may impede processing.

- Left justify information in each box and keep data from touching box edges or running outside of numbered boxes.

- Keep claims clean, free of smudges or discolored erasure marks. You may use white correction tape but not correction liquids because ICR can read through them. If you use correction tape, be certain any printing on it is blemish-free.

- The service area of the claim form (Blocks 24a-24j) must be no more than six lines per claim. If you need to submit more than six lines of services for one patient, use separate forms.

  Note: Enter “continued” in the Total Charges field on the first claim to ensure it is processed as a single claim.

- Use the proper units of service in Block 24g. If units are not used, the claim may default to 1 unit during processing, or the claim may be returned to you for more information.

- Enter appropriate ICD-10 codes in the diagnosis (Block 21) or the CPT and Modifier codes in service line (Blocks 24a-24j) areas. Comments or narrative descriptions of procedures, modifiers, or diagnosis codes will require claims to be manually entered into our processing system.

- Attachments cannot be read via ICR but will be reviewed by a claims specialist. To ensure attachments can be read and understood, they must be 8.5 by 11 inches and should be produced in clean, readable printing in dark ink, preferably on white paper.
Guidelines for Successful ICR Processing

This page intentionally left blank.
Where to Send Claims

Providers are required to submit claims electronically that do not have a record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected.

Using Electronic Data Interchange (EDI), providers submit claims and receive payments electronically for faster processing and payment. EDI allows paperless billing and payment for healthcare services and supplies and automates many types of routine inquiries. Please contact the EDI Help Desk at (800) 480-1221 or email edi_bsc@blueshieldca.com with any questions about EDI.

If you still need to submit paper claims, use the Claims Routing Tool, located on Provider Connection at blueshieldca.com/provider under the Claims tab, to determine the correct mailing address for each member. Because claims mailing addresses are different for different Blue Plan members, using the Claims Routing Tool is the most accurate way to determine a claims mailing address.

If you are unable to access the Claims Routing Tool, please use the specific P.O. Box numbers listed on this page. If the subscriber’s group is not listed, use the All Other Blue Shield Plans P.O. Box number shown below.

**BLUECARD OUT-OF-AREA PROGRAM**
Check subscriber ID for three-letter prefix before sending
Blue Shield of California
BlueCard Program
P. O. Box 1505
Red Bluff, CA 96080-1505
(800) 622-0632

**CALPERS**
(California Public Employees Retirement System)
Blue Shield of California
CalPERS
P. O. Box 272540
Chico, CA 95927-2540
(800) 541-6652

**FEDERAL EMPLOYEE PROGRAM (FEP)**
Subscriber ID number begins with the letter “R”
FEP
P.O. Box 272510
Chico, CA 95927-2510
(800) 824-8839

**NATIONAL ACCOUNTS - NASCO**
Subscriber number should be submitted with the 3-digit alpha prefix
Blue Shield of California
NASCO
P. O. Box 272570
Chico, CA 95927-2570
(800) 241-4896

**MEDICARE/BLEU SHIELD 65 PLUS (HMO)SM**
Blue Shield 65 Plus
P. O. Box 272640
Chico, CA 95927
(800) 541-6652
Fax (818) 228-5104

**INITIAL PROVIDER APPEAL AND RESOLUTION**
Blue Shield of California
P. O. Box 272620
Chico, CA 95927-2620

**FINAL PROVIDER APPEAL AND RESOLUTION**
Blue Shield of California
P.O. Box 629011
El Dorado Hills, CA 95762-9011

**SHORT-TERM CLAIMS FOR BLUE SHIELD LIFE & HEALTH INSURANCE COMPANY**
P. O. Box 9000
London, KY 40742

**ALL OTHER BLUE SHIELD PLANS**
Blue Shield of California
P. O. Box 272540
Chico, CA 95927-2540
(800) 541-6652
Where to Send Claims

Where to Send Claims for Foundations for Medical Care

When the name of a medical foundation appears on a subscriber’s identification card, the benefits for that subscriber are administered by that foundation. Forward all claims to that foundation for payment.

The medical foundations with which Blue Shield is affiliated are listed below:

**Foundation for Medical Care of Tulare & Kings Counties, Inc.**
Address: 3335 South Fairway  
           Visalia, CA 93277  
Phone: (800) 662-5502  
       (559) 734-1321  
Fax: (559) 334-0081 (Primary)  
     (559) 734-3828

**Foundation for Medical Care of Mendocino-Lake Counties**
Address: 620 S. Dora St., Suite 201  
         Ukiah, CA 95482-5482  
Phone: (707) 462-7607  
Fax: (707) 462-1206
Blue Shield Payment Processing Logic

The following provides a high-level, general overview of Blue Shield's payment processing logic. Please refer to Provider Connection at blueshieldca.com/provider under the Claims tab for the full payment policies. Please call Provider Information & Enrollment at (800) 258-3091 for additional information.

Blue Shield Claim Edits and Industry Standard Correct Coding

Blue Shield utilizes claims editing software that uses correct coding from industry standard sources, such as Centers for Medicare & Medicaid Services (CMS), the American Medical Association (AMA), Current Procedural Terminology (CPT), Healthcare Common Procedure Coding System (HCPCS), and health plan-developed policies, as applicable, during the claims adjudication process. Additional sources may be used as defined in the Claim Editing Payment Policy.

The claims editing software is also able to identify previously submitted historical claims that are related to current claim submissions, which may result in adjustments to claims previously processed.

Claims editing software will be updated periodically, without notification, to reflect the addition of newly released/revised/deleted codes and their associated claim edits, including but not limited to NCCI revisions, and health plan payment policies.

Manual Claim Review

There are numerous situations in which claims may undergo a manual review. When this takes place, the clinical documentation is compared to the submitted claims. If documentation does not support the codes submitted, the codes may be changed to reflect the documentation. If the submitted code is modified or changed after a manual claim review, the EOB message will further define the change.

Prescreen Claims

Blue Shield provides web access to Clear Claim Connection, a tool that enables providers to prospectively prescreen claims. Access and training instructions for Clear Claim Connection can be found on Provider Connection at blueshieldca.com/provider under Claims, Policies and Guidelines, then Payment Policies and Rules.

Professional and Ancillary Provider Payment Policies

Blue Shield has adopted payment policies for licensed and certified healthcare professional and ancillary provider types. Blue Shield Payment Policies are updated periodically to reflect the addition of newly released/revised/deleted codes without notification and can be found on Provider Connection at blueshieldca.com/provider under the Claims tab.
This page intentionally left blank.
<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
<th>CPT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>10021</td>
<td>Fna w/o image</td>
<td>12011</td>
<td>Repair superficial wound(s)</td>
</tr>
<tr>
<td>10040</td>
<td>Acne surgery</td>
<td>12013</td>
<td>Repair superficial wound(s)</td>
</tr>
<tr>
<td>10060</td>
<td>Drainage of skin abscess</td>
<td>12014</td>
<td>Repair superficial wound(s)</td>
</tr>
<tr>
<td>10080</td>
<td>Drainage of pilonidal cyst</td>
<td>12015</td>
<td>Repair superficial wound(s)</td>
</tr>
<tr>
<td>10120</td>
<td>Remove foreign body</td>
<td>15783</td>
<td>Abrasion treatment of skin</td>
</tr>
<tr>
<td>10160</td>
<td>Puncture drainage of lesion</td>
<td>15786</td>
<td>Abrasion, lesion, single</td>
</tr>
<tr>
<td>11000</td>
<td>Debride infected skin</td>
<td>15787</td>
<td>Abrasion, lesions, add-on</td>
</tr>
<tr>
<td>11055</td>
<td>Trim skin lesion</td>
<td>15788</td>
<td>Chemical peel, face, epiderm</td>
</tr>
<tr>
<td>11056</td>
<td>Trim skin lesions, 2 to 4</td>
<td>15789</td>
<td>Chemical peel, face, dermal</td>
</tr>
<tr>
<td>11057</td>
<td>Trim skin lesions, over 4</td>
<td>15792</td>
<td>Chemical peel, nonfacial</td>
</tr>
<tr>
<td>11100</td>
<td>Biopsy, skin lesion</td>
<td>15793</td>
<td>Chemical peel, nonfacial</td>
</tr>
<tr>
<td>11101</td>
<td>Biopsy, skin add-on</td>
<td>16000</td>
<td>Initial treatment of burn(s)</td>
</tr>
<tr>
<td>11200</td>
<td>Removal of skin tags</td>
<td>16020</td>
<td>Treatment of burn(s)</td>
</tr>
<tr>
<td>11201</td>
<td>Remove skin tags add-on</td>
<td>16025</td>
<td>Treatment of burn(s)</td>
</tr>
<tr>
<td>11300</td>
<td>Shave skin lesion</td>
<td>16030</td>
<td>Treatment of burn(s)</td>
</tr>
<tr>
<td>11301</td>
<td>Shave skin lesion</td>
<td>17000</td>
<td>Destroy benign/premlg lesion</td>
</tr>
<tr>
<td>11302</td>
<td>Shave skin lesion</td>
<td>17003</td>
<td>Destroy lesions, 2-14</td>
</tr>
<tr>
<td>11303</td>
<td>Shave skin lesion</td>
<td>17004</td>
<td>Destroy lesions, 15 or more</td>
</tr>
<tr>
<td>11305</td>
<td>Shave skin lesion</td>
<td>17106</td>
<td>Destruction of skin lesions</td>
</tr>
<tr>
<td>11306</td>
<td>Shave skin lesion</td>
<td>17107</td>
<td>Destruction of skin lesions</td>
</tr>
<tr>
<td>11307</td>
<td>Shave skin lesion</td>
<td>17108</td>
<td>Destruction of skin lesions</td>
</tr>
<tr>
<td>11308</td>
<td>Shave skin lesion</td>
<td>17110</td>
<td>Destruct lesion, 1-14</td>
</tr>
<tr>
<td>11310</td>
<td>Shave skin lesion</td>
<td>17111</td>
<td>Destruct lesion, 15 or more</td>
</tr>
<tr>
<td>11311</td>
<td>Shave skin lesion</td>
<td>17250</td>
<td>Chemical cauter, tissue</td>
</tr>
<tr>
<td>11312</td>
<td>Shave skin lesion</td>
<td>17340</td>
<td>Cryotherapy of skin</td>
</tr>
<tr>
<td>11313</td>
<td>Shave skin lesion</td>
<td>17360</td>
<td>Skin peel therapy</td>
</tr>
<tr>
<td>11719</td>
<td>Trim nail(s)</td>
<td>17380</td>
<td>Hair removal by electrolysis</td>
</tr>
<tr>
<td>11720</td>
<td>Debride nail, 1-5</td>
<td>17999</td>
<td>Skin tissue procedure</td>
</tr>
<tr>
<td>11721</td>
<td>Debride nail, 6 or more</td>
<td>19000</td>
<td>Drainage of breast lesion</td>
</tr>
<tr>
<td>11730</td>
<td>Removal of nail plate</td>
<td>19001</td>
<td>Drain breast lesion add-on</td>
</tr>
<tr>
<td>11740</td>
<td>Drain blood from under nail</td>
<td>20500</td>
<td>Injection of sinus tract</td>
</tr>
<tr>
<td>11765</td>
<td>Excision of nail fold, toe</td>
<td>20526</td>
<td>Ther injection, carp tunnel</td>
</tr>
<tr>
<td>11900</td>
<td>Injection into skin lesions</td>
<td>20527</td>
<td>Inj dupuytren cord w/enzyme</td>
</tr>
<tr>
<td>11901</td>
<td>Added skin lesions injection</td>
<td>20550</td>
<td>Inj tendon sheath/ligament</td>
</tr>
<tr>
<td>11921</td>
<td>Correct skin color defects</td>
<td>20551</td>
<td>Inj tendon origin/insertion</td>
</tr>
<tr>
<td>11922</td>
<td>Correct skin color defects</td>
<td>20552</td>
<td>Inj trigger point, 1/2 muscl</td>
</tr>
<tr>
<td>11950</td>
<td>Therapy for contour defects</td>
<td>20553</td>
<td>Inject trigger points, =/&gt; 3</td>
</tr>
<tr>
<td>11951</td>
<td>Therapy for contour defects</td>
<td>20555</td>
<td>Place ndl musc/tis for rt</td>
</tr>
<tr>
<td>11952</td>
<td>Therapy for contour defects</td>
<td>20600</td>
<td>Drain/inject, joint/bursa</td>
</tr>
<tr>
<td>11954</td>
<td>Therapy for contour defects</td>
<td>20605</td>
<td>Drain/inject, joint/bursa</td>
</tr>
<tr>
<td>11980</td>
<td>Implant hormone pellet(s)</td>
<td>20606</td>
<td>Drain/inj joint/bursa w/us</td>
</tr>
<tr>
<td>11981</td>
<td>Insert drug implant device</td>
<td>20610</td>
<td>Drain/injject, joint/bursa</td>
</tr>
<tr>
<td>11982</td>
<td>Remove drug implant device</td>
<td>20611</td>
<td>Drain/inj joint/bursa w/us</td>
</tr>
<tr>
<td>12001</td>
<td>Repair superficial wound(s)</td>
<td>20612</td>
<td>Aspirate/inj ganglion cyst</td>
</tr>
<tr>
<td>12002</td>
<td>Repair superficial wound(s)</td>
<td>20615</td>
<td>Treatment of bone cyst</td>
</tr>
<tr>
<td>12004</td>
<td>Repair superficial wound(s)</td>
<td>20950</td>
<td>Fluid pressure, muscle</td>
</tr>
<tr>
<td>CPT</td>
<td>Description</td>
<td>CPT</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------------------------</td>
<td>-------</td>
<td>---------------------------------------</td>
</tr>
<tr>
<td>20974</td>
<td>Electrical bone stimulation</td>
<td>29040</td>
<td>Application of body cast</td>
</tr>
<tr>
<td>20979</td>
<td>Us bone stimulation</td>
<td>29044</td>
<td>Application of body cast</td>
</tr>
<tr>
<td>24640</td>
<td>Treat elbow dislocation</td>
<td>29046</td>
<td>Application of body cast</td>
</tr>
<tr>
<td>24650</td>
<td>Treat radius fracture</td>
<td>29049</td>
<td>Application of figure eight</td>
</tr>
<tr>
<td>25500</td>
<td>Treat fracture of radius</td>
<td>29055</td>
<td>Application of shoulder cast</td>
</tr>
<tr>
<td>25530</td>
<td>Treat fracture of ulna</td>
<td>29058</td>
<td>Application of shoulder cast</td>
</tr>
<tr>
<td>25560</td>
<td>Treat fracture radius &amp; ulna</td>
<td>29065</td>
<td>Application of long arm cast</td>
</tr>
<tr>
<td>25600</td>
<td>Treat fracture radius/ulna</td>
<td>29075</td>
<td>Application of forearm cast</td>
</tr>
<tr>
<td>25622</td>
<td>Treat wrist bone fracture</td>
<td>29085</td>
<td>Apply hand/wrist cast</td>
</tr>
<tr>
<td>25630</td>
<td>Treat wrist bone fracture</td>
<td>29086</td>
<td>Apply finger cast</td>
</tr>
<tr>
<td>25650</td>
<td>Treat wrist bone fracture</td>
<td>29105</td>
<td>Apply long arm splint</td>
</tr>
<tr>
<td>26010</td>
<td>Drainage of finger abscess</td>
<td>29125</td>
<td>Apply forearm splint</td>
</tr>
<tr>
<td>26340</td>
<td>Manipulate finger w/anesth</td>
<td>29126</td>
<td>Apply forearm splint</td>
</tr>
<tr>
<td>26341</td>
<td>Manipulate palm cord post inj</td>
<td>29130</td>
<td>Application of finger splint</td>
</tr>
<tr>
<td>26600</td>
<td>Treat metacarpal fracture</td>
<td>29131</td>
<td>Application of finger splint</td>
</tr>
<tr>
<td>26641</td>
<td>Treat thumb dislocation</td>
<td>29200</td>
<td>Strapping of chest</td>
</tr>
<tr>
<td>26670</td>
<td>Treat hand dislocation</td>
<td>29240</td>
<td>Strapping of shoulder</td>
</tr>
<tr>
<td>26700</td>
<td>Treat knuckle dislocation</td>
<td>29260</td>
<td>Strapping of elbow or wrist</td>
</tr>
<tr>
<td>26720</td>
<td>Treat finger fracture, each</td>
<td>29280</td>
<td>Strapping of hand or finger</td>
</tr>
<tr>
<td>26725</td>
<td>Treat finger fracture, each</td>
<td>29305</td>
<td>Application of hip cast</td>
</tr>
<tr>
<td>26740</td>
<td>Treat finger fracture, each</td>
<td>29325</td>
<td>Application of hip casts</td>
</tr>
<tr>
<td>26750</td>
<td>Treat finger fracture, each</td>
<td>29345</td>
<td>Application of long leg cast</td>
</tr>
<tr>
<td>26755</td>
<td>Treat finger fracture, each</td>
<td>29355</td>
<td>Application of long leg cast</td>
</tr>
<tr>
<td>26770</td>
<td>Treat finger dislocation</td>
<td>29358</td>
<td>Apply long leg cast brace</td>
</tr>
<tr>
<td>27200</td>
<td>Treat tail bone fracture</td>
<td>29365</td>
<td>Application of long leg cast</td>
</tr>
<tr>
<td>27220</td>
<td>Treat hip socket fracture</td>
<td>29405</td>
<td>Apply short leg cast</td>
</tr>
<tr>
<td>27256</td>
<td>Treat hip dislocation</td>
<td>29425</td>
<td>Apply short leg cast</td>
</tr>
<tr>
<td>27899</td>
<td>Leg/ankle surgery procedure</td>
<td>29435</td>
<td>Apply short leg cast</td>
</tr>
<tr>
<td>28430</td>
<td>Treatment of ankle fracture</td>
<td>29440</td>
<td>Addition of walker to cast</td>
</tr>
<tr>
<td>28450</td>
<td>Treat midfoot fracture, each</td>
<td>29445</td>
<td>Apply rigid leg cast</td>
</tr>
<tr>
<td>28470</td>
<td>Treat metatarsal fracture</td>
<td>29450</td>
<td>Application of leg cast</td>
</tr>
<tr>
<td>28475</td>
<td>Treat metatarsal fracture</td>
<td>29505</td>
<td>Application, long leg splint</td>
</tr>
<tr>
<td>28490</td>
<td>Treat big toe fracture</td>
<td>29515</td>
<td>Application lower leg splint</td>
</tr>
<tr>
<td>28495</td>
<td>Treat big toe fracture</td>
<td>29520</td>
<td>Strapping of hip</td>
</tr>
<tr>
<td>28510</td>
<td>Treatment of toe fracture</td>
<td>29530</td>
<td>Strapping of knee</td>
</tr>
<tr>
<td>28515</td>
<td>Treatment of toe fracture</td>
<td>29540</td>
<td>Strapping of ankle and/or ft</td>
</tr>
<tr>
<td>28530</td>
<td>Treat sesamoid bone fracture</td>
<td>29550</td>
<td>Strapping of toes</td>
</tr>
<tr>
<td>28540</td>
<td>Treat foot dislocation</td>
<td>29580</td>
<td>Application of paste boot</td>
</tr>
<tr>
<td>28570</td>
<td>Treat foot dislocation</td>
<td>29581</td>
<td>Apply multilay comprs lwr leg</td>
</tr>
<tr>
<td>28600</td>
<td>Treat foot dislocation</td>
<td>29700</td>
<td>Removal/revision of cast</td>
</tr>
<tr>
<td>28630</td>
<td>Treat toe dislocation</td>
<td>29705</td>
<td>Removal/revision of cast</td>
</tr>
<tr>
<td>28660</td>
<td>Treat toe dislocation</td>
<td>29710</td>
<td>Removal/revision of cast</td>
</tr>
<tr>
<td>29000</td>
<td>Application of body cast</td>
<td>29720</td>
<td>Repair of body cast</td>
</tr>
<tr>
<td>29010</td>
<td>Application of body cast</td>
<td>29730</td>
<td>Windowing of cast</td>
</tr>
<tr>
<td>29015</td>
<td>Application of body cast</td>
<td>29740</td>
<td>Wedging of cast</td>
</tr>
<tr>
<td>29035</td>
<td>Application of body cast</td>
<td>29750</td>
<td>Wedging of clubfoot cast</td>
</tr>
<tr>
<td>CPT</td>
<td>Description</td>
<td>CPT</td>
<td>Description</td>
</tr>
<tr>
<td>-------</td>
<td>--------------------------------------------------</td>
<td>-------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>29799</td>
<td>Casting/strapping procedure</td>
<td>51792</td>
<td>Urinary reflex study</td>
</tr>
<tr>
<td>30300</td>
<td>Remove nasal foreign body</td>
<td>51797</td>
<td>Intraabdominal pressure test</td>
</tr>
<tr>
<td>30901</td>
<td>Control of nosebleed</td>
<td>51798</td>
<td>Us urine capacity measure</td>
</tr>
<tr>
<td>31231</td>
<td>Nasal endoscopy, dx</td>
<td>53621</td>
<td>Dilate urethra stricture</td>
</tr>
<tr>
<td>31298</td>
<td>Nasal sinus endoscopy surgical</td>
<td>53660</td>
<td>Dilation of urethra</td>
</tr>
<tr>
<td>31502</td>
<td>Change of windpipe airway</td>
<td>53661</td>
<td>Dilation of urethra</td>
</tr>
<tr>
<td>31575</td>
<td>Diagnostic laryngoscopy</td>
<td>53860</td>
<td>Transurethral rf treatment</td>
</tr>
<tr>
<td>32550</td>
<td>Insert pleural catheter</td>
<td>54050</td>
<td>Destruction, penis lesion(s)</td>
</tr>
<tr>
<td>32552</td>
<td>Remove lung catheter</td>
<td>54056</td>
<td>Cryosurgery, penis lesion(s)</td>
</tr>
<tr>
<td>32553</td>
<td>Ins mark thor for rt perq</td>
<td>54200</td>
<td>Treatment of penis lesion</td>
</tr>
<tr>
<td>32562</td>
<td>Lyse chest fibrin subq day</td>
<td>54235</td>
<td>Penile injection</td>
</tr>
<tr>
<td>36430</td>
<td>Blood transfusion service</td>
<td>54240</td>
<td>Penis study</td>
</tr>
<tr>
<td>36465</td>
<td>Inj noncompound foam sclerosant</td>
<td>54250</td>
<td>Penis study</td>
</tr>
<tr>
<td>36466</td>
<td>Inj noncompound foam sclerosant</td>
<td>55000</td>
<td>Drainage of hydrocele</td>
</tr>
<tr>
<td>36593</td>
<td>Declot vascular device</td>
<td>55920</td>
<td>Place needles pelvic for rt</td>
</tr>
<tr>
<td>36598</td>
<td>Inject rad eval central venous device</td>
<td>56820</td>
<td>Exam of vulva w/scope</td>
</tr>
<tr>
<td>36680</td>
<td>Insert needle, bone cavity</td>
<td>56821</td>
<td>Exam/biopsy of vulva w/scope</td>
</tr>
<tr>
<td>40800</td>
<td>Drainage of mouth lesion</td>
<td>57100</td>
<td>Biopsy of vagina</td>
</tr>
<tr>
<td>40804</td>
<td>Removal, foreign body, mouth</td>
<td>57150</td>
<td>Treat vagina infection</td>
</tr>
<tr>
<td>40830</td>
<td>Repair mouth laceration</td>
<td>57156</td>
<td>Ins vag brachytx device</td>
</tr>
<tr>
<td>41019</td>
<td>Place needles h &amp; n for rt</td>
<td>57160</td>
<td>Insert pessary/other device</td>
</tr>
<tr>
<td>42280</td>
<td>Preparation, palate mold</td>
<td>57170</td>
<td>Fitting of diaphragm/cap</td>
</tr>
<tr>
<td>42400</td>
<td>Biopsy of salivary gland</td>
<td>57420</td>
<td>Exam of vagina w/scope</td>
</tr>
<tr>
<td>42809</td>
<td>Remove pharynx foreign body</td>
<td>57421</td>
<td>Exam/biopsy of vag w/scope</td>
</tr>
<tr>
<td>43752</td>
<td>Nasal/orogastric w/stent</td>
<td>57452</td>
<td>Exam of cervix w/scope</td>
</tr>
<tr>
<td>43753</td>
<td>Tx gastro intub w/asp</td>
<td>57455</td>
<td>Biopsy of cervix w/scope</td>
</tr>
<tr>
<td>43754</td>
<td>Dx gastr intub w/asp spec</td>
<td>57505</td>
<td>Endocervical curettage</td>
</tr>
<tr>
<td>43755</td>
<td>Dx gastr intub w/asp specs</td>
<td>58100</td>
<td>Biopsy of uterus lining</td>
</tr>
<tr>
<td>43756</td>
<td>Dx duod intub w/asp spec</td>
<td>58110</td>
<td>Biopsy of uterus lining add on</td>
</tr>
<tr>
<td>43757</td>
<td>Dx duod intub w/asp specs</td>
<td>58300</td>
<td>Insert intrauterine device</td>
</tr>
<tr>
<td>43761</td>
<td>Reposition gastrostomy tube</td>
<td>58301</td>
<td>Remove intrauterine device</td>
</tr>
<tr>
<td>44705</td>
<td>Prepare fecal microbiota</td>
<td>58321</td>
<td>Artificial insemination</td>
</tr>
<tr>
<td>45520</td>
<td>Treatment of rectal prolapse</td>
<td>58322</td>
<td>Artificial insemination</td>
</tr>
<tr>
<td>46600</td>
<td>Diagnostic anoscopy</td>
<td>58323</td>
<td>Sperm washing</td>
</tr>
<tr>
<td>46601</td>
<td>Diagnostic anoscopy</td>
<td>59020</td>
<td>Fetal contract stress test</td>
</tr>
<tr>
<td>46900</td>
<td>Destruction, anal lesion(s)</td>
<td>59025</td>
<td>Fetal non-stress test</td>
</tr>
<tr>
<td>46916</td>
<td>Cryosurgery, anal lesion(s)</td>
<td>59050</td>
<td>Fetal monitor w/report</td>
</tr>
<tr>
<td>50391</td>
<td>Instill rx agnt into mal tub</td>
<td>59051</td>
<td>Fetal monitor/interpret only</td>
</tr>
<tr>
<td>50686</td>
<td>Measure ureter pressure</td>
<td>59200</td>
<td>Insert cervical dilator</td>
</tr>
<tr>
<td>51100</td>
<td>Drain bladder by needle</td>
<td>59412</td>
<td>Antepartum manipulation</td>
</tr>
<tr>
<td>51700</td>
<td>Irrigation of bladder</td>
<td>59425</td>
<td>Antepartum care only</td>
</tr>
<tr>
<td>51705</td>
<td>Change of bladder tube</td>
<td>59430</td>
<td>Care after delivery</td>
</tr>
<tr>
<td>51720</td>
<td>Treatment of bladder lesion</td>
<td>59899</td>
<td>Maternity care procedure</td>
</tr>
<tr>
<td>51736</td>
<td>Urine flow measurement</td>
<td>60100</td>
<td>Biopsy of thyroid</td>
</tr>
<tr>
<td>51741</td>
<td>Electro-uroflowmetry, first</td>
<td>60300</td>
<td>Aspir/inj thyroid cyst</td>
</tr>
<tr>
<td>51784</td>
<td>Anal/urinary muscle study</td>
<td>64405</td>
<td>N block inj, occipital</td>
</tr>
</tbody>
</table>
## List of Office-Based Ambulatory Procedures

