Independent Physician and Provider Manual

A procedure manual for direct-contract Blue Shield network providers

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blue california

blueshieldca.com

Table of Contents

Section 1: Introduction

Section 2: Provider Responsibilities

Section 2: Provider Responsibilities *(cont'd.)*

Section 3: Medical Care Solutions

Section 3: Medical Care Solutions *(cont'd.)*

Section 4: Billing

Section 4: Billing *(cont'd.)*

Section 5: Blue Shield Benefit Plans and Programs

Section 5: Blue Shield Benefit Plans and Programs *(cont'd.)*

Section 5: Blue Shield Benefit Plans and Programs *(cont'd.)*

Section 6: Supplemental Direct Contracting HMO Administrative Procedures and Responsibilities

Appendices

Appendix for Section 1

A. Glossary

B. Blue Shield Combined Eligibility/Capitation Report

C. Blue Shield HMO Eligibility Adds and Terminations Report

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

E. Palliative Care Services Recertification Form

Appendix for Section 3

There is no Appendix for Section 3.

Appendix for Section 4

A. Special Billing Guidelines and Procedures

B. Electronic Claims Submission

C. CMS 1500 General Instructions

D. Where to Send Claims

E. Blue Shield Payment Processing Logic

F. List of Office-Based Ambulatory Procedures

Appendix for Section 5

A. The BlueCard® Program

Appendix for Section 6

A. Blue Shield Medicare Advantage Plan Required Billing Elements

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Section 1: Introduction

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Table of Contents

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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 Medicare Advantage Plans - Individual and Group

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 Pathologists

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.

Purpose of the Independent Physician and Provider Manual *(cont'd.)*

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.

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 to hear eligibility and request fax confirmation.

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 on Provider Connection at **blueshieldca.com/provider** under *Guidelines & resources, Forms, then Patient care forms*.

Enrollment and Eligibility *(cont'd.)*

Monthly Eligibility Reports (Capitated Providers)

As a cost-effective measure, Blue Shield provides the Combined Eligibility/Capitation Report and the Eligibility Adds and Termination Report only in electronic format. Receiving eligibility information electronically enables capitated providers to use and sort the information in many ways to meet their specific reporting needs.

Blue Shield distributes these eligibility reports via Blue Shield secure email or SFTP to all capitated providers no later than the tenth of each calendar month. For details on the file formats, refer to Appendix 1 in the back of this manual.

Both reports include the member's name and identification number, the member's primary care physician name and identification number, as well as the activity code for all member status changes. The files also include the member's group number and Product IDs. The Product IDs are codes that identify the member's standard office visit copayments. Product IDs and Physician Office Copayment Guides are forwarded each month along with the Combined Eligibility/Capitation Reports.

Enrollment and Eligibility *(cont'd.)*

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.

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.

Enrollment and Eligibility *(cont'd.)*

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.

Enrollment and Eligibility *(cont'd.)*

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.

Enrollment and Eligibility *(cont'd.)*

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

Provider Procedures for Disenrollment *(cont'd.)*

- 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.

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 Medicare Advantage Plan)

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 Medicare Advantage plan 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 Medicare Advantage plan members involuntarily while continuing to provide appropriate treatment with an existing healthcare provider.

Enrollment and Eligibility *(cont'd.)*

Provider Requests to Transfer or Disenroll Members (Blue Shield Medicare Advantage Plan) *(cont'd.)*

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 Medicare Advantage plan members **may not** be involuntarily transferred without Blue Shield Medicare Advantage plan 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 Medicare Advantage plan 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.

Enrollment and Eligibility *(cont'd.)*

Provider Requests to Transfer or Disenroll Members (Blue Shield Medicare Advantage Plan) *(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 Medicare Advantage plan's Customer Care staff can assist by contacting the member in such a circumstance. Since such litigation demonstrates a breakdown in the patient/physician relationship, Customer Care 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 the Blue Shield Medicare Advantage Customer Care 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);

Enrollment and Eligibility *(cont'd.)*

Provider Requests to Transfer or Disenroll Members (Blue Shield Medicare Advantage Plan) *(cont'd.)*

Procedure *(cont'd.)*

- 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 the Blue Shield Medicare Advantage plan Customer Care Department.

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 Medicare Advantage plan members describing the behavior that has been identified as disruptive and how it has impacted the plan's ability to manage the individuals 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 Customer Care 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.

Enrollment and Eligibility *(cont'd.)*

Provider Requests to Transfer or Disenroll Members (Blue Shield Medicare Advantage Plan) *(cont'd.)*

Procedure *(cont'd.)*

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 Medicare Advantage plan 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 Medicare Advantage plan 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 Customer Care 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 Medicare Advantage plan grievance procedure is also included in the letter.

Enrollment and Eligibility *(cont'd.)*

Provider Requests to Transfer or Disenroll Members (Blue Shield Medicare Advantage Plan) *(cont'd.)*

Procedure *(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 PCP 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 Medicare Advantage plan 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 Medicare Advantage plan 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 HMO and PPO Commercial Members

Blue Shield has established Member Rights and Responsibilities that all Blue Shield members receive in their *Evidence of Coverage (EOC)* or *Certificate of Insurance (COI).* The information below is taken from the Members EOC/COI.

Statement of Member Rights

Blue Shield health plan members have the right to:

1. Receive considerate and courteous care, with respect for your right to personal privacy and dignity.
2. Receive information about all health services available to you, including a clear explanation of how to obtain health services.
3. Receive information about your rights and responsibilities.
4. Receive information about your Blue Shield plan, the services we offer you, the Physicians and other Health Care Providers available to care for you.
5. Select a PCP and expect their team to provide or arrange for your needs (HMO members only).
6. Have reasonable access to appropriate medical and mental health services.
7. Participate actively with your physician or PCP in decisions regarding your medical and mental health care. To the extent the law permits, you also have the right to refuse treatment.
8. A candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or Benefit coverage.
9. An explanation of your medical or mental health condition, and any proposed, appropriate or Medically Necessary treatment alternatives, so you can make an informed decision before you receive treatment. This includes available success/outcomes information, regardless of cost of Benefit Coverage.
10. Receive Preventive Health Services.
11. Know and understand your medical or mental health condition, treatment plan, expected outcome, and the effects these have on your daily living.
12. Have confidential health records, except when the law requires or permits disclosure. With adequate notice, you have the right to review your medical record with Physician or PCP.
13. Communicate with, and receive information, from Customer Services in a language you can understand.

Member Rights and Responsibilities- Blue Shield HMO and PPO Commercial Members *(cont'd.)*

Statement of Member Rights *(cont'd.)*

14. Know about any transfer to another Hospital, including information as to why the transfer is necessary and any alternatives available.
15. Be fully informed about the complaint and grievance process and understand how to use it without the fear of interruption in your health care.
16. Voice complaints or appeals about your Blue Shield plan or the care provided to you.
17. Make recommendations on Blue Shield's member rights and responsibilities policies.

Statement of Member Responsibilities

Blue Shield health plan members have the responsibility to:

1. Carefully read all Blue Shield health plan materials immediately after you are enrolled so you understand how to:
    a. Use your benefits;
    b. Minimize your out-of- pocket costs; and
    c. Follow the provisions of your health plan as explained in the *Evidence of Coverage* or *Health Service Agreement*.
2. Maintain your good health and prevent illness by making positive health choices and seeking appropriate care you need it.
3. Provide, to the extent possible, information that is needed to provide appropriate care.
4. Understand your health problems and take an active role in developing treatment goals with your Physician or PCP, whenever possible.
5. Follow the treatment plans and instructions you and your Physician or PCP agree to and consider the potential consequences if you refuse to comply with treatment plans or recommendations.
6. Ask questions about your medical or mental health condition and make certain that you understand the explanations and instructions you are given.
7. Make and keep medical and mental health appointments and inform your Health Care Provider ahead of time when you must cancel.
8. Communicate openly with your Physician or PCP so you can develop a strong partnership based on trust and cooperation.
9. Offer suggestions to improve the Blue Shield plan.

Member Rights and Responsibilities- Blue Shield HMO and PPO Commercial Members *(cont'd.)*

Statement of Member Responsibilities *(cont'd.)*

10. Help Blue Shield maintain accurate and current medical records by providing timely information regarding changes in your address, family status, and other plan coverage.
11. Notify Blue Shield as soon as possible if you are billed inappropriately or if you have any complaints or grievances.
12. Treat all Blue Shield personnel respectfully and courteously.
13. Pay your Premiums, Copayments, Coinsurance and charges for non-covered Services in full and on time.
14. Follow the provisions of the Blue Shield Medical Management Programs.

Member Rights and Responsibilities – Blue Shield Medicare 65 Plus

All Blue Shield Medicare 65 Plus plan members receive in their *Evidence of Coverage (EOC)* a Statement of Member Rights and Responsibilities. The information below is taken from the Blue Shield 65 Plus (HMO) plan EOC.

We must provide information in a way that works for you (in languages other than English, in large print, in braille or other alternate formats, etc.)

To get information from us in a way that works for you, please call Customer Care at (800) 776-4466 [TTY 711] 8 a.m. to 8 p.m. seven days a week, year-round.

Our plan has people and free language interpreter services available to answer questions from disabled and non-English speaking members. We can also give you information in braille, large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Customer Care.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with:

Blue Shield of California Civil Rights Coordinator
P.O. Box 629007 El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711) Fax: (844) 696-6070

Member Rights and Responsibilities – Blue Shield Medicare 65 Plus *(cont'd.)*

Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) or directly with the Office for Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact Customer Care.

We must ensure that you get timely access to your covered services and drugs.

As a member of our plan, you have the right to choose a primary care physician (PCP) in the plan's network to provide and arrange for your covered services. Call Customer Care to learn which doctors are accepting new patients. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, please refer to Chapter 9, Section 10 of the EOC for details on what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 4 tells what you can do.)

We must protect your privacy.

Federal and state laws protect the privacy of your medical records and protected health information. We protect your protected health information as required by these laws.

Your "protected health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice" that tells about these rights and explains how we protect the privacy of your health information.

Member Rights and Responsibilities – Blue Shield Medicare 65 Plus *(cont'd.)*

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These following exceptions are allowed or required by law:
    - For example, we are required to release health information to government agencies that are checking on quality of care.
    - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your protected health information, please call Customer Care.

Member Rights and Responsibilities – Blue Shield Medicare 65 Plus *(cont'd.)*

We are always committed to protecting the privacy of your personal and health information. Our Notice of Privacy Practices describes both your privacy rights as a member and how we protect your personal and health information. To obtain a copy of our privacy notice, you can:

1. Go to blueshieldca.com and click the *Privacy* link at the bottom of the homepage and print a copy.
2. Call the Customer Care phone number on your Blue Shield member ID card to request a copy.
3. Call the Blue Shield of California Privacy Office toll-free at (888) 266-8080 (TTY 711), 8 a.m. to 3 p.m., Monday through Friday.
4. Email us at privacy@blueshieldca.com

We must give you information about the plan, its network of providers, and your covered services.

As a member of Blue Shield 65 Plus, you have the right to get information from us in a way that works for you, including getting the information in languages other than English, in large print, or other alternate formats, such as:

- Information about our plan. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's Star ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- Information about our network providers including our network pharmacies.
    - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
    - For a list of the providers in the plan's network, see the Provider Directory.
    - For a list of the pharmacies in the plan's network, see the Pharmacy Directory.
    - For more detailed information about our providers or pharmacies, you can call Customer Care or visit our website at blueshieldca.com/find-a-doctor.
- Information about your coverage and the rules you must follow when using your coverage.

Member Rights and Responsibilities – Blue Shield Medicare 65 Plus *(cont'd.)*

- In Chapters 3 and 4 of the EOC we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
- To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of the EOC plus the plan's List of Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs (Formulary), tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
- If you have questions about the rules or restrictions, please call Customer Care.

- Information about why something is not covered and what you can do about it.
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.
  - If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of the EOC. It gives you the details how to make an appeal if you want us to change our decision. (Chapter 9 in the EOC also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of the EOC.

We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care.

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

Member Rights and Responsibilities – Blue Shield Medicare 65 Plus *(cont'd.)*

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choice**s. This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of the EOC explains how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself.

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.

- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

Member Rights and Responsibilities – Blue Shield Medicare 65 Plus *(cont'd.)*

The legal documents that you can use to give your directions in advance in these situations are called **"advance directives."** There are different types of advance directives and different names for them. Documents called **"living will"** and **"power of attorney for health care"** are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Customer Care to ask for the forms.

- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.

- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.

- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with Livanta. See Chapter 2, Section 4 of the EOC for contact information.

Member Rights and Responsibilities – Blue Shield Medicare 65 Plus *(cont'd.)*

You have the right to make complaints and to ask us to reconsider decisions we have made.

If you have any problems or concerns about your covered services or care, Chapter 9 of the EOC tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Care.

What can you do if you think you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights.

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at (800) 368-1019, TTY (800) 537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you think you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Care.**
- You can call the **State Health Insurance Assistance Program.** For details about this organization and how to contact it, go to Chapter 2, Section 3.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Member Rights and Responsibilities – Blue Shield Medicare 65 Plus *(cont'd.)*

How to get more information about your rights.

There are several places where you can get more information about your rights:

- You can **call Customer Care**.
- You can **call the SHIP**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare.**
    - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.)
    - Or, you can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You have some responsibilities as a member of the plan

What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Care. We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use the EOC to learn what is covered for you and the rules you need to follow to get your covered services.
    - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
    - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us. Please call Customer Care to let us know.
    - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 10.)

Member Rights and Responsibilities – Blue Shield Medicare 65 Plus *(cont'd.)*

- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
    - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
    - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
    - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. Some plan members must pay a premium for Medicare Part A. Most plan members must pay a premium for Medicare Part B to remain a member of the plan.
    - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services. Chapter 6 tells what you must pay for your Part D prescription drugs.
        - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
        - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 for information about how to make an appeal.
    - If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.
    - If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.

Member Rights and Responsibilities – Blue Shield Medicare 65 Plus *(cont'd.)*

- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Customer Care.
    - **If you move outside of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
    - **If you move within our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
    - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Customer Care for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
    - Phone numbers and calling hours for Customer are printed on the back cover of this booklet.
    - For more information on how to reach us, including our mailing address, please see Chapter 2.

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 Medicare Advantage plan 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 – Standard or Expedited
- Complaint

Definitions

Potential Quality Issue (PQI) – Any suspected deviation from expected provider or health plan performance related to the quality of care and/or the quality of service provided to any Blue Shield or Blue Shield Life enrollee during a course of care or treatment, regardless of Line of Business. Possible examples include but are not limited to those listed below. PQIs may 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 Medicare Advantage Plan Policy

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

The Blue Shield Medicare Advantage 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 Medicare Advantage plan Medical Director and a representative from the Blue Shield Medicare Advantage Appeals and Grievances Department.

All grievances are researched and investigated by the Blue Shield Medicare Advantage 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 Medicare Advantage plan 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. 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.

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.

Member Grievance Process *(cont'd.)*

External Exception Review

If Blue Shield denies an exception request for coverage of a Non-Formulary Drug, Step Therapy or a Prescription Drug Prior Authorization, the Member, authorized representative, or the Provider may submit a grievance requesting an external exception request review. Blue Shield will ensure a decision within 72 hours in routine circumstances or 24 hours in exigent circumstances. This review process applies to plans regulated by the DMHC or CDI.

Contacting the Appeals and Grievance Department

To contact the Appeals and Grievance Department, please refer to the *Contact us* section at the top of Provider Connection at blueshieldca.com/provider.

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. All reporting is confidential.

Fraud Prevention *(cont'd.)*

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.

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 Qlarant Integrity Solutions, LLC. Qlarant Integrity Solutions, LLC is responsible for monitoring for fraud, waste, or abuse in the Medicare Part C and Part D programs on a national level.

Qlarant Integrity Solutions, 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.

Qlarant Integrity Solutions, 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.

Fraud Prevention *(cont'd.)*

Fraud, Waste, and Abuse *(cont'd.)*

Medicare beneficiaries should contact Qlarant Integrity Solutions, LLC at (877) 772-3379 to report complaints about any of these types of fraud, waste and abuse issues or a related complaint. Qlarant Integrity Solutions, LLC may also be contacted via facsimile at (410) 819-8698 or at their website www.qlarant.com/wp-content/uploads/2020/11/Qlarant_I-MEDIC_Complaint_Form_2020_11_04.pdf. 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. All reporting is confidential and may be submitted anonymously.

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).

Blue Shield requires all 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 who work works with the Medicare Program that they successfully complete a fraud waste and abuse (FWA) training. This training should focus on how to detect, correct, and prevent non-compliance and fraud, waste, and abuse surrounding Medicare programs.

All FDRs must ensure that all personnel, Board members, employees and contracted staff involved in the administration or delivery of Medicare benefits complete a 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 that is accessible at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.

Blue Shield's Code of Conduct and the Corporate Compliance Program

Blue Shield of California is guided by our North Star: To create a healthcare system that is worthy of our family and friends and sustainably affordable. We have deeply held values that also guide us and the experiences we create – for our members, our partners, our communities, ourselves, and others.

Objectives:

1) To strengthen and sustain a corporate culture of compliance, ethics, and integrity.
2) To prevent, detect and remediate unlawful or unethical conduct.
3) To create, strengthen and sustain an environment that facilitates the reporting of actual or suspected violations of law, company policies, Code of Conduct, and other misconduct, without fear of retaliation.

Blue Shield's Code of Conduct is the written expression of our expectations, requiring compliance with the law and our policies, and helping us keep sight of our values and translate them into everyday actions. At Blue Shield, we recognize that to lead with integrity, we must do what's right for our members and our company in every action, every transaction, every conversation.

The Code cannot cover every detail of every rule or law that applies, but the Code is always the best place to start. It gives you a high-level view of important topics and points you to other resources.

We are honored to do business with partners that support our mission.

Providers can make confidential reports of concerns or report actual or potential violations 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

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

Blue Shield Medicare Advantage 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's Medicare Advantage-Prescription Drug 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 Medicare Advantage plan, have paid any premiums required for initial enrollment to be valid, and whose enrollment in Blue Shield Medicare Advantage plan has been confirmed by the Centers for Medicare & Medicaid Services (CMS). Blue Shield Medicare Advantage plans are 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 Medicare Advantage plans provides comprehensive coordinated medical services to members through an established provider network. Similar to the commercial HMO product, Blue Shield Medicare Advantage HMO plan members must choose a Primary Care Physician (PCP) and have all care coordinated through this physician.

The Blue Shield Medicare Advantage plans are regulated by CMS, the same federal agency that administers Medicare.

Blue Shield Medicare 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

Blue Shield Medicare Compliance Program *(cont'd.)*

- 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 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 Medicare Compliance Officer advises about CMS requirements and monitors compliance within the organization and in relation to Blue Shield's representatives in the community. The Medicare Compliance Officer 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).

Blue Shield Medicare Compliance Program *(cont'd.)*

The Medicare Compliance Officer 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

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.

Blue Shield Medicare Compliance Program *(cont'd.)*

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://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.

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.

Healthcare Regulatory Agencies *(cont'd.)*

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.

Providers can reach the DMHC at (888) 466-2219, TDD line (877) 688-9891 for the hearing and speech impaired, or through www.dmhc.ca.gov, where complaint forms, IMR application forms, and instructions can be found. A revised IMR form is available in English and the 16 threshold languages on the DMHC website at https://www.dmhc.ca.gov/FileaComplaint/IndependentMedicalReviewComplaintForms.aspx.

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's Medicare Advantage-Prescription Drug 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's stand-alone Medicare prescription drug 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 medicare.gov and cms.hhs.gov.

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Section 2: Provider Responsibilities

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Table of Contents

Section 2: Provider Responsibilities

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 Medicare Advantage plan products (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.

General Blue Shield Agreement Terms and Conditions *(cont'd.)*

- 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.

- 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.

- Providers agree to limit their number of reported practice locations to the following:

    - Primary Care Physician/Practitioner (PCP): When a PCP practices at multiple practice locations, practitioner or medical group will ensure that reported locations per practitioner shall be limited to seven (7) in-person practice locations. Where stricter limits are imposed relative to the number of practice locations for reasons including, but not limited to, regulatory or other constraints on a particular geography and/or benefit program, Blue Shield will accordingly limit members' enrollment options to a smaller subset of the practitioner's approved practice locations.

    - Specialty Care Practitioner/Subspecialty Care Practitioner (SCP): If a SCP practices at multiple practice locations, practitioner or medical group will ensure that reported locations per physician specialists, subspecialists, or other clinicians (e.g., chiropractors, acupuncturists, occupational therapists, speech therapists, physical therapist, etc.) shall be limited to eleven (11) in-person practice locations.

General Blue Shield Agreement Terms and Conditions *(cont'd.)*

- 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" prior to the date of service. To view and download a copy of this form, please log in to Blue Shield's provider portal at blueshieldca.com/provider, click on *Find forms* at the bottom of the page, then *Patient care forms.* 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.

Blue Shield Provider Standards *(cont'd.)*

- 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.

- 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.
- 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.
- Comply with the policy outlined below for inclusion in the Blue Shield Find a Doctor online directory.

Administrative Compliance *(cont'd.)*

General Administrative Criteria *(cont'd.)*

- Have an identifiable practice location to publish in the directory or clearly specify that services are provided in a telehealth setting only 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 for use in the directory or claims processes.

  Comply with Blue Shield's processes to attest to the accuracy of their data every 90 days in compliance with the 2020 Consolidated Appropriations Act (CAA)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

For inclusion in the Blue Shield network, practitioners which include any person licensed or certified to provide member care, must meet Blue Shield's network criteria.

To request a new record for billing and claims purposes, the application forms, or provider profile with equivalent data elements may be submitted to Provider Information & Enrollment by email or postal mail. Submit the completed application to

Email	BSCProviderInfo@blueshieldca.com
Postal mail	Provider Information & Enrollment P.O. Box 629017 El Dorado Hills, CA 95762-9017

To view, download or complete forms, please log in to Blue Shield's provider portal at blueshieldca.com/provider, click on *Find forms* at the bottom of the page, then *Network and procedure forms.*

Reporting Provider Status Changes

To keep Blue Shield records and directories current, Providers are required to notify Blue Shield of changes to demographic data and any changes to their practice. Upon notification of status changes, Blue Shield will update its provider database and directories accordingly. please contact the Provider Information and Enrollment team at **(800) 258-3091 for questions or guidance regarding the impacts of status changes to claims and the directory.**

The provider group or practice is required to notify Blue Shield of changes to its provider network, as follows:

- **Addition of New Providers**

  The medical group must notify Blue Shield 30 days prior to the date a new provider is added to the IPA/medical group. The medical group is required to send a practitioner profile for all new providers participating with a relationship to the medical group.

  Delegated Medical Groups may send new provider profiles directly to the Provider Information & Enrollment team to be added to the network relationship. Non-delegated Medical Groups must first submit a credentialing application with new provider profiles and receive credentialing approval prior to provider being added to the network.

  Blue Shield will not add a provider who does not meet Blue Shield Network Criteria, including eligibility to participate in any Blue Shield networks the IPA/Medical Group is contracted for.

  Blue Shield will not add a provider whose service location is outside Blue Shield's approved network.

Provider Certification *(cont'd.)*

Reporting Provider Status Changes *(cont'd.)*

Demographic/Administrative Changes

The provider or medical group must notify Blue Shield of demographic or administrative changes as soon as possible for timely directory updates. Examples of these types of demographic or administrative changes include panel status, office location, office hours, office email, telephone numbers, fax numbers, billing address, tax identification number, board status, key contact person, etc.

