Section 2: Provider Responsibilities
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# Section 2: Provider Responsibilities

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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.
Section 2: Provider Responsibilities

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.
Section 2: Provider Responsibilities

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.
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.
**Section 2: Provider Responsibilities**

**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.</td>
</tr>
<tr>
<td></td>
<td>(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</td>
</tr>
<tr>
<td></td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>a completed Provider Enrollment Application.</td>
</tr>
<tr>
<td>Leaving a group</td>
<td>Written request from the individual provider on letterhead, noting effective</td>
</tr>
<tr>
<td></td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>IRS</td>
</tr>
<tr>
<td>Changing name of group</td>
<td>Agreement and Provider Enrollment Application * Tax coupon, SS-4 or letter 147C from</td>
</tr>
<tr>
<td></td>
<td>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</td>
</tr>
<tr>
<td></td>
<td>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).
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.
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
- BSCPalliativeCare@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.
Section 2: Provider Responsibilities

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.
Section 2: Provider Responsibilities

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>Preventive Care Appointments</th>
<th>Access to preventive care with a PCP, Nurse Practitioner, or Physician Assistant at the same office site as a member’s assigned PCP.</th>
<th>Within 30 calendar days</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Regular and routine care PCP</strong></td>
<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>
<tr>
<td><strong>Regular and routine care SPC</strong></td>
<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>
<tr>
<td><strong>Urgent Care Appointment</strong></td>
<td>Access to urgent symptomatic care appointments that do not require prior authorization with the PCP, 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>
<tr>
<td><strong>Urgent Care Appointment</strong></td>
<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>
<tr>
<td><strong>Ancillary Care Appointments</strong></td>
<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>
<tr>
<td><strong>Rescheduling of Appointments and Authorizations</strong></td>
<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> (telephone answering service or machine)</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></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>
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>One PCP within 15 miles of each member or 30 minutes of each member</td>
<td>85%</td>
</tr>
<tr>
<td>Family Practitioner</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>Internist</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>Pediatric</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>Top 10 High Volume Specialists</td>
<td>HMO/POS PPO – CDI</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 – DMHC IFP ePPO</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>CCSB HMO/PPO</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>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 within 30 miles</td>
<td>90%</td>
</tr>
<tr>
<td>Lab</td>
<td></td>
<td>One lab within 30 miles</td>
<td>90%</td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
<td>One Pharmacy within 10 miles</td>
<td>95%</td>
</tr>
<tr>
<td>DME</td>
<td></td>
<td>One DME within 15 miles</td>
<td>85%</td>
</tr>
<tr>
<td>ASC</td>
<td></td>
<td>One ASC within 30 miles</td>
<td>95%</td>
</tr>
<tr>
<td>SNF</td>
<td></td>
<td>One SNF within 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>Total PCP To Member</td>
<td>HMO/PPO – DMHC/PPO – CDI</td>
<td>One PCP to 2,000 commercial members</td>
<td>100%</td>
</tr>
<tr>
<td>Availability Ratio</td>
<td></td>
<td></td>
<td></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>Acute Inpatient Hospitals</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac Surgery Program</td>
<td>30</td>
<td>15</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Cardiac Catheterization Services</td>
<td>30</td>
<td>15</td>
<td>10</td>
<td>5</td>
<td>15</td>
</tr>
<tr>
<td>Critical Care Services – Intensive Care</td>
<td>20</td>
<td>10</td>
<td>45</td>
<td>30</td>
<td>80</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>30</td>
<td>15</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>45</td>
<td>30</td>
<td>80</td>
</tr>
<tr>
<td>Orthotics and Prosthetics</td>
<td>30</td>
<td>15</td>
<td>45</td>
<td>30</td>
<td>80</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>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>80</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>30</td>
<td>15</td>
<td>60</td>
<td>40</td>
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<td>Physiatry, Rehabilitative N</td>
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Provider Availability Standards for Medicare Advantage Products (cont'd.)