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>64445</td>
<td>N block inj, sciatic, sng</td>
</tr>
<tr>
<td>64455</td>
<td>N block inj, plantar digit</td>
</tr>
<tr>
<td>64550</td>
<td>Apply neurostimulator</td>
</tr>
<tr>
<td>64611</td>
<td>Chemodenerv saliv glands</td>
</tr>
<tr>
<td>64615</td>
<td>Chemodenerv musc migraine</td>
</tr>
<tr>
<td>64616</td>
<td>Chemodenerv musc neck dyston</td>
</tr>
<tr>
<td>64617</td>
<td>Chemodenerv musc larynx EMG</td>
</tr>
<tr>
<td>64632</td>
<td>N block inj, common digit</td>
</tr>
<tr>
<td>65205</td>
<td>Remove foreign body from eye</td>
</tr>
<tr>
<td>65210</td>
<td>Remove foreign body from eye</td>
</tr>
<tr>
<td>65220</td>
<td>Remove foreign body from eye</td>
</tr>
<tr>
<td>65222</td>
<td>Remove foreign body from eye</td>
</tr>
<tr>
<td>65430</td>
<td>Corneal smear</td>
</tr>
<tr>
<td>65778</td>
<td>Cover eye w/membrane</td>
</tr>
<tr>
<td>65779</td>
<td>Cover eye w/membrane stent</td>
</tr>
<tr>
<td>67500</td>
<td>Inject/treat eye socket</td>
</tr>
<tr>
<td>67505</td>
<td>Inject/treat eye socket</td>
</tr>
<tr>
<td>67515</td>
<td>Inject/treat eye socket</td>
</tr>
<tr>
<td>67700</td>
<td>Drainage of eyelid abscess</td>
</tr>
<tr>
<td>67800</td>
<td>Remove eyelid lesion</td>
</tr>
<tr>
<td>67805</td>
<td>Remove eyelid lesions</td>
</tr>
<tr>
<td>67810</td>
<td>Biopsy of eyelid</td>
</tr>
<tr>
<td>68040</td>
<td>Treatment of eyelid lesions</td>
</tr>
<tr>
<td>68200</td>
<td>Treat eyelid by injection</td>
</tr>
<tr>
<td>68400</td>
<td>Incise/drain tear gland</td>
</tr>
<tr>
<td>68761</td>
<td>Close tear duct opening</td>
</tr>
<tr>
<td>69000</td>
<td>Drain external ear lesion</td>
</tr>
<tr>
<td>69020</td>
<td>Drain outer ear canal lesion</td>
</tr>
<tr>
<td>69090</td>
<td>Pierce earlobes</td>
</tr>
<tr>
<td>69200</td>
<td>Clear outer ear canal</td>
</tr>
<tr>
<td>69209</td>
<td>Remove impacted ear wax uni</td>
</tr>
<tr>
<td>69210</td>
<td>Remove impacted ear wax</td>
</tr>
<tr>
<td>69220</td>
<td>Clean out mastoid cavity</td>
</tr>
<tr>
<td>90867</td>
<td>Tcranial magn stim tx plan</td>
</tr>
<tr>
<td>90868</td>
<td>Tcranial magn stim tx deli</td>
</tr>
<tr>
<td>92132</td>
<td>Cmptm phth dx img ant segmt</td>
</tr>
<tr>
<td>92133</td>
<td>Cmptm phth img optic nerve</td>
</tr>
<tr>
<td>92134</td>
<td>Cmptm phth dx img post segmt</td>
</tr>
<tr>
<td>92537</td>
<td>Caloric vsblr test w/rec</td>
</tr>
<tr>
<td>92538</td>
<td>Caloric vsblr test w/rec</td>
</tr>
<tr>
<td>93050</td>
<td>Art pressure waveform analys</td>
</tr>
<tr>
<td>93464</td>
<td>Exercise w/hemodynamic meas</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CPT</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>97597</td>
<td>Active wound care/20 cm or &lt;</td>
</tr>
<tr>
<td>97598</td>
<td>Active wound care &gt; 20 cm</td>
</tr>
<tr>
<td>0071T</td>
<td>Focused ultrasound abl, uterine leiomyomata</td>
</tr>
<tr>
<td>0072T</td>
<td>Total leiomyomata vol, 200cc tissue</td>
</tr>
<tr>
<td>0190T</td>
<td>Place intraop radiation src</td>
</tr>
<tr>
<td>0207T</td>
<td>Clear eyelid gland w/heat</td>
</tr>
<tr>
<td>0213T</td>
<td>Njx paravert w/us cer/thor</td>
</tr>
<tr>
<td>0214T</td>
<td>Njx paravert w/us cer/thor</td>
</tr>
<tr>
<td>0215T</td>
<td>Njx paravert w/us cer/thor</td>
</tr>
<tr>
<td>0216T</td>
<td>Njx paravert w/us lumb/sac</td>
</tr>
<tr>
<td>0217T</td>
<td>Njx paravert w/us lumb/sac</td>
</tr>
<tr>
<td>0218T</td>
<td>Njx paravert w/us lumb/sac</td>
</tr>
<tr>
<td>0219T</td>
<td>Plmt post facet implt cerv</td>
</tr>
<tr>
<td>0220T</td>
<td>Plmt post facet implt thor</td>
</tr>
<tr>
<td>0221T</td>
<td>Plmt post facet implt lumb</td>
</tr>
<tr>
<td>0222T</td>
<td>Plmt post facet implt addl</td>
</tr>
<tr>
<td>0228T</td>
<td>Njx tfrml eprl w/us cer/thor</td>
</tr>
<tr>
<td>0230T</td>
<td>Njx tfrml eprl w/us lumb/sac</td>
</tr>
<tr>
<td>0272T</td>
<td>Interrogate crtd sns dev</td>
</tr>
<tr>
<td>0273T</td>
<td>Interrogate crtd sns w/pgrmg</td>
</tr>
<tr>
<td>0278T</td>
<td>Tempr</td>
</tr>
<tr>
<td>0295T</td>
<td>Ext ecg complete</td>
</tr>
<tr>
<td>0296T</td>
<td>Ext ecg recording</td>
</tr>
<tr>
<td>0297T</td>
<td>Ext ecg scan w/report</td>
</tr>
<tr>
<td>0298T</td>
<td>Ext ecg review and interp</td>
</tr>
<tr>
<td>0331T</td>
<td>Heart symp image plnr</td>
</tr>
<tr>
<td>0332T</td>
<td>Heart symp image plnr spect</td>
</tr>
<tr>
<td>0378T</td>
<td>Visual field assmt rev/rpt</td>
</tr>
<tr>
<td>0379T</td>
<td>Vis Field assmt tech suppt</td>
</tr>
<tr>
<td>0380T</td>
<td>Comp animat ret imag series</td>
</tr>
<tr>
<td>0419T</td>
<td>Dstrj Neurofibroma Xtnsv</td>
</tr>
<tr>
<td>0420T</td>
<td>Dstrj Neurofibroma Xtnsv</td>
</tr>
<tr>
<td>0465T</td>
<td>Supchrdl njx rx w/o supply</td>
</tr>
<tr>
<td>0474T</td>
<td>Insj aqueous drg dev io rsvr</td>
</tr>
<tr>
<td>0482T</td>
<td>Absolute quant myocardal bld flow</td>
</tr>
<tr>
<td>C8929</td>
<td>Transthoracic Echo, w/o contrast</td>
</tr>
<tr>
<td>C8930</td>
<td>Transthoracic Echo, w/o contrast foww with</td>
</tr>
</tbody>
</table>
Table of Contents

A. The BlueCard® Program
B. Other Payor Summary List
This page intentionally left blank.
Table of Contents

Section 1 Introduction to the BlueCard® Program ........................................................................ 1
  Definition of the BlueCard Program ............................................................................................... 1
  BlueCard Program Advantages to Providers .................................................................................. 1
  Services Processed Through the BlueCard Program ........................................................................ 1
  Products Included in the BlueCard Program ................................................................................... 2
  Products Excluded from the BlueCard Program .............................................................................. 3

Section 2 How Does the BlueCard Program Work? ...................................................................... 4
  How to Identify Members .................................................................................................................. 4
    Member ID Cards ............................................................................................................................. 4
    BlueCard PPO Basic ID Cards .......................................................................................................... 7
    How to Identify International Blue Plan Members .......................................................................... 8
    Consumer Directed Health Care and Healthcare Debit Cards ..................................................... 10
  Limited Benefit Products ................................................................................................................ 11
    Helpful Tips .................................................................................................................................... 13
  Coverage and Eligibility Verification ............................................................................................... 14
  Coordination of Benefits (COB) Information on Blue Plan Members ........................................... 15
  Coordination of Benefits Questionnaire .......................................................................................... 17
  Out-of-State Blue Plan Members’ Medical Policies and Pre-Certification/Prior Authorization
    Requirements .................................................................................................................................... 18
  Prior Authorization .......................................................................................................................... 18
  Utilization Review ............................................................................................................................ 19
  Electronic Provider Access ................................................................................................................. 20
    Using the EPA Tool ......................................................................................................................... 20
  Provider Financial Responsibility for Pre-Service Review for Blue Plan Members ....................... 21
  Medical Records Requests and Processing ...................................................................................... 22

Section 3 Claim Filing ....................................................................................................................... 23
  Processing BlueCard Claims ............................................................................................................ 23
  BlueCard Claim Tips ......................................................................................................................... 23
  Submitting BlueCard Claims ............................................................................................................ 25
  Traditional Medicare-Related Claims ............................................................................................... 27
  Ancillary Claims Filing Requirements ............................................................................................... 29
  Claims Filing for Air Ambulance Services for BlueCard Patients .................................................. 31
### The BlueCard® Program

Medical Records ..................................................................................................................................... 32
Claims Coding ......................................................................................................................................... 33
Claim Payment and Claim Status Inquiries ............................................................................................ 33
Calls from Members and Others with Claim Questions ......................................................................... 33
Value Based Provider Arrangements ..................................................................................................... 34
Claim Adjustments .................................................................................................................................. 34
Provider Claim Appeals .......................................................................................................................... 34

**Section 4 BlueCard Resources** ........................................................................................................... 35
Claims Routing Tool .................................................................................................................................. 35
BlueCard Program Tutorials .................................................................................................................... 35
BlueCard Program Webinars ................................................................................................................... 35
BlueCard Program Educational Resources ............................................................................................. 35

**Section 5 Medicare Advantage** ........................................................................................................ 36
Medicare Advantage Overview ................................................................................................................ 36
Types of Medicare Advantage Plans ....................................................................................................... 36
How to Recognize Medicare Advantage Members .................................................................................. 38
Eligibility Verification ................................................................................................................................ 39
Medicare Advantage Claims Submission ................................................................................................. 39
Reimbursement for Medicare Advantage PPO, HMO and POS ............................................................. 40
Reimbursement for Medicare Advantage Private Fee-For-Service (PFFS) ............................................. 41
Medicare Advantage Network Sharing ..................................................................................................... 42

**Section 6 Health Insurance Marketplaces (Exchanges)** ......................................................................... 44
Health Insurance Marketplaces Overview ............................................................................................... 44
OPM Multi-State Plan Program ................................................................................................................ 44
Exchange-Purchased Plans - Individual Grace Period ............................................................................. 45
Health Insurance Marketplaces Claims .................................................................................................... 46

**Section 7 Glossary of BlueCard Program Terms** .............................................................................. 47
Section 1

Introduction to the BlueCard® Program

As a contracted provider of Blue Shield of California (Blue Shield), you may render services to patients who are insured by other states’ Blue Plans, and who travel in or live within California.

This section describes the advantages of the BlueCard Program, and provides information to make filing claims easy. You will find helpful information about:

- Identifying out-of-state Blue plan members
- Verifying eligibility and benefits
- Other states’ Blue plan medical policies and pre-certification requirements
- Requesting and obtaining authorizations
- Submitting BlueCard claims and requesting medical records
- Resources and contact information

Definition of the BlueCard Program

BlueCard® is a national program that enables Blue Cross and Blue Shield (BCBS) Plan members to obtain healthcare services while traveling or living in another Blue Cross and/or Blue Shield Plan’s service area. The program links participating healthcare providers with all the independent Blue Cross and Blue Shield plans across the country through a single electronic network for claims processing and reimbursement. Additionally, the program links providers in more than 200 countries and territories worldwide.

BlueCard Program Advantages to Providers

The program allows you to conveniently submit claims for patients from out-of-state Blue Plans, either domestic or international, directly to Blue Shield.

Blue Shield is your primary contact for BlueCard claim submission, claims processing, and provider inquiries.

Blue Shield continues to experience growth in out-of-area membership because of our partnership with you. That is why we are committed to meeting your needs and expectations. In doing so, your patients will have a positive experience with each visit.

Services Processed Through the BlueCard Program

Claims for all inpatient, outpatient and professional services generated for out-of-state Blue plan members are processed through the BlueCard Program.
Products Included in the BlueCard Program

A variety of products and claim types are eligible to be delivered via BlueCard, however not all Blue Plans offer all the products listed below to their members.

- Traditional (indemnity insurance)
- PPO (Preferred Provider Organization)
- EPO (Exclusive Provider Organization)
- POS (Point of Service)
- HMO (Health Maintenance Organization)
  - HMO claims are eligible to be processed under the BlueCard Program or through the Away From Home Care Program.
- Blue Cross Blue Shield Global Core
- GeoBlue Expat claims
- Medigap – Medicare Complementary/Supplemental
- Medicaid: payment is limited to the member’s Plan state Medicaid reimbursement rates.
  - These cards will not have a suitcase logo.
- Stand-Alone SCHIP (State Children’s Health Insurance Plan) if administered as part of Medicaid
  - Payment is limited to the member’s Plan’s state Medicaid reimbursement rates. These cards do not have a suitcase logo. Stand-Alone SCHIP programs will have a suitcase logo
- Standalone vision
- Standalone prescription drugs

Note: Standalone vision and standalone self-administered prescription drugs programs are eligible to be processed through BlueCard when such products are not delivered using a vendor. Consult claim filing instructions on the back of the ID cards.

Note: Definitions of the above products are available in the Glossary of Terms section of this manual
Products Excluded from the BlueCard Program

The following claims are excluded from the BlueCard Program:

- Stand-alone dental
- Self-administered prescription drugs delivered through an intermediary model (using a vendor)
- Vision claims delivered through an intermediary model (using a vendor)
- Federal Employee Program (FEP) member claims
- Medicaid and SCHIP that is part of the Medicaid program
- Medicare Advantage*

*Medicare Advantage is a separate program from BlueCard and delivered through its own centrally-administered platform. However, since you might see members of other Blue Plans who have Medicare Advantage coverage there is a section on Medicare Advantage claims processing in this manual.
Section 2
How Does the BlueCard Program Work?

How to Identify Members

Member ID Cards

When members of out-of-state Blue plans arrive at your office or facility, be sure to ask them for their current Blue plan membership identification card.

The main identifier for out-of-area members is the three-character prefix. The ID cards may also have:

- PPO in a suitcase logo, for eligible PPO members
- Blank suitcase log, for eligible Traditional, HMO, POS or indemnity members
- PPOB in a suitcase logo, for PPO members with access to the BlueCard PPO Basic network

The PPO in a suitcase logo indicates that the member is enrolled in either a PPO product or an EPO product. In either case, you will be reimbursed according to Blue Shield’s PPO provider contract. Please note that EPO products may have limited benefits out-of-area. The potential for such benefit limitations are indicated on the reverse side of an EPO ID card.

The PPOB in a suitcase logo indicates that the member has selected a PPO or EPO product, from a Blue Plan, and the member has access to a new PPO network, referred to as BlueCard PPO Basic.

For members having traditional or HMO coverage, you will be reimbursed according to Blue Shield’s traditional provider contract. For members who have POS coverage, you will be reimbursed according to Blue Shield’s POS provider contract, if you participate in the BlueCard POS voluntary program or you will be reimbursed according to Blue Shield’s Traditional provider contract, if you don’t participate in the BlueCard POS voluntary program.

Some Blue ID cards don’t have any suitcase logo on them. The ID cards for Medicaid, State Children’s Health Insurance Programs (SCHIP) if administered as part of State’s Medicaid, and Medicare Complementary and Supplemental products, also known as Medigap. Government-determined reimbursement levels apply to these products. While Blue Shield routes these claims for out-of-area members to the member’s Blue Plan, most of the Medicare Complementary or Medigap claims are sent directly from the Medicare intermediary to the member’s Blue Plan via the established electronic crossover process.
How to Identify Members (cont’d.)

Member ID Cards (cont’d.)

Important facts concerning member IDs:

- A correct member ID includes the three-character prefix (first three positions) and all subsequent characters, up to a total of 17 positions. This means that you may see cards with IDs between 6 and 14 numbers or letters following the prefix.

- Do not add or delete characters or numbers within the member ID.

- Do not change the sequence of the characters following the prefix.

- The three-character prefix is critical for the electronic routing of specific HIPAA-compliant transactions to the appropriate Blue plan.

- Members who are part of the Federal Employee Program (FEP) will have the letter "R" in front of their member ID. FEP claims are not processed by the BlueCard Program. Instead, FEP professional claims should be sent to the FEP claims unit at P. O. Box 272510, Chico, CA 95927-2510.