In accordance with state law, all providers and medical groups must notify Blue Shield within five business days when a provider either ceases or resumes accepting new patients.

The minimum required data for all new providers and provider demographic adds, updates, or termination submissions is as follows:

- Complete name
- Primary office locations
- Telephone number and fax number, if applicable
- Office hours
- Specialty
- California license number or certification identifier as applicable
- Hospital staff privileges (list hospitals and types of privilege)
- Languages spoken by practitioner
- Languages spoken by others in the practice
- Wheelchair access
- IRS reporting number
- NPI identifiers (practitioner and entity as applicable)
- Designation as PCP or specialist
- Panel data including gender, age, or patient restriction
- Where required by law, individuals requiring supervision must also provide the name, NPI and license number of the supervising physician.

Credential Status Changes

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

Provider Certification *(cont'd.)*

Reporting Provider Status Changes *(cont'd.)*

Practice changes requiring supporting documentation:

IRS reporting number changes

- Providers are required to notify Blue Shield Provider whenever there is a change in their Tax reporting information.
- Blue Shield follows IRS reporting policies using the IRS reporting name and number on file.
- A new agreement, application materials and supporting certification documents are required when a contracted entity changes the IRS reporting number.

Name Changes

- Providers are required to provide supporting materials when a name is changed, while the legal entity name and tax reporting number remain the same.
- Such name supporting materials include:
  - Fictitious Name Permit issued by the applicable California licensing authority
  - County issued Fictitious Name Statement
  - License issued by the applicable California licensing authority
  - Certification issued by the applicable certifying body
  - Legal Entity Name as filed with the California Secretary of State

Provider Directory

In preparation for inclusion in Blue Shield's Directory publications, the IPA/medical group is required to attest to the accuracy of their data every 90 days in compliance with the 2020 Consolidated Appropriations Act (CAA). All providers with a contracted relationship with Blue Shield will display in the Blue Shield *Find a Doctor* online directory.

Providers have an opportunity to leverage Provider Connection online tools to support the process of attestation and submitting provider directory information updates. Non-responsive providers will be suppressed from the directory until they have attested to their information.

There are two ways to update provider directory data:

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

Provider Directory *(cont'd.)*

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

To discuss the information shared about your organization in the Blue Shield *Find a Doctor* online directory, please contact the Provider Information and Enrollment team at **(800) 258-3091**, from 6 a.m. to 6:30 p.m., Monday through Friday.

In order to reduce administrative burden on providers, Blue Shield may delegate some provider directory maintenance tasks to a vendor. As directed by Blue Shield, the provider may work with the vendor in lieu of Blue Shield to complete directory maintenance tasks.

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 providers 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 Director and the Credentials Committee. This committee, which is staffed by contracted network physicians, 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.

Credentialing and Recredentialing *(cont'd.)*

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).

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.

Specialty Credentialing Specifications

Nurse Practitioners (NP)

Assembly Bill 890 (AB 890) grants nurse practitioners full practice authority allowing them to work without physician supervision. To practice in an integrated setting, NPs must hold national certification and carry liability insurance. If an NP is interested in solo practice, completion of a three (3) year transition to practice will be required as well.

AB 890 allows NPs to practice to the full extent of their education and training and allow direct access to health care for millions of Californians who now have coverage, but often struggle to find healthcare providers. A nurse practitioner shall verbally inform all new patients in a language understandable to the patient that a nurse practitioner is not a physician and surgeon. For purposes of Spanish language speakers, the nurse practitioner shall use the standardized phrase "enfermera especializada." A nurse practitioner shall post a notice in a conspicuous location accessible to public view that the nurse practitioner is regulated by the Board of Registered Nursing. The notice shall include the board's telephone number and internet website where the nurse practitioner's license may be checked and complaints against the nurse practitioner may be made.

Credentialing and Recredentialing *(cont'd.)*

Specialty Credentialing Specifications *(cont'd.)*

Mental Health and Substance Use Disorder Providers

Assembly Bill 2581 (AB 2581) requires the following procedures be put in place for Mental Health/Substance Use Disorder providers, effective January 1, 2023:

- All Mental Health/Substance Use Disorder providers, upon receipt of a completed application, will receive an application received letter within seven days to verify receipt and inform the applicant whether the application is complete.

- All complete Mental Health/Substance Use Disorder provider applications for credentialing will be completed within sixty days.

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 certifications. 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 Record Review *(cont'd.)*

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 a fee for these requests.

Medical Record Review *(cont'd.)*

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.

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

Quality Management and Improvement *(cont'd.)*

Accreditation

Blue Shield maintains Health Plan Accreditation (HPA) with National Committee for Quality Assurance (NCQA). Blue Shield of California's Commercial HMO/POS, Commercial PPO, Marketplace HMO/POS (Covered CA/Exchange), Marketplace PPO (Covered CA/Exchange), Medicaid, and Medicare HMO hold NCQA Health Plan Accreditation. The NCQA accreditation survey process assesses a health plan's organizational policies and procedures, and performance against NCQA standards every three years.

Provider Responsibilities for Quality Management and Improvement

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

- QI Committees
- Credentialing, peer review and utilization management determinations
- Clinical QI workgroups
- Focus groups
- QI studies
- Investigation of member grievances and quality of care issues

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

Quality Management activities are considered privileged communication in conjunction with peer review activities conforming to California Evidence Code Section 1157 and Section 1370 of the California Health and Safety Code.

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.

Home-Based Palliative Care Program Providers

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

Member Eligibility

The following plan types are **eligible** for the home-based palliative care program:

HMO, PPO, Medicare Advantage, FEP HMO (Federal Employee Program HMO), IFP (Individual Family Plan), and EPO (Executive Provider Organization).

The following plan types are **not eligible** for the home-based palliative care program:

FEP-PPO (Federal Employee Program PPO), SA (Shared Advantage), and MED SUPP (Medicare Supplement).

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 three (3) business days of the receipt of the referral or, in the case of a hospitalized member, within three (3) days of the member's discharge from the hospital. The referral will be sent to the provider via secure email. Upon receipt, the provider is asked to acknowledge that the email has been received and reviewed. Reply ALL when confirming receipt of the initial email. Once acknowledged the provider can proceed with the outreach and engagement process to schedule an assessment/initial evaluation.

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 4th Edition, Domain 1: Structure and Processes of Care, Guideline 1.2 criteria*, when conducting the assessment (see Appendix 2).

The provider must notify Blue Shield via email to BSCPalliativeCare@blueshieldca.com within three (3) business days of completing any assessment, whether received from a Blue Shield case manager or another referral source, 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 the member's case can be transitioned to the program provider, as applicable.

Home-Based Palliative Care Program Providers *(cont'd.)*

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

Conducting the Assessment *(cont'd.)*

The status options are as follows:

1. Enrolled (Please use enrollment notification format described below.)
2. Accepted pending enrollment
3. Enrolled in hospice
4. Not eligible for the program
5. Member declined program

Enrolling a Member

A notification of enrollment must be emailed to the Blue Shield emails listed below within three (3) business days of a member's enrollment, as further described in the agreement.

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

Enrollment Notification must contain the following information:

- Member's Blue Shield of California Subscriber ID number
- Member First Name
- Member Last Name
- Member DOB
- Member Diagnosis (ICD-10 Code)
- Date of Enrollment into the program
- Palliative Care treating provider name
- Referral Date
- Referral Source
- AD & POLST Status
- Is the member enrolling in hospice? (yes/no)

A provider can recommend a member who they feel may benefit from the Program and/or fall under the "Other" category on the Eligibility Screening Tool, by submitting supporting clinical documentation for review before the member is enrolled in the program. Providers should complete an eligibility screening tool and submit, along with any other clinical documentation supporting the members diagnosis to BSCPalliativeCare@blueshieldca.com. The member will be reviewed for eligibility by a Blue Shield Clinical Program Manager, who will notify you if the member is appropriate for enrollment in the program.

Home-Based Palliative Care Program Providers *(cont'd.)*

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

Submission of Required Documentation Upon Enrollment

Providers are required to submit a copy of the initial clinical assessment upon member enrollment. Providers are also required to submit monthly clinical notes for all currently enrolled members. Please submit clinical notes to BSCPalliativeCare@blueshieldca.com.

Home-Based Palliative Care Program Recertification Guidelines

The purpose of the recertification process and required form is to justify the member's ongoing enrollment in the home-based palliative care program.

The Recertification must be completed by an MD, NP or PA involved in the member's care, using the Palliative Care Services Recertification Form (see Appendix 2 for a sample form or on Provider Connection at blueshieldca.com/provider under *Forms* then *Patient care forms*). The member's recertification for the Home-Based Palliative Care Program is required every six months upon admission to the program. The form should be submitted up to 15 days before the end of the six-month enrollment period or no later than 2 business days after the start of the next enrollment period. The form shall be sent to BSCPalliativeCare@blueshieldca.com for review.

Failure to comply with this requirement may result in corrective action, up to and including contract termination.

Disenrolling a Member

Blue Shield must be notified of a member's disenrollment from the program within three (3) business 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 disenrollment, the provider is also required to include the reason for the program member's disenrollment from the palliative care program.

Disenrollment Notification must contain the following information:

- Member's Blue Shield of California Subscriber ID number
- Member First Name
- Member Last Name
- Member DOB
- Disenrollment Date
- Disenrollment Reason
- Advance Directive status at discharge:
- POLST filing status at discharge:

Home-Based Palliative Care Program Providers *(cont'd.)*

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, and chaplain. It may also include a physician assistant (PA), licensed vocational nurse (LVN), home health aide, 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. It is the program expectation that the palliative care team visit members monthly. These visits can be completed by video, phone, or face to face.

It is required that a Blue Shield Clinical Program Manager attend monthly IDT meetings to discuss currently enrolled patients. It is the responsibility of the provider to schedule the IDT meetings and send invites to the assigned Blue Shield Clinical Program Manager. You will be required to submit monthly clinical documentation on all currently enrolled members. Please submit the clinical documentation to: BSCPalliativeCare@blueshieldca.com and your assigned Clinical Program Manager.

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 required that the palliative care provider executes the following to ensure adequate team engagement:

- 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).

Home-Based Palliative Care Program Providers *(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 members enrolled in the program. During this meeting, Blue Shield will review patient status, discuss issues, answer questions, provide support, and review quality criteria, as shown in the Quality Review Guidelines.

Quality Review Guidelines

The Blue Shield Palliative Care Program will perform a monthly quality review. The review is to ensure an effective and efficient delivery of palliative care services to our members, your patients. It is designed to evaluate the cost and quality of medical services provided by our home-based palliative care providers.

The quality review has the following objectives:

- Assist in the promotion and maintenance of achievable quality of care.
- Ensure patients receive care that is consistent with their preferences.
- Ensure minimum monthly visit frequency expectations are being met.
- Initiate process improvement activities and focus resources on a timely resolution of identified problems.
- Identify patterns of utilization including overutilization, underutilization, and inefficient use of resources.
- Educate medical providers and other health care professionals on appropriate and cost-effective use of health care resources.
- Facilitate communication and collaboration among members, providers, and the palliative care team to support cooperation and appropriate utilization of health care benefits.
- Help tell a consistent story of Blue Shield Palliative Care program and the effectiveness of our providers.

The process for the monthly, bi-monthly, and quarterly review is:

- Enrollment/Disenrollment Report: Providers will complete the enrollment/disenrollment report (sent on a bi-monthly basis). Providers have 7 days to submit the completed report to Blue Shield Palliative Care team.
- Utilization Report: Providers will receive a Utilization Report (sent on a quarterly basis) which will include Emergency Room Visits and Inpatient Hospital Admissions for your review, to assist with identification of potential over-utilization.
- Blue Shield Palliative Care team will work with providers to set acceptable targets. Blue Shield will provide feedback through Interdisciplinary Teams (IDTs) and discuss any issues arising from Blue Shield's ongoing and systematic utilization review during the quarterly operation calls.

Home-Based Palliative Care Program Providers *(cont'd.)*

Quality Review Guidelines *(cont'd.)*

- Additional quality and performance improvement coaching will be scheduled if needed.

Blue Shield retains the right to audit providers to ensure quality of care at any time and without notice.

Quality Areas of Focus

1. Enrollment and Disenrollment data: Patient demographics, clinical information, referral information and discharge disposition.
2. Advance Care Planning: Advance directive, confirmation of medical decision maker, POLST and patient's code status decision.
3. Utilization: Emergency Room Visits and Inpatient Hospital Admissions.
4. Patient and family satisfaction surveys.
5. Minimum monthly visit frequency expectations.
6. Hospice Transitions, when appropriate

Completing the Enrollment and Disenrollment Report

Providers must complete the required report sections using free text or drop-down options when applicable. Completed reports shall be emailed to BSCPalliativeCare@blueshieldca.com.

1. **Documentation of patient demographics**
   Patient's subscriber ID, name, date of birth
2. **Documentation of clinical information**
   ICD-10 code and diagnosis name
3. **Documentation of referral information**
   Referral date and source
4. **Documentation of enrollment and disenrollment information**
   Enrollment date, disenrollment date and reason
5. **Documentation of advance directive**
   Patient's wishes regarding their medical treatment. Providers must have a copy in the patient's medical record to respond yes.
6. **Documentation of POLST**
   Physician Orders for Life Sustaining Treatment (POLST) providing specific medical orders. Providers must have a copy in the patient's medical record to respond yes.
7. **Confirmation of patient's code status decision**
   Patient's wishes on the level of treatment preferred, i.e., Full Code, DNR etc.

Home-Based Palliative Care Program Providers *(cont'd.)*

Quality Review Guidelines *(cont'd.)*

Completing the Enrollment and Disenrollment Report *(cont'd.)*

8. **Confirmation of medical decision maker**
   Patient's healthcare proxy, i.e., a family member, friend, lawyer, or someone in their social or spiritual community. A person who can make life and medical decisions on patient's behalf. Providers must have the named decision maker in the patient's medical record to respond yes.
9. **Member Email address**
   Current email address for enrolled member.

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, Align Measure Perform (AMP), chronic condition 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. 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 the HEDIS Supplemental data team at HEDISSUPPDATA@Blueshieldca.com for additional details and requirements, as well as to initiate required submissions of laboratory results data.

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), Clinician Satisfaction Survey, Provider 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 may 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 the Blue Shield Medicare Advantage plan 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) 466-2219 or TDD (877) 688-9891
- The Centers for Medicare & Medicaid Services (CMS): (800)-MEDICARE [(800) 633-4227] or TTY/TTD (877) 486-2048

Service Accessibility Standards *(cont'd.)*

Service Accessibility Standards for Commercial and Medicare

ACCESS TO CARE	STANDARD
Preventive Care Appointments Access to preventive care with a PCP, Nurse Practitioner, or Physician Assistant at the same office site as a member's assigned PCP.	Within 30 calendar days
Regular and routine care PCP 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.	Within 10 business days
Regular and routine care SPC 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.	Within 15 business days
Urgent Care Appointment 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.	Within 48 hours
Urgent Care Appointment Access to urgent symptomatic care appointments requiring prior authorization. When a Practitioner refers a member (e.g., a referral to a specialist by a PCP or another specialist) for an urgent care need to a specialist and an authorization is required, the member must be seen within 96 hours or sooner as appropriate from the time the referral was first authorized. 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.	Within 96 hours

Service Accessibility Standards *(cont'd.)*

Service Accessibility Standards for Commercial and Medicare *(cont'd.)*

ACCESS TO CARE	STANDARD
Ancillary Care Appointments 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.	Within 15 business days
Rescheduling of Appointments and Authorizations 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.	As determined by licensed healthcare professional
After Hours PCP Access	PCP or covering physician available 24 hours a day, 7 days a week ** Please see "After Hours Requirements" in the section immediately following for more detail on this requirement.*
Emergency Care	Immediate
After Hours Emergency Instructions (telephone answering service or machine)	Specific instructions for obtaining emergency care such as directing the member to call 911 or to go to the nearest emergency room. ** Please see "After Hours Requirements" in section immediately following for more detail on this requirement.*
In-office Wait Time	**Standard**: Member care will not be adversely affected by excessive in-office wait time. **Recommendation**: In the absence of emergencies, medical offices should seek to limit wait time to 15 minutes after patient's scheduled appointment.
Hours of Operation	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.

Service Accessibility Standards *(cont'd.)*

Service Accessibility Standards for Commercial and Medicare *(cont'd.)*

ACCESS TO TELEPHONE SERVICE	STANDARD
Average Speed to Answer (ASA)	45 seconds
Abandonment Rate	≤ 5%
Blue Shield's **24/7 Nurse Advice Line** will be available for all enrollee triage and screening needs. The speed to answer will be:	Within 30 minutes
Access to the **Blue Shield Customer Service** line during normal business hours	Within 10 minutes

Behavioral Health Appointment Access Standards

ACCESS-TO-CARE	STANDARD
Care for an Emergent Non-Life-Threatening Situation	Within 6 hours
Urgent Care visits	Within 48 hours
Initial routine visits with non-physician practitioners and behavioral health physicians	Within 10 business days
Routine and follow-up visits with non-physician practitioners	Within 10 business days
Routine and follow-up visits with behavioral health physicians	Within 15 business days

Behavioral Health Geographic Access Standards

CATEGORY	ACCESS STANDARD	COMPLIANCE TARGET
Geographic Distribution of Behavioral Health Individual Practitioners including: - Psychologists - Psychiatrists - Master's Level Therapists	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 and Substance Use practitioner	1 provider of each type (i.e., Psychologists, Psychiatrists, or Master's Level Therapists) to 20,000 members	100%

After Hours Requirements

After Hours Emergency Instructions

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

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

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:

COMPLIANT RESPONSES	NON-COMPLIANT RESPONSES
1. Immediately, can cross connect	1. Within the next hour
2. Within 30 minutes	2. Unknown or next business day

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.

Provider Availability Standards for Commercial Products *(cont'd.)*

Geographic Distribution

CATEGORY	PRODUCT TYPE*	STANDARD	COMPLIANCE TARGET
Total PCPs	HMO/POS PPO – CDI PPO – DMHC IFP ePPO CCSB HMO/PPO	One PCP within 15 miles or 30 minutes of each member	100%
PCP **General Practitioner** **Family Practitioner** **Internist** **Pediatrician**		One PCP within 15 miles or 30 minutes of each member	100%
Obstetrician/Gynecologist		One OB/GYN within 30 miles of each member (non-Medicare)	85%
High-Volume Specialists **High-Impact Specialists**		One of each type of Top High-Volume Specialists and High-Impact Specialists within 30 miles of each member	90%
Hospitals		One hospital within 15 miles of each member	90%
Radiology		One Radiology facility in 30 miles	90%
Lab		One lab in 30 miles	90%
Pharmacy		One Pharmacy in 10 miles	90%
DME		One DME in 15 miles	85%
ASC		One ASC in 30 miles	95%
SNF		One SNF in 30 miles	95%
Urgent Care		Urban: 1 in 15 miles Suburban 1 in 20 miles Rural: I in 30 miles	90% 85% 75%
Dialysis		Urban: 1 in 15 miles Suburban 1 in 20 miles Rural: I in 30 miles	90% 85% 75%

Provider Availability Standards for Commercial Products *(cont'd.)*

Geographic Distribution *(cont'd.)*

CATEGORY	PRODUCT TYPE*	STANDARD	COMPLIANCE TARGET
Acupuncturist and Chiropractor	PPO	Urban/Suburban: 1 of each specialty within 20 miles of each member's residence or workplace or equivalent to 30 minutes. Rural: 1 of each specialty within 45 miles of each member's residence or workplace or equivalent to 60 minutes.	90%

Provider-to-Member Ratio

CATEGORY	PRODUCT TYPE*	STANDARD	COMPLIANCE TARGET
PCP **Family Practitioner, General Practitioner, Internist, Pediatrician**	HMO/PPO – DMHC/PPO – CDI	One PCP to 2,000 commercial members	100%
Top High-Volume Specialties and High-Impact Specialties to Member Ratio	HMO/POS PPO – DMHC IFP ePPO	1 OB/GYN to 5,000 female members 1 High-Volume Specialty of each type and 1 High-Impact Specialty to 10,000 members	100%
Acupuncturist to Member Ratio	PPO	1 acupuncturist to 5,000 members	100%

Provider Availability Standards for Commercial Products *(cont'd.)*

Provider-to-Member Ratio *(cont'd.)*

CATEGORY	PRODUCT TYPE*	STANDARD	COMPLIANCE TARGET
A total of four (4) Non-Physician Medical Practitioners in any combination that does not include more than: • **Two (2) Physician Assistants per supervising physician** • **Four (4) Nurse Practitioners per supervising physician** • **Three (3) Nurse Midwives per supervising physician**	HMO/POS PPO-DMHC IFP-ePPO	Each Non-Physician Medical Practitioner practicing under a physician increases that physician's capacity by 1,000 members to a maximum of 4,000 additional members. However, the following specification cannot be exceeded: • Physician Assistants: 1 FTE supervising Physician to Non-Physician Medical Practitioner ratio cannot exceed: Physician to Physician Assistant 1:2. • Nurse Practitioners: 1 FTE supervising Physician to Non-Physician Medical Practitioner ratio cannot exceed: Physician to Nurse Practitioner 1:4. • Nurse Midwives: 1 FTE supervising Physician to Non-Physician Medical Practitioner ratio cannot exceed: Physician to Nurse Midwife 1:3.	100%

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

** Threshold languages are Spanish, Chinese – Traditional, Korean, and Vietnamese.

Provider Availability Standards for Medicare Advantage Products

Facility Time and Distance Requirements as required by CMS

Specialty	Large Metro		Metro		Micro		Rural		CEAC	
	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)
Acute Inpatient Hospitals	20	10	45	30	80	60	75	60	110	100
Cardiac Surgery Program	30	15	60	40	160	120	145	120	155	140
Cardiac Catheterization Services	30	15	60	40	160	120	145	120	155	140
Critical Care Services – Intensive Care	20	10	45	30	160	120	145	120	155	140
Outpatient Dialysis	20	10	45	30	65	50	55	50	100	90
Surgical Services (Outpatient or ASC)	20	10	45	30	80	60	75	60	110	100
Skilled Nursing Facilities	20	10	45	30	80	60	75	60	95	85
Diagnostic Radiology	20	10	45	30	80	60	75	60	110	100
Mammography	20	10	45	30	80	60	75	60	110	100
Physical Therapy	20	10	45	30	80	60	75	60	110	100
Occupational Therapy	20	10	45	30	80	60	75	60	110	100
Speech Therapy	20	10	45	30	80	60	75	60	110	100
Inpatient Psychiatric Facility Services	30	15	70	45	100	75	90	75	155	140
Orthotics and Prosthetics	30	15	45	30	160	120	145	120	155	140
Outpatient Infusion/Chemotherapy	20	10	45	30	80	60	75	60	110	100