Provider Minimum Number Requirements

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<th>Micro</th>
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*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:**                                                          | 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%                      |
| - Psychologists  
- Psychiatrists  
- MFCC                                                                                                                                         |                                                                                                                                  |                          |
| **Geographic Distribution of Behavioral Health facilities including:**                                                                       | 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%                      |
| - Inpatient Psychiatric Hospital  
- Residential & OP Treatment Facility                                                                                                       |                                                                                                                                  |                          |
| **Behavioral Health Member Ratio including:**                                                                                                  | 1 provider: 20,000 members                                                                                                       | 100%                     |
| - Top 3 HVS Substance Abuse practitioner                                                                                                        |                                                                                                                                  |                          |

### Linguistic and Cultural Requirement

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

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<tr>
<th>METRICS</th>
<th>PRODUCT</th>
<th>STANDARD</th>
<th>FREQUENCY</th>
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<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>
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<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>
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<td>PCP, Specialist, and Hospital Network Change Analysis</td>
<td>IFP ePPO</td>
<td>10% (Net change)</td>
<td>Quarterly</td>
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<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>
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<tr>
<td>Average Enrollment per PCP</td>
<td>HMO/POS</td>
<td>&lt; 1,200</td>
<td>Semi-Annual</td>
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<tr>
<td>Open PCP Panel</td>
<td>HMO/POS DCHMO</td>
<td>85%</td>
<td>Semi-Annual</td>
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<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>
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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 as such 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.
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.hmohelp.ca.gov/dmhc_consumer/pc/pc_imrapp.aspx 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).
Language Assistance for Persons with Limited English Proficiency (LEP) (cont’d.)

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): Diné k’ehji doo bąąh ilįįgó shíka’ ał’oowol ninizingo, kwįį’ hodíilnih 1-866-346-7198.

Vietnamese (Tiếng Việt): Đế được hỗ trợ miễn phí tiếng Việt, vui lòng gọi đến số 1-866-346-7198.


Armenian (Հայերեն): Հայերենով անհրաժեշտություն ենթադրեք 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。無料で提供します。

Persian (فارسی): برای دریافت کمک رایگان زبان فارسی لطفاً با شماره تلفن 1-866-346-7198 تماس بگیرید.


Hmong (Hmoob): Xav tau kev pab dawb lub Hmoob, thov hu rau 1-866-346-7198.

Hindi (हिंदी): हिंदीमें हिंदी में 1-866-346-7198 परकॉल्टाकरें.

Thai (ไทย): สำหรับภาษาไทย 1-866-346-7198.

Laotian (ພາສາລາວ): ໃໝດລາວພາສາລາວ 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>
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| Provider receives a request for translation of a provider’s non-standardized vital document from a Blue Shield enrollee | Urgent: Response within one business day | Urgent: 1. Forward the following to Blue Shield within one business day:  
   a) Request for translation  
   b) Copy of the document  
   2. Log the following:  
      a) Date request was received from enrollee  
      b) Date request and document were forwarded to Blue Shield  
Non-Urgent: Response within two business days | Non-Urgent: 1. Forward the following to Blue Shield within two business days:  
   a) Request for translation  
   b) Copy of the document  
   2. Log the following:  
      a) Date request was received from enrollee  
      b) Date request and document were forwarded to Blue Shield |
| Blue Shield requests a provider’s non-standardized vital document | Urgent: Within one business day | Urgent: 1. Forward the following to Blue Shield within one business day:  
   a) Copy of the requested document  
   2. Log the following:  
      a) Date request was received from Blue Shield  
      b) Date document was forwarded to Blue Shield  
Non-Urgent: Within two business days | Non-Urgent: 1. Forward the following to Blue Shield within two business days:  
   a) Copy of the requested document  
   2. Log the following:  
      a) Date request was received from Blue Shield  
      b) Date document was forwarded to Blue Shield |
| Blue Shield member requests a Blue Shield standard vital document from provider. | All: Within one business day | All: 1. Provider informs member to call the Blue Shield Member/Customer Service number on the back of his/her Member ID Card or (866) 346-7198. |
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  
- 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](http://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](http://erc.msh.org/mainpage.cfm?file=1.0.htm&module=provider&language=English)
  [www.thinkculturalhealth.org](http://www.thinkculturalhealth.org)