- Note that most out-of-state Blue plan member ID cards have plan names that begin with “Blue Cross Blue Shield” brand names and identifies the state where members receive coverage. However, some Blue plans have unique plan names that do not begin with “Blue Cross Blue Shield” branding and do not identify the state where the member receives coverage. Nevertheless, you can submit BlueCard claims to Blue Shield for members whose ID cards have unique Blue plan names. For a current list of the unique Blue plan names, email BlueCardMarketing@blueshieldca.com.

Examples of member IDs:

- A2A1234567
- ABC1234H567
- 2A212345678901234

Prefix
Prefix
Prefix
The BlueCard® Program

How to Identify Members (cont’d.)

Three-Character Prefix

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 or National Account 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.

Do not assume that the member’s ID is the Social Security number. All Blue plans have replaced Social Security numbers on member ID cards with a unique, alternative identifier.

A correct member ID number includes the prefix (first three positions) and all subsequent characters, up to 17 positions total. This means that you may see cards with ID numbers between 6 and 14 characters following the prefix. Three-character prefix may contain a mix of alpha and numeric characters.

As a provider serving out-of-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.
- Verify with the member that the ID on the card is not his or her Social Security number. If it is, call the BlueCard® Eligibility line at (800) 676-BLUE to verify the ID.
- Member IDs must be reported exactly as shown in the ID card and must not be changed or altered. Do not add or omit any characters from the member ID.
- Blue plan member ID cards are formatted to reflect brand guidelines established by the Blue Cross and Blue Shield Association. The ID cards are designed to make it easier for members and providers to find information they need. Design elements include:
  - Easier-to-read member information featured on the front of the card.
  - A single toll-free provider phone number for provider customer service, hospital pre-admission or pre-authorization information and prescription processing information for pharmacists, listed together on the back of the card.
  - The Blue plan’s Web URL located on the back of the card.
  - The mailing instructions for medical claims included on the back of the card.

Note: ID card samples are not the actual depiction of cards; they show the general look and feel for the brand guidelines from the Association.
How to Identify Members (cont’d.)

BlueCard PPO Basic ID Cards

Verifying Blue patients’ benefits and eligibility is now more important than ever since new products and benefit types have entered the market, due to the Affordable Care Act. In addition to patients who have traditional Blue PPO, HMO, POS, or other coverage, you may now see patients who have a BlueCard PPO Basic product.

When you see the “PPOB in a suitcase” logo on the front of the member’s ID card, it means the member has selected a PPO or EPO product, from a Blue Plan, and the member has access to a new PPO network, referred to as BlueCard PPO Basic.

Currently, Blue Shield does not offer a BlueCard PPO Basic network to members. However, you may see patients with BlueCard PPO Basic coverage by an out-of-state Blue Plan. Providers will be reimbursed for covered services in accordance with your PPO contract with Blue Shield of California.

Sample of BlueCard PPO Basic Member ID Card
The BlueCard® Program

How to Identify Members (cont’d.)

How to Identify International Blue Plan Members

Occasionally, you may see identification cards that are from members of International Licensees or that are for international-based products. Currently those Licensees include Blue Cross Blue Shield of the U.S. Virgin Islands, BlueCross & BlueShield of Uruguay, Blue Cross and Blue Shield of Panama, and Blue Cross Blue Shield of Costa Rica, and those products include those provided through Blue Shield Global Core and the Blue Cross Blue Shield Global™ portfolio. Always check with Blue Shield of California as the list of International Licensees and products may change. ID cards from these Licensees and for these products will also contain three-character prefixes and may or may not have one of the benefit product logos referenced in the following sections. Please treat these members the same as you would domestic Blue Plan members (e.g., do not collect any payment from the member beyond cost-sharing amounts such as deductible, coinsurance and co-payment) and file their claims to Blue Shield of California. See below for sample ID cards for international members and products.

Example of an ID card from an International Licensee:

![Example of an ID card from an International Licensee](image)

Examples of ID cards for International Products

Illustration A – Blue Cross Blue Shield Global portfolio:
How to Identify Members (cont’d.)

How to Identify International Blue Plan Members (cont’d.)

Illustration B – Shield-only ID Card:

Please Note: In certain territories, including Hong Kong and the United Arab Emirates, Blue Cross branded products are not available. The ID cards of members in these territories will display the Blue Shield Global Core logo (see example below):

Canadian ID Cards

Please Note: The Canadian Association of Blue Cross Plans and its member plans are separate and distinct from the Blue Cross and Blue Shield Association (BCBSA) and its member Plans in the United States.

You may occasionally see ID cards for people who are covered by a Canadian Blue Cross plan. Claims for Canadian Blue Cross plan members are not processed through the BlueCard® Program.

Please follow the instructions of the Blue Cross plans in Canada and those, if any, on the ID cards for servicing their members. The Blue Cross plans in Canada are:

Alberta Blue Cross  Ontario Blue Cross  Quebec Blue Cross
Manitoba Blue Cross  Pacific Blue Cross  Saskatchewan Blue Cross
Medavie Blue Cross

Source: [http://www.bluecross.ca/en/contact.html](http://www.bluecross.ca/en/contact.html)
Consumer Directed Health Care and Healthcare Debit Cards

Consumer Directed Health Care (CDHC) is a broad umbrella term that refers to a movement in the healthcare industry to empower members, reduce employer costs and change consumer healthcare purchasing behavior. Health plans that offer CDHC plans provide the member with additional information to make an informed and appropriate healthcare decision using member support tools, provider and network information, and financial incentives. Members who have CDHC plans often carry healthcare debit cards that allow them to pay for out-of-pocket costs using funds from their Health Reimbursement Arrangements (HRA), Health Savings Accounts (HSA) or Flexible Spending Accounts (FSA). All three are types of tax favored accounts offered by the member’s employer to pay for eligible expenses not covered by the health plan.

Some cards are “stand-alone” debit cards to cover out-of-pocket costs, while others also serve as a member ID card with the member ID number. These debit cards can help you simplify your administration process and can potentially help:

- Reduce bad debt
- Reduce paper work for billing statements
- Minimize bookkeeping and patient-account functions for handling cash and checks
- Avoid unnecessary claim payment delays

In some cases, the card will have the nationally recognized Blue logos, along with the logo from a major debit card organization such as MasterCard® or Visa®.

Sample of Stand-Alone Healthcare Debit Card

Sample of Combined Healthcare Debit Card and Member ID Card
How to Identify Members (cont’d.)

Consumer Directed Health Care and Healthcare Debit Cards (cont’d.)

The cards include a magnetic strip so providers can swipe the card at the point of service to collect the member copayment. With the healthcare debit cards members can pay for copayments and other out-of-pocket expenses by swiping the card though any provider’s debit card swipe terminal. The funds will be deducted automatically from the member’s appropriate HRA, HSA or FSA account.

Combining a healthcare ID card with a source of payment is an added convenience to members and providers. Members can use their cards to pay outstanding balances on billing statements. They can also use their cards via phone to process payments. In addition, members are more likely to carry their current ID cards, because of the payment capabilities. If your office currently accepts credit card payments, there is no additional cost or equipment necessary beyond what you already pay to swipe other signature debit cards.

Limited Benefit Products

Verifying Blue plan patients’ benefits and eligibility is now more important than ever, since new products and benefit types entered the market. In addition to patients who have traditional Blue PPO, HMO, POS or other coverage, typically with high lifetime coverage limits (i.e., $1 million or more), you may now see Blue plan patients whose annual benefits are limited to $50,000 or less.

Currently, Blue Shield does not offer such limited benefit plans to our members. However, you may see patients with limited benefits who are covered by an out-of-state Blue Plan.

How to recognize members with limited benefits products

Members with Blue limited benefits coverage (that is, annual benefits limited to $50,000 or less) carry ID cards that may have one or more of the following indicators:

- Product name will be listed such as InReach or MyBasic
- A green stripe at the bottom of the card
- A statement either on the front or the back of the ID card stating this is a limited benefits product
- A black cross and/or shield to help differentiate it from other identification cards
How to Identify Members (cont’d.)

Limited Benefit Products (cont’d.)

These ID cards may look like this:

How to find out if the patient has limited benefit coverage

In addition to obtaining a copy of the patient’s ID card and regardless of the benefit product type, we recommend that you verify patient’s benefits and eligibility and collect any patient liability or copayment only. You may do so electronically by submitting an eligibility inquiry to Blue Shield at blueshieldca.com/provider or by calling BlueCard® Eligibility at (800) 676-BLUE (2583).

You will receive the patient’s accumulated benefits to help you understand the remaining benefits left for the member. If the cost of services extends beyond the patient’s benefit coverage limit, inform the patient of any additional liability he or she might have.

What to do if the patient’s benefits are exhausted before the end of their treatment

Annual benefit limits should be handled in the same manner as any other limits on the medical coverage. Any services beyond the covered amounts or the number of treatment might be member’s liability. We recommend that you inform patients of any potential liability they might have as soon as possible.
How to Identify Members (cont’d.)

Helpful Tips

- Carefully determine the member’s financial responsibility before processing payment. You can access the member’s accumulated deductible by logging on to blueshieldca.com/provider or by calling the BlueCard® Eligibility line at (800) 676-BLUE (2583).

- Ask members for their current member ID card and regularly obtain new photocopies (front and back) of the member ID card. Having the current card will enable you to submit claims with the appropriate member information (including three-character prefix) and avoid unnecessary claims payment delays.

- If the member presents a debit card (stand-alone or combined), be sure to verify the out-of-pocket amounts before processing payment:
  - Many plans offer well care services that are payable under the basic healthcare program. If you have any questions about the member’s benefits or to request accumulated deductible information, please log onto blueshieldca.com/provider or call the BlueCard® Eligibility line at (800) 676-BLUE (2583).
  - You may use the debit card for member responsibility for medical services provided in your office.
  - You may choose to forego using the debit card and submit the claims to Blue Shield for processing. The Remittance Advice will inform you of member responsibilities.
  - All services, regardless of whether or not you’ve collected the member responsibility at the time of service, must be filed to Blue Shield for proper benefit determination and to update the members’ claim history.

- Check eligibility and benefits electronically by logging onto Provider Connection at blueshieldca.com/provider or by calling (800) 676-BLUE (2583) and providing the three-character prefix. Additional features were added to all BlueCard eligibility and benefits search results. Online eligibility and benefits results for out-of-state Blue plan members also include the following elements:
  - Other payor information, if the member has other insurance
  - An authorization indicator, if authorization or referral is required
  - Pre-existing condition information, if applicable
  - Accumulated year-to-date deductible amounts
  - Accumulated year-to-date out-of-pocket costs
  - Accumulated year-to-date benefit maximum amounts
  - Accumulated year-to-date individual lifetime maximum amounts

- Please do not use the debit card to process full payment up front. If you have any questions about the member’s benefits, log onto blueshieldca.com/provider to perform a BlueCard eligibility and benefits search, or call (800) 676-BLUE (2583). For questions about the debit card processing instructions or payment issues, please contact the toll-free debit card administrator’s number on the back of the card.
Coverage and Eligibility Verification

Provider Connection, our provider website at blueshieldca.com/provider, gives you direct access to current, reliable information for out-of-state Blue Plan members’ eligibility, benefits, claims mailing address, and share of cost. You can receive more detailed benefit information when searching for out-of-state BlueCard members’ benefits online. Submit an online inquiry about certain benefits you would like more information on, and the benefit information will be returned to you in the Provider Connection Message Center. Electronic, online, and phone inquiries for eligibility and benefits for clinical lab, DME/HME, and specialty pharmacy services should be directed to the local plan as defined in the Ancillary Claims Filing Guidelines section of this appendix.

You can also verify out-of-state Blue Plan member eligibility, benefits coverage and share of cost information by calling BlueCard Eligibility® at (800) 676-BLUE (2583). This automated Voice Response Unit (VRU) will prompt you to provide the three-character prefix and will route your call to the member’s Blue Plan.

Keep in mind that Blue plans are located throughout the country and may operate on a different time schedule than Blue Shield. You may be transferred to a voice response system linked to customer enrollment and benefits.

The BlueCard Eligibility® line is for eligibility, benefit and pre-certification/referral authorization inquiries only. It should not be used for determining where to submit your BlueCard claims or for claim status. See the Claim Filing section in this manual for claim filing information.

Blue Shield has created a BlueCard Eligibility and Benefits Verification Guide to help you acquire eligibility and benefits information for out-of-state Blue plan members quickly and efficiently the first time, so you’re less likely to encounter issues with denials or delays. A PDF version of the guide is available on Provider Connection for downloading in the “Resources” tab of our BlueCard Program web page. Or if you’d like a printed copy of the guide, email BlueCardMarketing@blueshieldca.com.
Coordination of Benefits (COB) Information on Blue Plan Members

Coordination of Benefits (COB) refers to how the Blue System ensures that Blue plan members receive full benefits and prevent double payment for services when a Blue plan member has coverage from two or more sources. The member’s contract language explains the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

Blue plan member benefit structures vary and state requirements around the collection of other insurance information differ across the country. To reduce the number of BlueCard claims being denied for lack of COB information, new processing standard requirements are in place to limit instances when Blue plans can reject claims for COB investigations.

When you see Blue plan patients who you are aware might have other health insurance coverage (i.e., Medicare, other Blue plan), please keep in mind the following:

- If Blue Shield of California or any other Blue plan is the primary payor, submit the other carrier’s name and address with the claim to Blue Shield of California. If you do not include the COB information with the claim, the member’s Blue plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your volume of bookkeeping.

- If another non-Blue health plan is primary and Blue Shield of California or any other Blue plan is secondary, submit the claim to Blue Shield of California only after receiving payment from the primary payor, including the explanation of payment from the primary carrier. If you do not include the COB information with the claim, the member’s Blue plan will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your volume of bookkeeping.

Carefully review the payment information from all payors involved on the remittance advice before balance billing the patient for any potential liability. The information listed on the Blue Shield of California remittance advice as “patient liability” might be different from the actual amount the patient owes you, due to the combination of the primary insurer payment and your negotiated amount with Blue Shield of California.

If you have any questions regarding COB claims processing or payments in relation to Blue plan members, please contact the BlueCard Program Customer Service at (800) 622-0632.

Your involvement is needed to assist in collecting other insurance information from Blue plan members. To avoid claim rejections due to lack of COB information, use the COB Questionnaire to collect information from any Blue plan member who has insurance coverage in addition to his/her out-of-state Blue plan coverage.

When out-of-state Blue plan members state they have other insurance coverage in addition to their out-of-state Blue plan coverage, please perform one of the following:

1. During the patient’s visit, request the patient complete and return the COB Questionnaire to you, then mail the completed form on behalf of the patient to Blue Shield to:
   Blue Shield of California, BlueCard Program, P.O. Box 1505, Red Bluff CA 96080
2. During the patient’s visit, give the patient a COB Questionnaire with instructions to complete and submit the form to his or her out-of-state Blue plan as soon as possible.

Refer to the COB Questionnaire on the following pages or on blueshieldca.com/provider under Guidelines and Resources, then Forms, then Patient Care Forms.
## Coordination of Benefits Questionnaire

Provider: After the policy holder has completed and signed, please forward this form to your local Blue Cross and/or Blue Shield Plan immediately. Do not hold to submit with the claim.

- [ ] Check here if you will be electronically submitting this to your local BC and/or BS Plan and you have the Policy Holders signature on file.

Member: Your Blue Cross and/or Blue Shield contract may contain a Coordination of Benefits (COB) provision. Your Plan depends upon your help in order to process your claims correctly and appreciate your prompt and accurate reply. If any of the information below changes, please contact your Blue Cross and/or Blue Shield Plan immediately.

<table>
<thead>
<tr>
<th>Provider Name:</th>
<th>NPI (Give Tax ID if no NPI Number):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Policyholder Name:</th>
<th>Group ID Number with Three Letter Prefix:</th>
</tr>
</thead>
</table>

### Section A  Other Insurance

Are you or any other member of this Blue Cross and/or Blue Shield policy covered by another medical or dental insurance policy, any other Blue Cross and/or Blue Shield policy or Medicare?

- [ ] No
- [ ] Yes

If No, please complete Section D, sign, date and return this questionnaire to us, indicating "No other insurance."

If Yes, please complete all the fields below that pertain to the member(s) that has the other coverage.

What type of policy is this?
- [ ] Other Health Insurance
- [ ] Other Dental Insurance
- [ ] Student Policy
- [ ] Medicare Supplemental

<table>
<thead>
<tr>
<th>Other Insurance Carriers Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>State</th>
<th>Zip</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Dependent(s) listed on the other insurance</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Other Insurance Policyholder's Name</th>
<th>Policyholder's Date of Birth</th>
<th>ID Number</th>
</tr>
</thead>
</table>

Effective Date of Other Insurance: If Cancelled, Cancellation Date:

Is the policy holder:
- [ ] Actively working for the group
- [ ] Inactive
- [ ] Retired, retirement date: ____________
- [ ] On COBRA, which began: ____________

<table>
<thead>
<tr>
<th>Policyholder's Employer</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Address</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Phone Number</th>
</tr>
</thead>
</table>

The BlueCard® Program

Section B  Medicare Information

Do the policyholder and/or dependent(s) have Medicare?  
☐ Yes  ☐ No

Name of person(s) with Medicare

Medicare Number, including alpha character(s)

Effective Date of Medicare Part A:  
Effective date of Medicare Part B:  

Medicare Entitlement:  
☐ Yes  ☐ Disability*  ☐ Yes  ☐ End Stage Renal Disease (ESRD)*  

If the reason is for Disability or ESRD, please provide the following:

1st Date of Disability:  
1st Date of Dialysis for ESRD:  
Was ESRD started in a facility?  
☐ Yes  ☐ No  
Was ESRD started as Self Dialysis of Home Dialysis?  
☐ Yes  ☐ No

Has a transplant been performed?  
☐ Yes  ☐ No

If yes, please provide the date of the transplant:  

Section C  Court Order Information

Is there a Court Order specifying a person(s) to maintain health coverage for any of your dependent(s)?

☐ Yes  ☐ No

List the name(s) of the dependent(s) that this applies to.

If yes, who is the person(s) listed to maintain health coverage?

What is the relationship to the child(ren)?  
Who has custody of the child(ren) more than 50% of the time?

Documentation of the court order may be requested from your Blue Cross and/or Blue Shield Plan

Section D  Names of Dependent(s) on Blue Cross and/or Blue Shield Policy

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Date of Birth</th>
<th>Sex</th>
<th>Social Security Number (Optional)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Policy Holder Signature  
Date
The BlueCard® Program

Out-of-State Blue Plan Members’ Medical Policies and Pre-Certification/Prior Authorization Requirements

On Provider Connection, our provider website, you can now find information to help you treat out-of-state Blue plan members. You can view medical policies and general pre-certification/prior authorization requirements applicable to out-of-state Blue plan members, along with contact information to initiate the pre-certification/prior authorization process.

To access the medical policy and pre-certification/prior authorization requirements, follow the steps below:

2. Click on Pre-Service Review for Out-of-Area Members within the Authorizations section of the opening landing page.
3. Enter the out-of-state Blue plan member’s three-character prefix, select either the medical policy or the prior authorization button, and then click on “Search.”

This online functionality gives providers easy access to information and provides a valuable supplement to the information you currently receive when verifying out-of-state Blue plan members’ benefits, eligibility and share of costs, directly from the member’s out-of-state Blue plan.

Prior Authorization

Prior authorization of medical services for out-of-state Blue plan members is provided by the member’s Blue plan. Providers can request authorization for an out-of-state Blue plan member online by using the Electronic Provider Access (EPA) tool. The EPA tool will enable you to use Blue Shield’s provider website to gain secured access to an out-of-area Blue plan’s provider website to request authorization.

To access the EPA tool, log onto Provider Connection at blueshieldca.com/provider and click on Pre-Service Review for Out-of-Area Members within the Authorizations section. Choose from the available options to assist in obtaining the necessary information:

- Medical Policy Information – Select this option to obtain medical policy for a service.
- Prior Authorization Information – Select this option to determine if pre-service and pre-authorization is required for a service.
- Electronic Provider Access – Select this option to submit a pre-certification and prior authorization request.

Providers will need the member’s three-character prefix to complete each search. The prefix is the first three characters that precede the member identification number.
Prior Authorization (cont’d.)

By entering a valid prefix, you will then be automatically routed to the member’s Blue plan provider portal to begin an authorization request. Please note that each Blue plan’s website is customized to their authorization services they offer.

Providers can also contact the member’s Blue plan by calling the designated telephone number of the Health Care Services department located on the back of the member’s ID card.

Electronic, online, and phone inquiries for eligibility and benefits for clinical lab, DME/HME, and specialty pharmacy services should be directed to the local plan as defined in the Ancillary Claims Filing Guidelines section of this appendix. The member’s Blue plan may contact you directly related to clinical information or to request medical records prior to treatment or for concurrent review or disease management for a specific member.

Note: Failure to obtain required prior authorization or admission review may result in partial or total benefit denial and/or greater out-of-pocket expenses for Blue plan members. However, obtaining approval is not a guarantee of payment.

Utilization Review

You should remind patients that they are responsible for obtaining pre-certification/authorization for outpatient services from their Blue Plan. Participating providers are responsible for obtaining pre-service review for inpatient facility services when the services are required by the account or member contract (see section entitled Provider Financial Responsibility). In addition, members are held harmless when pre-service review is required and not received for inpatient facility services (unless an account receives an approved exception).

Providers must also follow specified timeframes for pre-service review notifications:

1. 48 hours to notify the member’s Plan of change in pre-service review; and
2. 72 hours for emergency/urgent pre-service review notification.

General information on pre-certification/preauthorization information can be found on the Out-of-Area Member Medical Policy and Pre-Authorization/Pre-Certification Router at blueshieldca.com/provider utilizing the three-character prefix found on the member ID card.

When obtaining pre-certification/preauthorization, please provide as much information as possible, to minimize potential claims issues. Providers are encouraged to follow-up immediately with a member’s Blue Plan to communicate any changes in treatment or setting to ensure existing authorization is modified or a new one is obtained, if needed. Failure to obtain approval for the additional days may result in claims processing delays and potential payment denials.