Provider Time and Distance Requirements as required by CMS

Specialty	Large Metro		Metro		Micro		Rural		CEAC	
	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)	Maximum Time (minutes)	Maximum Distance (miles)
Primary Care	10	5	15	10	30	20	40	30	70	60
Allergy and Immunology	30	15	45	30	80	60	90	75	125	110
Cardiology	20	10	30	20	50	35	75	60	95	85
Chiropractor	30	15	45	30	80	60	90	75	125	110
Dermatology	20	10	45	30	60	45	75	60	110	100
Endocrinology	30	15	60	40	100	75	110	90	145	130
ENT/Otolaryngology	30	15	45	30	80	60	90	75	125	110
Gastroenterology	20	10	45	30	60	45	75	60	110	100
Infectious Diseases	30	15	60	40	100	75	110	90	145	130
Nephrology	30	15	45	30	80	60	90	75	125	110
Neurology	20	10	45	30	60	45	75	60	110	100
Neurosurgery	30	15	60	40	100	75	110	90	145	130
Oncology - Medical, Surgi	20	10	45	30	60	45	75	60	110	100
Oncology - Radiation/Radi	30	15	60	40	100	75	110	90	145	130
Ophthalmology	20	10	30	20	50	35	75	60	95	85
Orthopedic Surgery	20	10	30	20	50	35	75	60	95	85
Physiatry, Rehabilitative M	30	15	45	30	80	60	90	75	125	110
Plastic Surgery	30	15	60	40	100	75	110	90	145	130
Podiatry	20	10	45	30	60	45	75	60	110	100
Psychiatry	20	10	45	30	60	45	75	60	110	100
Pulmonology	20	10	45	30	60	45	75	60	110	100
Rheumatology	30	15	60	40	100	75	110	90	145	130
Urology	20	10	45	30	60	45	75	60	110	100
Vascular Surgery	30	15	60	40	100	75	110	90	145	130
Cardiothoracic Surgery	30	15	60	40	100	75	110	90	145	130

Provider Availability Standards for Medicare Advantage Products *(cont'd.)*

Provider Minimum Number Requirements

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

*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)

Linguistic and Cultural Requirement

MEASURE	PRODUCT	STANDARD	COMPLIANCE TARGET
Ethnic/ Cultural and Language Needs	HMO/POS *PPO – DMHC*	1 PCP speaking a threshold language to 1,200 members speaking a threshold language	100%

Additional Measurements for Multidimensional Analysis for Commercial Products

METRICS	PRODUCT	STANDARD	FREQUENCY
Access and availability related member complaints and grievances	HMO/POS/ PPO-	Rate of complains/grievances ≤1 per thousand members per month (non-Medicare) Rate of complains/grievances ≤5 per thousand members per month (Medicare)	Assessed Quarterly against Standard
Availability-related PCP Transfers	HMO	Rate of PCP transfers 1.68 per thousand members per month (Medicare)	Assessed Quarterly against Standard
PCP Turnover	HMO/POS	10% change	Assessed Quarterly against Standard
PCP, Specialist, and Hospital Network Change Analysis	IFP ePPO	10% change	Assessed Quarterly against Standard
PCP to Member Ratio	IFP PPO	1:2000	Quarterly
Top HVS Turnover	HMO/PPO/ CDI/ SHOP HMO/PPO	10%	Assessed Quarterly against Standard
Hospital Turnover	HMO/PPO	5%	Ad hoc for Block Transfer Filings and 10% Change Analysis
Open PCP Panel	HMO/POS/ Directly Contracted HMO	70%	Assessed Annually against Standard

Additional Measurements for Multidimensional Analysis for Commercial Products *(cont'd.)*

METRICS	PRODUCT	STANDARD	FREQUENCY
Member Satisfaction	HMO/POS/PPO	HMO – Patient Assessment Survey at IPA/MG level HMP/PPO – CAHPS at Health Plan level	Annual

Additional Measurements for Multidimensional Analysis for Medicare Advantage Products

METRICS	COMPLIANCE TARGET	FREQUENCY
Availability related member complaints and grievances	Rate of complaints and grievances 8.81 PTM	Semi-Annual
Availability related PCP Transfers	Rate of PCP transfers per thousand members 1.68 PTM	Semi-Annual
PCP Turnover Rate	10%	Semi-Annual
Top 10 HVS Turnover Rate	10%	Semi-Annual
Hospital Turnover Rate	5%	Semi-Annual
Open PCP Panels	85%	Semi-Annual
PCP to Member Assignment Ratio	1: 1200	Semi-Annual
High-Volume and High-Impact Specialist to Member Ratio	1:20,000	Annual

Language Assistance for Persons with Limited English Proficiency (LEP)

Blue Shield does not delegate overall responsibility for culturally and linguistically appropriate services to contracted providers unless otherwise noted in their contract with Blue Shield. 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 Language Assistance Program

Blue Shield is committed to providing quality health care services to all enrollees regardless of their ability to speak English. Providing services that support diverse languages is one-way Blue Shield addresses some barriers to accessible health care. We provide documents and telephonic support in various languages to improve access to healthcare services for our shared members. Additionally, we provide language assistance resources for easy download on our website, such as a multilingual sign for your office and member forms already translated into the designed member's threshold language.

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.

To request interpreter services, written language translation, or our provider notice of availability of language assistance services, please call our Provider Customer Service at (800)-541-6652 or visit our Language Assistance Program Resources webpage at blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/guidelines_resources/patient_care_resources/language_assistance

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

Blue Shield's Demographics and Language Services

Blue Shield may share individual patient demographics, which include language data, directly with providers. We share member data on the service area population for the top threshold languages and the U.S. Census data for the state of California to bring awareness of the needs of our members.

California population language data from the United States Census can be accessed online at www.census.gov/quickfacts/facts/table/CA/PST045221

Blue Shield's Commercial/Exchange threshold languages are:

- English
- Spanish
- Chinese – Traditional
- Korean
- Vietnamese

Blue Shield's Medicare threshold language are:

- English
- Spanish

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.

Identifying LEP Enrollees at Points of Contact

When an enrollee communicates their language preference to Blue Shield, it is added to the enrollee's profile and printed on their 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 representatives who have access to telephonic interpretation services to provide timely interpretive services in other languages. Blue Shield may employ Member Services/Customer Care Representatives who are multi-lingual and demonstrate proficiency in the non-English language to assist non-English-speaking LEP members.

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

Providing Interpretation Services *(cont'd.)*

- 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.

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) 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 Record Application Form at the onset of their relationship with Blue Shield. The Record Application Form 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 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.

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

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.

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.

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

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.

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.

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

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*. 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. A revised Independent Medical Review/Complaint Form is available in English and the 16 threshold languages on DMHC website at Independent Medical Review/Complaint Forms.

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

Blue Shield has identified documents that contain enrollee-specific information and has translated these documents into its threshold languages. Examples of non-standard vital documents 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, as follows:

English: For assistance in English at no cost, call 1-866-346-7198.

Spanish (Español): Para obtener asistencia en Español sin cargo, llame al 1-866-346-7198.

Tagalog (Tagalog): Kung kailanganninyo ang libreng tulongsa Tagalog tumawag sa 1-866-346-7198.

Chinese (中文): 如果需要中文的免费帮助，请拨打这个号码 1-866-346-7198.

Navajo (Dine): Diné k'ehjí doo bąąh ílínígó shíka' at'oowoł nínízingo, kwijį' hodíílnih 1-866-346-7198.

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

Korean (한국어): 한국어도움이필요하시면, 1-866-346-7198 무료전화 로전화하십시오.

Armenian (Հայերեն): Հայերենլեզվովանվճարօգնությունստանալուհամարխնդրում ենքզանգահարել 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.

Punjabi (پنجابی):۔مفت کال کرو تے 1-866-346-7198 پنجابی وچ مدد لئی مہربانی کر کے

Khmer (ភាសាខ្មែរ): សូមជំនួយជាភាសាអង់គ្លេសដោយឥតគិតថ្លៃ សូមទាក់ទងមកលេខ 1-866-346-7198.

Arabic (العربية): لحصول على المساعدة في اللغة العربية مجانا ، تفضل باتصال على هذا الرقم: 1-866-346-7198.

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

Hindi (हिन्दी): हिन्दीमेंबिना खर्च केसहायताकेलिए, 1-866-346-7198 परकॉलकरें।.

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

Laotian (ພາສາລາວ): ສໍາລັບການຊ່ວຍເຫຼືອເປັນພາສາລາວແບບບໍ່ເສຍຄ່າ, ກະລຸນາໂທ1-866-346-7198.

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*.

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

> "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."

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 translations of non-standard vital documents and must forward such requests received from enrollees to Blue Shield.

A provider who receives a request for a vital document translation should call our Provider Customer Service at (800) 541-6652. Non-urgent requests should be forwarded to Blue Shield within one day if it is urgent or within two days if it is not urgent.

To forward the vital document to Blue Shield:

1. Complete Blue Shield's "Language Assistance Form" available at blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/guidelines_resources/patient_care_resources/language_assistance;
2. Attach a copy of the document to be translated;
3. Fax the request to (248) 733-6331.

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:

Element	Type of Request	Timeliness Standards
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 Non-Urgent: Response within two business days	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: 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 Non-Urgent: Within two business days	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: 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.

Cultural Awareness and Linguistic Resources and Training

Blue Shield is dedicated to reducing healthcare disparities among cultural and linguistic minority groups that exist within our communities. To increase knowledge and awareness of cultural and linguistically appropriate services (CLAS) we are sharing a free e-learning that offers Continuing Education Units (CEU) credits for physicians, physician assistants, nurse practitioners, and any other direct service providers interested in learning about CLAS. Additionally, we offer several websites that will provide guidance, tools, and information that may help provider offices treat diverse populations and assist you in compliance with LAP requirements. The topics covered by these websites include bias, cultural competency, diversity, effective communication, equity, inclusion, providing language services, and more.

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

Below you will find a list of helpful trainings and resources.

- We encourage you to attend "A Physician's Practical Guide to Culturally Competent Care." This training covers the fundamentals of CLAS, communication, and language assistance, including how to work effectively with an interpreter, and much more. This training along with additional free provider trainings and webinars are available on the U.S. Department of Health & Human Services Think Cultural Health website at https://thinkculturalhealth.hhs.gov/education/physicians
- Blue Shield Provider Connection Learning resources offer free provider training and webinars at

  blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/news_education/learning_resources
- American Academy of Family Physicians Cultural Proficient, Health Care https://www.aafp.org/cme/topic/health-equity.html
- American Medical Association: Delivering Care, Health Equity https://www.ama-assn.org/delivering-care/health-equity
- Health Industry Collaboration Effort (HICE) Cultural and Linguistics Provider Toolkit https://www.iceforhealth.org/library.asp?sf=&scid=1284#scid1284

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

Cultural Awareness and Linguistic Resources and Training *(cont'd.)*

- The Georgetown University Center for Child and Human Development – National Center for Cultural Competence Curricula Enhancement Module Series https://nccc.georgetown.edu/curricula/overview/index.html
- U.S. Department of Health and Human Services, Office of Minority Health. www.minorityhealth.hhs.gov

Multilingual Resources

- The Blue Shield website is offered in multiple language formats. Members can click the global icon located on the top left corner of our homepage to select their desired threshold language. In addition, several translated vital documents, including grievance forms, a confidential communications request, member forms, and notice of language availability are available online at blueshieldca.com/en/home
- Our downloadable Grievance Form includes an attached notice of the availability of language assistances services translated into 17 languages. blueshieldca.com/en/home/help-and-support/grievance-process
- Members can request confidential information using multilingual request forms on our confidential Communications Request page at blueshieldca.com/en/home/help-and-resources/confidential-communications-request
- Our Language Assistances Sign may be viewed and downloaded or printed from our website by visiting blueshieldca.com/bsca/bsc/wcm/connect/member/member_content_en/content%20root/language%20assistance
- Member Forms, including notice of availability of language assistance services are available at blueshieldca.com/en/home/forms-unauth

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.

Health Information Data and Record Sharing with Blue Shield

Providers shall comply with State requirements regarding electronic health record data exchange, including without limitation those outlined in the California Health and Human Services Data Exchange Framework, and the compliance milestones established for Calendar Year 2022-2024 and other program policy and procedure requirements, and additional state and federal regulations as applicable, and as updated and amended from time to time. Such program requirements and State law, implementing regulations and regulatory guidance shall govern the sharing of electronic health record data beginning January 31, 2024. Blue Shield is able to receive electronic health record data through the following platforms: (i) EPIC Payer platform, (ii) Manifest MedEx platform, and (iii) State Qualifying Health Data Exchange platform. Providers shall participate in and utilize one of the aforementioned options in providing electronic health record data to Blue Shield within the timelines set forth in the State requirements as they may be amended from time to time. For informational purposes, as of January 1, the required timelines include:

On or before January 31, 2024, unless otherwise stated:

- General acute care hospitals, as defined by Section 1250. (Fewer than 100 beds, the compliance date is 1/31/26.)
- Provider and physician organizations and medical groups. as defined by Section 127500.2. (Fewer than 25 physicians, and nonprofit clinics with fewer than 10 providers, the compliance date is 1/31/26.)
- Skilled nursing facilities, as defined by Section 1250, that currently maintain electronic records. (Fewer than 100 beds, the compliance date is 1/31/26.)
- Clinical laboratories, as that term is used in Section 1265 of the Business and Professions Code, and that are regulated by the State Department of Public Health.
- Acute psychiatric hospitals, as defined by Section 1250. (Fewer than 100 beds and state-run acute psychiatric hospitals, the compliance date is 1/31/26.)
- Emergency medical services, as defined by Section 1797.72.

Section 3: Medical Care Solutions

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Table of Contents

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Medical Care Solutions Program Overview

The Medical Care Solutions Department within Blue Shield's Health Solutions division is established to provide oversight of the delivery of care to members. Medical Care Solutions provide inpatient utilization management 7 days a week from 8 a.m. to 5 p.m., except for company designated holidays.

The Blue Shield Medical Care Solutions professional staff includes California-licensed physicians, and clinicians 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 the coverage of medically necessary services.

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

Medical Care Solutions Program Overview *(cont'd.)*

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 Care Management through a variety of sources, including their physician, Social Services, family members, employers, etc.

Medical Necessity

Medical Necessity (Medically Necessary)*

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

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

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

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

Medical Necessity *(cont'd.)*

Medical Necessity (Medically Necessary)**

Benefits are provided only for services which are medically necessary.

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

- Consistent with Blue Shield medical policy and/or evidenced based clinical guidelines;
- Consistent with the symptoms or diagnosis;
- Not furnished primarily for the convenience of the patient, the attending physician, or other provider;
- Furnished at the most appropriate level which can be provided safely and effectively to the patient; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member's illness, injury, or disease.
- Hospital Inpatient Services which are medically necessary include only those services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in a physician's office, an Outpatient department of a hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered. Inpatient services which are not medically necessary include hospitalization:
    - Diagnostic studies that can be provided on an Outpatient basis;
    - Medical observation or evaluation;
    - Personal comfort;
    - Pain management that can be provided on an outpatient basis; and
    - Inpatient rehabilitation that can be provided on an Outpatient basis.

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

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

UM Criteria and Guidelines

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 clinicians, medical directors, pharmacists, peer review committees, physician peer reviewers and other consultants.

Blue Shield may also delegate utilization management (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 Health Solutions 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.

Medical necessity reviews (for both authorizations and non-authorizations) made by Blue Shield use a hierarchy of criteria for both medical and Mental Health/Substance Use Disorder (MH/SUD). Coverage for Mental Health and Substance Use Disorder (MH/SUD) services is provided under the same terms and conditions as those applied to medical/surgical services conditions.

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

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

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

UM Criteria and Guidelines *(cont'd.)*

The criteria utilizes generally accepted standards of medical practice in the United States; and clinically appropriate, in terms of type, frequency, extent, site, and duration; and considered effective for the patient's illness, injury, disease, or its symptoms; and not primarily for the convenience of the patient, physician, or other healthcare provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results for the diagnosis or treatment of that patient's illness, injury, or disease, or its symptoms; and not part of or associated with scholastic education or vocational training of the patient; and 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 facility at a lower level of care without adversely affecting the patient's condition or the quality of medical care rendered. The following are services that will not be covered at the inpatient level of care:

- For diagnostic studies that can be provided on an outpatient basis;
- For medical observation level of care;
- 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.

UM Criteria and Guidelines *(cont'd.)*

Blue Shield applies evidence-based clinical criteria and Medical Policy to determine medical necessity. Blue Shield and Blue Shield Life use the UM criteria found in the following resources to determine medical appropriateness and coverage. The resources are not listed in use order for utilization management and medically necessary decisions. The specific hierarchy for each line of business is determined by regulatory government bodies. For example, Medicare requires use of the Medicare Managed Care Manual and NCD/LCD's first.

- Center for Medicare & Medicaid Services (CMS) and other state and federal guidelines
    - Note: The Medicare Coverage Issues Manual for Durable Medical Equipment applies across product lines and can be found online at https://www.cms.gov/; all other services apply to Medicare
- Medicare Local (LCD) and National (NCD) coverage determination
- Medicare Managed Care Manual
- Guide to Clinical Preventive Services: Report to U.S. Preventative Services Taskforce
- Blue Shield Medication policies
- Standardized criteria sets (i.e., MCG®, DSM-5)
- Provider Organization Criteria or Guidelines
- Resources may include MCG®, Medicare Benefit Policy Manual Coverage Guidelines
- World Professional Association for Transgender Health (WPATH)
- American Society of Addiction Medicine (ASAM)
- Early Childhood Services Intensity Instrument (ECSII)
- The Child & Adolescent Level of Care Utilization System (CALOCUS-CASII)
- Level of Care Utilization System (LOCUS)
- Blue Cross® and Blue Shield® Service Benefit Plan Brochure (FEP PPO Plan only)
- Federal Administrative Manual (FEP PPO only)
- Federal Employee Program Medical Policy (FEP PPO only)
- AIM Specialty Health Radiology Guidelines (DSNP only)
- National Comprehensive Cancer Network Guidelines (DSNP only)
- DHCS Medi-Cal UM Criteria (DSNP only)

UM Criteria and Guidelines *(cont'd.)*

IPA/medical groups must use the most current version of the policies and manage updates to their UM review processes. These policies may be found on Provider Connection at blueshieldca.com/provider and may be updated quarterly as needed. For fully-insured products, Mental Health and Substance Use Disorder medical necessity review is conducted by Blue Shield's MHSA and utilizes the American Society of Addiction Medicine (ASAM) criteria, Level of Care Utilization System (LOCUS) guidelines, Child and Adolescent Level of Care Utilization System (CALOCUS) guidelines, and Early Childhood Service Intensity Instrument (ECSII) guidelines. Additional guidelines may be added as they become available from non-profit professional associations in accordance with California law. Medical services for the treatment of gender dysphoria, eating disorder or substance use disorder are reviewed by Blue Shield utilizing the criteria as outlined in the UM Program Description.

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 (BCBSA) Evidence Street, the Blue Cross Blue Shield Association Medical Policy Panel (BCBSA MPRP), and the California Technology Assessment Forum (CTAF).

Blue Shield Medical & Medication Policies *(cont'd.)*

Medical Policy *(cont'd.)*

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.

The P&T Committee bases clinical decisions on the strength of the available scientific evidence and standards of practice, including accessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data, and other relevant information as deemed appropriate.

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 formulary placement and medication coverage policy recommendations are based on the principles of evidence-based medicine, which is a review of scientific evidence from peer-reviewed published medical literature.
    a. Multi-center, randomized, prospective clinical trial results published in the peer-reviewed literature demonstrating the treatment to be at least as safe and effective as other established modalities of therapy are considered as best evidence.
    b. In absence of randomized controlled trials, lesser level of evidence, such as observational studies, medical society guidelines, and accepted community standard of practice will be considered

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.

Blue Shield Medical & Medication Policies *(cont'd.)*

Medication Policy *(cont'd.)*

Additional authorization for select medical drugs may also be required for the administration of the drug at an outpatient hospital facility site in addition to authorization of coverage for the drug. Step therapy may also apply requiring the use of preferred agents including generic or biosimilar drugs. Refer to the medication policy. For Blue Shield Medicare Advantage HMO Members, Blue Shield follows Medicare guidelines for risk allocation, Medicare national and local coverage guidelines. For Blue Shield Medicare PPO Plans, Blue Shield Medication Policies and Step Therapy requirements may also apply for select medications.

If Blue Shield determines that a previously rendered service does not match the authorization or is not medically necessary, or does not qualify for coverage, the provider will not be paid for the service and will not be able to collect payment from the member without a signed notice of non-coverage.

Medical or Medication policy information is available through Provider Connection at 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.

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.

Clinical Practice Guidelines are available on Provider Connection at blueshieldca.com/provider under *Guidelines & resources*, then *Guidelines and procedures*.

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 Out of Network Health Care Professionals and Facilities

Blue Shield members should be referred to in network health care professionals and facilities 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 in network health care professionals and facilities when making a referral to an out of network health care professional or facility for non-emergent services. This policy is not intended to dissuade members from utilizing their out of network benefits, but instead is intended to help them understand the impact of their decisions. Often the use of an out of network health care professional or facility 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 an out of network health care professional or facility, the referring physician and the member must complete the *Member Advance Notice Form – Out of Network Referral* available on blueshieldca.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 Out of Network Health Care Professionals and Facilities

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 services. Blue Shield will pay/price these services at the member's in-network benefit level.

Since members incur higher copayments and deductibles when out of network health care professionals or facilities are used, every effort must be made to ensure referrals are made to in network health care professionals and facilities. When there are no Blue Shield in network health care professionals (for specialty, acute care, ancillary care, etc.) or facilities available in the member's service area, the member or provider may request a referral to an out of network health care professional or facility. Providers requesting a referral to an out of network health care professional or facility must call Blue Shield at (800) 541-6652 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 blueshieldca.com/provider in the *Guidelines & resources* section, then *Forms* section, and then select the *Patient care forms* link. Requests for referrals to out of network health care professionals and facilities 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 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 an out of network health care professional or facility include:

- There are no in network health care professionals accepting new patients.
- The in-network health care professional or facility 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 in-network health care professional or facility are unable to perform a medically necessary service.
- The in-network health care professional is unable to admit the member to an in-network facility due to timing, capacity, etc.
- The in-network health care professional is 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 by the attending physician or the hospital within 24 hours of 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 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 if all the necessary information is received at the time of the 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 is not 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 administration. Places of care include the physician's office, outpatient hospital 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, step therapy requirements, use of a biosimilar first, and approval to administer the drug at an outpatient hospital 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. Additionally, if the claim for the drug or site of care does not match the authorization, payment may be denied.

A complete list of medications and their authorization requirements for coverage in the medical benefit can be found on Provider Connection at blueshieldca.com/provider under *Authorizations*, *Clinical policies and guidelines, Medication policy,* then *Medication policy list for Commercial and Medicare plans.*

The provider ordering the specialty drug is responsible for obtaining a prior authorization number prior to any rendering of the specialty drug, authorization for place of service if applicable 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 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 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.

Prior Authorizations *(cont'd.)*

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

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.

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 require additional authorization for select specialty drugs. If the authorization for the place of care does not match the claim, the medication claim may be denied.

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 Provider Customer Service Medical Care Solutions unless otherwise indicated at:

blueshieldca.com/provider
(800) 541-6652
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 blueshieldca.com/provider.

ALL INPATIENT ADMISSIONS Require Prior Authorization

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
- Mental Health
- Substance Use Disorder
- Acute Rehabilitation

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

OUTPATIENT PROCEDURES / EQUIPMENT

Prior Authorization/Pre-service Review Required

A complete list of procedures and their authorization requirements for coverage can be found on Provider Connection at 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.

Providers may submit prior authorization requests online at blueshieldca.com/provider under *Authorizations* then *Request a medical authorization*.

Prior Authorization List for Network Providers *(cont'd.)*

TYPE OF SERVICE / PROCEDURE	PPO AND DIRECT CONTRACT HMO
Ambulance Service Non-Emergency: Blue Shield covers non-emergency ambulance services using our contracted providers. Non-emergency ambulance requires prior authorization. Non-emergency ambulance (surface and air) 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. *Note: Non-Emergency services provided solely for the convenience of the patient or physician would not be covered.*	Go to Provider Connection at blueshieldca.com/provider and click on *Guidelines & resources, Patient care resources,* then *Ancillary provider rosters* to view a list of contracted ambulance providers or call Provider Information & Enrollment at (800) 258-3091 for information on contracted options.
All Homecare, Home Hospice, and Home IV	Prior authorization required (800) 541-6652 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.