When the length of an inpatient hospital stay extends past the previously-approved length of stay, any additional days must be approved. Failure to obtain approval for the additional days may result in claim processing delays and potential payment denials.
Electronic Provider Access

Electronic Provider Access (EPA) gives providers the ability to access out-of-area member’s Blue Plan provider portals to conduct electronic pre-service review. The term pre-service review is used to refer to pre-notification, pre-certification, pre-authorization and prior approval, amongst other pre-claim processes. EPA enables providers to use their local Blue Plan provider portal to gain access to an out-of-area member’s Blue Plan provider portal, through a secure routing mechanism. Once in the Blue Plan provider portal, the out-of-area provider has the same access to electronic pre-service review capabilities as the Blue Plan’s local providers.

The availability of EPA varies depending on the capabilities of each Blue Plan. Some Blue Plans have electronic pre-service review for many services, while others do not. The following describes how to use EPA and what to expect when attempting to contact other Blue Plans.

Using the EPA Tool

Logon to blueshieldca.com/provider and click on Pre-Service Review for Out-of-Area Members within the Authorizations section. Choose the Electronic Provider Access option. You will be asked to enter the three-character prefix from the member’s ID card. The prefix is the first three characters that precede the member subscriber identification number. The NPI and location of requesting provider are also required, as is whether or not you’re a Blue Shield of California contracted provider. Once those fields have been filled out, click the “Submit” button.

After submitting, you are routed to the member’s Blue Plan EPA landing page. This page welcomes you to the out-of-state Blue Plan’s portal and indicates that you have left Blue Shield of California’s provider portal. The landing page allows you to connect to the available electronic pre-service review processes. Because the screens and functionality of out-of-state Blue Plan pre-service review processes vary widely, other Blue Plans may include instructional documents or e-learning tools on their Blue Plan landing page to provide instruction on how to conduct an electronic pre-service review. The page may also include instructions for conducting pre-service review for services where the electronic function is not available.

The out-of-state Blue Plan landing page looks similar across the Blue Plan system but will be customized to the particular Blue Plan based on the electronic pre-service review services they offer.
Provider Financial Responsibility for Pre-Service Review for Blue Plan Members

Blue Shield’s participating providers are responsible for obtaining pre-service review for inpatient facility services for BlueCard members and holding the member harmless when pre-service review is required by the account or member contract and not received for inpatient services. Participating providers must also:

- Notify the member’s Blue Plan within 48 hours when a change or modifications to the original pre-service review occurs.
- Obtain pre-service review for emergency and/or urgent admissions within 72 hours.

Failure to contact the member’s Blue Plan for pre-service review or for a change or modification of the pre-service review will result in claim processing delays and potential payment denials for inpatient facility services. The Blue plan member must be held harmless and cannot be balance-billed if pre-service review has not occurred*.

Pre-service review contact information for a member’s Blue Plan is provided on the member’s identification card. Pre-service review requirements can also be determined by:

- Using the Electronic Provider Access (EPA) tool available at Blue Shield’s provider portal at blueshieldca.com/provider. Note: the availability of EPA will vary depending on the capabilities of each member’s Blue Plan.
- Submitting an ANSI 278 electronic transaction to Blue Shield or calling (800) 676-BLUE.

Services that deny as not medically necessary remain the member’s liability.

If you have any questions on Provider Financial Responsibility or general questions, please call Blue Shield at (800) 622-0632.

*Unless the member signed a written consent to be billed prior to rendering service.
Medical Records Requests and Processing

Blue Shield is dedicated to achieving a seamless delivery of medical records requests and processing for out-of-state Blue plan members and the providers who serve them.

Medical records related to your out-of-state Blue plan patients may be requested as part of the pre-claim experience, as part of a concurrent review or as part of the BlueCard claim appeal process. It is Blue Shield’s responsibility to obtain medical records from our providers at the request of the member’s Blue plan. However, in pre-claim situations, the member’s Blue plan may directly contact you to request medical records if the member’s Blue plan needs the records to make a determination as part of the prior authorization or pre-certification process or in situations that are deemed as an urgent medical need. Please note that when requesting medical records for DME/HME services, the ordering provider’s information is required to process the request.

Blue Shield performs the following steps to ensure delivery of medical record requests and processing:

- When receiving a medical records request from the member’s Blue plan, we verify whether or not the provider has already submitted the records.
- When a member’s Blue plans requests medical records, we send the request to our providers within two business days of receipt of the out-of-state Blue plan’s request.
- When requesting medical records from a provider, we strive to send concise and specific details to fulfill the request.
- We send medical record requests to the address and department indicated in your provider demographics profile.
- When providers respond to requests and submit medical records to us, we ensure that all records are sent electronically to the member’s Blue plan within three business days on their receipt.
- We follow up with the member’s Blue plan to ensure that records are reviewed and adjusted in a timely manner.
- We maintain copies or images of all medical records received from providers.

To make the medical records process more efficient, please respond to medical record requests within 10 days of the request.
Section 3
Claim Filing

Processing BlueCard Claims

Blue Shield processes BlueCard claims for inpatient, outpatient, professional, and ancillary* services rendered to out-of-state Blue plan members. Be sure to include the member’s complete identification number when you submit the claim. The complete identification number includes the three-character prefix—do not make up prefixes. Claims with incorrect or missing prefixes and member identification numbers cannot be filed correctly.

*Ancillary providers who are Independent Clinical Laboratory, Durable/Home Medical Equipment and Supplies, and Specialty Pharmacy providers should file their claims according to the Ancillary Claims Filing Requirements listed further in this document.

Providers are required to submit BlueCard claims electronically to Blue Shield that do not have a medical record attached. Except as otherwise specified in your agreement, claims not submitted in accordance with these requirements will be rejected. Please indicate the member’s subscriber ID number, including the three-character prefix, on each electronically submitted claim. If you have any questions about the process or require additional information on electronic claim submission, contact our EDI Help Desk by calling (800) 480-1221 or emailing EDI_BSC@blueshieldca.com. You may now submit claims online through clearinghouse vendor Office Ally at https://cms.officeally.com.Pages/ResourceCenter/Landing/BlueShieldCA.aspx. Once at the EDI clearinghouse’s website, you’ll have the option to review the claim submission services offered. To visit Office Ally and for detailed information about electronic submissions, go to Provider Connection at blueshieldca.com/provider and click on Claims.

Mail hard-copy BlueCard claims that require medical records to:

Blue Shield of California
BlueCard Program
P. O. Box 1505
Red Bluff, CA 96080-1505

BlueCard Claim Tips

After the member of another Blue Plan receives services from you, you should submit the claim to Blue Shield of California. We will work with the member’s Blue Plan to process the claim and the member’s Blue Plan will send an explanation of benefit (EOB) to the member. We will send you an explanation of payment or remittance advice and applicable payment to you under the terms of our contract with you, and based on the member’s benefits and coverage.

Following these helpful tips will improve your claim experience:

- Ask members for their current member ID card and regularly obtain new photocopies of the (front and back). Having the current card enables you to submit claims with the appropriate member information (including three-character prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits electronically at www.blueshieldca.com/provider or by calling (800) 676-BLUE (2583). Be sure to provide the member’s three-character prefix.
BlueCard Claim Tips (cont’d.)

- Verify the member’s cost sharing amount before processing payment. Please do not process full payment upfront as Blue Plan members are responsible for their share of cost, deductible, co-insurance, and non-covered services.

- Indicate any payment you collected from the patient on the claim. (On the 837 electronic claim submission form, check field AMT01=F5 patient paid amount; on the CMS1500 locator 29 amount paid.)

- Submit all BlueCard claims to Blue Shield of California. Be sure to include the member’s complete subscriber identification number when you submit the claim. This includes the three-character prefix. Submit claims with only valid prefixes; claims with incorrect or missing prefixes and member identification numbers cannot be processed.

- Reduce claim adjustments by double-checking to ensure you’ve indicated the correct provider Tax ID Number (TIN), Provider Identification Number (PIN) and/or the National Provider Identifier (NPI) number.

- In cases where there is more than one payor and a Blue Plan is a primary payor, submit Other Party Liability (OPL) information with the BlueCard claim. Upon receipt, Blue Shield of California will electronically route the claim to the member’s Blue Plan.

- **Do not send duplicate claims.** Sending another claim, or having your billing agency resubmit claims automatically, slows down the claims payment process and creates confusion for the member. Go to Provider Connection at blueshieldca.com/provider for direct access, 24 hours a day, seven days a week, for current, reliable information on BlueCard claims, payment status and claim reporting tools.

- To avoid denials as duplicates when submitting corrected BlueCard claims, file them after the original claim has finalized. After the original claim is finalized, you may submit the corrected claim electronically by identifying the claim as Type of Bill (XX7).

- If medical records are requested, send them to either the claims address listed on the request letter you received from Blue Shield or to the address that appears in the search results of the Claims Routing Tool or the eligibility and benefits inquiry.

- Check claims status by contacting Blue Shield of California at blueshieldca.com/provider, contact Blue Shield’s dedicated BlueCard Customer Service Unit at (800) 622-0632, or submit an electronic HIPAA 276 transaction to Blue Shield of California.

Send BlueCard claims electronically. However, when medical records must be attached with paper BlueCard claims, please consider these paper claim tips:

- Applying a stamp on the paper claims with clear messages is acceptable to Blue Shield; however, **do not** cover key information with the stamp. Attaching a cover sheet to the claim is an acceptable alternative to applying a stamp to the claim form.

- Please type or write in a font size that is large enough so that your message can be clearly read.

- When medical records must be attached, mail BlueCard claims to:
  
  Blue Shield of California  
  BlueCard Program  
  P.O. Box 1505  
  Red Bluff, CA  96080-1505
BlueCard Claim Tips (cont’d.)

After you have submitted BlueCard claims to Blue Shield, you may obtain status and verify payment information on your BlueCard claims by accessing the Claims section on our website at blueshieldca.com/provider. Use this tool as your primary resource for requesting and receiving details and status of BlueCard claim.

If you have remaining questions about your BlueCard claims after accessing the Claims section on our website, download the BlueCard Program claims brochure for professional providers (which is available in the resources tab of the BlueCard Program web page at blueshieldca.com/bluecard), or contact Blue Shield’s dedicated BlueCard Customer Service Unit at (800) 622-0632.

Submitting BlueCard Claims

Providers can electronically submit BlueCard claims to Blue Shield. To determine where to send BlueCard claims, providers may:

1) Access our Claims Routing Tool on Provider Connection at blueshieldca.com/provider by clicking on the Access Claims Routing Tool link within the BlueCard Program section of the welcome landing page. Simply enter the member’s three-character prefix and date of service to immediately learn where to send the BlueCard claim.

2) Note the claim address and patient benefit information added to the online verification of Eligibility and Benefits search results returned by blueshieldca.com/provider. You’ll find the information you need to correctly send BlueCard claims, as well as local Blue Shield commercial and FEP claims. On the right-hand side of your search results, refer to the appropriate payor information, claims mailing address, claims unit’s toll-free telephone number and member eligibility toll-free telephone number.

3) If and for so long as your independent physician practice is not contracted with another licensee of the Blue Cross Blue Shield Association in the State of California, providers shall submit to Blue Shield for processing all claims for medical services furnished by your independent physician practice and process through the BlueCard Program, unless the member receiving such services is enrolled in a benefit plan having an exclusive arrangement with such other licensee of the Association.

4) If and for so long as your independent physician practice is contracted with both Blue Shield and another licensee of the Blue Cross Blue Shield Association in the State of California, and there is no exclusive arrangement with either Blue Shield nor the other license of the Association, your independent physician practice shall use best efforts to increase the number of claims for medical services process through the BlueCard Program (as defined in the Provider Manual) sent to Blue Shield for processing.

5) Request a BlueCard routing option from Blue Shield. The BlueCard routing option is a streamlined IT solution developed by Blue Shield that integrates with a provider’s clearinghouse and/or eligibility and benefits verification vendor’s system to simplify and automate selecting the correct California Blue plan for processing BlueCard claims. The BlueCard routing option is an alternative to using Blue Shield’s Claims Routing Tool on Provider Connection. To inquire about the BlueCard routing option, email BlueCardMarketing@blueshieldca.com Or submit an EDI inquiry online on Provider Connection.

6) If submitting a claim for ancillary services (independent clinical lab, DME/HME, or specialty pharmacy), please refer to the Ancillary Claims Filing Guidelines section of this appendix.
Submitting BlueCard Claims (cont’d.)

If you have any questions about electronic claims submission, contact our EDI Help Desk at (800) 480-1221, email EDI_BSC@blueshieldca.com.

In cases where there is more than one payor and Blue Cross and/or Blue Shield is a primary payor, submit Other Party Liability (OPL) information with the Blue Cross and/or Blue Shield claim. Upon receipt, Blue Shield will electronically route the claim to the member’s Blue plan. The member’s Blue plan then processes the claim and applicable payment. Blue Shield will reimburse you for services.

Below is an example of how claims flow through BlueCard

1. Member of an out-of-state Blue Plan receives services from you, the provider.
2. Provider submits claim to Blue Shield.
3. Blue Shield recognizes out-of-state Blue member and transmits claim to the member’s Blue Plan.
4. Member’s Blue Plan adjudicates claim according to member’s benefit plan.
5. Member’s Blue Plan issues an EOB to the member.
6. Member’s Blue Plan transmits claim payment disposition to Blue Shield.
7. Blue Shield pays you, the provider.
Traditional Medicare-Related Claims

The following are guidelines for the processing of traditional Medicare-related claims:

- When Medicare is primary payor, submit claims to your local Medicare intermediary.

- All Blue claims are set up to automatically cross-over to the member’s Blue Plan after being adjudicated by the Medicare intermediary.

How do I submit Medicare primary/Blue plan secondary claims?

- For members with Medicare primary coverage and Blue plan secondary coverage, submit the claim first to your Medicare intermediary.

- Be certain that you include the exact name of the secondary plan and the complete subscriber number. The member’s Blue plan subscriber number will include the three-character prefix followed by alphanumeric values.

- When you receive the remittance advice from the Medicare intermediary, verify whether the claim has been automatically forwarded (crossed over) to the secondary payor (Blue plan). If the Medicare remittance advice indicates the claim has been crossed over, it means that Medicare has forwarded the claim, on your behalf, to the appropriate secondary plan for processing. There is no need for you to resubmit the claim to the Blue plan.

When should I expect to receive payment?

The Medicare intermediary will process and cross over the claim within about 14 business days. This means that the Medicare intermediary will be forwarding the claim to the secondary Blue plan on approximately the same date you receive the Medicare remittance advice. Please allow up to 30 additional calendar days before expecting payment or instructions regarding the secondary processing of the claim.

What should I do if I have not received a Medicare remittance advice and/or payment for the claim?

If you submitted the claim to the Medicare intermediary and you have not received a response to your initial claim submission, do not automatically submit another claim to the secondary Blue plan. Instead, please take the following steps:

- Confirm that the Medicare intermediary received the claim and resend it to the Medicare intermediary only if it was not initially received.

- Wait until you receive the Medicare remittance advice for the claim.

- Wait an additional 30 calendar days after you receive the remittance advice to receive payment or instructions from the Blue plan regarding secondary coverage processing.

- If, after 30 calendar days, you have not received payment or instructions from the Blue plan regarding secondary claim processing, we recommend that you submit a secondary claim, including complete Medicare adjudication information, to the local Blue plan, as appropriate.

To avoid having your claim denied by the Blue plan as a duplicate, do not submit a secondary claim to the local Blue plan before taking each of the steps described above.
Traditional Medicare-Related Claims (cont’d.)

Whom should I contact if I have questions?

If Blue Shield is the secondary healthcare coverage carrier for the patient, please contact us using the following information:

- Online at www.blueshieldca.com/provider
- Provider Customer Service, by telephone at (800) 541-6652
- By postal mail at Blue Shield of California, P.O. Box 272540, Chico, CA 95927-2540

If the patient’s secondary plan is a Blue plan in a state other than California, please contact us using the following information:

- BlueCard Provider Customer Service, by telephone at (800) 622-0632
- By postal mail at BlueCard Claims, P.O. Box 1505, Red Bluff, CA 96080-1505
Ancillary Claims Filing Requirements

Ancillary providers include Independent Clinical Laboratory, Durable/Home Medical Equipment and Supplies, and Specialty Pharmacy providers. These providers must file their claims according to the Blue Cross Blue Shield Association’s Ancillary Claims Filing Requirements, as follows:

- **Independent Clinical Laboratory (Lab)**
  - The Plan in whose state the specimen was drawn based on the location of the referring provider.

- **Durable/Home Medical Equipment and Supplies (D/HME)**
  - The Plan in whose state the equipment was shipped to or purchased at a retail store.

- **Specialty Pharmacy**
  - The Plan in whose state the Ordering Physician is located.

* If you contract with more than one Plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either Plan.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>How to File (Required Fields)</th>
<th>Where to File</th>
<th>Example</th>
</tr>
</thead>
</table>
| **Independent Clinical Laboratory** (any type of non-hospital based laboratory) | **Referring Provider:**
  - Field 17B on CMS 1500 Health Insurance Claim Form or
  - Loop 2310A (claim level) on the 837 Professional Electronic File the claim in whose state the specimen was drawn.

  * Where the specimen was drawn will be determined by which state the referring provider is located. |
| **Durable/Home Medical Equipment and Supplies (D/HME)** | **Patient’s Address:**
  - Field 5 on CMS 1500 Health Insurance Claim Form or
  - Loop 2010CA on the 837 Professional Electronic Submission.

  **Ordering Provider:**
  - Field 17B on CMS 1500 Health Insurance Claim Form or
  - Loop 2420E (line level) on the 837 Professional Electronic Submission.

  **Place of Service:**
  - Field 24B on the CMS 1500 Health Insurance Claim Form or
  - Loop 2300, CLM05-1 on the 837 Professional Electronic Submissions.

  **Service Facility Location Information:**
  - Field 32 on CMS 1500 Health Insurance Form or
  - Loop 2310C (claim level) on the 837 Professional Electronic Submission. |
| | **File the claim in whose state the equipment was shipped to or purchased in a retail store.** | **File to:** [enter Plan y service area].
  Blood analysis is done in [enter Plan y service area].
  *Claims for the analysis of a lab must be filed to the Plan in whose state the specimen was drawn.* |
| | | A. Wheelchair is purchased at a retail store in [enter Plan y service area].
  File to: [enter Plan y service area]
  B. Wheelchair is purchased on the internet from an online retail supplier in [enter Plan x service area] and shipped to [enter Plan y service area].
  File to: [enter Plan x service area] |
| | | C. Wheelchair is purchased at a retail store in [enter Plan x service area] and shipped to [enter Plan y service area].
  File to: [enter Plan y service area] |
### Specialty Pharmacy

**Types of Service:** Non-routine, biological therapeutics ordered by a healthcare professional as a covered medical benefit as defined by the member’s Plan’s Specialty Pharmacy formulary. Include, but are not limited to: injectable, infusion therapies, etc.

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>How to File (Required Fields)</th>
<th>Where to File</th>
<th>Example</th>
</tr>
</thead>
</table>
| Specialty Pharmacy  | **Referring Provider:**  
- Field 17B on CMS 1500 Health Insurance Claim Form or  
- Loop 2310A (claim level) on the 837 Professional Electronic Submission.  | File the claim to the Plan whose state the **Ordering Physician is located.**  | Patient is seen by a physician in [enter Plan x service area] who orders a specialty pharmacy injectable for this patient. Patient will receive the injections in [enter Plan y service area] where the member lives for 6 months of the year. File to: [enter Plan x service area] |

- The ancillary claim filing rules apply regardless of the provider’s contracting status with the Blue Plan where the claim is filed.

- Providers are encouraged to verify member eligibility and benefits by contacting the phone number on the back of the member ID card or call (800)676-BLUE prior to providing any ancillary service.

- Providers that utilize outside vendors to provide services (e.g., sending blood specimen for special analysis that cannot be done by the Lab where the specimen was drawn) should utilize in-network participating ancillary providers to reduce the possibly of additional member liability for covered benefits. A list of in-network participating providers may be obtained by contacting Blue Shield’s Provider Information & Enrollment unit at (800) 258-3091 or logging onto blueshieldca.com/provider.

- Members are financially liable for ancillary services not covered under their benefit plan. It is the provider’s responsibility to request payment directly from the member for non-covered services.

- Providers who wish to establish Trading Partner Agreements with other Plans should contact the other Blue Plans to obtain additional information.

- If you have questions about the Ancillary Claims Filing Requirements, please contact Blue Shield’s BlueCard Customer Service Unit at (800) 622-0632 or log onto Provider Connection at blueshieldca.com/provider, click on the **Ancillary Providers** link under the **Helpful Resources** subhead and then **Ancillary Claims Filing Requirements** at the bottom.
Claims Filing for Air Ambulance Services for BlueCard Patients

Generally, as a healthcare provider you should file claims for your Blue Cross and Blue Shield patients to the local Blue Plan. However, there are unique circumstances when claims filing directions will differ based on the type of service rendered.

Claims for air ambulance services must be filed to the Blue Plan in whose service area the point of pickup ZIP code is located.

Note: If you contract with more than one Plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either Plan.

<table>
<thead>
<tr>
<th>Service Rendered</th>
<th>How to File (Required Fields)</th>
<th>Where to File</th>
<th>Example</th>
</tr>
</thead>
</table>
| Air Ambulance Services  | Point of Pickup ZIP Code:                                                                   | File the claim to the Plan in whose service area the point of pickup ZIP code is located*.
|                         | - Populate item 23 on CMS 1500 Health Insurance Claim Form, with the 5-digit ZIP code of the point of pickup
|                         | - For electronic billers, populate the origin information (ZIP code of the point of pick-up), in the Ambulance Pick-Up Location Loop in the ASC X12N Health Care Claim (837) Professional.
|                         | - Where Form CMS-1450 (UB-04) is used for air ambulance service not included with local hospital charges, populate Form Locators 39-41, with the 5-digit ZIP code of the point of pickup. The Form Locator must be populated with the approved Code and Value specified by the National Uniform Billing Committee in the UB-04 Data Specifications Manual.
|                         | - Form Locators (FL) 39-41
|                         | - Code: A0 (Special ZIP code reporting), or its successor code specified by the National Uniform Billing Committee.
|                         | - Value: Five digit ZIP code of the location from which the beneficiary is initially placed on board the ambulance.
|                         | - For electronic claims, populate the origin information (ZIP code of the point of pick-up) in the Value Information Segment in the ASC X12N Health Care Claim (837) Institutional. |

*BlueCard rules for claims incurred in an overlapping service area and contiguous county apply.