Prior Authorization List for Network Providers *(cont'd.)*

TYPE OF SERVICE / PROCEDURE	PPO AND DIRECT CONTRACT HMO
Home-based Palliative Care Services Not Included in the Program Case Rate *Note: 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* BSCPalliativeCare@blueshieldca.com.	Prior authorization required (800) 541-6652 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.
Laboratory Services 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.	Prior authorization may be required (800) 541-6652 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.

Prior Authorization List for Network Providers *(cont'd.)*

TYPE OF SERVICE / PROCEDURE	PPO AND DIRECT CONTRACT HMO
Mental Health and Substance Use Disorder For commercial plans managed by Blue Shield's mental health service administrator (MHSA). This includes fully-insured HMO, PPO, EPO, and self-funded plans. Prior authorization is required for: • Non-emergency mental health or substance use disorder Hospital admissions, including acute and residential care • Outpatient Mental Health and Substance Use Disorder Services listed below, as required by the applicable plans *Evidence of Coverage* or *Health Service Agreement.* o Behavioral Health Treatment (BHT) including Applied Behavior Analysis (ABA). o Electro-convulsive Therapy (ECT) and associated anesthesia. o Intensive Outpatient Program. o Partial Hospitalization Program. o Neuropsychological Testing should be considered for coverage through the patient's mental health benefit when: ▪ After completion of a comprehensive Behavioral Health evaluation and neurological evaluation, if the Behavioral Health provider or neurologist determines the neuropsychological testing is required, the provider will request authorization and coordinate the request, Blue Shield MHSA will cover Neuropsychological testing when, the purpose of testing is to clarify whether there is a psychiatric diagnosis (even when medical conditions are present). o Transcranial Magnetic Stimulation.	Contact MHSA (800) 378-1109
For Blue Shield Medicare Advantage Plans managed by Blue Shield's mental health service administrator (MHSA). Prior authorization is required for: • Inpatient admissions • Partial hospitalization programs • Intensive outpatient program • Office Based Opioid Treatment • Other Outpatient • Residential Treatment	Contact MHSA (800) 985-2398 Contact Blue Shield Medical Care Solutions (800) 541-6652 or Fax: (844) 807-8997 or online at blueshieldca.com/provider under *Authorizations, Authorization tools,* then *Request a medical authorization.*

Prior Authorization List for Network Providers *(cont'd.)*

TYPE OF SERVICE / PROCEDURE	PPO AND DIRECT CONTRACT HMO
FDA-Approved Prescription Pharmaceuticals / Drugs FDA-approved prescription pharmaceuticals/drugs 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.)	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 & guidelines,* then *Medication policy.* 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 a medical 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 or Fax: (844) 262-5611 or Submit online, with attached documentation, via AuthAccel in the *Authorizations* section of Provider Connection at www.blueshieldca.com/provider.
Radiology The following radiologic procedures are managed by National Imaging Associates, Inc. (NIA): • CT, All examinations • MRI/MRA, All examinations • Nuclear Cardiology Imaging • PET (Positron Emission Tomography)	Prior authorization required Submit authorization requests online at RadMD.com or contact NIA at (888) 642-2583
Transplants Solid Organ and Bone Marrow Transplants	Prior authorization required Kidney / Cornea / Skin Transplants (800) 541-6652 SOT and BMT Transplants (800) 637-2066 ext. 841-1130 Fax: (916) 350-8865

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 Medicare Advantage plan 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 Medical Care Solutions Transplant Department in Rancho Cordova.

Blue Shield Medicare Advantage Plan – Prior authorization for all Blue Shield Medicare Advantage Plan 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 Medicare Advantage plan members requires authorization by Blue Shield for members in a PPO product, and by the IPA/medical group for members in an HMO product.

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 Medicare Advantage plan 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, with the exception of IFP PPO, 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 Authorizations

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 treatment 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 can submit a prior authorization request electronically by utilizing one of our contracted electronic prior authorization (ePA) vendors, Surescripts or Cover My Meds. Providers also 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,* and then *Prior authorization forms and list*. Providers may also submit prior authorization requests online by going to blueshieldca.com/provider under *Authorizations* then *Request pharmacy authorization* or *Request pharmacy prior authorization electronically* to submit a prior authorization request through an ePA vendor.

Providers have the alternate option to use AuthAccel to complete, submit, attach documentation, track status, and receive determinations for pharmacy prior authorizations. Registered users may access the tool, in the Authorizations section, after logging into Provider Connection at blueshieldca.com/provider. When providers submit 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 required information is built into the tool.

Medicare Plans

The Centers for Medicare & Medicaid Services (CMS) complies 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 began on January 1, 2019.

Providers can submit a prior authorization request electronically by utilizing one of our contracted electronic prior authorization (ePA) vendors, Surescripts or Cover My Meds. Providers also have the option to request a prior authorization or exception request by faxing a Medicare Coverage Determination 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.

Drug Formulary *(cont'd.)*

Providers have the alternate option to use AuthAccel to complete, submit, attach documentation, track status, and receive determinations for pharmacy prior authorizations. Registered users may access the tool, in the *Authorizations* section, after logging into Provider Connection at blueshieldca.com/provider. When providers submit requests via AuthAccel, it is not necessary for them to complete a separate Medicare Coverage Determination Request Form, as the required information is built into the tool.

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 Pharmacy.

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.

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 or biosimilar. 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 associated drug 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.

Drug Formulary *(cont'd.)*

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 no more than a 30-day supply of Specialty Drugs by mail or, upon a member's request, at an associated retail pharmacy for pickup, if available.

The list of Specialty Drugs and information about Network Specialty Pharmacies may be accessed at blueshieldca.com/pharmacy.

Specialty Drugs may be dispensed by any willing pharmacy for Medicare Part D plans.

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Section 4: Billing

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Table of Contents

Section 4: Billing

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

Real Time Claims Settlement

Real-Time Claims Settlement provides an enhanced provider experience through speed, accuracy and most importantly transparency in the claim's adjudication process. The end goal solution Blue Shield is building toward is an end-to-end automated process from claim creation to payment reconciliation.

Current Enhancements

While we are working to fully automate the transaction process, one of our first steps is the creation of a Real Time Claims Web Tool in Provider Connection. This tool will allow you to estimate and submit claims online to process with a target of 3-9 seconds. While it does take some data entry, it can provide a glimpse of how we are working to speed up the claims adjudication process.

The Web Tool provides two main features:

1. Claim Estimate: Providers will have the ability to submit a claim estimate and receive a response with payment assurance for the total payment (including payer payment and member liability amounts) for services. A claim estimate can be submitted up to 7 days prior to services performed and will be valid up to 7 days.
2. Claim Submission: Providers will have the ability to submit claims to Blue Shield of California and connect with Blue Shield's processing system for real time adjudication. The finalized claim/payment decision is then presented to the provider. Claims are then paid upon the regular payment cadence.

The Real Time Claims Web Tool is available to registered users on Provider Connection at blueshieldca.com/provider. If you are not a registered user, please see the section Welcome to Provider Connection on the home page of blueshieldca.com/provider for instructions on how to register.

Claims Processing *(cont'd.)*

Real Time Claims Settlement *(cont'd.)*

Current Enhancements *(cont'd.)*

Once you are registered on Provider Connection, you will need to request access to the Real Time Claims Web Tool via your Account Manager, MSO, or Billing Service. After access is obtained for the Real Time Claims Web Tool it can be opened by clicking *Claims* on the menu bar then clicking *Real Time Claims*.

The Real Time Claims Web Tool is an intuitive system designed with provider ease of use in mind. A resource guide can be found on the Real Time Claims landing page under *Guidelines and resources.* In addition, a reference guide, FAQ documentation, and an eLearning can be found on the Real Time Claims landing page under *News and Education*.

Future State

To further realize our long-term solution, Blue Shield is working to make claims processing automated. These offerings will revolutionize how we as an industry process claims and we look forward to continuing to deliver new capabilities in the future. The upcoming claims processing solutions are further defined below.

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

Claims Processing *(cont'd.)*

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. Electronically submitted claims will be acknowledged within 2 days.

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 Help Desk at (800) 480-1221 or EDI_BSC@blueshieldca.com.

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 blueshieldca.com/provider and click on the *Claims* tab for more information about the options listed above.

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.

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 Help Desk: EDI_BSC@blueshieldca.com or (800) 480-1221 – EDI questions only

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

Claims Processing *(cont'd.)*

Encounter Submission *(cont'd.)*

EDI Clearinghouse Vendors

A list of approved Clearinghouse Vendors can be found on Provider Connection at 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 or EDI_BSC@blueshieldca.com.

Performance - Regular and Complete Submission of Encounter Data

Monthly Submission

It is Blue Shield's requirement that encounter data be submitted at least once each month and each submission must be in the correct HIPAA Compliant electronic format with usable data. Files with significant data quality problems may be rejected and may require correction of problems.

Complete Submission

Blue Shield will measure encounter submissions based on a rolling year of utilization data. The Centers for Medicare & Medicaid Services (CMS) requires EOBs for Medicare Advantage members with Medicare Part C. Providers are required to submit encounter submissions with Maximum Out-of- Pocket "MOOP" for Medicare Advantage members.

There is also a compliance measurement reflecting the data collection period. Benchmarks using Evaluation and Management (E&M) CPT codes are used. The benchmark is:

Medicare Advantage Membership: 8.0 E&M Visits PMPY

Certain types of denied services are included in calculating each provider's annual E&M visit rates.

Denials

All denied *Medicare Advantage* encounters should be submitted to Blue Shield, except for duplicate encounters and eligibility denials.

A provider contract may include an incentive program or capitation withhold provision that would apply for performance relative to the above benchmarks. The current performance target is at least 90% of the benchmark.

Blue Shield requires that, on a periodic basis, an officer of the provider group attest to the completeness and truthfulness of encounter data submission.

Claims Processing *(cont'd.)*

Paper Claim Forms (Using the CMS 1500 Claim Form)

For faster processing and turnaround, please submit all claims electronically. When paper claims forms must be used, Blue Shield requires accurately completed CMS 1500 (or successor) forms to process claims quickly and efficiently. Paper claims will be acknowledged within 15 days. 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 or HCPCS 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)

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.

Claims Processing *(cont'd.)*

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.

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 or HCPCS 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. CPT or HCPCS and NDC codes are required for drug claims submitted as an encounter.

Note: This only applies to IPA/medical group's that have it specified in their contract.

Claims Processing *(cont'd.)*

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.

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.

Claims Processing *(cont'd.)*

Medicare Crossover *(cont'd.)*

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 institutional 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

Claims Review Monitoring Program *(cont'd.)*

Provider on Review *(cont'd.)*

- 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 lesser of the current Blue Shield Provider Allowances or Provider's billed charges, 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 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.

With the exception of new and deleted codes and drug and immunization allowances, Blue Shield Provider Allowances are reviewed no more often than annually. New and deleted codes are reviewed quarterly as new CPT-4 and HCPCS Level II Codes are added or existing codes change, per the American Medical Association. Blue Shield Provider Allowances for drugs and immunizations reimbursed using Average Sales Price (ASP) or Average Wholesale Price (AWP) methodologies are also reviewed quarterly.

Except for the quarterly updates to Blue Shield Provider Allowances specified above, Blue Shield will give providers at least 45 working days' notice of changes to the Blue Shield Provider Allowances. Quarterly adjustments for new and deleted codes and for drug and immunization may be made without notification.

Provider Payment *(cont'd.)*

Blue Shield Provider Allowances *(cont'd.)*

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

- Logging onto Provider Connection at 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-F which provides an overview of common Blue Shield claims adjudication processes. Blue Shield's Payment Policies are available on Provider Connection at blueshieldca.com/provider under the *Claims* tab; Medical Policies are found on Provider Connection under the *Authorizations* tab.

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 therapies, biosimilars, multi-source therapies, and therapies preferred by Blue Shield 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. CMS published ASP pricing will continue to apply unless CMS discontinues the HCPCS code. 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, or HCPCS and NDC are required for payment regardless of reimbursement methodology.

Provider Payment *(cont'd.)*

Blue Shield Provider Allowances *(cont'd.)*

Summary of Blue Shield Provider Allowances *(cont'd.)*

- 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.

    - Expenses related to supplies, equipment, staff time, and activities for visits performed during a public health emergency declared on or after January 1, 2022 due to respiratory-transmitted infectious diseases that are billed under CPT code 99072.

- Unlisted, unspecified, or miscellaneous codes

    - These codes should be reported only if no other specific HCPCS code, including Category III HCPCS codes, does not exist to adequately describe the diagnosis, procedure, service or item rendered. Reimbursement is based on review of the unlisted, unspecified or miscellaneous code on an individual claim basis. When submitting a claim with an unlisted, unspecified or miscellaneous code, the following information and/or documentation must be provided:

        - A written description, office notes or operative report describing the procedure or service performed.

        - An invoice and written description of items and supplies.

        - The corresponding NDC for an unlisted drug code.

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 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 blueshieldca.com/provider in the *Claims* section under *Enroll in Electronic Data Interchange* or by contacting the EDI Help Desk 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 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 contact the EDI Help Desk at (800) 480-1221 or EDI_BSC@blueshieldca.com.

> *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;

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:

Coordination of Benefits *(cont'd.)*

- 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.

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*

  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.

For faster processing and turnaround, please submit all claims electronically.

All claim correspondence and paper claim forms that require medical records, can be mailed to BlueCard Program :

Blue Shield of California
BlueCard Program
P.O. Box 272630
Chico CA 95927-2630
(800) 622-0632

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 https://www.blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/guidelines_resources/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.

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.

Limitations for Duplicate Coverage (Commercial) *(cont'd.)*

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 Payer 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. Where the specimen was drawn will be determined by the state of service area in which the referring provider is located.
- **Durable/Home Medical Equipment and Supplies (D/HME) and Orthotics & Prosthetics (O&P):** All claims for DME and O&P provided to Blue Plan members must be submitted to the Blue Plan located in the state or service area to which the DME or O&P 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, go to blueshieldca.com/provider, click on *Claims* at the top of the landing page, then *Policies & guidelines,* and select the *Ancillary claims filing* box.

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.

Special Billing Situations *(cont'd.)*

Genetic and Molecular Testing

For Genetic and Molecular Testing, a Genetic Testing Unit (GTU) is required for unlisted or unspecified codes. Please refer to Appendix 4-A Special Billing Guidelines and Procedures for specific billing instructions.

Home Infusion Billing

Home infusion claims for medications covered under the medical benefit must be submitted with the appropriate National Drug Code (NDC) with total units of measurement dispensed together with the associated Healthcare Common Procedure Coding System (HCPCS) drug code. Unless otherwise agreed to in writing by Blue Shield, home infusion providers are required to submit claims directly through Blue Shield's ancillary care management vendor.

Infusion therapy supplies should be billed utilizing the appropriate per diem HCPCS codes (i.e., S codes) for the specific drug or drug category. When billing for commercial benefit programs, the per diem and drug HCPCS and NDC must be billed on the same claim as the corresponding drug for the same dates of service under the medical benefit. When billing for Medicare Advantage benefit programs, home infusion providers are required to submit separate claims: the drug under the pharmacy benefit and per diem fees under the medical benefit.

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.

Special Billing Situations *(cont'd.)*

Hospice Billing (Commercial) *(cont'd.)*

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	0656 – General inpatient care
0652 – Continuous home care	0657 – Physician care
0655 – Inpatient respite 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.

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:

Special Billing Situations *(cont'd.)*

Hospice Billing (Medicare) *(cont'd.)*

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 RHHI 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.

Special Billing Situations *(cont'd.)*

Hospice Billing (Medicare) *(cont'd.)*

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, Commercial PPO Plans, select medications are available for Drop Ship from a Blue Shield preferred program. Drop Ship is a voluntary program for Commercial PPO Plans, 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. Drop Ship requests are to be managed through our Blue Shield vendor, ASPN Pharmacies. ASPN Pharmacies will triage the drug procurement and coordinate prescription fulfillment and can be reached at (888) 349-0884, Monday through Friday, 5 a.m. to 7 p.m. A list of the Drop Ship medications and program information and requirements can be found on Provider Connection at blueshieldca.com/provider.. For questions regarding billing of office administered injectable medications, please call Provider Information & Enrollment at (800) 258-3091.

Special Billing Situations *(cont'd.)*

Office-Administered Injectable Medications *(cont'd.)*

Additionally, Blue Shield physicians 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 blueshieldca.com/provider under *Authorizations, Clinical policies and guidelines, Medication policy,* and then *Medication policy list*.

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-G 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 Non EDI

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 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.)*

Resubmissions or Corrected Claims Non EDI *(cont'd.)*

Corrected Claims *(cont'd.)*

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

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 or digital online portal, 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, requests for reimbursement of an overpayment of a claim; 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 or digital online portal, 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, or requesting resolution of billing determinations, such as bundling/unbundling of claims/procedures codes allowances, or requests for reimbursement of an overpayment of a claim; that are individually numbered using the Blue Shield assigned claim number to identify each claim contained in the bundled appeal; or 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 is first delivered to the designated Provider Appeal Office, post office box, or portal by physical or electronic means.

Provider Appeals and Dispute Resolution *(cont'd.)*

Definitions *(cont'd.)*

Appeal Determination Date

The working day when the written provider dispute determination or amended provider dispute determination is delivered by physical or electronic means.

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.)/regulatory requirement;
- Acts of war/terrorism;
- System wide loss of computer data (system crash);
- BlueCard claims sent to the wrong Blue Plan.

Provider Appeals and Dispute Resolution *(cont'd.)*

Definitions *(cont'd.)*

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.

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 claim 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

Provider Appeals and Dispute Resolution *(cont'd.)*

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

Unfair Payment Patterns *(cont'd.)*

- 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
- 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 time period

Provider Appeals and Dispute Resolution *(cont'd.)*

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

Unfair Payment Patterns *(cont'd.)*

- 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 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 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.)*

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

Online Access

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

Provider Manuals

The Provider Appeal Resolution Process is documented in the *Hospital and Facility Guidelines*, *Independent Physician and Provider Manual* and the *HMO IPA/Medical Group Procedures Manual.*

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 Provider Dispute and Resolution Department is responsible for the Provider Appeal Resolution Process.

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 Written Initial Appeals

Written initial appeals must be submitted to the following address:

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

Written initial appeals regarding commercial facility contract exception(s) must be submitted 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

Please submit to the above addresses on paper only. Digital media such as compact discs, USB data keys, flash drives, and other digital formats are not permissible. Submission of digital media will not be effective to initiate an appeal, and any digital media received by Blue Shield will be destroyed without review or further notice to the submitting party.

For additional information regarding the appeal process, and to review digital submission options, please visit Provider Connection at blueshieldca.com/provider.

Required Information/Appeal

An appeal must 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

Provider Appeals and Dispute Resolution *(cont'd.)*

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

- The date of service, when applicable
- 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), 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.

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 claim 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.

Provider Appeals and Dispute Resolution *(cont'd.)*

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

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.

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 overpaid. 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 appeal submission. Paper appeals are acknowledged within 15 working days and electronic submissions are acknowledged within 2 working days.

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.

Provider Appeals and Dispute Resolution *(cont'd.)*

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

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.

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 written 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 request to the following address:

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

Written 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

Provider Appeals and Dispute Resolution *(cont'd.)*

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

Please submit to the above addresses on paper only. Digital media such as compact discs, USB data keys, flash drives, and other digital formats are not permissible. Submission of digital media will not be effective to initiate an appeal, and any digital media received by Blue Shield will be destroyed without review or further notice to the submitting party.

For additional information regarding the appeal process, and to review digital submission options, please visit Provider Connection at www.blueshieldca.com/provider.

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.

Capitated Entity (IPA/MG/Capitated Hospital) Appeal Resolution Requirements *(cont'd.)*

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 workdays 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.

Providing all supporting documentation at the time the initial dispute is submitted will help ensure timely processing.

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

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 – valid mailing address and phone number
- Blue Shield's Internal Control Number (ICN)/Claim number
- 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.)*

Timeframe for Submitting Appeal

Initial appeals must be submitted within 365 calendar 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 calendar 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.

Provider Appeals of Medicare Advantage Claims *(cont'd.)*

Non-Contracted Providers

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 (Prescription Drug Plans).

Provider disputes include any decisions where a non-contracted/deemed provider contends that the amount paid by the organization (MAO) 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'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 A provider has the right to request a reconsideration of the denial of payment within 60 calendar days for $0 payments and 120 calendar days for underpayments after the receipt of notice of initial determination/decision.

Providers who wish to submit an appeal must also submit a signed Waiver of Liability (WOL) statement holding the member harmless regardless of the outcome of the appeal. Providers should include documentation such as a copy of the original claim, remittance notification showing the denial and any clinical records and other documentation that supports the provider's argument for reimbursement. If there is no WOL submitted, the plan will make three attempts to request the WOL. If the WOL is <u>not</u> submitted after 3 attempts and before the 60th calendar day, the plan may dismiss the provider appeal.
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 60 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 60 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.

Provider Appeals of Medicare Advantage Claims *(cont'd.)*

Non-Contracted Providers *(cont'd.)*

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

To appeal the provider organization's decision upholding initial payment, the provider must submit a written request to:

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

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

Section 5: Blue Shield Benefit Plans and Programs

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Table of Contents

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
- Medicare Advantage Plans
- Point of Service (POS) Plans
- Federal Employee Program (FEP) PPO
- Medicare Supplement Plans
- The BlueCard® Program
- Other Payors
- Mental Health and Substance Use Disorder Services
- Ancillary Benefits

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+ Specialist℠ 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 Medicare Advantage Plans

Blue Shield's Medicare Advantage 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 a Blue Shield Medicare Advantage plan, have paid any premiums required for initial enrollment to be valid, and whose enrollment in a Blue Shield Medicare Advantage plan, has been confirmed by the Centers for Medicare & Medicaid Services (CMS). Blue Shield Medicare Advantage plans are 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 a Blue Shield Medicare Advantage plan program, the member must have both Medicare Part A and Medicare Part B and live within the CMS-approved Blue Shield Medicare Advantage plan service area. On May 22, 2020, CMS issued a Final Rule that permits enrollment of individuals with End Stage Renal Disease (ESRD) in MA-PD plans, effective January 1, 2021, as long as they meet the Medicare Advantage carriers' eligibility criteria.

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

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)).

Medicare Part D *(cont'd.)*

Part D Eligibility

In general, an individual is eligible to enroll in a MA-PD or PDP plan 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 MA-PD or 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 MA-PD or PDP sponsor may not deny enrollment to otherwise eligible individuals covered under an employee benefit plan. If the individual enrolls in a MA-PD or 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.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.

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 list 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
- www.sam.gov

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 *(cont'd.)*

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

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 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 and medical supplies directly associated with delivering insulin to the body, including syringes, needles, alcohol swabs, gauze, and insulin injection delivery devices not otherwise covered under Medicare Part B 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 essence, if the drug is administered to the member or dispensed within the four walls of a provider's office or facility, it is a Part B medication. CMS' understanding that the practice of "brown-bagging" drugs is opposed by medical societies. CMS continues to urge providers to reinforce this message to their members. The following drug categories are covered by Medicare Part B and therefore excluded from Part D:

Medicare Part D *(cont'd.)*

Medicare Part D Prescriber Preclusion List *(cont'd.)*

1) Any injectable or infusible drug that is defined by a Medicare contractor as usually not self-administrable (e.g., injectable chemotherapy) or
2) Any injectable or infusible drug that there exists a safety concern such that it would go against accepted medical practice for a particular injectable or infusible to be dispensed directly to a patient based on medical literature.

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 establishes that the administration fee of a Medicare Part D vaccine is to be considered part of the Part D vaccine cost.

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

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

Medicare Part D *(cont'd.)*

Medication Therapy Management Program (MTMP) *(cont'd.)*

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 in network health care professional or facility is used.

A member's copayments and deductible amounts for covered services will vary depending on whether he or she selects an in-network health care professional or facility. Therefore, there is a financial incentive for members to use in network health care professionals and facilities.

If a member chooses to go to an out of network health care professional or facility, Blue Shield's payment for a service by that out of network health care professional or facility 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 out of network health care professionals and facilities. It is therefore to the member's advantage to obtain medical and hospital services from in network health care professionals and facilities.

The Virtual Blue PPO plan uses remote, digital engagement as the default care delivery method when appropriate. Members have access to virtual primary care and specialist care, including psychiatry and psychology. A care team consisting of a virtual PCP, health coach and behavioral health specialist help members get the care they need. When in-person care is either preferred by the member or referred to by the care team, members have access to both in network and out of network health care professionals and facilities as outlined above.

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.

Blue Shield PPO Plans *(cont'd.)*

PPO Primary Care Physician Requirement for IFP PPO Members

All individual and family plan (IFP) PPO benefit plan members are 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.

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.
- 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 Provider Information and Enrollment by email to BSCProviderInfo@blueshieldca.com or mail to P.O. Box 629017, El Dorado Hills, CA 95762-9017.

Blue Shield Medicare (PPO) (Medicare Advantage)

Blue Shield Medicare (PPO) is one of 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 Medicare (PPO), have paid any premiums required for initial enrollment to be valid, and whose enrollment in Blue Shield Medicare (PPO), has been confirmed by the Centers for Medicare & Medicaid Services (CMS). Blue Shield Medicare (PPO) 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 Medicare (PPO) program, the member must have both Medicare Part A and Medicare Part B and live within the CMS-approved Blue Shield Medicare (PPO) service area. On May 22, 2020, CMS issued a Final Rule that permits enrollment of individuals with End Stage Renal Disease (ESRD) in MA-PD plans, effective January 1, 2021, as long as they meet the Medicare Advantage carriers' eligibility criteria.

The Blue Shield Medicare (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 Medicare 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 provider or a non-network provider. Therefore, there is a financial incentive for members to use Blue Shield Medicare preferred providers.

The Blue Shield Medicare (PPO) plan is regulated by the Centers for Medicare & Medicaid Services (CMS), the same federal agency that administers Medicare. Please contact Blue Shield Medicare Customer Care (877) 654-6500 (for Providers), (800) 776-4466 (for Members), if you have questions about benefit information, eligibility, claims, and/or billing.

Blue Shield Medicare (PPO) Service Area

The definition of a service area, as described in the Blue Shield Medicare (PPO) *Evidence of Coverage* (EOC), is the geographic area approved by the CMS in which a person must permanently reside to be able to become or remain a member of a Blue Shield Medicare (PPO) plan. Blue Shield Medicare (PPO) has one service area within the state. The specific service area in which the member permanently resides determines the Blue Shield Medicare (PPO) plan(s) in which the member may enroll. Members who temporarily move outside of the service area (as defined by CMS as six months or less) are eligible to receive emergency care and urgently needed services outside the service area.

Individual Blue Shield Medicare (PPO) Service Areas

Alameda County
Orange County
San Diego County

Blue Shield Medicare (PPO) (Medicare Advantage) *(cont'd.)*

Blue Shield Medicare (PPO) Benefits

Premiums and Copayments or Coinsurance

Medicare Premiums

All Blue Shield Medicare (PPO) members (individual and group) must continue paying their Medicare Part B premium. The Medicare Part B premium is either deducted from their monthly Social Security or Railroad Retirement Board annuity check or is paid directly to Medicare by the member or someone on his/her behalf (i.e., the Medi-Cal program).

The Affordable Care Act requires Part D enrollees with higher income levels to pay a monthly adjustment amount, the Part D Income Related Monthly Adjustment Amount (IRMAA). This IRMAA applies to all Medicare beneficiaries, both group and individual, who fall into higher income levels. The Part D IRMAA is paid directly to the government and, like the Part B premium, may be deducted from the monthly Social Security or Railroad Retirement Board annuity check or paid directly to Medicare by the member or someone on his/her behalf.

Failure to pay either the Medicare Part B premium or Part D IRMAA will result in the member being involuntarily disenrolled from Blue Shield's Medicare Advantage plan, both individual and group.

Plan Premiums

Blue Shield Medicare (PPO) individual plans have a monthly plan premium. Please refer to the Blue Shield Medicare (PPO) individual *Summary of Benefits* for additional plan premium information.

The monthly plan premium for Blue Shield Medicare (PPO) group plans are determined through an actuarial-based pricing process and model which Underwriting uses to develop the rates. Plan premiums vary by employer group.

Copayments or Coinsurance

Blue Shield Medicare (PPO) members must pay a copayment or coinsurance for certain services. Please refer to the Blue Shield Medicare (PPO) individual or group *Summary of Benefits* for additional copayment or coinsurance information.

Pharmacy Copayments or Coinsurance

Copayment or coinsurance amounts vary by the Blue Shield Medicare (PPO) individual or group plan, as well as by the tier placement of the covered medication and whether the member obtains the medications from a network pharmacy with preferred cost-sharing, an out-of-network pharmacy, a network pharmacy with standard cost-sharing, or the mail service pharmacy.

Blue Shield Medicare (PPO) (Medicare Advantage) *(cont'd.)*

Blue Shield Medicare (PPO) Benefits *(cont'd.)*

Inpatient Benefits

Blue Shield Medicare (PPO) individual and group plans provide benefits for treatment in hospitals and skilled nursing facilities (SNFs) and extend the basic benefits provided by Medicare. Blue Shield Medicare (PPO) individual and group plans provide coverage according to Medicare guidelines.

In addition to hospital care, Blue Shield Medicare (PPO) individual and group members who meet Medicare guidelines for skilled nursing facility care have coverage for SNF benefits. Please refer to the Blue Shield Medicare (PPO) Summary of Benefits for the number of days covered for care provided by a skilled nursing facility.

Outpatient Benefits

Blue Shield Medicare (PPO) individual and group plans cover all outpatient medical services according to Medicare guidelines. Outpatient medical services are provided and paid for the diagnosis or treatment of illness and injury when they are considered to be reasonable and medically necessary. Please refer to the *Blue Shield Medicare (PPO) Summary of Benefits* (sent separately to IPA/medical groups) for a list of covered outpatient services.

Blue Shield Medicare (PPO) (Medicare Advantage) *(cont'd.)*

Blue Shield Medicare (PPO) Benefits *(cont'd.)*

Outpatient Prescription Drugs

Blue Shield Medicare (PPO) individual and group plans provide coverage for plan-approved generic and brand name prescription medications included in the Blue Shield Medicare (PPO) Drug Formulary. The formulary may vary by plan, by plan service area, or by employer group. The formulary for group plan members includes some drugs that are "excluded" drugs per CMS. The employer groups may choose to cover some of these excluded drugs as part of their additional supplemental coverage. Some formulary medications may require prior authorization or step therapy. The Blue Shield Medicare (PPO) utilization management criteria can be found within the plan drug search tools located at blueshieldca.com/medformulary2022. Prescriptions from non-plan providers are covered only if issued in conjunction with covered emergency services and filled through a network pharmacy.

The formulary contains medications approved by the Food & Drug Administration (FDA) which are subject to a rigorous clinical review by clinical pharmacists and physicians to evaluate comparative safety, comparative efficacy, likelihood of clinical impact, cost-effectiveness when safety and efficacy are similar. The Blue Shield Pharmacy & Therapeutics (P&T) Committee determines formulary decisions and medication coverage policies consistent with the currently accepted medical evidence and standards. The Blue Shield P&T Committee has oversight responsibility for pharmaceutical/utilization management programs, drug utilization review programs, and other drug-related matters impacting patient care. The voting members of the P&T Committee include actively participating network physicians and clinical pharmacists who are not employees of Blue Shield. The P&T Committee determines formulary status and/or medication coverage policies for drugs covered in the prescription benefit on at least a quarterly basis.

In general, outpatient prescription drugs are covered under Blue Shield Medicare (PPO) when they are:

- Included in the Blue Shield Medicare (PPO) Drug Formulary. (Blue Shield may periodically add, remove and/or make changes to coverage limitations on certain drugs, or alter the member price of a drug. If Blue Shield implements a formulary change that limits member ability to fill a prescription, Blue Shield will notify affected enrollees in advance of the change.)
- Prescribed by a provider (a doctor, dentist, or other prescriber) who either accepts Medicare or has filed documentation with CMS showing that he or she is qualified to write prescriptions.

Blue Shield Medicare (PPO) (Medicare Advantage) *(cont'd.)*

Blue Shield Medicare (PPO) Benefits *(cont'd.)*

Outpatient Prescription Drugs *(cont'd.)*

- Filled at a Blue Shield Medicare (PPO) network pharmacy.
- Used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by the following CMS-approved references: the *American Hospital Formulary Service Drug Information*; the *DRUGDEX Information System*; the *USPDI*; and the *National Comprehensive Cancer Network and Clinical Pharmacology*, or their successors.

Network Retail Pharmacy – A pharmacy where members can get their prescription drug benefits. They are termed "network pharmacies" because they contract with our plan. In most cases, member prescriptions are covered only if they are filled at one of our network pharmacies.

Standard Cost-Sharing – Standard cost-sharing is cost-sharing other than preferred cost-sharing offered at a network pharmacy.

Preferred Cost-Sharing – Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs that members get from out-of-network pharmacies are not covered by our plan unless certain conditions apply.

Non-Formulary Outpatient Prescription Drugs

If a drug is not listed in the Blue Shield Medicare (PPO) individual or group drug formulary, the prescriber or member may contact Blue Shield Medicare (PPO) Member Services to confirm the drug's coverage status.

If Member Services confirms that the drug is not part of the Blue Shield Medicare (PPO) individual or group drug formulary and not covered, the member has two options:

- The member can ask the prescriber to prescribe a different drug, one that is part of the Blue Shield Medicare (PPO) individual or group drug formulary.
- The member can request that Blue Shield make a Formulary Exception (a type of Coverage Determination) to cover the specific drug.

If a member recently joined Blue Shield and is taking a drug not listed in the Blue Shield Medicare (PPO) Drug Formulary at the time he/she joined, the member may be eligible to obtain a temporary supply. For more information, please refer to the next section, which reviews the rules that govern dispensing temporary supplies of a non-formulary drug.

Blue Shield Medicare (PPO) (Medicare Advantage) *(cont'd.)*

Blue Shield Medicare (PPO) Benefits *(cont'd.)*

Non-Formulary Outpatient Prescription Drugs *(cont'd.)*

Transition Policy

New Blue Shield members may be taking drugs not listed in the Blue Shield Medicare (PPO) individual or group drug formulary, or the drug(s) may be subject to certain restrictions, such as prior authorization or step therapy. Members are encouraged to talk to their doctors to decide if they should switch to an appropriate drug in the plan formulary or request a Formulary Exception (a type of Coverage Determination) in order to obtain coverage for the drug. While these new members may discuss the appropriate course of action with their doctors, Blue Shield may also cover the non-formulary drug or drug with a coverage restriction in certain cases during the first 90 days of new membership.

For each of the drugs not listed in the formulary or that have coverage restrictions or limits, Blue Shield will cover a temporary 30-day supply (unless the prescription is written for fewer days) when the new member goes to a Network Pharmacy (and the drug is otherwise a "Part D drug"). After the first 30-day supply, Blue Shield will not pay for these drugs, even if the new member has been enrolled for less than 90 days.

If a member is a resident of a long-term-care facility (LTC) such as a nursing home, Blue Shield will cover supplies of Part D drugs in increments of 14 days or less for a temporary 31-day transition supply (unless the prescription is written for fewer days) during the first 90 days a new member is enrolled in our Plan beginning on the member's effective date of coverage. A transition supply notice will be sent to the member within 3 business days of the first incremental transition fill. If the LTC resident has been enrolled in our Plan for more than 90 days and needs a non-formulary drug or a drug that is subject to other restrictions, such as step therapy or dosage limits, Blue Shield will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception. For members being admitted to or discharged from a LTC facility, early refill edits are not used to limit appropriate and necessary access to the formulary, and such enrollees are allowed to access a refill upon admission or discharge.

Blue Shield Medicare (PPO) (Medicare Advantage) *(cont'd.)*

Blue Shield Medicare (PPO) Benefits *(cont'd.)*

Non-Formulary Outpatient Prescription Drugs *(cont'd.)*

Transition Policy *(cont'd.)*

To request a Formulary Exception (a type of Coverage Determination), Prescribers should submit persuasive evidence in the form of studies, records, or documents to support the existence of the situations listed above via a prior authorization request.

Providers can submit a prior authorization request electronically by utilizing one of our contracted electronic prior authorization (ePA) vendors, Surescripts or Cover My Meds. Providers also have the option to request a prior authorization or exception request by faxing a Medicare Coverage Determination 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 have the alternate option to use AuthAccel to complete, submit, attach documentation, track status, and receive determinations for pharmacy prior authorizations. Registered users may access the tool, in the *Authorizations* section, after logging into Provider Connection at blueshieldca.com/provider. When providers submit requests via AuthAccel, it is not necessary for them to complete a separate Medicare Coverage Determination Request Form, as the required information is built into the tool.

Once all required supporting information is received, a coverage decision based upon medical necessity is provided within 24 hours for an expedited review and 72 hours for standard requests.

Blue Shield Medicare (PPO) (Medicare Advantage) *(cont'd.)*

Blue Shield Medicare (PPO) Benefits *(cont'd.)*

Vision Services

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

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

Hearing Services

Blue Shield Medicare (PPO) individual and group plans cover hearing exams in accordance to Medicare guidelines. Please refer to the member's *Blue Shield Medicare (PPO) Summary of Benefits* for additional information.

Optional Buy-Up Services (Group Members Only)

Blue Shield Medicare (PPO) also offers optional buy-up benefits for hearing aids, vision, podiatry, chiropractic, and acupuncture that offer routine coverage beyond what is covered by Medicare. In addition, Silver Sneakers Fitness is available. These benefits are not part of the standard plan offering and may be available at an additional cost when selected by the employer group/union. If purchased, they must be made available to all Blue Shield Medicare (PPO) GMAPD members within that employer group/union. (There are also optional buy-up dental plans being offered to Blue Shield Medicare (PPO) individual plan members.)

Blue Shield Medicare (PPO) (Medicare Advantage) *(cont'd.)*

Exclusions to Blue Shield Medicare (PPO) Benefits

General Benefit Exclusions

Blue Shield files benefits with CMS on an annual basis. Coverage for the following benefits, services, and conditions are **excluded** from coverage under the Blue Shield Medicare (PPO) plan, effective January 1, 2020:

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment, and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study or by our plan. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in a member's hospital room or a skilled nursing facility room, such as a telephone or a television.
- Full-time nursing care in the member's home.
- Custodial care unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps members with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by the member's immediate relatives or members of their household.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines, unless specifically indicated as covered by the Blue Shield Medicare (PPO) plan in which the member is enrolled.

Blue Shield Medicare (PPO) (Medicare Advantage) *(cont'd.)*

Exclusions to Blue Shield Medicare (PPO) Benefits *(cont'd.)*

General Benefit Exclusions *(cont'd.)*

- Unless the member has enrolled in the optional supplemental dental PPO benefit, routine dental care, such as cleanings, fillings, or dentures, unless specifically indicated as covered by the Blue Shield Medicare (PPO) plan in which the member is enrolled. Non-routine dental care received at a hospital may be covered.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines or as specifically indicated as covered by the Blue Shield Medicare (PPO) plan in which the member is enrolled.
- Orthopedic shoes unless the shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Routine hearing exams, hearing aids, or exams to fit hearing aids, unless specifically indicated as covered by the Blue Shield Medicare (PPO) plan in which the member is enrolled.
- Eyeglasses, routine eye examinations, radial keratotomy, LASIK surgery, vision therapy, and low vision aids unless specifically indicated as covered by the Blue Shield Medicare (PPO) plan in which the member is enrolled.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Routine Acupuncture, except for chronic low back pain, unless specifically indicated as covered by the Blue Shield Medicare (PPO) plan in which the member is enrolled.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, Blue Shield will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
- Immunizations for foreign travel purposes.

The plan will not cover the excluded services listed above. Even if members receive the services at an emergency facility, the excluded services are still not covered.

Blue Shield Medicare (PPO) (Medicare Advantage) *(cont'd.)*

Exclusions to Blue Shield Medicare (PPO) Benefits *(cont'd.)*

Prescription Drug Benefit Exclusions

Blue Shield files benefits with CMS on an annual basis. The following exclusions apply to the Blue Shield Medicare (PPO) prescription drug benefits:

- Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B. This includes any injectable or infusible drug that is defined by a Medicare contractor as usually not self-administrable (e.g., chemotherapy and supportive/adjunctive injectable drugs), any drug that is administered to the member or dispensed within the four walls of a provider's office or facility, or any drug BSC has determined, based on medical literature, there exist safety concerns such that it would go against accepted medical practice for a particular injectable or infusible drug to be dispensed directly to a patient.
- Drugs purchased outside the United States and its territories are not covered.
- Off-label use of prescription drugs is usually not covered. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration. Generally, coverage for "off-label use" is allowed only when the use is supported by the following CMS-approved references: the *American Hospital Formulary Service Drug Information,* the *DRUGDEX Information System*, for cancer the *National Comprehensive Cancer Network and Clinical Pharmacology,* and *Lexi-Drugs* or their successors. If the use is not supported by one of these reference sources, then our plan cannot cover its "off-label use."
- By law, the following categories of drugs are not covered by Medicare drug plans:
  - Non-prescription drugs (also called over-the-counter drugs)
  - Drugs related to assisted reproductive technology (ART)
  - Drugs when used for the relief of cough or cold symptoms
  - Drugs when used for cosmetic purposes or to promote hair growth
  - Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
  - Drugs when used for the treatment of sexual or erectile dysfunction (ED)
  - Drugs that are prescribed for medically accepted indications other than sexual or erectile dysfunction (such as pulmonary hypertension) are eligible for Part D coverage
  - Drugs when used for treatment of anorexia, weight loss, or weight gain
  - Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

National Medicare Coverage Determinations

A National Coverage Determination (NCD) is a national policy determination made by CMS regarding the coverage status of a particular service under Medicare. A NCD does not include a determination of what code, if any, is assigned to a service or a determination about the payment amount for the service.

National Medicare Coverage Determinations that arise between contract years allow Medicare Advantage Organizations and contracted providers to bill Medicare on a fee-for-service basis for newly covered items that exceed the significant cost criterion.

When the significant cost criterion is not met:

- The MAO is required to provide coverage for the NCD or legislative change in benefits and assume risk for the costs of that service or benefit as of the effective date of the NCD or as of the date specified in the legislation/regulation.

When the significant cost criterion is met:

- The MAO is not required to assume risk for the costs of that service or benefit until the contract year for which payments are appropriately adjusted to take into account the significant cost of the service or benefit. However, a plan must pay for the following:
    - Diagnostic services related to the NCD item, service, or legislative change in benefits and most follow-up services related to the NCD item, service, or legislative change (42 CFR § 422.109(c)(2)(i),(ii));
    - NCD items, services, or legislative change in benefits that are already included in the plan's benefit package either as Original Medicare benefits or supplemental benefits.

Billing to Medicare must include a notice that the item being billed involves a new coverage issue and that the person or organization submitting the bill is requesting fee-for-service reimbursement.

For select medications, Blue Shield Medicare PPO Medication Policies and Step Therapy requirements may also apply. The Blue Shield Medicare (PPO) benefit for medication coverage under the benefit can be found on Provider Connection at blueshieldca.com/provider under *Authorizations*, *Clinical policies and guidelines*, and then *Medication Policy*.

For more information on NCDs, go to the Medicare Coverage Database on the CMS website at https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx

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

Network	How Care is Accessed	Financial Responsibility
HMO Network	Member's care is coordinated through the primary care physician who makes any necessary specialist referrals.	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.
PPO In-network	Member self-refers to a Blue Shield Preferred Provider.	Applicable PPO copayment and deductible applies.
Non-Network PPO (non-preferred or non-participating)	Member self-refers to a non-network provider.	Applicable PPO copayment and deductible applies. Member may be balance-billed.

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) (PPO)

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 Anthem Blue Cross' Preferred Hospitals. FEP members may select the FEP Blue Focus, 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. FEP Blue Focus Members and Basic Option Member's must seek care from in-network providers to be covered for any services. 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

Federal Employee Program (FEP) (PPO) *(cont'd.)*

About the BlueCross and BlueShield Service Benefit Plan *(cont'd.)*

Under both the FEP Blue Focus and the Basic Option plans, members must use Preferred providers in order to receive benefits, except under the following special circumstances. In addition, certain types of care must be approved in advance.

- 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, other than those described above. We encourage the member to contact Blue Shield of California for more information in these types of situations before they receive services from a non-preferred provider.
- Care received outside the United States, Puerto Rico, and the U.S. Virgin Islands

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.

Federal Employee Program (FEP) *(cont'd.)*

Precertification for Inpatient Hospital Admissions

Preferred providers are responsible for obtaining precertification for all inpatient admissions to preferred hospitals. Precertification 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 precertification is not obtained. The member is ultimately responsible for ensuring that precertification has been completed. If the precertification 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).

Precertification is not needed for a maternity admission for a routine delivery. However, if the mother's medical condition requires her to stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, the physician or the hospital must contact Blue Shield for precertification of additional days. Further, if the baby stays after the mother is discharged, then the physician or the hospital must contact Blue Shield for precertification of additional days for the baby.

> *Note:* When a newborn requires definitive treatment during or after the mother's confinement, the newborn is considered a patient in his or her own right. If the newborn is eligible for coverage, regular medical or surgical benefits apply rather than maternity benefits.

Federal Employee Program (FEP) *(cont'd.)*

Mental Health and Substance Use Disorder Services for FEP

It is important to follow these policies to help ensure your patient's needs for mental health and substance use disorder 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 Mental Health and Substance Use Disorder 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, telehealth, or home visits for FEP PPO members. For questions regarding coverage, please call FEP Customer Service at (800) 824-8839. For questions regarding prior authorization call FEP Prior Authorization department at (800) 633-4581.

Federal Employee Program (FEP) *(cont'd.)*

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 affirmation 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:* Necessary medical evidence for BRCA related genetic testing includes the results of genetic counseling. Genetic counseling and evaluation services are required before *preventive* BRCA testing is performed.

Federal Employee Program (FEP) *(cont'd.)*

Required Prior Authorization *(cont'd.)*

Prior Approval is required for:	Additional Information
Surgical services	Morbid Obesity- See the Blue Cross Blue Shield Service Benefit Plan Brochure for requirements. Surgical correction of congenital anomalies (see definition in the Service Benefit Plan Booklet); and oral maxillofacial surgery needed to correct accidental injuries to jaws, cheeks, lips, tongue, roof, and floor of mouth (see definition in the Service Benefit Plan Brochure). Orthognathic surgery procedures, bone grafts, osteotomies, and surgical management of the temporomandibular joint (TMJ). Breast reduction or augmentation not related to treatment of cancer. Reconstructive surgery for conditions other than breast cancer. Orthopedic procedures: hip, knee, ankle, spine, shoulder, and all orthopedic procedures using computer-assisted musculoskeletal surgical navigation. Rhinoplasty, Septoplasty and Varicose vein treatment. 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.