If you have questions about the claims filing for Air Ambulance Services for an out-of-state Blue plan member, please contact Blue Shield’s BlueCard Customer Service Unit at (800) 622-0632.
Medical Records

Blue Plans around the country have made improvements to the medical records process to make it more efficient. We now are able to send and receive medical records electronically among each other. This new method significantly reduces the time it takes to transmit supporting documentation for our out-of-area claims, reduces the need to request records multiple times and significantly reduces lost or misrouted records.

Under what circumstances may the provider get requests for medical records for out-of-area members?

- **As part of the pre-authorization process** - If you receive request for medical records from the member’s Blue Plan prior to rendering services, as part of the pre-authorization process, you will be instructed to submit the records directly to the member’s Blue Plan that requested them. This is the only circumstance where you would not submit them to Blue Shield.

- **As part of claim review and adjudication** - These requests will come from Blue Shield in a form of a letter requesting specific medical records and including instructions for submission.

  *Note: When requesting medical records for DME/HME services, the ordering provider’s information is required to process the request.*

BlueCard Medical Record Process for Claim Review

- An initial communication, generally in the form of a letter, should be received by your office requesting the needed information.

- A remittance may be received by your office indicating the claim is being denied pending receipt and review of records. Occasionally, the medical records you submit might cross in the mail with the remittance advice for the claim indicating a need for medical records. A remittance advice is not a duplicate request for medical records. If you submitted medical records previously, but received a remittance advice indicating records were still needed, please contact Blue Shield’s dedicated BlueCard Customer Service team at (800) 622-0632 to ensure your original submission has been received and processed. This will prevent duplicate records being sent unnecessarily.

- If you received only a remittance advice indicating records are needed, but you did not receive a medical records request letter, contact Blue Shield’s dedicated BlueCard Customer Service team at (800) 622-0632 to determine if the records are needed from your office.

- Upon receipt of the information, the claim will be reviewed to determine the benefits.
Medical Records (cont’d.)

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 to Blue Shield’s dedicated BlueCard Customer Service team at: Blue Shield, BlueCard Program, P. O. Box 1505, Red Bluff, CA 96080-1505
- Follow the submission instructions given on the request, using the specified address, email address or fax number. The address or fax number for medical records may be different than the address you use to submit claims.
- Include the cover 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.
- Please submit the information to Blue Shield within 10 days of the request to avoid further delay.
- Only send the information specifically requested. Frequently, complete medical records are not necessary.
- Please do not proactively send medical records with the claim. Unsolicited claim attachments may cause claim payment delays.

Claims Coding

Code claims as you would for Blue Shield claims. Please refer to Section 4: Billing and Payment for further claim billing information and requirements.

Claim Payment and Claim Status Inquiries

Blue Shield processes BlueCard claims in accordance to our contract agreement with you. Go to Provider Connection at blueshieldca.com/provider 24 hours a day, seven days a week for current, reliable information on BlueCard claims, payment status, and claim reporting tools.

To obtain status and verify payment information on your BlueCard claims, access the Claims section on blueshieldca.com/provider. Use this tool as your primary resource for requesting and receiving details on BlueCard claims. If you have remaining questions about your BlueCard claims after accessing the Claims section on our website, contact Blue Shield’s dedicated BlueCard Customer Service Unit at (800) 622-0632. Electronic, online and phone inquiries for eligibility and benefits for clinical lab, DME/HME, and specialty pharmacy services should be directed to the local plan as defined in the Ancillary Claims Filing Guidelines section of this appendix.

Calls from Members and Others with Claim Questions

If Blue Plan members contact you, advise them to contact their Blue Plan and refer them to their ID card for a customer service number.

The member’s Blue Plan should not contact you directly regarding claims issues, but if the member’s Blue Plan contacts you and asks you to submit the claim to them, refer them to Blue Shield of California.
Value Based Provider Arrangements

Plans have value-based care delivery arrangements in place with their providers. Each Plan has created their own arrangement with their provider(s), including reimbursement arrangements. Due to the unique nature of each Plan/provider arrangement, there is no common provider education template for value-based care delivery arrangements that can be created and distributed for use by all Plans.

Claim Adjustments

Contact the Blue Shield BlueCard Customer Service team at (800) 622-0632 if an adjustment is required.

Provider Claim Appeals

Provider claim appeals for all BlueCard claims processed by Blue Shield are handled through Blue Shield. BlueCard claim appeals must be resolved within a 30-day timeframe. We will coordinate the appeal process with the member’s Blue Plan, if needed. For more information on the BlueCard claim appeal process, contact our BlueCard dedicated Customer Service Unit at (800) 622-0632.
Section 4
BlueCard Resources

Claims Routing Tool

Determining where to submit BlueCard claims is the number one question providers ask about BlueCard claims. To find out which California Blue Plan can process your BlueCard claim, access our Claims Routing Tool on Provider Connection at blueshieldca.com/provider and click on the Access Claims Routing Tool link within the BlueCard Program section. Simply enter the member’s three-character prefix and date of service to instantly learn where to send your BlueCard claim.

BlueCard Program Tutorials

Access our online BlueCard Program tutorials and quickly learn about our online tools. BlueCard tutorials are available anytime, 24 hours a day, 7 days a week. Select the topics you want to learn about, whenever it’s convenient for you.

The tutorials will help you learn how to:

- Verify eligibility and benefits
- Access other Blue plans’ medical policies, pre-certification guidelines and request medical authorizations
- Instantly determine where to submit claims with the Claims Routing Tool
- Check claims status, payment details and EOB’s
- Get help on Medicare secondary claims involving out-of-state Blue plans

Log into Provider Connection at blueshieldca.com/provider and click on the BlueCard Program link. Then choose from a variety of tutorial modules offered.

BlueCard Program Webinars

We offer complimentary online BlueCard Program training sessions to give providers detailed information about serving other states’ Blue plan members and processing out-of-state Blue plan claims.

We conduct monthly BlueCard Basics training as well as quarterly online training sessions on a wide variety of BlueCard topics. To attend one of our webinars, access our Webinars tab in the BlueCard Program web page on Provider Connection for the date, time, topic and type of provider whom the webinar is intended. You can also register for available BlueCard webinars by accessing News & Education on Provider Connection’s opening landing page and clicking on the Register for Webinars link. To receive notification about BlueCard webinars, request more information by emailing BlueCardMarketing@blueshieldca.com.

BlueCard Program Educational Resources

A wide variety of BlueCard educational flyers, brochures, and training videos are available on our BlueCard Program web page on Provider Connection. The BlueCard educational materials are also available in the News & Education link.
Section 5
Medicare Advantage

Medicare Advantage Overview

“Medicare Advantage” (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage (generally referred to as “traditional Medicare”). It offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans. All Medicare Advantage plans must offer beneficiaries at least the standard Medicare Part A and B benefits, but many offer additional covered services as well (e.g., enhanced vision and dental benefits).

In addition to these products, Medicare Advantage organizations may also offer a Special Needs Plan (SNP) which can limit enrollment to subgroups of the Medicare population in order to focus on ensuring that their special needs are met as effectively as possible.

Medicare Advantage plans may allow in-and out-of-network benefits, depending on the type of product selected. Providers should confirm the level of coverage by calling the members’ health plans or submitting an electronic inquiry for all Medicare Advantage members prior to providing service since the level of benefits, and coverage rules may vary depending on the Medicare Advantage plan.

Types of Medicare Advantage Plans

Medicare Advantage HMO

A Medicare Advantage HMO is a Medicare managed care option in which members typically receive a set of predetermined and prepaid services provided by a network of physicians and hospitals. Generally (except in urgent or emergency care situations), medical services are only covered when provided by in-network providers. The level of benefits, and the coverage rules, may vary by Medicare Advantage plan.

Medicare Advantage POS

A Medicare Advantage POS program is an option available through some Medicare HMO programs. It allows members to determine—at the point of service—whether they want to receive certain designated services within the HMO system, or seek such services outside the HMO’s provider network (usually at greater cost to the member). The Medicare Advantage POS plan may specify which services will be available outside of the HMO’s provider network.

Medicare Advantage PPO

A Medicare Advantage PPO is a plan that has a network of providers, but unlike traditional HMO products, it allows members who enroll access to services provided outside the contracted network of providers. Required member cost-sharing may be greater when covered services are obtained out-of-network. Medicare Advantage PPO plans may be offered on a local or regional (frequently multi-state) basis. Special payment and other rules apply to regional PPOs.
Types of Medicare Advantage Plans *(cont’d.)*

**Medicare Advantage PFFS**

A Medicare Advantage PFFS plan is a plan in which the member may go to any Medicare-approved doctor or hospital that accepts the plan’s terms and conditions of participation. Acceptance is “deemed” to occur where the provider is aware, in advance of furnishing services, that the member is enrolled in a PFFS product and where the provider has reasonable access to the terms and conditions of participation.

The Medicare Advantage organization, rather than the Medicare program, pays physicians and providers on a fee-for-services basis for services rendered to such members. Members are responsible for cost-sharing, as specified in the plan, and balance billing may be permitted in limited instance where the provider is a network provider and the plan expressly allows for balance billing.

Medicare Advantage PFFS varies from the other Blue products you might currently participate in:

- You can see and treat any Medicare Advantage PFFS member without having a contract with Blue Shield.
- If you do provide services, you will do so under the Terms and Conditions of that member’s Blue Plan.
- Please refer to the back of the member’s ID card for information on accessing the Plan’s Terms and Conditions. You may choose to render services to a MA PFFS member on an episode of care (claim-by-claim) basis.
- MA PFFS Terms and Conditions might vary for each Blue Cross and/or Blue Shield Plan and we advise that you review them before servicing MA PFFS members.
- You can determine the Terms and Conditions related to a members’ Medicare Advantage Plan by accessing the Medicare Advantage Plan Terms and Conditions Lookup Tool located under the “BlueCard Resources” link on the BlueCard Program page at blueshieldca.com/provider. To use the tool, enter the first three characters of the member’s identification number on the Blue Cross Blue Shield Medicare Advantage PFFS card and click “GO” to view the BCBS Medicare Advantage PFFS Plan’s Terms & Conditions.
- Submit your MA PFFS claims to Blue Shield.

**Medicare Advantage Medical Savings Account (MSA)**

A Medicare Advantage MSA plan is made up of two parts. One part is the Medicare Medical Savings Account (MSA) which is a type of savings account for members to pay for qualified medical expenses. The other part is the Medicare MSA Health Policy that is a special health insurance policy with a high deductible. Qualified medical expenses are services and products that otherwise could be deducted as medical expenses on the member’s annual tax return, which includes but is not limited to doctor visits, hospital stays, dental exams and medical equipment. The Blue Plan calculates the amount and the Medicare program deposits the funds into the member’s savings account. Savings balances accumulate interest or dividends tax free until spent and as long as the member spends the funds on qualified medical expenses, the money is tax free to the member.
Types of Medicare Advantage Plans (cont’d.)

Medicare Advantage SNP

A Medicare Advantage SNP allows a Medicare Advantage organization to offer benefit plans targeted to special needs populations and limit enrollment to only members with the special needs. Many MA organizations target Medicare populations with special needs defined by the presence of certain chronic diseases. For example, a SNP may only provide coverage for members with cardiovascular disease or members who have diabetes. Unlike other Medicare Advantage Plans, SNPs must provide Medicare prescription drug coverage. Medical Advantage SNPs also may target enrollment to dual-eligibles and to beneficiaries residing in institutions.

How to Recognize Medicare Advantage Members

Members of Medicare Advantage plans will not have a standard Medicare card; instead, a Blue Cross and/or Blue Shield logo will be visible on the ID card. The following examples illustrate how the different products associated with the Medicare Advantage program will be designated on the front of the member ID cards:

<table>
<thead>
<tr>
<th>Member ID cards for Medicare Advantage products will display one of the benefit product logos shown here:</th>
<th>Health Maintenance Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Advantage HMO</td>
<td>Medical Savings Account</td>
</tr>
<tr>
<td>Medicare Advantage MSA</td>
<td>Private Fee-For-Service</td>
</tr>
<tr>
<td>Medicare Advantage PFFS</td>
<td>Point of Service</td>
</tr>
<tr>
<td>Medicare Advantage POS</td>
<td>Network Sharing Preferred Provider Organization</td>
</tr>
</tbody>
</table>

When these logos are displayed on the front of a member’s ID card, it indicates the coverage type the member has in his/her Blue Plan service area or region. However, when the member receives services outside his/her Blue Plan service area or region, provider reimbursement for covered services is based on the Medicare allowed amount, except for PPO network sharing arrangements.

Blue Shield of California participates in Medicare Advantage PPO Network Sharing arrangements, and contracted provider reimbursement is based on the contracted rate with Blue Shield of California. Non-contracted provider reimbursement is the Medicare allowed amount based on where services are rendered.

Tip: While all MA PPO members have suitcases on their ID cards, some have limited benefits outside of their primary carrier’s service area. Providers should refer to the back the member’s ID card for language indicating such restrictions apply.
Eligibility Verification

Verify eligibility by contacting Medicare Member Services at (800) 676-BLUE (2583) and providing the member’s prefix or by submitting an electronic inquiry to Blue Shield and providing the alpha prefix. Be sure to ask if Medicare Advantage benefits apply. If you experience difficulty obtaining eligibility information, please record the prefix and report it to Blue Shield.

Medicare Advantage Claims Submission

Submit all Medicare Advantage claims to Blue Shield. Do not bill Medicare directly for any services rendered to a Medicare Advantage member. Payment will be made directly by a Blue Plan.
The BlueCard® Program

Reimbursement for Medicare Advantage PPO, HMO and POS

No Plan Contract: Services for out-of-area and local Medicare Advantage members

Based upon the Centers for Medicare & Medicaid Services (CMS) regulations, if you are a provider who accepts Medicare assignment and you render services to a Medicare Advantage member for whom you have no obligation to provide services under your contract with a Blue plan, you will generally be considered a non-contracted provider and be reimbursed the equivalent of the current Medicare allowed amount for all covered services (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare). Special payment rules apply to hospitals and certain other entities (such as skilled nursing facilities) that are non-contracted providers.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan or its branded affiliate. In general, you may collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

Note: Enrollee payment responsibilities can include more than copayments (e.g., deductibles). Please review the remittance notice concerning Medicare Advantage plan payment, member’s payment responsibility, and balance billing limitations.

Plan Contract: Services for local Blue Medicare Advantage members

If you are a provider who accepts Medicare assignment and you render services to a local Medicare Advantage member for whom you have an obligation to provide services under your contract with a Blue Plan, you will be considered a contracted provider and be reimbursed per the contractual agreement.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual Plan contractual arrangements. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan. In general, you may collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

Please review the remittance notice concerning Medicare Advantage plan payment, member’s payment responsibility, and balance billing limitations.

Plan Contract: Services for out-of-area Medicare Advantage Blue members

If you are a provider who accepts Medicare assignment, has a Blue Plan contract to provide services for local Medicare Advantage enrollees only, and you render services to out-of-area Blue Medicare Advantage members, you will be reimbursed at the Medicare allowed amount (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare).

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual Plan contractual arrangements. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan. In general, you may collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

Please review the remittance notice concerning Medicare Advantage plan payment, member’s payment responsibility and balance billing limitations.
Reimbursement for Medicare Advantage Private Fee-For-Service (PFFS)

Plan Contract: Services for local Medicare Advantage PFFS member

If you are a provider who accepts Medicare assignment and you render services to a PFFS local Medicare Advantage member for whom you have an obligation to provide services under your contract with a Blue Plan, you will generally be considered a contracted provider and be reimbursed per the contractual agreement. This amount may be less than your charge amount.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual Plan contractual arrangements. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan. In general, you may collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service, but may be able to balance bill the member in certain limited instances where the Blue plan with which you contract expressly allows for balancing billing of PFFS members.

Please review the remittance notice concerning Medicare Advantage plan payment, member’s payment responsibility and balance billing limitations.

Services for out-of-area Blue Medicare Advantage PFFS members

If you have rendered services for a Blue out-of-area Medicare Advantage PFFS member, but are not obligated to provide services to such member under a contract with a Blue Plan, you will generally be reimbursed the Medicare allowed amount for all covered services (i.e., the amount you would collect if the beneficiary were enrolled in traditional Medicare).

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules. Other than the applicable member cost sharing amounts, reimbursement is made directly by a Blue Plan. In general, you may collect only the applicable cost sharing (e.g., copayment) amounts from the member at the time of service, and may not otherwise charge or balance bill the member.

Please review the remittance notice concerning Medicare Advantage plan payment, member’s payment responsibility and balance billing limitations.
Medicare Advantage Network Sharing

What is BCBS Medicare Advantage PPO Network Sharing?

Network sharing allows MA PPO members from MA PPO Blue Plans to obtain in-network benefits when traveling or living in the service areas of the MA PPO Plans as long as the member sees a contracted Medicare Advantage PPO provider. Medicare Advantage PPO shared networks are available in 35 states and one territory:

- Alabama
- Arkansas
- California
- Colorado
- Connecticut
- Florida
- Georgia
- Hawaii
- Idaho
- Illinois*
- Indiana
- Kentucky
- Maine
- Massachusetts
- Michigan
- Missouri
- Montana
- North Carolina
- Nevada
- New Hampshire
- New Jersey
- New Mexico
- New York
- Ohio
- Oklahoma
- Oregon
- Pennsylvania
- Puerto Rico
- South Carolina
- Tennessee
- Texas
- Utah
- Virginia
- Washington
- Wisconsin
- West Virginia

What does the BCBS Medicare Advantage PPO Network Sharing mean to me?

There is no change from your current practice. You should continue to verify eligibility and bill for services as you currently do for any out-of-area Blue Medicare Advantage member you agree to treat. Benefits will be based on the Medicare allowed amount for covered services and be paid under the member’s out-of-network benefits unless for urgent or emergency care. Once you submit the MA claim, Blue Shield will send you payment.

When the logo is displayed on the front of a member’s ID card, it indicates the coverage type the member has in his/her Blue Plan service area or region. However, when the member receives services outside his/her Blue Plan service area or region, provider reimbursement for covered services is based on the Medicare allowed amount, except for PPO network sharing arrangements.

Do I have to provide services to these Medicare Advantage PPO network sharing members or other Blue MA members from out-of-area?

If you are a contracted Medicare Advantage PPO provider with Blue Shield of California, you must provide the same access to care as you do for local members. You can expect to receive the same contracted rates for such services.

If you are not a Medicare Advantage PPO contracted provider, you may see Medicare Advantage members from other Blue Plans but you are not required to do so. Should you decide to provide services to Blue Medicare Advantage members, you will be reimbursed for covered services at the Medicare allowed amount based on where the services were rendered and under the member’s out-of-network benefits. For urgent or emergency care, you will be reimbursed at the in-network benefit level.

If you choose to provide services to a Blue Private-Fee-for-Service (PFFS) member (as a “deemed” provider), you will be reimbursed for covered services at the Medicare allowed amount, as outlined in the Plan’s PFFS Terms and Conditions.
Medicare Advantage Network Sharing (cont’d.)

What if my practice is closed to new local Blue Medicare Advantage PPO members?

If your practice is closed to new local Blue MA PPO members, you do not have to provide care for Blue MA PPO out-of-area members. The same contractual arrangements apply to these out-of-area network sharing members as your local MA PPO members.

If I chose to provide services, how do I verify benefits and eligibility?

Call BlueCard Eligibility® at (800) 676-BLUE (2583) and provide the member’s three-character prefix located on the ID card. You may also submit electronic eligibility requests for Blue members, following these three easy steps:

1. Log in to Provider Connection at blueshieldca.com/provider.
2. Click on the Eligibility & Benefits tab at the top of the web page and enter the required data fields to verify member eligibility.
3. Submit your request online.

Where do I submit the claim?

You should submit the claim to Blue Shield under your current billing practices. Do not bill Medicare directly for any services rendered to a Medicare Advantage member.

What can I expect for reimbursement?

Benefits will be based on the Medicare allowed amount when providing covered services to any Blue Medicare Advantage out-of-area members. Once you submit the MA claim, Blue Shield will send you the payment. These services will be paid under the members out-of-network benefits, unless services were for urgent or emergency care.

What is the member cost sharing level and copayments?

Any MA PPO members from out-of-area will pay the out-of-network cost sharing amount. You may collect the copayment amounts from the member at the time of service.

May I request payment upfront?

Generally, once the member receives care, you should not ask for full payment up front other than out-of-pocket expenses (deductible, copayment, coinsurance, and non-covered services).

Under certain circumstances, when the member has been notified in advance that a service will not be covered, you may request payment from the member before services are rendered or billed to the member. The member should sign an Advance Benefit Notification (ABN) form before services are rendered in these situations.

May I balance bill the member the difference in my charge and the allowance?

No. You may not balance bill the member for this difference. Members may be balanced billed for any deductibles, co-insurance, and/or copays.

What if I disagree with the reimbursement amount I received?

If there is a question concerning the reimbursement amount, contact Blue Shield at (800) 622-0632.
Health Insurance Marketplaces Overview

The Patient Protection and Affordable Care Act of 2010 provides for the establishment of Health Insurance Marketplaces (i.e. Exchanges), in each state, where individuals and small businesses can purchase qualified insurance coverage through internet websites. The intent of the Marketplace is to:

- Create a more organized and competitive health insurance marketplace by offering consumers a choice of health insurance plans,
- Establish common rules regarding insurance offerings and pricing,
- Provide information to help consumers better understand the options available to them and,
- Allow individual and small businesses to have the purchasing power comparable to that of large businesses.

The Marketplaces makes it easier for consumers to compare health insurance plans by providing transparent information about health insurance plan provisions such as product information, premium costs, and covered benefits, as well as a plan’s performance in encouraging wellness, managing chronic illnesses, and improving consumer satisfaction.

Each state is given the option to set-up its own “state-based” Marketplace approved by HHS for marketing products to individual consumers and small businesses. If states do not set up a state-based marketplace, the Department of Health and Human Services (HHS) establishes a federally-facilitated Marketplace, federally-supported Marketplace, or a state-partnership Marketplace in the state. Blue Plans that offer products on the Marketplaces collaborate with the state and federal governments for eligibility, enrollment, reconciliation, and other operations to ensure that consumers can seamlessly enroll in individual and small business health insurance products. Blue Shield of California has on-Exchange state-subsidized plans available for purchase through Covered California. Information on Covered California plans offered by Blue Shield can be accessed through Provider Connection at blueshieldca.com/provider. Click on the Health Care Reform for Providers link in the Guidelines & Resources tab.