Federal Employee Program (FEP) *(cont'd.)*

Required Prior Authorization *(cont'd.)*

Prior Approval is required for:	Additional Information
Transplants – Prior approval is required for both the procedure and the facility	Prior Approval is required for all transplants, except cornea and kidney. Covered Organ/tissue Transplants - See the list of covered transplant services in the Blue Cross Blue Shield 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. For Medicare's approved programs, go to https://qcor.cms.gov/main.jsp 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. *Note*: For the purposes of the blood or marrow stem cell clinical trial transplants covered under this Plan, a clinical trial is a research study whose protocol has been reviewed and approved by the Institutional Review Board (IRB) of the FACT-accredited facility, Blue Distinction Center for Transplants, or Cancer Research Facility where the procedure is to be performed. Clinical trials for certain blood or marrow stem cell transplants – See the list of conditions covered only in clinical trials in the Blue Cross Blue Shield Service Benefit Plan Brochure. All members (including those who have Medicare Part A or another group health insurance policy as their primary payor) must contact us at the customer service telephone number listed on the back of their ID card before obtaining services.
Prescription drugs and supplies	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 https://www.caremark.com/wps/portal/WEBSUPPORT_FAQS?cms=CMS-PWCM-2034779 to request prior approval, or to obtain a list of drugs and supplies that require prior approval. *Note:* 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.
Mail Order Prescription Drug Program	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.

Federal Employee Program (FEP) *(cont'd.)*

Required Prior Authorization *(cont'd.)*

Prior Approval is required for:	Additional Information
Medical foods covered under the pharmacy benefit	Contact CVS Caremark, our Pharmacy Program administrator, at (800) 624-5060 (TTY: 800-624-5077 for the hearing impaired) to request prior approval.
Specialty DME	Specialty hospital beds, deluxe wheelchairs, power wheelchairs and mobility devices including scooters and related supplies.
Gene Therapy and Cellular Immunotherapy	Including Car-T and T-cell receptor therapy.
Air Ambulance Transport (Non-Emergent)	Air ambulance transport related to immediate care of a medical emergency or accidental injury does not require prior approval.
Outpatient Intensity Modulated Radiation Therapy (IMRT)	Prior approval is required for all outpatient IMRT services except IMRT related to the treatment of head, neck, breast, prostate, or anal cancer. Brain cancer is not considered a form of head or neck cancer; therefore, prior approval is required for IMRT treatment of brain cancer.
Rehabilitation Services	Cardiac Rehab and Pulmonary Rehab.
Devices	Cochlear implants and external prosthetic devices, including microprocessor-controlled limb prosthesis and electronically and externally powered prosthesis.
Outpatient Residential Treatment Center Care	For any condition.
High tech Radiology	MRI, CT, and PET Scans. *Note*: High technology radiology related to immediate care of a medical emergency or accidental injury does not require prior approval.

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 Care 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 Care Management Program include:

- Acute Catastrophic – Includes members with immediate needs relating to an acute episode of care for conditions such as stroke, septicemia, 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 Substance Use Disorder diagnosis. Participates in discharge planning for all inpatient mental health and substance use disorder 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 link to a Guided Imagery Toolkit is available to members prior to or following surgery 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:

Plan and Group Numbers	Medicare Unassigned Claims
Benefit Plan A, B, C, D, H, K, N	Patients pay balance of billed charges (limiting charge).*
Benefit Plan F, G, I, J	Blue Shield pays 100 % of the difference between Medicare's payment and billed charges.
Golden Coronet Senior	Blue Shield pays 80 % of the difference between Medicare's payment and billed charges. Patients pay balance of billed charges.*
Coronet Major Medicare	Patients pay balance of billed charges (limiting charge).*
Coronet Senior	Patients pay balance of billed charges (limiting charge).*
Preferred Senior	Patients pay balance of billed charges (limiting charge).*

*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 other state Blue Plans, including international Blue Plans, directly to Blue Shield of California. Blue Shield offers you a one-payor 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 https://www.blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/guidelines_resources/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. The Other Payor Summary List is located on Provider Connection at www.blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/guidelines_resources/policies_standards/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 and Substance Use Disorder Services

The terms "mental health and substance use disorder services" and "behavioral health" are used interchangeably throughout this manual.

Blue Shield provides coverage for the diagnosis and medically necessary treatment of mental health and substance use disorders. This includes conditions that fall under any diagnostic categories of the World Health Organization's *International Statistical Classification of Diseases and Related Health Problems* or that are listed in the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Blue Shield's mental health service administrator (MHSA) for commercial HMO and PPO members is Human Affairs International of California (HAI-CA).

Members must utilize the Blue Shield MHSA provider network to access mental health and substance use disorder covered services. The MHSA participating provider must obtain prior authorization from the MHSA for services listed under the section Blue Shield MHSA Covered Services for Commercial Plan Members below.

Mental health and substance use disorder office visits **do not** require prior authorization.

Commercial HMO and PPO members should use the Member Self-Referral phone number (877) 263-9952 to contact Blue Shield's MHSA to access behavioral health care.

Mental Health and Substance Use Disorder Services *(cont'd.)*

Primary Care Physician Consultation Line

The Blue Shield MHSA offers a Primary Care Physician Consultation Line at (877) 263-9870 to facilitate Primary Care Physician discussion with a Board-Certified psychiatrist regarding mental health and substance use disorder 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 online PCP Behavioral Health Toolkit at any time by visiting blueshieldca.com/provider, selecting *Guidelines & resources*, *Patient care resources*, *Behavioral health resources,* then *PCP Behavioral Toolkit*. 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 *Provider Search Telebehavioral* on the left of the screen.

Mental Health and Substance Use Disorder Services *(cont'd.)*

Blue Shield MHSA Covered Services for Commercial Plan Members

The Blue Shield MHSA will utilize ASAM, LOCUS, CALOCUS, and ECSII for mental health and substance use disorder reviews for commercial members. Additional mental health and substance use disorder guidelines may be added as they become available from non-profit professional associations in accordance with California law.

Blue Shield's MHSA is responsible for prior authorization and paying claims for the following services:

- Non-emergency mental health or substance use disorder Hospital inpatient admissions, including acute and residential care
- Outpatient Mental Health and Substance Use Disorder Services listed below when provided by a MHSA contracted provider, as required by the applicable plans *Evidence of Coverage* or *Health Service Agreement.*
  - Behavioral Health Treatment (BHT) including Applied Behavior Analysis (ABA).
  - Electro-convulsive Therapy (ECT) and associated anesthesia.
  - Intensive Outpatient Program.
  - Partial Hospitalization Program.
  - Neuropsychological Testing should be considered for coverage through the patient's mental health benefit when:
    - After completion of a comprehensive Behavioral Health evaluation and neurological evaluation, if the Behavioral Health provider or neurologist determines the neuropsychological testing is required, the provider will request authorization and coordinate the request, Blue Shield MHSA will cover Neuropsychological testing when the purpose of testing is to clarify whether there is a psychiatric diagnosis (even when medical conditions are present) for the purposes of facilitating treatment.
  - Transcranial Magnetic Stimulation.
  - Non-emergency inter-facility transports.

For the following other services, please see the member's health plan benefits:

- Outpatient radiology, laboratory, speech therapy, occupational therapy, and physical therapy services associated with a mental health and/or substance use disorder diagnosis.
- Medical consultations requested by the MHSA.
- Structured Pain Management Program.
- Nutritional counseling.
- Experimental or investigational treatments.
- Outpatient prescription medications.

Mental Health and Substance Use Disorder Services *(cont'd.)*

Mental Health and Substance Use Disorder Services for Self-Funded Accounts (ASO) and the Federal Employee Program (FEP) (PPO)

Self-Funded Accounts (ASO) and the Federal Employee Program (FEP) use Blue Shield of California's network of contracted mental health and substance use disorder providers. Claims are billed to Blue Shield.

For additional mental health and substance use disorder information for ASO and FEP PPO accounts, see the following sections within this manual:

Section 2: Service Accessibility Standards for Behavioral Health
Section 5: Federal Employee Program (FEP) (PPO); Mental Health and Substance Use Disorder Services for FEP

Ancillary Benefits

The following benefits are listed in the members' *Evidence of Coverage* (EOC) and will include the number of allowed visits and member copay responsibility. Providers are required to look up members benefits and eligibility on Provider Connection at blueshieldca.com/provider under *Eligibility and benefits.* Review the benefits for acupuncture and chiropractic to determine if the members plan includes these benefits as they may or may not be included and vary by plan.

Acupuncture Services

For Blue Shield fully-insured plans, benefits are provided for medically necessary acupuncture services, for a maximum number of visits per calendar year, when received from an American Specialty Health Group, Inc. (ASH Group) participating provider. Covered services must be determined as Medically Necessary by American Specialty Health Plans, Inc. (ASH Plans). This benefit includes an initial examination, subsequent office visits, acupuncture services, and adjunctive therapy specifically for the treatment of neuromusculoskeletal disorders, nausea, and pain up to the benefit maximum.

Questions concerning these benefits may be directed to:

ASH Plan Member Services (800) 678-9133

ASH Plan Provider Services (800) 972-4226

For Self-Funded, ASO, Shared Advantage, FEP PPO, and BlueCard members, all medically necessary acupuncture services that are included in these plans are provided by Blue Shield's direct network of acupuncturists.

Ancillary Benefits *(cont'd.)*

Chiropractic Services

For Blue Shield fully-insured plans, benefits are provided for medically necessary chiropractic services, including spinal manipulation or adjustment, when received from an American Specialty Health Group, Inc. (ASH Group) participating provider. Covered services must be determined as Medically Necessary by American Specialty Health Plans, Inc. (ASH Plans). This benefit includes an initial examination and subsequent office visits, adjustments, and adjunctive therapy up to the benefit maximum. Benefits are also provided for x-rays.

Members are referred to the primary care physician for evaluation of conditions not related to a neuromusculo-skeletal disorder and of evaluation for non-covered services, such as CT Scans or MRIs.

Chiropractic appliances are covered up to a maximum of $50 in a calendar year as authorized by ASH Plans.

Questions concerning these benefits may be directed to:

ASH Plan Member Services (800) 678-9133

ASH Plan Provider Services (800) 972-4226

For Self-Funded, ASO, Shared Advantage, FEP PPO, and BlueCard members, all medically necessary chiropractic services that are included in these plans are provided by Blue Shield's direct network of chiropractors.

Additional Hearing Aid Benefits

For Core Accounts, this optional coverage includes hearing aid services subject to the conditions and limitations listed below. This rider provides an allowance towards the purchase of hearing aids and ancillary equipment.

For benefit coverage, review the member's Hearing Aid Rider language to obtain allowance, frequency, and limitations of the hearing aid benefit.

The hearing aid allowance includes:

- A hearing aid instrument, monaural, or binaural, including ear mold(s)
- Visit for fitting, counseling, device checks and adjustments
- Electroacoustic evaluations for hearing aids
- The initial battery and cords

Ancillary Benefits *(cont'd.)*

Additional Hearing Aid Benefits *(cont'd.)*

The following services and supplies are not covered:

- Purchase of batteries or other ancillary equipment, except those covered under the terms of the initial hearing aid purchase
- Spare hearing aids
- Assisted listening devices or amplification devices
- Charges for a hearing aid which exceed specifications prescribed for correction of a hearing loss
- Replacement parts for hearing aids, repair of hearing aid after the covered warranty period and replacement of a hearing aid more than the benefit allowance period
- Surgically implanted hearing devices

Additional Infertility Benefits

Covered services for Infertility Benefit include all professional, hospital, ambulatory surgery center, ancillary services, injectable drugs when authorized by the primary care physician, to a member for the inducement of fertilization.

Please refer to the member's Infertility Benefit Rider for coverage limitations, exclusions, lifetime maximums and copayments, coinsurance, and deductibles. Benefits are only provided for services received from a Participating Provider.

Infertility is defined as:

The member must be actively trying to conceive and has either:

1) A demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or

2) The inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.

Note: Services to diagnosis and treat the cause of infertility are covered by all group HMO plans under basic medical benefits.

The IPA/medical group provider network is to be used for all infertility services. All covered services under the infertility rider are the financial responsibility of and are authorized and reimbursed by Blue Shield.

Ancillary Benefits *(cont'd.)*

Dental

Section 1367.71 of the Health & Safety Code requires that health plans cover general anesthesia and associated facility charges for dental procedures performed in a hospital or surgery center when required due to clinical status or underlying medical condition, and:

- The patient is less than seven years of age, or
- The patient is developmentally disabled, regardless of age, or
- The patient's health is compromised and for whom general anesthesia is medically necessary, regardless of age.

Prior authorization is required by Blue Shield HMO and coverage for anesthesia and associated facility charges are subject to all other terms and conditions of the plan. Blue Shield HMO is not responsible for the cost of dental procedures. Dental procedures for diagnostic services, endodontics, periodontics, preventive care, prosthetics, and restorative dentistry are covered in plans administered by Dental Benefit Providers of California (DBP) and are available for purchase separately from medical plans.

Vision

This benefit is administered through EyeMed. It covers services for refractions, lenses, and frames. Any questions concerning these benefits may be directed to:

EyeMed (877) 601-9083

Blue Shield Benefit Programs

Care Management

Blue Shield's comprehensive, integrated care management programs, including Shield Support, Shield Advocate, Shield Concierge, and Connect, include member-focused clinical interventions to optimize health and quality of life. These programs offer 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.

Blue Shield's experienced care management 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.

Blue Shield's 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. The care team prepares members in advance for hospital stays, including guided imagery recordings to assist members in preparing for surgery or dealing with other health issues. These programs are supported by medical directors who provide clinical direction and oversight to the care team.

Blue Shield's care management programs are 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.

Care Management *(cont'd.)*

Member identification for Blue Shield's care management programs 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.

Members may also be identified from an acute event or hospital admission or discharge. Care management encompasses a broad spectrum of interventions that provide support for short-term care coordination as well as ongoing complex case management including but not limited to 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 care management programs:

- Telephonic coaching from nurses, behavioral health clinicians, social workers, and pharmacists
- Biometric home monitoring (for some members with diabetes, coronary artery disease, COPD, and heart failure)
- Cognitive behavioral therapy modules
- Online tools and educational materials

In addition to the care management programs described above, the following maternity support is available.

Care Management *(cont'd.)*

Maternity Management

Blue Shield has teamed up with Maven to offer Maven Maternity to our members. Maven Maternity is a 24/7 digital and virtual program designed to support Blue Shield members during and after pregnancy. Maven is also available to eligible Blue Shield medical plan members and their partners who have experienced a pregnancy loss. Blue Shield members can use Maven to book coaching and educational video appointments with providers across more than 30 specialties, including OB-GYNs, mental health specialists, doulas, lactation consultants, and more. Providers can encourage members to enroll in the Maven Maternity Program by visiting blueshieldca.com/maternity.

Screening, treatment, and referral to services for maternal mental health-related conditions is strongly encouraged. If a member screens positive for a mental health condition, such as anxiety or depression, Blue Shield physicians can refer directly to a behavioral health provider. Physician referrals are an important component of Blue Shield's Care Management Programs and may allow for identification of a member in need more quickly. Blue Shield providers may connect a member to appropriate maternal mental health resources through accessing multiple pathways based on the member's needs. These include connecting directly to Maven, through Blue Shield Care Management, or behavioral health providers through the Mental Health Service Administrator, Magellan network.

Providers can refer to Blue Shield Care Management Programs 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. Providers can refer members to Magellan by calling Customer Service at (877) 263-9952 or request a clinical referral form at BSCClinicalLiaison@MagellanHealth.com. Each referral will be evaluated for eligibility and appropriateness.

Care Management *(cont'd.)*

Additional Care Management Program Descriptions

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.

Care Management *(cont'd.)*

Additional Care Management Program Descriptions *(cont'd.)*

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

- **Home-Based Complex Care.** Chronically ill members meeting certain criteria are offered 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 these chronically ill members with complex needs. This does not replace members' primary care providers but rather supports the work of these members' existing providers. The program clinicians communicate and collaborate with the patients' PCPs and specialists to reinforce the PCP's in-office care plan. Blue Shield identifies eligible members for this program based on their health status and needs.

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.

Home-Based Palliative Care Program *(cont'd.)*

Eligibility/Referral

The home-based palliative care program is available to all Blue Shield members except for those covered under a Federal Employee Plan (FEP) PPO, a Blue Shield Medicare supplemental insurance plan (Medigap), or those currently enrolled in hospice or who have an illness that is primarily a mental health 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 or online at blueshieldca.com/provider under *Forms*) 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:

Diabetes Prevention Program (DPP)

The Diabetes Prevention Program helps members who are at risk of type 2 diabetes lose weight and adopt healthy habits. During the six months program, 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 embedded in the Wellvolution platform can be accessed by enrolling in Wellvolution at wellvolution.com.

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 will 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 coach on money matters or an attorney on a variety of legal services. Members may be eligible to receive a 60-minute legal consult and two 30-minute financial consults at no cost to them.

- **Personal challenges including relationship problems or coping with grief** – Members receive 3 telephonic or face to face sessions with a licensed therapist in any six-month period 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, adult, and elder care, childcare, meal programs, relocation services, 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.

Wellness and Prevention Programs *(cont'd.)*

NurseHelp 24/7SM

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 at 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 Preventive health guidelines | Blue Shield of CA Provider (blueshieldca.com).

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.

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:

- **Fitness Your Way by Tivity** –With 4 different gym packages to choose from, including a digital only package, members have access to thousands of well-known fitness locations near home, work, or when traveling nationwide all for a low one time initiation fee and a low monthly cost. Simply visit fitnessyourway.tivityhealth.com/bsc to enroll.
- **Alternative Care Discounts** – 25% savings on acupuncture, chiropractic services, and therapeutic massage services from practitioners participating with the ChooseHealthy® program.
- **Discount Vision Program** – Discounts on vision exams, frames and lenses, contacts lenses, and more.
- **LASIK surgery** – Discounts on LASIK surgery through QualSight LASIK, and LASIK and PRK surgery through NVISION, Inc.

Wellness and Prevention Programs *(cont'd.)*

Wellvolution

Wellvolution focuses on things that make our members happier and healthier. The platform offers digital and in-person whole health programs designed to give our members a way to go beyond just doctors and prescriptions and live their best life. There are over 10 programs to choose from, ranging from general well-being, to supporting stress, sleep, and other mental health concerns, to helping members prevent or treat and reverse the course of serious chronic conditions. With the right tools, coaching, nutrition counseling and health professional support, members can succeed with small changes today to make a big difference for a healthier tomorrow. Once the member receives their Blue Shield member ID card, they can go to wellvolution.com to set up their profile, preferences and pick programs. Wellvolution customizes the path to better health, matching the member with programs and popular apps that are personalized and have proven results, at no extra cost.

The following programs are offered through Wellvolution:

- **Well-Being Programs –** A hand-selected set of proven general well-being programs, designed to help generally healthy members achieve their health goals of sleeping better, lowering stress, exercising more, eating better, or quitting smoking.
- **Mental Health Programs** – To support our members in achieving optimal whole person health, our mental health programs are perfect for members that are seeking opportunities to incorporate everyday mindfulness into their daily lives to reduce stress, increase resilience, and get a better night's rest as well as for members seeking support for low- to moderate- anxiety or depression. Programs include guided meditations, sleepcasts, mindfulness exercises, 24/7 Behavioral Health coaching, personalized care plan, and more.
- **Weight Loss Programs –** Programs specifically designed to help you make changes that fit your lifestyle and promote a healthy weight. You can lose weight and keep it off with coaching support and a personalized step by step plan on how to decrease cravings, hunger, and weight without dieting. Most members see an average loss of 3-4 lbs. per week and improvement in their quality of life across the board.

Wellness and Prevention Programs *(cont'd.)*

Wellvolution *(cont'd.)*

- **Disease Prevention Programs –** Targeting reduction of risk for type 2 diabetes and heart disease, prevention programs provide you with a health coach and an individualized plan that meet your unique needs and address several areas of your life, including physical activity, nutrition, sleep, and stress management. Most members see a reduction in medications they take, as well as normalization of blood sugar and blood pressure.
- **Chronic Condition Reversal Programs** – Turn back the clock and reverse the course of chronic conditions like hyperlipidemia, hypertension, type 2 diabetes and more with the support from physician, health coaches and a supportive patient community. Our high touch reversal programs, often incorporating in-person or digital coaching options, are focused on normalization of A1C levels, weight, and blood pressure, as well as elimination of medication dependence in a matter of weeks.

All Wellvolution programs are 100% covered by Blue Shield of California.

Section 6: Supplemental Direct Contracting HMO Administrative Procedures and Responsibilities

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Section 6: Supplemental Direct Contracting HMO Administrative Procedures and Responsibilities

Table of Contents

Section 6: Supplemental Direct Contracting HMO Administrative Procedures and Responsibilities

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Section 6: Supplemental Direct Contracting HMO Administrative Procedures and Responsibilities

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 Medicare Advantage plan 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 Solutions 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.

Section 6: Supplemental Direct Contracting HMO Administrative Procedures and Responsibilities

HMO Practitioner Responsibilities

Role of the Primary Care Provider (PCP)

For the HMO plan, the primary care provider (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 provider 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. Referrals to specialists not listed in the Blue Shield HMO provider directory require prior authorization.

> *Note: Blue Shield HMO Provider Directories may be obtained 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 providers meet appropriate office site quality standards. Upon receipt of one or more member complaints, Blue Shield may conduct site visits to review the quality of the office(s) where patient care is provided. Blue Shield staff, or a Blue Shield-contracted vendor may perform these office site evaluations. Areas covered in the evaluation may include but are not limited to 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 will be conducted (at least every six months) until deficient offices meet office site quality 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 Provider Change

Commercial HMO members may change their primary care provider 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 Medicare Advantage plan members may change their PCP by calling the Blue Shield Medicare Member Services Department

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.

HMO Member-Related Issues *(cont'd.)*

Provider Requests to Disenroll HMO Members *(cont'd.)*

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 Medicare Advantage plan members, refer to Section 1 of this manual.*

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 Provider Termination Notification Requirements

Blue Shield has established procedures to ensure that our HMO members (Commercial and Medicare) are provided timely written notification in the event that a Blue Shield HMO primary care provider terminates. This policy and procedure is specific to individual PCP terminations only. The following are requirements for Primary Care Provider Termination Notification:

1. Contracting IPA/medical groups 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).
2. Notification to Blue Shield must include the following: termination reason (deceased, retirement from all practice, closed practice site, left IPA, etc)
   Terminating provider identifiers such as name and NPI or California license number
   When applicable, the name and NPI of the receiving PCP may be included for consideration in member reassignment.
3. Blue Shield provides affected members at least 60 calendar days' advance written notice of their primary care provider's termination which aligns with standard accreditation and regulatory requirements. The letter to the member includes notification of the PCP's termination, the termination date, their new PCP and/or IPA/medical group and the procedures for selecting another PCP by calling the Member Services toll free number.
4. In very limited circumstances the IPA/medical group may be unable to provide the required advance notice of a primary care physician termination,
   In these circumstances, the IPA/Medical group must work with the assigned Provider Relations Representative contact to facilitate the expedited transfer of impacted members to a new PCP
   In such cases where the IPA/medical group is not the source of a PCP termination, Blue Shield will notify and reassign members as outlined in section **Termination of Providers.**

Provider Status Changes *(cont'd.)*

Primary Care Provider Termination Notification Requirements *(cont'd.)*

The limited circumstances or exceptions referenced above include:

- Death
- Status change of medical license, or Medicare sanction and debarment, or any other sanction status which results in administrative termination due to the practitioner being ineligible to render care.
- A determination by Blue Shield's Credentialing or Legal Departments after an investigation of "Grossly unprofessional conduct", which includes any criminal or fraudulent acts (e.g., allegations of molestation or abuse).
- Relocation of practice out of the area without adequate notice.
- Practice closure without adequate notice.
- The physician is an employee of a medical group and resigns or is terminated effective immediately.

5. If an IPA/medical group is unable to provide Blue Shield with the required 90-day notice of a primary care provider termination due to one of the limited circumstances listed in number above, Blue Shield will automatically assign a PCP, IPA/medical group, and effective date for 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 Medicare Advantage plan members.

6. In instances when a Medicare primary care provider 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.

Provider Status Changes *(cont'd.)*

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.

Section 6: Supplemental Direct Contracting HMO Administrative Procedures and Responsibilities

HMO Claims Submission and Processing

Physicians (primary care providers 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-E.

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 provider 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+ *Specialist*℠ 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 copayment has been collected.

Blue Shield of California
Capitated Services Team
P.O. Box 629012
El Dorado Hills CA 95762-9012

Table of Contents

Appendix for Section 1

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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.

ASP
ASP refers to the Average Sales Price is a market based price that reflects the weighted average of all manufacturer sales prices that includes all manner of discounts. The ASP is issued by CMS quarterly based on the information submitted by the manufacturer and is a reference point to estimate acquisition costs.

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.

AWP
AWP refers to the Average Wholesale Price of pharmaceuticals dispensed per NDC Code as set forth in a nationally recognized pricing source such as First Data Bank and its supplements or other such sources, as determined by Blue Shield.

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.

Benefits
Covered health care services pursuant to the terms of the member's health services contract.

Benefit Period (Blue Shield Medicare Advantage Plan)
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.

Glossary

Biosimilar
A Federal Drug Administration (FDA) approved biological product that is highly similar in structure and function to an existing biologic. Biosimilars have been tested to demonstrate no clinically meaningful differences in safety and efficacy from the original product.

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 out-of-state Blue plans.

BlueCard National Doctor and Hospital Finder
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 Medicare Advantage Plans
Blue Shield's Medicare Advantage plans; Blue Shield 65 Plus (HMO), Blue Shield Plus Choice Plan (HMO), Blue Shield Trio Medicare (HMO), Blue Shield Inspire (HMO), Blue Shield Vital (HMO) and Blue Shield Medicare (PPO). The terms "Medicare Advantage" and "MA-PD" may be used interchangeably throughout this manual.

Blue Shield Medicare Advantage Plan Member
An individual who meets all of the applicable eligibility requirements for membership, has voluntarily elected to enroll in Blue Shield Medicare Advantage HMO or PPO plan, has paid any premiums required for initial enrollment to be valid, and whose enrollment in Blue Shield Medicare Advantage HMO or PPO plan has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Blue Shield Medicare Advantage HMO Plan 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 Medicare Advantage HMO plan 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.

Glossary

Blue Web
Blue Cross and Blue Shield Association's website at blueweb.bcbs.com which contains useful information for providers.

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.

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 members' *Summary of Benefits*.

Coinsurance (Blue Shield Medicare Advantage HMO and PPO Plans)
The percentage of the Blue Shield Medicare Advantage HMO and PPO plans 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 Medicare Advantage HMO and PPO Plans)
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 members' *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 to 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 are defined as:

1. A subscriber's legally married spouse who is:
    a. Not covered for benefits as a subscriber; and
    b. Not legally separated from the subscriber; or,
2. A subscriber's domestic partner who is not covered for benefits as a subscriber; or,
3. A child of, adopted by, or in legal guardianship of the subscriber, spouse, or domestic partner. This category includes any stepchild or 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, who is not covered for benefits as a subscriber, is less than 26 years of age, has been enrolled and accepted by Blue Shield of California as a dependent, and has maintained membership in accordance with the contract.

Dependent (Commercial Only) *(cont'd.)*

Note: Children of dependent children (i.e., grandchildren of the subscriber, spouse, or domestic partner) are not dependents 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, benefits for such dependent 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 submits 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
   c. Thereafter, certification of continuing disability and dependency from a physician is submitted to Blue Shield on the following schedule:
      i. Within 24 months after the month when the dependent would otherwise have been terminated; and
      ii. Annually thereafter on the same month when certification was made in accordance with item 4 (a) above. In no event will coverage be continued beyond the date when the dependent child becomes ineligible for coverage under this plan for any reason other than attained age.
5. AB 570 requires an individual health plan/policy that provides dependent coverage to make dependent coverage available to a parent or stepparent who meets the definition of a qualifying relative under Section 152(d) of Title 26 of the United States Code and who lives or resides within the health care service plan's service area.
   a. The bill redefines "dependent" under both the Health and Safety Code and the Insurance Code to include the "parent or stepparent" of an individual, subject to applicable terms of the health benefit plan.
   b. Under Section 152(d) of Title 26 of the United States Code, the term "qualifying relative" means, with respect to any taxpayer for any taxable year, an individual:
      i. who bears a relationship to the taxpayer described in the statute, including parent or stepparent,
      ii. whose gross income for the calendar year in which such taxable year begins is less than the exemption amount (as defined in 26 USC Section 151(d), currently listed as $2000),
      iii. with respect to whom the taxpayer provides over one-half of the individual's support for the calendar year in which such taxable year begins, and
      iv. who is not a qualifying child of such taxpayer or of any other taxpayer for any taxable year beginning in the calendar year in which such taxable year begins.

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 www.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 predominantly 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 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 Medicare Advantage HMO and PPO Plans)
For Blue Shield Medicare Advantage plan members, CMS has contracted with a national independent review body, MAXIMUS Federal Services, Inc. MAXIMUS Federal Services, Inc. is an independent CMS contractor that review appeals by members of Medicare managed care plans, including Blue Shield Medicare Advantage plan.

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.

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 Medicare Advantage plan, this is also known as traditional or original Medicare.

FEP
The Federal Employee Program.

Formulary
A continually updated list of prescription medications that are approved by the Food and Drug Administration (FDA) and are selected based on safety, effectiveness, and cost for coverage 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, is 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, medically 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 a CMS-approved accreditation agency, 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.

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. A demonstrated condition recognized by a licensed physician and surgeon as a cause for infertility; or
2. The inability to conceive a pregnancy or to carry a pregnancy to a live birth after a year of regular sexual relations without contraception.

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 Medicare Advantage plan only).

Maximum Enrollee Out-of-Pocket Costs (Blue Shield Medicare Advantage HMO and PPO Plans)

For Blue Shield Medicare Advantage plan 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 Medicare Advantage plan 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.

MAXIMUS Federal Services, Inc. (Blue Shield Medicare Advantage HMO and PPO Plans)

An independent Centers for Medicare & Medicaid Services (CMS) contractor that review appeals by members of Medicare managed care plans, including Blue Shield Medicare Advantage plan.

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).

Medical Necessity

See Section 3.

Medicare Advantage Organization (MAO)

A public or private entity that contracts with CMS to offer a Medicare Advantage plan. Blue Shield of California is a MAO that offers Blue Shield Medicare Advantage HMO and PPO plans.

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, and medical supplies directly associated with delivering insulin to the body, including syringes, needles, alcohol swabs, gauze, and insulin injection delivery devices not otherwise covered under Medicare Part B 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. This includes injectable drugs that are not usually self-administered. CMS' understanding that the practice of "brown-bagging" drugs is opposed by medical societies. CMS continues to urge providers to reinforce this message to their members. In essence, if the injection is administered to the member or dispensed within the four walls of a provider's office or facility, it is a Part B medication. In addition, member's share of cost for these types of medications are usually higher under Part D due to the tiering structure of the plan and are not eligible for tier exceptions. 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 does not 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.

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 Drug Code (NDC)
The National Drug Code (NDC) is a universal number that identifies a drug or a related drug item. The NDC number consists of 11 digits with hyphens separating the number into three segments in a 5-4-2-digit format.

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 which 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, which provides medical and/or surgical services on an outpatient basis.

Part B Premium (Blue Shield Medicare Advantage HMO and PPO Plans)
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 Medicare Advantage plans 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 Medicare Advantage plan.

Part D Premium (Blue Shield Medicare Advantage HMO and PPO Plans)
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 and substance use disorder 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.

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.

Place of Care
The options for the physical location in which a medication can be administered. Places of care include the physician's office, outpatient facility, ambulatory infusion center or home health/home infusion.

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 use disorder 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
Blue Shield's provider website at www.blueshieldca.com/provider.

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.

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.

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.

Reasonable Layperson
A non-medically trained individual using reasonable judgement under the circumstances. For emergency services, coverage is provided when a member would believe that an emergency situation exists.

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, which 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 and Substance Use Disorder 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 Medicare Advantage HMO and PPO plans)
The geographic area in which a person must permanently reside in to be able to become or remain a member of a Blue Shield Medicare Advantage plan. Blue Shield Medicare Advantage plans have 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.

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Blue Shield Combined Eligibility/Capitation Report

COMMERCIAL

FIELD NAME	NOTES	FIELD LENGTH
CapitatedEntity		12
CapitatedEntityEffDate		10
CapitatedEntityCancelDate		10
ActivityType	A, T, R, C, blank	9
MemberLastName		35
MemberFirstName		15
MemberMiddleInitial		1
MemberCertNumberCurrent	Sub ID + SFX	14
MemberCertNumberPrevious		14
MemberRelationship	E, S, D	1
MemberAddressLine1		40
MemberAddressLine2		20
MemberAddressLine3		20
MemberCity		20
MemberState		2
MemberZipCode		10
MemberPhoneNumber		20
MemberGender		1
MemberAge		3
MemberDateOfBirth		10
MemberLanguagePref		4
SubscriberSsn		9
PCPID		12
NPIforPCP		10
PCPName		55
PCPEffDate		10
PCPCxlDate		10
GroupID		8
GroupName		50
GroupType		10
GroupEffDate		10
GroupRenewalDate		10
ProductID		8
ProductIdDescription		115
ProductIdEffDate		10
PlanID		8
PlanName		70
NetworkId		12
AlphaPrefix		4
ClassId		4

Blue Shield Combined Eligibility/Capitation Report

FIELD NAME	NOTES	FIELD LENGTH
LineOfBusinessId		4
LineOfBusinessDescription		50
CostAccountingCategory		3
OfficeVisitCopayAmount		3
IndivDeductibleAmount		7
FamilyDeductibleAmount		7
CobFlag		1
CobOrder		1
CobEffDate		10
CobTermDate		10
CobOtherCovId		9
CobOtherCovDescription		50
EarnedDate		10
CapitationAmount		11
AdminFeeAmount		11
OtherPayAmount		11
MemberMonths		11
ReasonCode		4
GroupCapConvertDate		10
SubConvertDate		10
SrcSysId	FACETS	10
Grace Period Start Date		10
Grace Period End Date		10
Grace Period Suspended Date		10
Anticipated End Date if no payment		10

Blue Shield Combined Eligibility/Capitation Report

MEDICARE

Field Number	FieldName	FiedDesc	Format (if applicable)	Max Length	Data Type	Prior Field Name (If applicable)	Notes
1	CapitatedEntity	BSC Facets IPA number		12	Text	IPA_Code	Medicare Site IDs are now identical to the equivalent 12 character commercial IDs
2	CapitatedEntityEffDate	Member effective date with IPA	YYYY-MM-DD	10	Date	IPA_Eff_Date	
3	CapitatedEntityCancelDate	Member cancel date with IPA	YYYY-MM-DD	10	Date	IPA_Cancel_Date	
4	ActivityType	A, R, C, T, Blank		2	Text	Activity	Medical Group **R** = Member added then terminated from the IPA Medical Group for the purpose of paying retro capitation **C** = Change in assigned PCP, no change to assigned IPA **T** = Member terminated from the IPA Medical Group **Blank** = Member continues eligibility with no changes
5	MemberLastName	Member last name		35	Text	Last_Name	
6	MemberFirstName	Member first name		15	Text	First_Name	
7	MemberMiddleInitial	Member middle initial		1	Text		
8	MemberCertNumberCurrent	BSC member ID	NNNNNNNNN-NNN	13	Text	Member_No	Same format as commercial ID
9	MemberCertNumberPrevious	Previous BSC member ID		14	Text	Prior_Mbr#	Legacy system ID (if available)
10	MemberAddressLine1	Member address		40	Text	Street_Address	
11	MemberAddressLine2	Member address		40	Text		
12	MemberAddressLine3	Member address		40	Text		
13	MemberCity	Member city		20	Text	City	
14	MemberState	Member state		2	Text	State	
15	MemberZIPCode	Member ZIP		5	Text	ZipCode	
16	MemberPhoneNumber	Member phone number		20	Text	Phone_No	
17	MemberGender	Member gender		1	Text	Sex	
18	MemberAge	Member age	0	3	Number	Age	
19	MemberDateOfBirth	Member date of birth	YYYY-MM-DD	10	Date	DOB	
20	MemberLanguagePref	Member language (ie EN, SP)		4	Text	e	
21	HICN	Medicare (CMS) Health Insurance Number (HICN)		12	Text		CMS HICN number
22	PcpID			12	Text	PCP_No	Same format as commercial PCP ID, for capitated hospital, this field contains the IPA number, not PCP
23	NPIforPCP			10	Text	NPI	
24	PcpName			55	Text	PCP_Name	Name, for capitated hospital, this field contains the IPA name, not PCP
25	PcpEffDt		YYYY-MM-DD	10	Date	PCP_Eff_Date	

Blue Shield Combined Eligibility/Capitation Report

Field Number	FieldName	FiedDesc	Format (if applicable)	Max Length	Data Type	Prior Field Name (If applicable)	Notes
25	PcpEffDt		YYYY-MM-DD	10	Date	PCP_Eff_Date	
26	PcpCxlDt		YYYY-MM-DD	10	Date	PCP_Cancel_Date	
27	GroupID			8	Text	Group_ID	GroupID for IMAPD, GroupID for GMAPD will be the same as the commercial Facets ID (if any).
28	GroupName			50	Text		Employer group name
29	ProductID			8	Text	Current_Coverage_Code	ProductID varies by county for IMAPD and by employer group for Group Medicare.
30	ProductIDDescription			115	Text	Current_Coverage_Desc	Text field describes product IMAPD or GMAPD
31	ProductIDEffDate		YYYY-MM-DD	10	Date	ff	
32	PlanID			8	Text		
33	PlanName			70	Text		
34	NetworkID	MGMAPD000001 - Group Medicare Advantage MIMAPD000001 - Blue Shield 65 Plus MIMAPD000002 - Blue Shield 65 Plus Choice		12	Text		12 character network ID identifies Group, Individual, or Choice Medicare
35	OfficeVisitCopayAmount		0	3	Number	Office_Copay_Amt	
36	MedicaidStatus	or N		1	Text	Medicaid_Status	
37	CobFlag	Indicates other coverage Y or N		1	Text		
38	CobOtherCoverageDescription			50	Text	Other_Coverage_ID	CIGNA, BLUE CROSS etc. if available)
39	EarnedDate		YYYY-MM-DD	10	Date	SVC_Month	paid
40	CapitationAmount		0.00	18	Currency	Capitation_Amount	Core capitation payment
41	AdminFeeAmount		0.00	18	Currency	Admin_Amount	Admin fee (if any)
42	OtherPayAmount		0.00	18	Currency	Other_Cap_Amount	Medicare Advantage premium (if any).
43	ReasonCode	One adjustment code i.e. 42 Two adjustment codes i.e. 10, 08		10	Text		All HCFA 2 digit adjustment reason codes that occur in a given payment month
44	RiskScore	CMS risk score i.e. 1.089	NN.DDDD	7	Number	Risk_Scores	
45	CountyCode	CMS county code i.e. 200	NNN	3	Text	County_Code	
46	StateCode	CMS state code i.e. 05	NN	2	Text	State_Code	
47	MedicaidAddOn	Y or N		1	Text	Medicaid_Add-On	used in calculating the risk score, i.e., at least a one month period of Medicaid eligibility during the data collection period was established in CMS systems at the time that risk scores were calculated.
48	HealthStatus	i.e. E would indicate ESRD, H for Hospice		10	Text	Health_Status	
49	ExceptionCode	T or blank		1	Text	Exception_Code	capitation if HCFA risk, health status or Demo code unavailable or in dispute)
50	MemberMonthCount	1, or -1		2	Number	Member_Month_Counter	Indicates 1, -1 for events equating to a full member month being added or backed out.

Blue Shield HMO Eligibility Adds and Terminations Report

FIELD NAME	NOTES	FIELD LENGTH
CapitatedEntity		12
CapitatedEntityEffDate		10
CapitatedEntityCancelDate		10
ActivityType	A, T, R, C, blank	9
MemberLastName		35
MemberFirstName		15
MemberMiddleInitial		1
MemberCertNumberCurrent	Sub ID + SFX	14
MemberCertNumberPrevious		14
MemberRelationship	E, S, D	1
MemberAddressLine1		40
MemberAddressLine2		20
MemberAddressLine3		20
MemberCity		20
MemberState		2
MemberZipCode		10
MemberPhoneNumber		20
MemberGender		1
MemberAge		3
MemberDateOfBirth		10
MemberLanguagePref		4
SubscriberSsn		9
PCPID		12
NPIforPCP		10
PCPName		55
PCPEffDate		10
PCPCxlDate		10
GroupID		8
GroupName		50
GroupType		10
GroupEffDate		10
GroupRenewalDate		10
ProductID		8
ProductIdDescription		70
ProductIdEffDate		10
PlanID		8

Blue Shield HMO Eligibility Adds and Terminations Report

FIELD NAME	NOTES	FIELD LENGTH
PlanName		70
NetworkId		12
RiderCode	may not be available	
ClassId		4
LineOfBusinessId		4
LineOfBusinessDescription		50
CostAccountingCategory		3
OfficeVisitCopayAmount		3
IndivDeductibleAmount		7
FamilyDeductibleAmount		7
CobFlag		1
CobOrder	P/S different than Legacy	1
CobEffDate		10
CobTermDate		10
CobOtherCovId		9
CobOtherCovDescription		50
GroupCapConvertDate		10
SubConvertDate		10
SrcSysId	FACETS	10

Table of Contents

Appendix For Section 2

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CALIFORNIA PHYSICIANS' SERVICE

Blue Shield of California

bylaws

revised May 2, 2023

TABLE OF CONTENTS

BYLAWS

CALIFORNIA PHYSICIANS' SERVICE

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 corporations, 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. At least two Directors shall be physicians.

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; provided however, that if the Board determines extenuating circumstances exist such that extending the service of a retiring Director is in the best interest of the corporation, the Board may elect a Director to an additional single term of not more than three years. Except as otherwise provided in this Chapter 5, Section 2, a Director who has served 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 (including voice message), facsimile, electronic mail, or as otherwise in accordance with Section 307 of the California Corporations Code.

(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. The foregoing maximum may be extended by resolution of the Board. 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. The foregoing maximum may be extended by resolution of the Board.

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.

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.

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[1] (Formerly Chapter I, Section 5.)

[2] (Formerly Chapter XI, Section 8.)

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 may at any time be established by the Board at any place or places where the corporation is qualified to do business.

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 event

Date: ____/____/____ **Recommended program** (Click link to access vendor referral email below):

☒ Palliative Care ☐ Heal ☐ Partners In Care Foundation (PICF) ☐ Personal Care Services

Referral information

Referral Title: ☐ CM Nurse ☐ UM Nurse ☐ Other: _____

First name	Last name	MI
Phone number	Contact Name (if different from Referring Person)	Email (of referring contact)

Member information

Last name	First name	MI	Gender ☐ M ☐ F
Date of birth (mm/dd/yyyy)____/____/____ Age		Member ID	CAC#
Street address		City	
County		State	Zip Code
Home phone		Cell phone	
Service facility (if applicable)		Bus Phone	

Member consent (if applicable): ☐ Yes ☐ No	**Preferred language:** ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Other: **English fluency:** Member: ☐ High ☐ Medium ☐ Low ☐ No fluency Caregiver/family member: ☐ High ☐ Medium ☐ Low ☐ No fluency	Power of Attorney? (POA) ☐ Yes ☐ No

Care Giver / Alternate contact information (If no Caregiver, enter "None"; if POA is **Yes**, enter Medical Decision Maker info)

Name	Relationship
Cell phone number	Preferred phone number

Primary Care Physician information

Name			NPI
Street address			City
State	Zip Code	Bus Phone	Fax number

BSC requesting (Check the appropriate box that applies to ANY home care referral)

☐ **1) Home Visit (Indicate Vendor Program Above)**
- ☐ Post-Discharge (All LOBs)
- ☐ All Other (All LOBs)

☐ **2) Evidence-Based Self-Management Program**

☐ **3) Onsite Facility Visit (In-patient at the facilities listed below)**
- ☐ UCLA Ronald Reagan
- ☐ UCLA Santa Monica
- ☐ Other

Expected Discharge Date: _____

Room #: _____

Blue Shield Concurrent Review RN

Name: _____

Phone: _____

Email: _____

☐ **4) Palliative Care/Other (Vendor Name):** _____

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 to 9 medications
- ☐ Radiation / chemotherapy / immunotherapy
- ☐ Cognitive impairment (Dependent Question below)

Level of Impairment: ☐ Mild, ☐ Moderate, ☐ Severe

- ☐ > 2 psychosocial needs ☐ Home safety
- ☐ Extensive DME needs

Greatest Need (Brief Synopsis of Request)

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National Consensus Project (NCP) Clinical Practice Guidelines for Quality Palliative Care

Domain 1: Structure and Processes of Care

Guideline 1.2 Criteria

1. An initial comprehensive assessment is completed as soon after the referral as is reasonably possible.
2. Each member of the IDT contributes to a comprehensive assessment as soon as reasonably possible, depending on the urgency of patient needs.
3. The initial assessment includes conversations with the patient, family caregivers, clinicians and others according to the patient's preferences.
4. The initial assessment is conducted in person by one or more IDT members, depending on the needs and concerns of the patient, is documented, and includes:
    a. Patient and family understanding of the serious illness, goals of care, treatment preferences, and a review of signed advance directives, if available.
    b. A determination of decision-making capacity or identification of the person with legal decision-making authority.
    c. A physical examination including identification of current symptoms and functional status.
    d. A thorough review of medical records and relevant laboratory and diagnostic test results.
    e. A review of the medical history, therapies, recommended treatments, and prognosis.
    f. The identification of comorbid medical, cognitive and psychiatric disorders.
    g. A medication reconciliation, including over-the-counter medications.
    h. Social determinants of health, including financial vulnerability, housing, nutrition and safety.
    i. Social and cultural factors and caregiving support, including caregiver willingness and capacity to meet patient needs.
    j. Patient and family emotional and spiritual concerns, including previous exposure to trauma.

National Consensus Project (NCP) Clinical Practice Guidelines for Quality Palliative Care *(cont'd.)*

Domain 1: Structure and Processes of Care *(cont'd.)*

Guideline 1.2 Criteria *(cont'd.)*

k. The ability of the patient, family and care providers to communicate with one another effectively, including considerations of language, literacy, hearing, and cultural norms.

l. Patient and family needs related to anticipatory grief, loss, and bereavement, including assessment of family risk for prolonged grief disorder.

5. The team identifies and documents if the adult patient or a family member served in the military and whether the patient or family member may be eligible for VA benefits.

6. For pediatric patients, the team ascertains the developmental status and children or teens' understanding of their disease, as well as parental preferences for their child's care at the time of initial consultation. This is revisited throughout the trajectory of care.