OPM Multi-State Plan Program

Under the Affordable Care Act of 2010, the Office of Personnel Management (OPM) was required to offer OPM sponsored products on the Marketplaces beginning in 2014. For a coverage effective date of Jan. 1, 2017, Blue Cross and Blue Shield Plans will participate in this program by offering these Multi-State Plans on Marketplaces in 21 states.

For 2017, the following Plans will offer Multi-State Plan products: ARBCBS, HCSC (IL, TX, OK, and MT), BCBSAL, BCBSM, BCBSC, and Anthem (CA, CO, CT, GA, IN, KY, ME, MO, NV, NH, NY, VA, and WI).

The Multi-State Plan products are similar to other Qualified Health Plan products offered on the Marketplaces. Generally, all of the same requirements that apply to other state Marketplace products also apply to these Multi-State Plan products.
Health Insurance Marketplaces Overview (cont’d.)

Exchange-Purchased Plans - Individual Grace Period

The Patient Protection and Affordable Care Act (PPACA) mandates a three month grace period for individual members who receive a premium subsidy from the government and are delinquent in paying their portion of premiums. The grace period applies as long as the individual has previously paid at least one month’s premium within the benefit year. The health insurance plan is only obligated to pay claims for services rendered during the first month of the grace period. PPACA clarifies that the health insurance plan may pend claims during the second and third months of the grace period.

Blue Plans are required to either pay or pend claims for services rendered during the second and third month of the grace period. Consequently, if a member is within the last two months of the federally mandated individual grace period, providers may receive a notification from Blue Shield of California indicating that the member is in the grace period.

Exchange Individual Grace Period – Post Service Notification Letter to Provider

Communication to providers will include the following information:

1. Notice-unique identification number (claim includes member information):
   Claim #: __________

2. Name of the QHP and affiliated issuer (Home Plan name):

3. Explanation of the three month grace period:

   Under the Patient Protection and Affordable Care Act (PPACA), there is a three month grace period under Exchange-purchased individual insurance policies, when a premium due is not received for members eligible for premium subsidies. During this grace period, carriers may not disenroll members and, during the second and third months of the grace period, are required to notify providers about the possibility that claims may be denied in the event that the premium is not paid.

4. Purpose of the notice, applicable dates of whether the enrollee is in the second or third month of the grace period & individuals affected under the policy and possibly under care of the provider:

   Please be advised that a premium due has not been received for this subsidy eligible member and that the member and any eligible dependents are and at the time that your care was provided, were in the second or third month of the Exchange individual health insurance grace period. The above-referenced claim thus was pended due to non-payment of premium, and will be denied if the premium is not paid by the end of the grace period.

5. Consequences:

   If the premium is paid in full by the end of the grace period, any pended claims will be processed in accordance with the terms of the contract. If the premium is not paid in full by the end of the grace period, any claims incurred in the second and third months may be denied.

6. QHP customer service telephone number:

   Please feel free to contact Blue Shield of California Monday through Friday, at our Provider Customer Service Unit at (800) 541-6652 if you have any questions regarding this claim.
Health Insurance Marketplaces Overview (cont’d.)

Health Insurance Marketplaces Claims

The products offered on the Marketplaces will follow local business practices for processing and servicing claims. Providers should continue to follow current practices with Blue Shield of California for claims processing and handling such as outlined below.

- Eligibility and Benefits
- Care Management
  - Pre-Service Review
  - Medical Policy
- Claim Pricing and Processing
  - Contracting
  - Claim Filing
  - Pricing
  - Claim Processing
  - Medical Records
  - Payment
  - Customer Service

How can I get more information about Health Insurance Marketplaces (Exchanges)?

If you would like more information about Health Insurance Marketplaces (Exchanges), log onto Provider Connection at blueshieldca.com/provider. Once you are logged onto our provider portal, follow these steps for more information:

1) Click on the Guideline & Resources tab at the top of the landing page.

2) Find the Features Topics subhead on the right-hand side of the Guidelines & Resources page and click on the link entitled Health Care Reform for Providers.

3) On the next page, click on the link Products and Network Available through Covered California.

Here, you will find a wide variety of provider and member resources to enhance your understanding of Health Insurance Marketplaces.
## Section 7

### Glossary of BlueCard Program Terms

<table>
<thead>
<tr>
<th>Administrative Services Only (ASO)</th>
<th>ASO accounts are self-funded, where the local plan administers claims on behalf of the account, but does not fully underwrite the claims. ASO accounts may have benefit or claims processing requirements that may differ from non-ASO accounts. There may be specific requirements that affect; medical benefits, submission of medical records, Coordination of Benefits or timely filing limitations. Blue Shield of California receives and prices all local claims, handles all interactions with providers, with the exception of Utilization Management interactions, and makes payment to the local provider.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordable Care Act</td>
<td>The comprehensive healthcare reform law enacted in March 2010. The law was enacted in two parts: The Patient Protection and Affordable Care Act was signed into law on March 23, 2010, and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” is used to refer to the final, amended version of the law.</td>
</tr>
<tr>
<td>Ancillary Services</td>
<td>Ancillary services include independent clinical laboratory services, durable/home medical equipment and supply services, and specialty pharmacy services.</td>
</tr>
<tr>
<td>bcbs.com</td>
<td>Blue Cross and Blue Shield Association’s website, which contains useful information for providers.</td>
</tr>
<tr>
<td>BlueCard Access</td>
<td>Providers or members can use this toll-free number (800) 810-BLUE (2583) to locate healthcare providers in another Blue plan’s area. This number is useful when you need to refer the patient to a physician or healthcare facility in another location.</td>
</tr>
<tr>
<td>BlueCard Doctor and Hospital Finder</td>
<td>A website providers and members can use to locate providers in another Blue Cross and Blue Shield plan’s service area. This is useful when you need to refer the patient to a physician or healthcare facility in another location. You can access provider information for all 50 states as well as the BlueCard Worldwide network through blueshieldca.com. Click on <em>Find a Doctor</em> and then click on the <em>Providers outside of CA</em> link on the bottom of the page.</td>
</tr>
<tr>
<td>BlueCard Eligibility®</td>
<td>Providers can use this toll-free eligibility line at (800) 676-BLUE (2583) to verify membership and coverage information, and obtain pre-certification on patients from other Blue Plans. Providers can also access eligibility and benefits information for other Blue plan members by accessing blueshieldca.com/provider.</td>
</tr>
</tbody>
</table>
# The BlueCard® Program

<table>
<thead>
<tr>
<th><strong>BlueCard PPO</strong></th>
<th>A national program that offers members traveling or living outside of their Blue Cross and/or Blue Shield plan’s service area the PPO level of benefits when they obtain services from a physician or hospital designated as a PPO provider.</th>
</tr>
</thead>
</table>
| **BlueCard PPO Basic** | A national program that offers members traveling or living outside of their Blue Cross and/or Blue Shield Plan’s service area the PPO basic level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO Basic provider.  

When you see the “PPOB” in a suitcase logo on the front of the member’s Blue Plan ID card, it means the member has selected a PPO plan product from a Blue Cross Blue Shield plan. Since Blue Shield of California does not have a BlueCard PPO Basic network, providers will be reimbursed for covered services in accordance with your PPO contract with Blue Shield of California |
<p>| <strong>BlueCard PPO Member</strong> | A Blue plan patient who carries an ID card with this identifier on it. Only members with this identifier can access the benefits of the BlueCard PPO. |
| <strong>BlueCard PPO Network</strong> | The network comprising those physicians, hospitals and other healthcare providers PPO members may elect to use to obtain the highest level of PPO benefits. |
| <strong>BlueCard PPO Provider</strong> | A doctor, hospital or other healthcare entity enrolled in a network of designated PPO providers. |
| <strong>BlueCard Traditional</strong> | A national program that offers members traveling or living outside of their Blue plan’s service area the traditional, or indemnity, level of benefits when they obtain services from a physician or hospital outside of their Blue plan’s service area. These members will carry an ID card featuring an “empty” suitcase logo. |
| <strong>Blue Shield Global Core®</strong> | A program that allows Blue plan members traveling or living outside of the United States to receive healthcare services from participating international Blue plan healthcare providers. The program also allows members of international Blue plans to access U.S. Blue plan provider networks. The Global Network of participating providers can be accessed through blueshieldca.com. Click on Find a Doctor and then click on the Providers outside of CA link on the bottom of the page. |
| <strong>Consumer Directed Health Care/Health Plans (CDHC/CDHP)</strong> | Consumer Directed Health Care (CDHC) is a broad umbrella term that refers to a movement in the healthcare industry to empower members, reduce employer costs and change consumer healthcare purchasing behavior. CDHC plans provide the member with additional information to make an informed and appropriate decision through the use of member support tools, provider and network information, and financial incentives. |</p>
<table>
<thead>
<tr>
<th><strong>Coinsurance</strong></th>
<th>A provision in a member’s coverage that limits the amount of coverage by the plan to a certain percentage. The member pays any additional costs out-of-pocket.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coordination of Benefits (COB)</strong></td>
<td>Ensures that members receive full benefits and prevents double payment for services when a member has coverage from two or more sources. The member’s contract language gives the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.</td>
</tr>
<tr>
<td><strong>Copayment</strong></td>
<td>A specified charge that a member incurs for a specified service at the time the service is rendered.</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>A flat amount the member incurs before the insurer will make any benefit payments.</td>
</tr>
<tr>
<td><strong>Electronic Provider Access</strong></td>
<td>Electronic Provider Access (EPA) is an online tool giving providers the ability to access out-of-area members’ Blue plan provider websites to request medical authorization and pre-service review. To access the EPA tool, log into Provider Connection at blueshieldca.com/provider and click on the Authorizations tab at the top, then Managing Out-of-Area Blue Plan Members. On the next screen, select Pre-Service Review for Out-of-Area Members. Choose the Electronic Provider Access option and you will be connected directly to the Blue plan within a secured routing mechanism to begin your request.</td>
</tr>
<tr>
<td><strong>Essential Community Providers</strong></td>
<td>Healthcare providers that serve predominately low-income, high-risk, special needs and medically-underserved individuals. The Department of Health and Human Services (HHS) proposes to define essential community providers as including only those groups suggested in the ACA, namely those named in section 340B(a)(4) of the Public Health Service Act and in section 197(c)(1)(D)(i)(IV) of the Social Security Act.</td>
</tr>
<tr>
<td><strong>Exclusive Provider Organization (EPO)</strong></td>
<td>An Exclusive Provider Organization is a health benefits program in which the member receives no benefits for care obtained outside the network except emergency care and does not include a Primary Care Physician selection. EPO benefit coverage may be delivered via BlueCard PPO and is restricted to services provided by BlueCard PPO providers.</td>
</tr>
<tr>
<td><strong>FEP</strong></td>
<td>The Federal Employee Program.</td>
</tr>
<tr>
<td><strong>Hold Harmless</strong></td>
<td>An agreement with a healthcare provider not to bill the member for any difference between billed charges for covered services (excluding coinsurance) and the amount the healthcare provider has contractually agreed with a Blue plan as full payment for these services.</td>
</tr>
</tbody>
</table>
## Marketplace/Exchange

For purposes of this document, the term Marketplace/Exchange refers to the public exchange as established pursuant to the Affordable Care Act (ACA): A transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans. Affordable Insurance Marketplaces will offer a choice of health plans that meet certain benefits and cost standards.

The ACA allows the opportunity for each state to establish a State-based Marketplace. Recognizing that not all states may elect to establish a State-based Marketplace, the ACA directs the Secretary of HHS to establish and operate a federally-facilitated Marketplace in any state that does not do so.

## Medicaid

A program designed to assist low-income families in providing healthcare for themselves and their children. It also covers certain individuals who fall below the federal poverty level. Other people who are eligible for Medicaid include low-income children under age 6 and low-income pregnant women, Medicaid is governed by overall federal guidelines in terms of eligibility, procedures, payment level etc., but states have a broad range of options within those guidelines to customize the program to their needs and/or can apply for specific waivers. State Medicaid programs must be approved by CMS; their daily operations are overseen by the State Department of Health (or similar state agency).

## Medicare Advantage

Medicare Advantage (MA) is the program alternative to standard Medicare Part A and Part B fee-for-service coverage; generally referred to as “traditional Medicare.”

MA offers Medicare beneficiaries several product options (similar to those available in the commercial market), including health maintenance organization (HMO), preferred provider organization (PPO), point-of-service (POS) and private fee-for-service (PFFS) plans.

## Medicare Crossover

The Crossover program was established to allow Medicare to transfer Medicare Summary Notice (MSN) information directly to a payor with Medicare’s supplemental insurance company.
| **Medicare Supplemental (Medigap)** | Pays for expenses not covered by Medicare. Medigap is a term for a health insurance policy sold by private insurance companies to fill the “gaps” in original Medicare Plan coverage. Medigap policies help pay some of the healthcare costs that the original Medicare Plan doesn’t cover. Medigap policies are regulated under federal and state laws and are “standardized.” There may be up to 12 different standardized Medigap policies (Medigap Plans A through L). Each plan, A through L, has a different set of basic and extra benefits. The benefits in any Medigap Plan A through L are the same for any insurance company. Each insurance company decides which Medigap policies it wants to sell. Most of the Medigap claims are submitted electronically directly from the Medicare intermediary to the member’s Home Plan via Medicare Crossover process. Medigap does not include Medicare Advantage products, which are a separate program under the Centers for Medicare & Medicaid Services (CMS). Members who have a Medicare Advantage Plan do not typically have a Medigap policy because under Medicare Advantage these policies do not pay any deductibles, copayments or other cost-sharing. |
| **National Account** | An employer group with employees and/or retirees located in more than one Blue Plan service area. |
| **Other Party Liability (OPL)** | A cost containment program that ensure Blue plans meet their responsibilities efficiently without assuming the monetary obligations of others and without allowing members to profit from illness or accident. OPL includes coordination of benefits, Medicare, Workers’ Compensation, subrogation and no-fault auto insurance. |
| **Plan** | Refers to any Blue Cross and/or Blue Shield plan member’s health care service coverage, e.g., HMO, PPO, EPO, and POS. |
| **Point of Service (POS)** | Point of Service is a health benefit program in which the highest level of benefits is received when the member obtains services from his/her primary care provider/group and/or complies with referral authorization requirements for care. Benefits are still provided when the member obtains care from any eligible provider without referral authorization, according to the terms of the contract. |
| **PPOB** | A health benefit program that provides a significant financial incentive to members when they obtain services from any physician or hospital designated as a PPO provider and that does not require a primary care physician gatekeeper/referral to access PPO providers. Similar to BlueCard PPO/EPO, this network includes providers specializing in numerous types of care, as well as other provider types, such as Essential Community and Indian Health Service providers where they are available. |
### The BlueCard® Program

<table>
<thead>
<tr>
<th><strong>Preferred Provider Organization (PPO)</strong></th>
<th>Preferred Provider Organization is a health benefit program that provides a significant incentive to members when they obtain services from a designated PPO provider. The benefit program does not require a gatekeeper (primary care physician) or referral to access PPO providers.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Prefix</strong></td>
<td>The three characters preceding the subscriber identification number on the Blue plan ID cards. The prefix identifies the Blue plan or national account to which the member belongs and is required for routing claims.</td>
</tr>
<tr>
<td><strong>Provider Connection</strong></td>
<td>Blue Shield’s provider website at blueshieldca.com/provider contains useful information for our providers including: basic BlueCard patient administration and claims processing steps, eligibility and benefits information on other Blue plan members, and instructions on where to send BlueCard claims by accessing our Claims Routing Tool.</td>
</tr>
<tr>
<td><strong>Qualified Health Plan (QHP)</strong></td>
<td>Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by an Exchange, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments, and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each Marketplace in which it is sold.</td>
</tr>
<tr>
<td><strong>Small Business Health Options Program (SHOP)</strong></td>
<td>Allows employers to choose the level of coverage and offer choices among health insurance plans. State-run Marketplaces were scheduled to become available by January 2014, with the federal government stepping in to run Marketplaces for states that were not ready. In 2016, all businesses with 100 or fewer employees must be able to purchase insurance through these Exchanges. The Marketplaces have the option of including employees with more than 100 employees beginning in 2017.</td>
</tr>
<tr>
<td><strong>State Children’s Health Insurance Program (SCHIP)</strong></td>
<td>SCHIP is a public program administered by the United States Department of Health and Human Services that provides matching funds to states for health insurance to families with children. The program was designed with the intent to cover uninsured children in families with incomes that are modest but too high to qualify for Medicaid. States are given flexibility in designing their SCHIP eligibility requirements and policies within broad federal guidelines. Some states have received authority through waivers of statutory provisions to use SCHIP funds to cover the parents of children receiving benefits from both SCHIP and Medicaid, pregnant women, and other adults.</td>
</tr>
<tr>
<td><strong>Traditional Coverage</strong></td>
<td>Traditional coverage is a health benefit plan that provides basic and/or supplemental hospital and medical/surgical benefits (e.g., basic, major medical and add-on riders) designed to cover various services. Such products generally include cost sharing features, such as deductibles, coinsurance or copayments.</td>
</tr>
</tbody>
</table>
### Other Payor Summary List

<table>
<thead>
<tr>
<th>Other Payor Summary List</th>
<th>Type of Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blue Cross Blue Shield Plans</td>
<td>Individual and Group Health Plans</td>
</tr>
<tr>
<td>Other Arrangements</td>
<td></td>
</tr>
<tr>
<td>Blue Shield of California Life &amp; Health Insurance</td>
<td>Individual Health Plans (Blue Shield Life Network)</td>
</tr>
<tr>
<td>Risk Management Accounts (RMCs)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Arrangements pursuant to which Blue Shield subsidiaries, e.g., Blue Shield of California Life &amp; Health Insurance Company, may utilize the Blue Shield Life Network.</td>
</tr>
<tr>
<td></td>
<td>Group health plans - Blue Shield of California provides one or more of the following services for a fixed administrative fee: administrative services (such as eligibility and claims processing), benefit determinations, generation of identification (ID) cards, check issuance, and reconciliation.</td>
</tr>
<tr>
<td></td>
<td>The group is at risk for the cost of health care.</td>
</tr>
<tr>
<td></td>
<td>Only large groups are eligible.</td>
</tr>
<tr>
<td></td>
<td>This list is updated periodically. Please contact Blue Shield of California directly if an updated list is needed.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Name A-P</th>
<th>Name P-Z</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 Hour Fitness USA, Inc.</td>
<td>PIH Health (Presbyterian Intercommunity Hospital)</td>
</tr>
<tr>
<td>ACCO Management Company</td>
<td>Pinterest Inc</td>
</tr>
<tr>
<td>Activision Publishing, Inc.</td>
<td>Pioneers Memorial Healthcare District</td>
</tr>
<tr>
<td>Adventist Health Systems/West</td>
<td>Playworks Education Energized</td>
</tr>
<tr>
<td>AGI Publishing DBA Valley Yellow Pages</td>
<td>Pomona Valley Hospital Medical Center</td>
</tr>
<tr>
<td>Air Conditioning and Refrigeration Industry Joint Trust</td>
<td>Premium Packing, Inc</td>
</tr>
<tr>
<td>Alhambra Unified School District</td>
<td>Prime Healthcare Services</td>
</tr>
<tr>
<td>All FAB Precision Sheetmetal</td>
<td>Printing Specialties &amp; Paper Products Joint Benefits H&amp;W</td>
</tr>
<tr>
<td>Allen Lund Company, Inc.</td>
<td>Public Storage</td>
</tr>
<tr>
<td>Alliance Health Care Services</td>
<td>Radnet, Inc.</td>
</tr>
<tr>
<td>Amarnath College of Hairdressing dba Milan Institute</td>
<td>Raley's</td>
</tr>
<tr>
<td>Ament Fleet Solutions</td>
<td>REC Solar Commercial Corp</td>
</tr>
<tr>
<td>Ampla Health</td>
<td>Rescue Public Agency</td>
</tr>
<tr>
<td>Andreini agAdvantageCaptive</td>
<td>Risk Management Strategies</td>
</tr>
<tr>
<td>Anciency US Inc</td>
<td>Riverside Community College District</td>
</tr>
<tr>
<td>ARM, INC. (ARM, Physical IP, Inc.)</td>
<td>Rolling Hills Casino</td>
</tr>
<tr>
<td>Armanino, LLP</td>
<td>Roman Catholic Bishop of Sacramento</td>
</tr>
<tr>
<td>bebette stores inc</td>
<td>Ruiz Food Products, Inc.</td>
</tr>
<tr>
<td>Big Creek Lumber</td>
<td>Sabor Farms LLC</td>
</tr>
<tr>
<td>Blackhawk Network Holdings, Inc.</td>
<td>Sadleback Valley USD</td>
</tr>
<tr>
<td>Bolthouse Farms Inc</td>
<td>Sakura Fineback USA Inc</td>
</tr>
<tr>
<td>Braun Electric Company Inc</td>
<td>San Benito Health Care District</td>
</tr>
<tr>
<td>Brighton Collectibles LLC</td>
<td>San Francisco Electrical Workers Health &amp; Welfare</td>
</tr>
<tr>
<td>Burrtec Waste Industries Inc</td>
<td>San Francisco Symphony Inc.</td>
</tr>
<tr>
<td>Buttonwillow Warehouse Co Inc</td>
<td>San Joaquin Valley College</td>
</tr>
<tr>
<td>California Olive Ranch Inc.</td>
<td>Saticoy Lemon</td>
</tr>
<tr>
<td>California Valued Trust</td>
<td>Save Mart Supermarkets</td>
</tr>
<tr>
<td>Cambiro Manufacturing Company</td>
<td>Saxson International LLC</td>
</tr>
<tr>
<td>Carl Warren and Company</td>
<td>Self-Insured Schools of California</td>
</tr>
<tr>
<td>Carlisle Unified School District</td>
<td>Sensient Technologies Corporation</td>
</tr>
<tr>
<td>Citrus Valley Health Partners, Inc.</td>
<td>Servicon Systems. Inc.</td>
</tr>
</tbody>
</table>

---

Other Payor Summary List

Blue Shield of California
Independent Physician and Provider Manual
April 2019
## Other Payor Summary List

<table>
<thead>
<tr>
<th>Name A-Pe</th>
<th>Name Pi-Z</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of San Jose</td>
<td>Sheet Metal Workers Intl Assoc Local Union 104</td>
</tr>
<tr>
<td>City of Tulare</td>
<td>Sheppard, Mullin Richter &amp; Hampton LLP</td>
</tr>
<tr>
<td>City of Tulare - SJ/IA</td>
<td>Shoretel, Inc.</td>
</tr>
<tr>
<td>Clovis Unified School District</td>
<td>Sign Pictorial and Display Industry</td>
</tr>
<tr>
<td>Cornerstone On Demand Inc</td>
<td>SISC/Alexander Valley</td>
</tr>
<tr>
<td>Cotton On USA, Inc</td>
<td>SISC/Alpaugh USD</td>
</tr>
<tr>
<td>County of Imperial</td>
<td>SISC/Alvord USD</td>
</tr>
<tr>
<td>County of Kings</td>
<td>SISC/Antelope Valley CCD</td>
</tr>
<tr>
<td>County of Orange</td>
<td>SISC/Arcadia USD</td>
</tr>
<tr>
<td>County of San Mateo</td>
<td>SISC/ASCP La Canada USD</td>
</tr>
<tr>
<td>CrossFit, Inc</td>
<td>SISC/Azusa Unified School District</td>
</tr>
<tr>
<td>CSAC Excess Insurance Authority</td>
<td>SISC/Bennett Valley Union Elementary</td>
</tr>
<tr>
<td>CSEBA/Alta Loma School District</td>
<td>SISC/Cabrillo College</td>
</tr>
<tr>
<td>CSEBA/Bear Valley Unified School District</td>
<td>SISC/Calistoga Joint Unified School District</td>
</tr>
<tr>
<td>CSEBA/Beaumont Unified School District</td>
<td>SISC/Ceiba Public Schools</td>
</tr>
<tr>
<td>CSEBA/Central School District</td>
<td>SISC/Central Region School</td>
</tr>
<tr>
<td>CSEBA/Centralia School District</td>
<td>SISC/Ceres Unified School District</td>
</tr>
<tr>
<td>CSEBA/Chaffey Community College District</td>
<td>SISC/Chawanneke USD</td>
</tr>
<tr>
<td>CSEBA/CharterSafe - Clear Passage Education Center</td>
<td>SISC/Chowchilla Elementary</td>
</tr>
<tr>
<td>CSEBA/CharterSafe - New Opportunities Organization</td>
<td>SISC/Cinnabar Elementary</td>
</tr>
<tr>
<td>CSEBA/CharterSafe - Paramount Collegiate Academy</td>
<td>SISC/Cloverdale Unified</td>
</tr>
<tr>
<td>CSEBA/CharterSafe - Pathways</td>
<td>SISC/College of the Desert</td>
</tr>
<tr>
<td>CSEBA/CharterSafe - River Springs Charter School</td>
<td>SISC/Denair Unified</td>
</tr>
<tr>
<td>CSEBA/CharterSafe - Sierra</td>
<td>SISC/El Centro Elementary School District</td>
</tr>
<tr>
<td>CSEBA/Chino Valley</td>
<td>SISC/Empire Union Elementary</td>
</tr>
<tr>
<td>CSEBA/Covina Valley Unified School District</td>
<td>SISC/Fort Ross Elementary</td>
</tr>
<tr>
<td>CSEBA/Cucamonga School District</td>
<td>SISC/Fullerton Elementary School District</td>
</tr>
<tr>
<td>CSEBA/East San Gabriel Valley ROP</td>
<td>SISC/Geyersville Unified</td>
</tr>
<tr>
<td>CSEBA/East Whittier City School District</td>
<td>SISC/Graton Elementary</td>
</tr>
<tr>
<td>CSEBA/Encinitas Union School District</td>
<td>SISC/Gravenstein Union Elem</td>
</tr>
<tr>
<td>CSEBA/Etiwanda School District</td>
<td>SISC/Guerneville SD</td>
</tr>
<tr>
<td>CSEBA/Hemet Unified School District</td>
<td>SISC/Harmony Union Elementary</td>
</tr>
<tr>
<td>CSEBA/Hesperia Unified School District - Classified</td>
<td>SISC/Hart Ransom Union Elementary</td>
</tr>
<tr>
<td>CSEBA/Mountain View School District</td>
<td>SISC/Hickman Community Charter School District</td>
</tr>
<tr>
<td>CSEBA/North Orange County ROP</td>
<td>SISC/Holtville Unified</td>
</tr>
<tr>
<td>CSEBA/Ontario-Montclair School District</td>
<td>SISC/Kashia Elementary</td>
</tr>
<tr>
<td>CSEBA/Ramona Unified School District</td>
<td>SISC/Kentfield School District</td>
</tr>
<tr>
<td>CSEBA/Rim of the World Unified School District</td>
<td>SISC/Kernwood Elementary</td>
</tr>
<tr>
<td>CSEBA/San Bernardino Community College District</td>
<td>SISC/Keyes Union School District</td>
</tr>
<tr>
<td>CSEBA/San Bernardino CSS</td>
<td>SISC/Kings Canyon Unified</td>
</tr>
<tr>
<td>CSEBA/San Marino Unified School District</td>
<td>SISC/Liberty Elementary</td>
</tr>
<tr>
<td>CSEBA/Santee School District</td>
<td>SISC/Los Banos USD</td>
</tr>
<tr>
<td>CSEBA/Savanna School District</td>
<td>SISC/Madera County Office of Education</td>
</tr>
<tr>
<td>CSEBA/Summit Leadership Academy High Desert</td>
<td>SISC/Marin Community College District</td>
</tr>
<tr>
<td>CSEBA/Victor Valley College</td>
<td>SISC/Mark West Union</td>
</tr>
<tr>
<td>CSEBA/Yucaipa Calimesa Joint USD (Classified)</td>
<td>SISC/Mendocino USD</td>
</tr>
<tr>
<td>DataSafe, Inc</td>
<td>SISC/Monte Rio Union Elem</td>
</tr>
<tr>
<td>Delano Union School District</td>
<td>SISC/Montgomery Elem</td>
</tr>
<tr>
<td>Delta Dental of California</td>
<td>SISC/Oak Grove Union Elem</td>
</tr>
</tbody>
</table>
### Other Payor Summary List

<table>
<thead>
<tr>
<th>Name A-Pe</th>
<th>Name Pi-Z</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dexcom Inc</td>
<td>SISCO/Old Adobe Union Elem</td>
</tr>
<tr>
<td>Downey Unified School District</td>
<td>SISCO/Pajaro Valley Unified School District</td>
</tr>
<tr>
<td>eBay, Inc</td>
<td>SISCO/Palmdale Aerospace Academy</td>
</tr>
<tr>
<td>EDCO Disposal Corp Inc</td>
<td>SISCO/Palmdale School District</td>
</tr>
<tr>
<td>Educational Media Foundation</td>
<td>SISCO/Pasadena Unified School District</td>
</tr>
<tr>
<td>El/Amarador County</td>
<td>SISCO/Petaluma School District</td>
</tr>
<tr>
<td>El/A/City of Huntington Beach</td>
<td>SISCO/Piner-Olivet Union Elem</td>
</tr>
<tr>
<td>El/A/City of Irvine</td>
<td>SISCO/Plumas Unified School District</td>
</tr>
<tr>
<td>El/A/City of Redding</td>
<td>SISCO/Redwood Empire School Ins Grp</td>
</tr>
<tr>
<td>El/A/City of Walnut Creek</td>
<td>SISCO/Rincon Valley Union Elem</td>
</tr>
<tr>
<td>El/A/City of Yuba City</td>
<td>SISCO/Rio School District</td>
</tr>
<tr>
<td>El/A/Community Development Commission of Los</td>
<td>SISCO/Roberts Ferry Union Elementary</td>
</tr>
<tr>
<td>El/A/County of Imperial</td>
<td>SISCO/Roseland Elem</td>
</tr>
<tr>
<td>El/A/County of Santa Barbara</td>
<td>SISCO/Salida Union Elementary</td>
</tr>
<tr>
<td>El/A/El Dorado County</td>
<td>SISCO/Santa Cruz City Schools</td>
</tr>
<tr>
<td>El/A/Mendocino Coast District Hospital</td>
<td>SISCO/Santa Maria Joint Union High School District</td>
</tr>
<tr>
<td>El/A/Santa Barbara Superior Courts</td>
<td>SISCO/Santa Rosa Junior College</td>
</tr>
<tr>
<td>El/A/Small Group Program</td>
<td>SISCO/Sebastopol Ind Charter</td>
</tr>
<tr>
<td>El/A/South Coast Air Quality Management District</td>
<td>SISCO/Shiloh Elementary</td>
</tr>
<tr>
<td>Emser Tile, LLC</td>
<td>SISCO/Shoreline Unified</td>
</tr>
<tr>
<td>Enphase Energy Inc</td>
<td>SISCO/Sierra Joint Community College District</td>
</tr>
<tr>
<td>Ensign Services, Inc</td>
<td>SISCO/Sierra Unified</td>
</tr>
<tr>
<td>Excess Insurance Authority (EIA)</td>
<td>SISCO/Sonoma County Office of Ed</td>
</tr>
<tr>
<td>Faith Farming LLC &amp; Innovative Produce Inc.</td>
<td>SISCO/South Orange County CCD</td>
</tr>
<tr>
<td>Fire Districts Association of California</td>
<td>SISCO/Stansius Union Elementary</td>
</tr>
<tr>
<td>Foster Farms</td>
<td>SISCO/Tamalpais Union HSD</td>
</tr>
<tr>
<td>Fox Factory Inc</td>
<td>SISCO/Tree of Life Charter</td>
</tr>
<tr>
<td>Freedom Communications</td>
<td>SISCO/Twin Hills Union SD</td>
</tr>
<tr>
<td>Fresno City Employees Health &amp; Welfare Trust</td>
<td>SISCO/Two Rock Union Elementary</td>
</tr>
<tr>
<td>Fresno Truck Center</td>
<td>SISCO/Waugh Elem</td>
</tr>
<tr>
<td>Fry's Electronics</td>
<td>SISCO/West Hills CCD</td>
</tr>
<tr>
<td>Gallo Cattle Co a Ltd Partnership</td>
<td>SISCO/West Side Union School District</td>
</tr>
<tr>
<td>Golden Gate Bridge Highway &amp; Transport Dist.</td>
<td>SISCO/West Sonoma County HSD</td>
</tr>
<tr>
<td>Golden State Medical Supply, Inc.</td>
<td>SISCO/Westminster School District</td>
</tr>
<tr>
<td>Hanford Joint Union High School District</td>
<td>SISCO/Westside Union Elem</td>
</tr>
<tr>
<td>Hankey Investment Co.</td>
<td>SISCO/Wilmar Union Elem</td>
</tr>
<tr>
<td>HCL America Inc</td>
<td>SISCO/Yosemite Community College District</td>
</tr>
<tr>
<td>Healdsburg District Hospital</td>
<td>SISCO/Yosemite USD</td>
</tr>
<tr>
<td>HealthCare Conglomerate Associates LLC</td>
<td>SoCell Pipe Trades</td>
</tr>
<tr>
<td>Hunt &amp; Sons, Inc</td>
<td>Southern California Edison Company</td>
</tr>
<tr>
<td>Hutchinson &amp; Bloodgood</td>
<td>SpaceX</td>
</tr>
<tr>
<td>ILWU-PMA Welfare Plan</td>
<td>SSL (Space Systems/Loral LLC)</td>
</tr>
<tr>
<td>Indian Health Council, Inc</td>
<td>Stanford University</td>
</tr>
<tr>
<td>Integro USA</td>
<td>Stanford University Postdoctoral Scholars</td>
</tr>
<tr>
<td>Interface Rehab, Inc.</td>
<td>Stellartech Research Corporation</td>
</tr>
<tr>
<td>Irvine Unified School District</td>
<td>Sukut Construction Inc</td>
</tr>
<tr>
<td>JBR Inc. DBA San Francisco Bay Gourmet Coffee</td>
<td>Tanimura &amp; Antle Fresh Foods, Inc.</td>
</tr>
<tr>
<td>John Muir Health</td>
<td>The Symboree Corp</td>
</tr>
<tr>
<td>John Muir Health</td>
<td>The Heffernan Group</td>
</tr>
<tr>
<td>KS Industries LP</td>
<td>The Lagunitas Brewing Company</td>
</tr>
<tr>
<td>La Tapatia Tortilleria, Inc.</td>
<td>The Sun Valley Group</td>
</tr>
</tbody>
</table>
### Other Payor Summary List

<table>
<thead>
<tr>
<th>Name A-Pe</th>
<th>Name Pi-Z</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linear Technology Corporation</td>
<td>The Sun Valley Group, Inc.</td>
</tr>
<tr>
<td>Long Beach Unified School District</td>
<td>Threshold Enterprises LTD</td>
</tr>
<tr>
<td>Lush Handmade Cosmetics, Ltd.</td>
<td>Tom's Truck Center</td>
</tr>
<tr>
<td>Madsen, Knepers and Associates</td>
<td>Topcon Positioning Systems Inc. dba Topcon America Corp</td>
</tr>
<tr>
<td>Manco Abbott, Inc.</td>
<td>Tri Cal</td>
</tr>
<tr>
<td>Main Healthcare District</td>
<td>Trulite WSG, LLC</td>
</tr>
<tr>
<td>Mendocino County Schools (Staywell JPA)</td>
<td>Tule River Indian Tribal Council</td>
</tr>
<tr>
<td>Methodist Hospital</td>
<td>Tutor Perini Corporation</td>
</tr>
<tr>
<td>Mi Pueblo</td>
<td>UA 447 Local Pipe Trades &amp; Welfare Trust Fund</td>
</tr>
<tr>
<td>Mi Pueblo Newco LLC</td>
<td>Uber Technologies Inc.</td>
</tr>
<tr>
<td>Monterey Peninsula Surgery Center LLC</td>
<td>UFCW &amp; Employers Benefit Trust</td>
</tr>
<tr>
<td>Mutual Trading Company</td>
<td>UFCW Northern California and Drug Employers Health and Welfare Trust</td>
</tr>
<tr>
<td>National University</td>
<td>United Agricultural Benefit Trust</td>
</tr>
<tr>
<td>Newport Group, Inc.</td>
<td>University of California</td>
</tr>
<tr>
<td>Nichole Farm</td>
<td>Valley Children's Hospital</td>
</tr>
<tr>
<td>Nikon Precision, Inc.</td>
<td>Valley Pacific Petroleum Services</td>
</tr>
<tr>
<td>North Coast Schools Medical Insurance Group</td>
<td>Verity Health System</td>
</tr>
<tr>
<td>Northern CA Sheet Metal Workers Local 162</td>
<td>Victor Community Support Services Inc</td>
</tr>
<tr>
<td>Northern California General Teamsters Security Fund &amp; Teamsters Retiree Trust</td>
<td>Washington Hospital</td>
</tr>
<tr>
<td>Northern California Tile Industry Health Trust</td>
<td>Wesco Aircraft Hardware Corp</td>
</tr>
<tr>
<td>Omni Group/Onni Properties</td>
<td>Whittier Union High School District</td>
</tr>
<tr>
<td>Orchard Machinery Corporation</td>
<td>Yocha Dehe Wintun Nation (Cache Creek Casino)</td>
</tr>
<tr>
<td>Pacific Southwest Container, LLC</td>
<td>Yusen Logistics</td>
</tr>
<tr>
<td>Palantir Technologies</td>
<td>ZenDesk Inc.</td>
</tr>
<tr>
<td>Pandora Media Inc</td>
<td>Zenith Talent Corporation</td>
</tr>
<tr>
<td>PayPal Holdings, Inc.</td>
<td>Zynga Inc.</td>
</tr>
<tr>
<td>Pechanga Band Of Luiseno Mission Indians</td>
<td></td>
</tr>
</tbody>
</table>
Table of Contents

A. Blue Shield 65 Plus (HMO) Medicare Advantage Required Billing Elements
This page intentionally left blank.
Skilled Nursing Facility Discharges (SNF or TCU)

Background

There have been longstanding federal regulations designed to protect member rights for Medicare Advantage (MA) enrollees. These regulations include the right to due process, with appeal rights when any service or item being denied or, as cited in section 422.568(c) of the Balanced Budget Act, when a discontinuation of a service occurs and the member disagrees.

For skilled nursing facility discharges, discontinuation of service, continued stay beyond the maximum Medicare / Blue Shield 65 Plus (HMO) covered benefit of 100 days per benefit period, a specific, regulatory notice is required to be provided to the beneficiary (member) (or legal representative) and said notice requires a signed acknowledgement of receipt.

What constitutes a valid acknowledgement of receipt?

The Centers for Medicare & Medicaid Services (CMS) has external review performed through Maximus Federal Services (Maximus). We are summarizing from Maximus “Reconsideration Notes”, the guidelines for appropriate notice of receipt of the Notice of Non-Coverage (NONC) for SNF discharges. Signature validates receipt of the notice, but does not imply any agreement. The notice ties to delivery of member rights and for a notice to be considered to have occurred, the following guidelines apply:

Delivery in person is preferable and the member must sign the actual notice. For appeals cases, the plan must provide a copy of the actual notice delivered, not a sample letter, along with the signature page, with the member signature, acknowledging receipt.

If a member refuses to sign an acknowledgment of receipt of the Notice of Non-Coverage, both the beneficiary’s medical chart and the “refusal to sign” page of the notice should reflect:

- The date the notice was delivered.
- The individual who delivered the notice.
- Specific reasons for the member’s refusal to sign the notice receipt acknowledgment form.
- If a witness is able to attest a patient’s refusal to sign, document the delivery of the notice and obtain the witness’s signature as attestment to the patient’s refusal to sign.
- If a witness is not available, the individual delivering the notice should sign the acknowledgment form to attest the attempted delivery of the Notice of Non-Coverage.

Enhancements to build on the acknowledgment of receipt in the case of a refusal to sign:

- Often, a verbal notice of a planned discharge occurs prior to delivery of the actual written notice. Although not required, if a verbal notice occurs, it can be easily noted on the Acknowledgment of Receipt page prior to delivery of the notice to the member. By noting the verbal notice on the acknowledgment of receipt, the case documentation is enhanced, should an issue be subsequently appealed. NOTE: Verbal notice does not meet the requirements for valid notice. Verbal notice can only be used to enhance the case documentation related to the actual delivery of a valid notice with a signed acknowledgement of receipt.
Skilled Nursing Facility Discharges (SNF or TCU) *(cont’d.)*

**Guardians and Incompetent Patients**

A Notice is not valid if delivered knowingly to an incompetent patient. Having a patient being discharged from skilled nursing care with a diagnosis of dementia is not likely to hold as a valid notice on appeal unless there are documented attempts to also deliver the Notice of Non-Coverage (NONC) to and secure a signed acknowledgment from any legal guardian or other family members.

Legal guardians include court appointed guardians, family members with Durable Power of Attorney for Health Care, or appropriate legal counsel/attorney representation. Additionally, it is also recognized that, as a practical matter, there are circumstances when appointment documentation cannot be obtained in a timely manner. If a member is not competent or is physically unable to sign the statement, and the representative is the spouse or next of kin, the notice acknowledgement that is signed by a default representative should be clearly documented by the facility as to the applicability of a state allowable person to be a default representative. In the event there is any controversy related to such default representation, only a representative as determined by the appropriate state court would be accepted.

If verbal or telephonic notice is provided to a representative, this is only as back up to the actual signed acknowledgement of written notice. The member officially receives notice when the written notice is delivered and a signed acknowledgement obtained or a clearly documented refusal to sign the acknowledgement occurs.

We are challenged when a guardian is unwilling to sign the acknowledgment of receipt of the notice and direct hand delivery is not viable. In such cases, document all attempts to both verbally inform and to physically deliver the notice carefully. If delivery of the notice to a guardian for an incompetent patient is via mail, keep all receipts from the courier service or certified mail (return receipt required) to demonstrate delivery of the notice. In such cases, the signed courier service or other confirmation of delivery can be submitted as valid acknowledgement of receipt.

- The patient’s chart should document any verbal notice
- Document attempted delivery to member and guardian
- Obtain signed acknowledgement of receipt or document (and preferably witness) actual delivery of the notice, where there is a refusal to sign

*Note:* In cases where care must be coordinated through an offsite guardian, provide adequate time for delivery of a valid notice. *(A courier service delivery will delay notice and potentially discharge by only one day, if they are able to deliver to the guardian. U.S. Certified mail is not as predictable.)*
Skilled Nursing Facility Discharges (SNF or TCU) *(cont’d.)*

Regulatory Changes and the Centers for Medicare & Medicaid Services

*Important Notice:* The Grijalva Final Rule 42 C.F.R. § 422.620 contains provisions required under the settlement agreement in the Grijalva v. Shalala litigation concerning appeal rights under the Medicare managed care program to Medicare Advantage (MA) enrollees at the time of discharge from an inpatient hospital stay. For the Grijalva portion, which relates to SNF, Home Health and CORF discharges, the effective date was January 1, 2004. The current requirement still in effect for IPAs is to deliver the Notice of Non-Coverage (NONC) within one day prior to the effective date of the discharge.

*The Final Rule Requires:*

- The right to an immediate review of a Medicare Advantage Organization (MAO) discharge decision by an independent review body if the enrollee believes services should continue.
- Advanced written notice to all MA enrollees at least two days before the termination of certain services (before planned termination of Medicare coverage of their skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) services), with instructions on how to obtain a detailed notice and file an appeal.
- Upon request, a specific and detailed explanation of why services are either no longer medically necessary or are no longer covered by the health plan. The health plan also needs to describe any applicable Medicare coverage rule, MA policy, contract provision or rationale upon which the termination decision was based.

In addition, the final rule requires MAOs to provide detailed discharge notices only in those situations where enrollees indicate dissatisfaction with the health plan's decision. All Medicare beneficiaries who are treated in a hospital will continue to receive generic notices upon admission that will inform them of their appeal rights, but only those beneficiaries that disagree with the decision to be discharged must be issued a detailed written notice of non-coverage one day before their hospital coverage ends. If an appeal is filed, beneficiaries remain entitled to continuation of coverage for their hospital stay until the quality improvement organization renders a decision.

Enrollees then may request an independent review of the MA organization’s decision to end coverage of SNF, HHA or CORF services. In the event of a timely appeal request, an MA organization must issue a second, detailed notice that explains the reasons why Medicare coverage should end.

CMS has designated Quality Improvement Organizations (QIOs) to conduct these fast-track reviews. QIOs are suitable for the fast-track appeals process in light of their experience in performing similar, immediate reviews of inpatient hospital discharges. The QIO that has an agreement with the SNF, HHA, or CORF providing the enrollee’s services will process the appeal. The MA organization must provide the second, detailed notice to both the QIO and the enrollee.
Skilled Nursing Facility Discharges (SNF or TCU) (cont'd.)

Regulatory Changes & the Centers for Medicare & Medicaid Services (cont'd.)

Provider Notification of Termination. An important feature of the final rule provisions is that Medicare would charge providers with the actual delivery of the required notices. CMS believes that the providers themselves are in the best position to deliver the notices to enrollees, and that it would be placing an unreasonable burden on MAO’s to require that they deliver the notices to affected enrollees. The MA organization would retain ultimate responsibility for the decision to terminate services and for financial coverage of the services, however. The services would remain covered until four calendar days after an enrollee receives the termination notice, or if the Independent Review Entity reviews the decision, until noon on the day after an Independent Review Entity decision upholding the MAO’s decision. CMS believes that the requirement that providers issue these notices, in effect on behalf of MAO’s, best ensures that beneficiaries receive these notices in a timely manner. To facilitate implementation of this policy, we are proposing under §422.502(I) that all contracts between MAO’s and their providers must specify that the providers will comply with the notice and appeal provisions in subpart M of the federal requirements.

Timing of Notices. Section 422.624(b)(1) addresses the timing of the required notices. In general, the provider would notify the enrollee of the MAO’s decision to terminate covered services two calendar days before the scheduled termination. Again, the current requirement still in effect is within one day of the date of discharge. If the provider services are expected to be furnished to an enrollee for a time span of fewer than two calendar days in duration, the enrollee should be given the notice upon admission to the provider (or at the beginning of the service period if there is no official “admission” to a non-institutional provider, such as in an HHA setting). The notice must be given in all situations, regardless of whether an enrollee agrees with the decision that his or her services should end.

CMS would allow providers a full working “day” within which to deliver the termination notice, with any notification delivered during normal business hours on a given day serving to initiate the four-day standard on that day, even if the timing of the delivery of the notice resulted in fewer than 24 hours to ask for an Independent Review Entity appeal, and fewer than 96 hours between notification and the proposed termination of services. That is, a notice delivered to a member at 2 p.m., Monday, would indicate that the member has until noon, Tuesday, to appeal to the Independent Review Entity, with termination of services scheduled for noon, Friday.
Skilled Nursing Facility Discharges (SNF or TCU) (cont’d.)

Regulatory Changes & the Centers for Medicare & Medicaid Services (cont’d.)

Delivery of Notices. §422.624(c) specifies that “delivery” of a notice is valid only if a member has signed and dated the notice to indicate that he or she both received the notice and can comprehend its contents. This policy is consistent with our requirements governing delivery of similar notices, such as the requirements set forth in HCFA Program Memoranda A-02-018 for HHA Advanced Beneficiary Notices. Under this concept, a member who is comatose, confused, or otherwise unable to understand or act on his or her rights could not validly “receive” the notice, necessitating the presence of an authorized representative for purposes of receiving the notice. Similarly, presenting the standardized notice to a person who is illiterate, blind, or unable to understand English would not constitute successful “delivery” of the notice. Such situations could be remedied either through use of an authorized representative if that person has no barriers to receiving the notice or through other steps (such as use of a translator or language accessible version of the notice) that overcome the difficulties associated with notification.

Note: CMS would not interpret the requirement for successful delivery to permit an enrollee to extend coverage indefinitely by refusing to sign a notice of termination. If an enrollee refuses to sign a notice, the provider would annotate its copy of the notice to indicate the refusal, and the date of the refusal would be considered the date of receipt of the notice. Paragraph (c) describes what constitutes an effective delivery of a termination notice. The notice would have to be delivered timely, using standardized format and language, and include all of the elements required under §422.624(b)(2).

BLUE SHIELD OF CALIFORNIA

APPEAL PROCESS FOR NOTICE OF NON-COVERAGE HHA, SNF, CORF

<table>
<thead>
<tr>
<th>#</th>
<th>Responsible Party</th>
<th>Activity</th>
<th>Time Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>___</td>
<td>IPA/MSO</td>
<td>Determines termination date and drafts Notice of Medicare Non-Coverage (NOMNC). Faxes to SNF, HHA, CORF. If SNF, HHA, CORF prepare their own notices then notification needs to be given for termination date.</td>
<td>No less than 2 days prior to termination of services</td>
</tr>
<tr>
<td>1.</td>
<td>SNF, HHA, CORF</td>
<td>Issues NOMNC and obtains member's signature. SNF- at least 2 days prior to termination If &lt; 2 days of service, then on admission or first visit, if the enrollee’s services are expected to be fewer than 2 days in duration, the SNF, HHA, or CORF should notify the enrollee at the time of admission to the provider. If, in a non-institutional setting, the span of time between services exceeds two days, the provider should deliver the notice no later than the next to last time that services are furnished. If benefits are exhausted a notice is required, the member may appeal, however these are referred back to the health plan to review and respond to this appeal. If a HHA is going out for an evaluation only, the agency is not required to send a notice. Also when only partial services are being discontinued (i.e., PT ends, but HHC continues), no notice is needed until all services end.</td>
<td>2 days prior to termination of services</td>
</tr>
</tbody>
</table>
### Blue Shield 65 Plus (HMO) Medicare Advantage

#### Required Billing Elements

<table>
<thead>
<tr>
<th>#</th>
<th>Responsible Party</th>
<th>Activity</th>
<th>Time Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.</td>
<td>Enrollee</td>
<td>Disagrees with the discharge, the enrollee must contact the Quality Improvement Organization (QIO), Health Services Advisory Group, Inc. This request is made either in writing, telephone or fax, by noon the day after receipt of the NOMNC. The notice is still considered timely as long as Health Services Advisory Group, Inc. receives the appeal request no later than noon the day before the effective date that Medicare coverage ends.</td>
<td>No later than noon the day after receipt of notice</td>
</tr>
<tr>
<td>3.</td>
<td>QIO = Health Services Advisory Group, Inc.</td>
<td>Receives Appeal request from enrollee or representative. Immediately notifies Medicare Advantage and the provider of the enrollee's request for a fast track appeal by phone and fax.</td>
<td>Day 1 begins</td>
</tr>
<tr>
<td>4.</td>
<td>MA (Medicare Advantage) = Blue Shield 65 Plus (HMO)</td>
<td>Receives notice of appeal from Health Services Advisory Group, Inc. (by phone &amp; fax) requesting the following information for review: A copy of the advance notice of termination (NONMC), a copy of the detailed explanation of Non-coverage (DENC), a copy of enrollee’s medical records, and a copy of other documents as requested.</td>
<td>Day 1</td>
</tr>
<tr>
<td>5.</td>
<td>Blue Shield 65 Plus (HMO)</td>
<td>Contact CM at IPA/MSO and request the information above faxed to Health Services Advisory Group, Inc. for review. Advise of same day requirement for sending these records. Request coversheet confirming records were sent to Health Services Advisory Group, Inc., copy of NONMC and DENC faxed to Blue Shield 65 Plus (HMO). Also contact should be made to SNF requesting records &amp; NOMNC be faxed to Health Services Advisory Group, Inc. for review with confirmation of this to BSC. Health Services Advisory Group, Inc. needs the detailed chart notes that SNF's have for review.</td>
<td>Day 1</td>
</tr>
<tr>
<td>6.</td>
<td>Blue Shield 65 Plus (HMO)</td>
<td>If IPA/MSO is unable to make Day 1 submission requirement, notify Manager, Director or Medical Director</td>
<td>Day 1</td>
</tr>
<tr>
<td>7.</td>
<td>Blue Shield 65 Plus (HMO)</td>
<td>Manager, Director or Medical Director then contacts IPA Director of UM/QM &amp; or Medical Director to obtain documents.</td>
<td>Day 1</td>
</tr>
<tr>
<td>8.</td>
<td>IPA/MSO</td>
<td>Faxes records to: 1.) Health Services Advisory Group, Inc. Copy of NOMNC with member's signature or documentation of refusal to sign, copy of DENC and copy of enrollee’s medical records. 2.) Blue Shield 65 Plus (HMO): Cover sheet confirming documentation was sent to Health Services Advisory Group, Inc., copy of NOMNC with member's signature or documentation of refusal to sign &amp; copy of DENC 3.) Member/representative: Mails DENC. Upon request, all documents sent to Health Services Advisory Group, Inc.</td>
<td>Day 1</td>
</tr>
<tr>
<td>9.</td>
<td>IPA/MSO</td>
<td>IPA makes decision to rescind the termination date and send new letter to member Fax copy of letter to Health Services Advisory Group, Inc.&amp; Blue Shield 65 Plus (HMO)</td>
<td>Resolved Go to step 14</td>
</tr>
<tr>
<td>#</td>
<td>Responsible Party</td>
<td>Activity</td>
<td>Time Requirement</td>
</tr>
<tr>
<td>----</td>
<td>-------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td>10.</td>
<td>Health Services Advisory Group, Inc.</td>
<td>Reviews documents</td>
<td>Day 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Renders decision to uphold or overturn</td>
<td>If Resolved</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Notifies IPA &amp; Blue Shield 65 Plus (HMO) of decision by phone or fax. Mails letters of determination to Blue Shield 65 Plus (HMO) and enrollee</td>
<td>Go to step 14</td>
</tr>
<tr>
<td>11.</td>
<td>Health Services Advisory Group, Inc.</td>
<td>If documents not received by Health Services Advisory Group, Inc., on Day 2, Health Services Advisory Group, Inc. sends to Blue Shield 65 Plus (HMO), &quot;Notice: Failure to Comply&quot; requesting documents again.</td>
<td>Day 2</td>
</tr>
<tr>
<td>12.</td>
<td>Blue Shield 65 Plus</td>
<td>Call IPA/MSO contact again to ensure all documents are faxed to Health Services Advisory Group, Inc. for review.</td>
<td>Day 2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Render decision to uphold or overturn</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Notifies IPA &amp; Blue Shield 65 Plus (HMO) of decision by phone or fax. Mails letters of determination to Blue Shield 65 Plus (HMO) and enrollee</td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td>Blue Shield 65 Plus (HMO)</td>
<td>Logs all actions, dates &amp; times in Notes document</td>
<td>Real time</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Prepare file for each appeal with notes on left side of folder, all other documents are filed on right side of folder, latest on top Record case in Grijalva Appeals tracking log</td>
<td></td>
</tr>
<tr>
<td>15.</td>
<td>Blue Shield 65 Plus (HMO)</td>
<td>Cases are filed away in a locked cabinet alphabetically</td>
<td>Conclusion</td>
</tr>
</tbody>
</table>
Skilled Nursing Facility Discharges (SNF or TCU) (cont’d.)

Contractual and Billing Requirements

Contracts already obligate providers to compliance with state and federal regulations. As part of the new CMS rule, contracted entities must comply with applicable notice and appeal provisions in subpart M, including but not limited to, the notification requirements in §§422.620 and 422.624 and the requirements in §422.626 concerning supplying information to an Independent Review Entity.

Questions & Answers:

- **Is the provider or MA organization required to obtain an enrollee’s signature on the advance termination notice or detailed termination notice?**
  
The provider must obtain the enrollee’s or authorized representative’s signature on the advance termination notice (NOMNC), which ensures that the enrollee received the notice, and that financial liability may be properly transferred to the enrollee for any days beyond the effective date that Medicare coverage ends. The provider must place the original NOMNC in the enrollee’s case file, and give a copy to the enrollee. In the event of an appeal, the provider must also provide a copy to the Quality Improvement Organization (QIO), since the QIO is responsible for verifying that the provider delivered a valid notice to the enrollee.

  The MA organization does not need to obtain the enrollee’s or authorized representative’s signature on the detailed notice, which is called the Detailed Explanation of Non-Coverage (DENC).

- **Suppose that an enrollee is receiving physical therapy, wound care, and IV in a SNF. If the SNF only discontinues the IV, is the SNF required to deliver an NOMNC to the enrollee two days prior to the IV ending?**
  
  No. A provider is not required to deliver the NOMNC two days prior to one service ending, while other Medicare-covered services continue. The fast-track appeals process applies only to situations when the enrollee will no longer receive Medicare-covered services from the provider. The scenario described would be considered a reduction, rather than a termination, of services.

- **Many patients receiving home health care only require a single visit. Can the NOMNC be given during the first (and last) visit?**
  
  Yes. In cases where the services or visits will be less than two days, the NOMNC may be given upon admission, or during the only visit.

- **If a member is in a SNF, gets pneumonia and subsequently needs to go to an acute setting, should the member receive the NOMNC?**
  
  No. The NOMNC is not intended or required for this situation.

- **Will SNFs, HHAs, and CORFs be required to retain copies of NOMNCs in patients’ medical records? Will the MA organization need to obtain a copy?**
  
  The provider should retain a copy of the NOMNC as part of the patient’s medical record; however, MAO’s and providers should determine how and where the notices should be maintained to meet medical records’ retention policies.
Skilled Nursing Facility Discharges (SNF or TCU) *(cont’d.)*

**Contractual & Billing Requirements (cont’d.)**

- If a provider is discontinuing a previously authorized, discrete increment of services, e.g., the MA organization authorized 12 skilled nursing visits by an HHA nurse, does the provider still have to issue a NOMNC if the provider is planning to discharge the patient as scheduled on the last visit?  
  Why?  
  Yes. The provider must deliver the NOMNC no later than the next-to-last visit in this example. Providing a notice to the enrollee not only conveys when the services are going to end, but also informs the enrollee of the right to appeal if the enrollee disagrees, and transfers liability to the enrollee if the enrollee continues to receive non-covered services.

- Can you please clarify if whether the fast-track appeals process also includes psychiatric home health services?  
  Yes, the fast-track appeals process applies to psychiatric home health services.

- How will providers know what their responsibilities are under the new fast-track appeals process?  
  CMS provides information to providers on their responsibilities under this new appeals process through CMS’ Medlearn website, CMS’ “list serve” of participating providers, outreach to provider trade associations, and CMS open door forums. In addition, we are instructing our fiscal intermediaries and carriers to include an article about the process in their next provider bulletins. QIOs also are required to provide education and training to the providers with whom they have agreements. MAO’s must also do their part to ensure that their providers are educated about their responsibilities under the fast-track appeals process.

- Will CMS release the NOMNC to providers, or will MAO’s be required to distribute the notices to the providers directly?  
  The notices are available online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html. MAO’s should work with their providers to determine whether direct distribution is necessary. The provider education material that we have distributed refers providers to the “appeals” website.
Blue Shield 65 Plus (HMO) Medicare Advantage
Required Billing Elements

CMS Model Letters:

➢ DETAILED NOTICE OF DISCHARGE (Attachment A)
➢ NOTICE OF MEDICARE NON-COVERAGE (Attachment B)

(Attachment A – CMS Model Letter – SAMPLE - Must be 12 point font)

Patient Name: 
Patient ID Number:      Date Issued: 
Physician: 

{Insert Hospital or Plan Logo here} 
DETAILED NOTICE OF DISCHARGE

You have asked for a review by the Quality Improvement Organization (QIO), an independent reviewer hired by Medicare to review your case. This notice gives you a detailed explanation about why your hospital and your managed care plan (if you belong to one), in agreement with your doctor, believe that your inpatient hospital services should end on ____________________.

This is based on Medicare coverage policies listed below and your medical condition. This is not an official Medicare decision. The decision on your appeal will come from your Quality Improvement Organization (QIO).

• Medicare Coverage Policies:
  _____Medicare does not cover inpatient hospital services that are not medically necessary or could be safely furnished in another setting. (Refer to 42 Code of Federal Regulations, 411.15 (g) and (k)).
  _____Medicare Managed Care policies, if applicable: ______________________________
  __________Other ________________________________________________________________

{insert specific managed care policies}

• Specific information about your current medical condition:

• If you would like a copy of the documents sent to the QIO, or copies of the specific policies or criteria used to make this decision, please call {insert hospital and/or plan telephone number}.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1019. The time required to complete this information collection is estimated to average 60 minutes per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. CMS 10066 (approved 5/2007)
NOTICE OF MEDICARE NON-COVERAGE

Patient name:     Patient number:

The Effective Date Coverage of Your Current Services Will End: {insert type} {insert effective date}

• Your Medicare provider and/or health plan have determined that Medicare probably will not pay for your current {insert type} services after the effective date indicated above.

• You may have to pay for any services you receive after the above date.

Your Right to Appeal This Decision

• You have the right to an immediate, independent medical review (appeal) of the decision to end Medicare coverage of these services. Your services will continue during the appeal.

• If you choose to appeal, the independent reviewer will ask for your opinion. The reviewer also will look at your medical records and/or other relevant information. You do not have to prepare anything in writing, but you have the right to do so if you wish.

• If you choose to appeal, you and the independent reviewer will each receive a copy of the detailed explanation about why your coverage for services should not continue. You will receive this detailed notice only after you request an appeal.

• If you choose to appeal, and the independent reviewer agrees services should no longer be covered after the effective date indicated above.

• Neither Medicare nor your plan will pay for these services after that date.

• If you stop services no later than the effective date indicated above, you will avoid financial liability.

How to Ask For an Immediate Appeal

• You must make your request to your Quality Improvement Organization (also known as a QIO). A QIO is the independent reviewer authorized by Medicare to review the decision to end these services.

• Your request for an immediate appeal should be made as soon as possible, but no later than noon of the day before the effective date indicated above.

• The QIO will notify you of its decision as soon as possible, generally no later than two days after the effective date of this notice if you are in Original Medicare. If you are in a Medicare health plan, the QIO generally will notify you of its decision by the effective date of this notice.

• Call your QIO at: Health Services Advisory Group of California, Inc., 1-800-841-1602, TTY 1-800-881-5980, to appeal, or if you have questions.
If You Miss The Deadline to Request An Immediate Appeal, You May Have Other Appeal Rights:

• If you have Original Medicare: Call the QIO listed on page 1.

• If you belong to a Medicare health plan: Call your plan at the number given below.

Plan contact information:

Blue Shield 65 Plus HMO
Attn: Medicare Appeals and Grievances Dept.
P.O. Box 927
Woodland Hills, CA 91365-9856

Ph: 1-800-776-4466
TTY: 1-800-794-1099
Fax: 1-916-350-6510

Additional Information (Optional):

Please sign below to indicate you received and understood this notice.

I have been notified that coverage of my services will end on the effective date indicated on this notice and that I may appeal this decision by contacting my QIO.
Optional Attachment to assist with documentation

Please fax completed (signed) Notice of Medicare Non-Coverage (NOMNC) to:

<table>
<thead>
<tr>
<th>CONFIRMATION OF NOTICE BY TELEPHONE</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Notification by telephone is done only in situations where the notice must be delivered to an incompetent enrollee in an institutional setting. See Medicare Managed Care Manual, Chapter 13, Section 60.1.3 for reference.)</td>
</tr>
<tr>
<td>Name of person contacted:</td>
</tr>
<tr>
<td>Date of contact:</td>
</tr>
<tr>
<td>Time:</td>
</tr>
<tr>
<td>☐ AM ☐ PM</td>
</tr>
<tr>
<td>Signature of Health Plan/SNF/HHA/CORF/Medical Group Representative</td>
</tr>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONFIRMATION OF FOLLOW-UP NOTICE BY MAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Notification by mail must also be done if telephone notification was made. This is done only in situations where the notice must be delivered to an incompetent enrollee is in an institutional setting. See Medicare Managed Care Manual, Chapter 13, Section 60.1.3 for reference.)</td>
</tr>
<tr>
<td>Mailing address:</td>
</tr>
<tr>
<td>Date sent:</td>
</tr>
<tr>
<td>☐ US Mail ☐ Certified Mail ☐ FedEx ☐ Priority Mail</td>
</tr>
<tr>
<td>Tracking # (if applicable):</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CONFIRMATION OF REFUSAL TO SIGN</th>
</tr>
</thead>
<tbody>
<tr>
<td>I confirm that the Notice of Medicare Non-Coverage was hand-delivered to the member or the member's authorized representative; however, the member or the member’s authorized representative refused to sign the acknowledgment of receipt.</td>
</tr>
<tr>
<td>Name of person receiving notice:</td>
</tr>
<tr>
<td>Date of delivery:</td>
</tr>
<tr>
<td>Time:</td>
</tr>
<tr>
<td>☐ AM ☐ PM</td>
</tr>
<tr>
<td>Signature of Person Delivering Notice</td>
</tr>
<tr>
<td>Date</td>
</tr>
</tbody>
</table>
### Guidance Checklist When Issuing NOMNC to Other Than Member (See Medicare Managed Care Manual, Chapter 13, Section 60.1.3)

<table>
<thead>
<tr>
<th>Respoensible Party</th>
<th>SNF</th>
<th>MG/IPA</th>
<th>Initial Completed</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
</table>

Call patient’s representative the day letter is issued. *(Date of conversation is the date of the receipt of the NONMC). ID self and give organization, contact name and number, purpose of call (right to file an appeal) and describe the appeal right being discussed (e.g., QIO vs. expedited).*

Inform representative that skilled services will no longer be covered beginning on: *(date) ________ and financial responsibility starts on (date) ___________

Advise representative of appeal rights. *(You must read directly from the letter)*

Advise representative that an appeal must be phoned to HSAG by 12:00 p.m. the following day of receipt of the NOMNC or phone call.

Provide the representative with the QIO name (HSAG) and phone number listed in the appeal section of the letter. Provide address, fax or other method of communication needed by representative for QIO to receive appeal in a timely fashion.

Inform representative how to get a detailed notice describing why the enrollee’s services are not being covered

Provide at least one phone number of an advocacy organization or 1-800-MEDICARE

Confirm the telephone contact by written notice mailed same day.

If direct phone contact cannot be made, including leaving voice mail, mail the notice to the representative, certified mail, return receipt requested. *(If the Medical Group is sending the certified mail, the Facility must notify the Medical Group immediately that certified mail is required.)*

*(If the Facility sent the certified mail, and HSAG is processing an appeal, the certified returned receipt must be submitted to HSAG. If not submitted, the appeal may be decided in favor of the member solely due to lack of the receipt which is the evidence of timely notification.)*

Document that representative understands the information provided.