7. The IDT performs subsequent assessments at regularly defined intervals and whenever the patient's status significantly changes, new problems are identified, or the patient experiences a transition in health care setting or provider.

To view Domains 3-8, visit the National Coalition for Hospice and Palliative Care's National Consensus Project page.

Palliative care services screening criteria for program participation

Member information			
Member name		Member ID#	
Date of birth		Evaluation date	
Referring party information			
Provider name		Organization name	
Address			
City		State	ZIP code
Phone number		Email	

For a plan member to be considered for participation in the Home-Based Palliative Care Program, the plan member must meet the following palliative care eligibility screening requirements.

Section 1:	Eligibility criteria for all members
1.a. General eligibility criteria The member must meet all of the general eligibility criteria. (If the member is younger than 21 years old, also see Section 2 for broader pediatric eligibility criteria.)	☐ Is likely to, or has started to, use the hospital or emergency department as a means to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures. ☐ Has an advanced illness, as defined in Section 1.b below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment. ☐ Death within a year would not be unexpected based on clinical status. ☐ Has received appropriate patient-desired medical therapy **OR** is a member for whom patient-desired medical therapy is no longer effective. The member is **NOT** in reversible acute decompensation. ☐ The member and, if applicable, the family/member-designated support person, agrees to: o Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and o Participate in Advance Care Planning discussions.
1.b. Disease-specific eligibility criteria The member must meet at least one of the four disease-specific eligibility criteria. (If the member is younger than 21 years old, also see Section 2 for broader pediatric eligibility criteria.)	☐ **Congestive heart failure (CHF): Must meet (a) AND (b)** a. The member is hospitalized due to CHF as the primary diagnosis with no further invasive interventions planned **OR** meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher. b. The member has an ejection fraction of less than 30% for systolic failure **OR** significant co-morbidities. ☐ **Chronic obstructive pulmonary disease (COPD): Must meet (a) OR (b)** a. The member has a forced expiratory volume (FEV) of 1 less than 35% of predicted **AND** a 24-hour oxygen requirement of less than 3 liters per minute. b. The member has a 24-hour oxygen requirement of greater than or equal to 3 liters per minute. ☐ **Advanced cancer: Must meet (a) AND (b)** a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia. b. The member has a Karnofsky Performance Scale score less than or equal to 70% **OR** has failure of two lines of standard of care therapy (chemotherapy or radiation therapy).

Palliative Care Patient Eligibility Screening Tool

1.b. Disease-specific eligibility criteria (cont'd)	☐ **Liver disease: Must meet (a) AND (b) combined or (c) alone** a. The member has evidence of irreversible liver damage, serum albumin less than 3.0, an international normalized ratio (INR) greater than 1.3. b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices. c. The member has evidence of irreversible liver damage and has a Model for End-Stage Liver Disease (MELD) score of greater than 19. ☐ **Cerebral vascular accident/stroke:** a. Inability to take oral nutrition, change in mental status, history of aspiration or aspiration pneumonia. ☐ **Chronic kidney disease (CKD) or end-stage renal disease (ESRD).** ☐ **Severe dementia or Alzheimer's disease.** ☐ **Other (fill in):** _____

If the member does not meet the above eligibility requirements and is younger than 21 years old, proceed to Section 2.

Section 2:	**Pediatric palliative care eligibility criteria**
2.a. General eligibility criteria The member must meet all the general eligibility criteria.	☐ The member is under the age of 21. ☐ The family and/or legal guardian agrees to the provision of pediatric palliative care services.
2.b. Disease-specific eligibility criteria: The member must meet at least one of the four life-threatening diagnosis criteria.	☐ Conditions for which curative treatment is possible, but may fail (e.g., advanced or progressive cancer or complex and severe congenital or acquired heart disease). ☐ Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy). ☐ Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta). ☐ Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms).
Servicing provider	**Home-Based Palliative Care Program status**
Indicate member program status:	☐ Member is enrolled in the program. *(Enter enrollment date):* _____ ☐ Member did not agree to enroll in the program. ☐ Member did not qualify for enrollment in the program. ☐ Member enrolled in hospice.
PCP/Specialist	

☐ I am referring the member to Blue Shield of California for a full Palliative Care Service Evaluation.

blue california

Palliative Care Services
Recertification Tool

Member Information	
Member Name:	Member ID #:
Date of Birth:	Date of Enrollment:
Provider :	Current Recertification Date:
Provider Signature:	Next Recertification Date:

Guidelines

The Recertification form must be completed by MD, NP, or PA involved in the member's care. The member's recertification for BSC's Palliative Care Program is required every six months upon admission to the program. The form should be submitted up to 15 days before the end of the six-month enrollment period or no later than 2 business days after the start of the next enrollment period. The form shall be sent to bscpalliativecare@blueshieldca.com for review.

Failure to comply with this requirement may result in corrective action, up to and including contract termination.

Please complete all sections below

Section 1:	Eligibility Criteria for All Members
1.a. General Eligibility Criteria The member must meet all the general eligibility criteria.	☐ Is likely to, or has started to, use the hospital or emergency department to manage the member's advanced disease; this refers to unanticipated decompensation and does not include elective procedures. ☐ Has an advanced illness, as defined in Section 1.b below, with appropriate documentation of continued decline in health status, and is not eligible for or declines hospice enrollment. ☐ Death within a year would not be unexpected based on clinical status. ☐ Has received appropriate patient-desired medical therapy or is a member for whom patient-desired medical therapy is no longer effective. The member is NOT in reversible acute decomposition. ☐ The member and, if applicable, the family/member-designated support person, agrees to: o Attempt, as medically/clinically appropriate, in-home, residential-based, or outpatient disease management/palliative care instead of first going to the emergency department; and o Participate in Advance Care Planning discussions.
1.b. Disease-Specific Eligibility Criteria: The member must meet at least one of the four disease-specific eligibility criteria.	☐ **Congestive heart failure (CHF): Must meet (a) AND (b)** a. Meets criteria for the New York Heart Association's (NYHA) heart failure classification III or higher. b. The member has an ejection fraction of less than 30 percent for systolic failure OR significant co-morbidities. ☐ **Chronic obstructive pulmonary disease (COPD): Must meet (a) OR (b)** a. The member has a forced expiratory volume (FEV) of 1 less than 35 percent of predicted AND a 24-hour oxygen requirement of less than three liters per minute. b. The member has a 24-hour oxygen requirement of greater than or equal to three (3) liters per minute.

	☐ Advanced cancer: Must meet (a) AND (b) a. The member has a stage III or IV solid organ cancer, lymphoma, or leukemia. b. The member has a Karnofsky Performance Scale score less than or equal to 70 percent OR has failure of two lines of standard of care therapy (chemotherapy or radiation therapy). ☐ Liver disease: Must meet (a) AND (b) combined or (c) alone a. The member has evidence of irreversible liver damage, serum albumin less than 3.0, an international normalized ratio (INR) greater than 1.3. b. The member has ascites, subacute bacterial peritonitis, hepatic encephalopathy, hepatorenal syndrome, or recurrent esophageal varices. c. The member has evidence of irreversible liver damage and has a Model for End-Stage Liver Disease (MELD) score of greater than 19. ☐ Cerebral Vascular Accident/stroke: a. Inability to take oral nutrition, change in mental status, history of aspiration or aspiration pneumonia. ☐ Chronic Kidney Disease (CKD) or End Stage Renal Disease (ESRD). ☐ Severe Dementia or Alzheimer's Disease. ☐ Other (Fill in):_____
2. Please provide a brief narrative	Please provide information that describes findings that support continued enrollment into the program; please include the following in the narrative, update on medical, psychosocial, spiritual needs; the member's acuity; frequency of visits and how the member is still benefiting from the program.

Please provide a brief narrative that describes findings that support continued enrollment into the program.

Section 2	Brief Narrative

There is no appendix for Section 3.

Appendix for Section 3

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Table of Contents

Appendix For Section 4

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If you have questions about electronic claim submission, please call the Electronic Data Interchange (EDI) Help Desk at (800) 480-1221. You may also visit Provider Connection at blueshieldca.com/provider and click on the *Claims* section under *Enroll in Electronic Data Interchange*.

Special Guidelines for the CMS 1500 Claim Form

The following instructions apply to the related "field" of the electronic claim record. Refer to Appendix 4-D for comprehensive instructions for completing the CMS 1500 claim form.

Block 1 - 8 – Patient Information

1a. Insured's ID number.

Consult the system documentation provided by your software vendor to ensure your system can accept and transmit the three-letter alpha-numeric prefix in your electronic claims submissions.

Blocks 9 - 9d – If Blue Shield is the Secondary Payor

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.

Block 17 – 17b - Referring or Ordering Physician

17. Name of Referring or Ordering Physician or Other Source

Electronic claim record of Referring Physician:

- Last Name Field (Claim Header Record) -Enter "Self-referral"
- First Name Field (Claim Header Record) -Leave Blank

Guidelines for Successful OCR Processing

Follow the guidelines below to assure successful Optical Character Recognition (OCR) 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 OCR 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 OCR but will be reviewed by a claim's 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.

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 National Drug Code (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's 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.

Additional Claims Submission Pointers *(cont'd.)*

- 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.

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 with any questions.

Page Number	Loop ID	Reference	Name	Codes	Notes/Comments
170	2300	CLM	Claim Information		
172	2300	CLM05	Health Care Service Location Indicator (Place of Service)	41 - land 42 - water	Use for 'type of transport.'
227	2300	REF	Prior Authorization or Referral Number		
227	2300	REF01	Reference Identification Qualifier	G1	Prior authorization qualifier
	2300	REF02	Prior Authorization or Referral Number		911 plus any free form comments/ information up to 26 characters
246	2300	NTE02	Description		Report location to which patient was transported. Include facility name, city, and zip code.
247	2300	NTE01	Note Reference Code	ADD	Use in conjunction with NTE02 to identify the purpose of the notes in NTE02
248	2300	CR	Ambulance Transport Information		
249	2300	CR103	Ambulance Transport Code	I, R, T, X	Use for 'transport information.' All values are accepted.
250	2300	CR106	Quantity		Use to report transport distance.
250	2300	CR109	Description		Free format field. Use to clarify the purpose for the round-trip service.
250	2300	CR110	Description		Free format field. Use to clarify details regarding use of a stretcher during service.
303	2310D	NM1	Service facility location		
304	2310D	NM101	Entity identifier code	77	Service location. Qualifies patient pick-up location.
304	2310D	NM102	Entity Type qualifier	2	Non-person entity qualifier

Page Number	Loop ID	Reference	Name	Codes	Notes/Comments
304	2310D	NM103	Organization name		Name of location where patient was picked-up, e.g., RESIDENCE (up to 35 characters).
307	2310D	N3	Service facility location address		
307	2310D	N301	Address Information		Address of location where patient was picked up
308	2310D	N4	Service facility location city/state/zip code		
308	2310D	N401	City		City in which patient was picked up
309	2310D	N402	State		State in which patient was picked up
309	2310D	N403	Zip Code		Zip code of location where patient was picked up
400	2400	SV1	Professional Service		
404	2400	SV105	Place of Service		Line level place of service value
412	2400	CR1	Ambulance Transport Information		
412	2400	CR1	Ambulance Certification		Line level ambulance information (see page 248-Loop 2300 CR103, CR104, CR106, CR109, and CR110).
488	2400	NTE	Line Note		
488	2400	NTE01	Note Reference Code	ADD	Use in conjunction with NTE02 to identify the purpose of the notes in NTE02.
488	2400	NTE02			Free format field. Use for any additional comments.

Drug Requirements - 837 Professional Claims

Home infusion services and office administered 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.

For billing purposes, drugs must be submitted with a HCPCS code and NDC. NDCs contain 11 digits in a fixed 5-4-2 configuration. The NDC found on the outer package must be submitted. DO NOT submit NDC found on individual vials or doses. If the NDC on a product does not contain 11 digits, leading zeros should be added to fill in the missing number(s) to maintain the 5-4-2 format.

Example for billing purposes when the NDC has less than 11 digits should be used:

- NDC On Product: 345-1234-2 (NDC has only 8 digits, but 11 digits are required)
- NDC For Billing: **00**345-1234-02 (Leading zeros are added to conform with the 5-4-2 configuration)

Please use the following guidelines:

- Report the appropriate HCPCS 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.

Page Number	Loop ID	Reference	Name	Codes	Notes/Comments
400	2400	SV101-1	Product/Service ID qualifier	HC	
400	2400	SV101-2	Product/Service ID	HCPCS	J or Q codes for home, office infusion/drugs
435	2400	DTP01	Service line date qualifier	472	Service line date of service
	2400	DTP03	Date time period	DATE	Date, a time, range of dates
472	2400	REF02	Line Item control number	Provider control number	Providers submit these to assist posting the 835 sent back.
488	2400	NTE01	Note reference code	"ADD"	Only "ADD" is acceptable for these claims.

Page Number	Loop ID	Reference	Name	Codes	Notes/Comments
488	2400	NTE02	Description		Name of drug and any pertinent information – up to 80 bytes
AD 73	2410	LIN02	Product/Service ID qualifier	"N4"	National drug format 5-4-2
AD 74	2410	LIN03	Product/Service ID		National drug code
AD 75	2410	CTP03	Drug unit price		Required only if price is different from how it appears in the SV102. Price per unit of product, service, commodity, etc.
AD 75	2410	CTP04	Quantity		National drug unit count
AD 75	2410	CTP05	Composite unit of measure		Unit or basis of measurement
AD 75	2410	CTP05-1	Unit or basis of measurement code	F2-International Unit GR-Gram ML-Milliliter UN-Unit	Include the appropriate qualifier.
AD 77	2410	REF02	Pharmacy prescription number		Required if the drug has been dispensed with an assigned RX number.

Genetic and Molecular Testing – 837 Professional Claims

A procedure description is required for Unlisted Genetic and Molecular Testing procedure codes with use of the Genetic Testing Unit (GTU). The specific GTU for each procedure code can be identified by accessing Concert Genetics Provider Portal at www.concertgenetics.com/join-blue-shield-california. Providers are required to bill according to the CPT coding established in the Concert Genetics portal.

Page Number	Loop ID	Reference	Name	Codes	Notes/Comments
	2400	SV101-7	Genetic Testing Unit		Insert the exact GTU or the GTU preceded by "GTU-." For example, insert either: • 6V98G • GTU-6V98G

Nurse Practitioner and Physician Assistant

Claims submitted for these services should include the Name and NPI of the Nurse Practitioner or Physician Assistant as the rendering provider (Loop 2310 B) and the Supervising Physician Name and NPI referenced in the 2310D Loop.

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 HCPCS 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).

Page Number	Loop ID	Reference	Name	Codes	Notes/Comments
207	2300	NTE01	Note reference code	"MED"	Medications
207	2300	NTE02	Description		Name of drugs. Use up to 80 bytes and show in order of service lines. Following is an example: (NTE*MED*J9265 PACLITAXEL 30MG J1644 HEPARIN 1000UN J3490 CIMETIDINE 300MG~).
446	2400	SV202-1	Product/Service ID qualifier	"HC"	HCPCS code qualifier
447	2400	SV202-2	Product/service		Service code
456	2400	DTP01	Service line date qualifier	"472"	Service line date of service
456	2400	DTP03	Date time period		Date, a time, or range of dates
AD37	2410	LIN02	Product/service ID qualifier	"N4"	National drug format 5-4-2
AD38	2410	CTP03	Unit price		Required only if the price is different from how it appears in SV102. Price per unit of product, service, commodity, etc.

Page Number	Loop ID	Reference	Name	Codes	Notes/Comments
AD38	2410	CP04	Quantity		National drug unit count
AD38	2410	CTP05	Composite unit of measure		Unit or basis of measurement
AD38	2410	CTP05-1	Unit or basis of measurement code	F2-Int'l Unit GR-Gram ML-Milliliter UN-Unit	Include the appropriate qualifier.
AD77	2410	REF02	Pharmacy prescription number		Required if the drug has been dispensed with an assigned RX number

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/HCPCS codes, please use CPT Category II codes to help your office to meet criteria for HEDIS measures:

Metabolic Monitoring for Children and Adolescents on Antipsychotics	
Test or Biometric Value	**CPT Category II Code**
HbA1c Tests Most recent hemoglobin A1c level <7.0%c	3044F
HbA1c Tests Most recent hemoglobin A1c level ≥ to 7.0% and < 8.0%	3051F
HbA1c Tests Most recent hemoglobin A1c level ≥ to 8.0% and ≤ to 9.0%	3052F
HbA1c Tests Most recent hemoglobin A1c level greater than 9.0%	3046F
LDL-C Tests Most recent LDL-C < 100 mg/dL	3048F
LDL-C Tests Most recent LDL-C 100 - 129 mg/dL	3049F
LDL-C Tests Most recent LDL-C ≥ to 130 mg/dL	3050F

Comprehensive Diabetes Care	
Test or Biometric Value	**CPT Category II Code**
Diabetic Retinal Screening Negative *Low risk for retinopathy (no evidence of retinopathy in the prior year)*	3072F
Diabetic Retinal Screening With Eye Care Professional Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy	2022F
Diabetic Retinal Screening With Eye Care Professional Dilated retinal eye exam with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy	2023F
Diabetic Retinal Screening With Eye Care Professional 7 standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed; with evidence of retinopathy	2024F
Diabetic Retinal Screening With Eye Care Professional 7 standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist documented and reviewed; without evidence of retinopathy	2025F

Diabetic Retinal Screening With Eye Care Professional Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; with evidence of retinopathy	2026F
Diabetic Retinal Screening With Eye Care Professional Eye imaging validated to match diagnosis from 7 standard field stereoscopic retinal photos results documented and reviewed; without evidence of retinopathy	2033F
Diastolic Most recent diastolic blood pressure < 80 mm Hg	3078F
Diastolic Most recent diastolic blood pressure 80 – 89 mm Hg	3079F
Diastolic Most recent diastolic blood pressure ≥ 90 mm Hg	3080F
HbA1c Tests Most recent hemoglobin A1c level <7.0%Diastolic Less Than	3044F
HbA1c Tests Most recent hemoglobin A1c level ≥ to 7.0% and < 8.0%	3051F
HbA1c Tests Most recent hemoglobin A1c level ≥ to 8.0% and ≤ to 9.0%	3052F
HbA1c Tests Most recent hemoglobin A1c level > 9.0%	3046F
Systolic Most recent systolic blood pressure < 130 mm Hg	3074F
Systolic Most recent systolic blood pressure 130 to 139 mm Hg	3075F
Systolic Most recent systolic blood pressure < 140 mm Hg	3076F
Systolic Most recent systolic blood pressure ≥ 140 mm Hg	3077F

Care for Older Adults	
Test or Biometric Value	**CPT Category II Code**
Advance care plan or similar legal document present in the medical record	1157F
Advance care planning discussion documented in the medical record	1158F
Functional status assessed	1170F
Medication list documented in medical record	1159F
Medication Review of all medications by a prescribing practitioner or clinical pharmacist (such as, prescriptions, OTCs, herbal therapies and supplements) documented in the medical record	1160F
Pain Assessment Pain severity quantified; pain present	1125F
Pain Assessment Pain severity quantified; no pain present	1126F

Frequency of Ongoing Prenatal Care	
Test or Biometric Value	**CPT Category II Code**
Stand Alone Prenatal Visits: Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care. Report also date of visit and, in a separate field, the date of the last menstrual period [LMP])	0500F
Stand Alone Prenatal Visits: Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the last menstrual period [LMP] (Note: If reporting 0501F Prenatal flow sheet, it is not necessary to report 0500F Initial prenatal care visit)	0501F
Stand Alone Prenatal Visits Subsequent prenatal care visit	0502F

Medication Reconciliation Post-Discharge	
Test or Biometric Value	**CPT Category II Code**
Medication Reconciliation Discharge medications reconciled with the current medication list in outpatient medical record	1111F
Postpartum Care Visit	0503F

Prenatal and Postpartum Care	
Test or Biometric Value	**CPT Category II Code**
Stand Alone Prenatal Visits: Initial prenatal care visit (report at first prenatal encounter with health care professional providing obstetrical care. Report also date of visit and, in a separate field, the date of the last menstrual period [LMP])	0500F
Stand Alone Prenatal Visits: Prenatal flow sheet documented in medical record by first prenatal visit (documentation includes at minimum blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery). Report also: date of visit and, in a separate field, the date of the last menstrual period [LMP] (Note: If reporting 0501F Prenatal flow sheet, it is not necessary to report 0500F Initial prenatal care visit)	0501F
Stand Alone Prenatal Visits Subsequent prenatal care visit	0502F

Cardiovascular Monitoring for People With Cardiovascular Disease	
Test or Biometric Value	**CPT Category II Code**
LDL-C Tests Most recent LDL-C < 100 mg/dL	3048F
LDL-C Tests Most recent LDL-C 100 - 129 mg/dL	3049F
LDL-C Tests Most recent LDL-C ≥ to 130 mg/dL	3050F

Diabetes Monitoring for People With Diabetes and Schizophrenia	
Test or Biometric Value	**CPT Category II Code**
HbA1c Tests Most recent hemoglobin A1c level <7.0%	3044F
HbA1c Tests Most recent hemoglobin A1c level ≥ to 7.0% and < 8.0%	3051F
HbA1c Tests Most recent hemoglobin A1c level ≥ to 8.0% and ≤ to 9.0%	3052F
HbA1c Tests Most recent hemoglobin A1c level > 9.0%	3046F
LDL-C Tests Most recent LDL-C < 100 mg/dL	3048F
LDL-C Tests Most recent LDL-C 100 - 129 mg/dL	3049F
LDL-C Tests Most recent LDL-C ≥ to 130 mg/dL	3050F

Diabetes Screening for People With Schizophrenia or Bipolar Disorder	
Test or Biometric Value	**CPT Category II Code**
HbA1c Tests Most recent hemoglobin A1c level <7.0%	3044F
HbA1c Tests Most recent hemoglobin A1c level ≥ to 7.0% and < 8.0%	3051F
HbA1c Tests Most recent hemoglobin A1c level ≥ to 8.0% and ≤ to 9.0%	3052F
HbA1c Tests Most recent hemoglobin A1c level > 9.0%	3046F

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 us any approved clearinghouse listed on Provider Connection. Provider 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 Help Desk at (800) 480-1221.

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 EDI,* contact the EDI Help Desk at (800) 480-1221.

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

Improve Security of PHI and Financial Information *(cont'd.)*

- 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 *Manage electronic transactions* or contact the EDI Help Desk at (800) 480-1221.

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 EDI* or contact the EDI Help Desk 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 EDI* or by contacting the EDI Help Desk at (800) 480-1221.

Improve Security of PHI and Financial Information *(cont'd.)*

Electronic Funds Transfer (EFT)

- Get administrative time and cost with direct deposits into specified accounts faster payment and reduce
- 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 EDI,* contact the EDI Help Desk at (800) 480-1221.

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.

Providers needing to schedule ambulance services should go to Provider Connection at blueshieldca.com/provider and click on *Guidelines & resources*, *Patient care resources*, then *Ancillary Provider Rosters* 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 Help Desk at (800) 480-1221.

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~

Special Billing Situations *(cont'd.)*

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 HCPCS 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).

  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~

Special Billing Situations *(cont'd.)*

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 ccyymmdd format)
- The third field is the date range approved (use ccyymmdd 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 Help Desk at (800) 480-1221.

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-digit number BSC Payer Claim Control Number 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 Information Report 277CA v 5010 – Blue Shield validates inbound electronic data interchange (EDI) for HIPAA compliance, advising only of HIPAA level rejections.

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Instructions for Completing a CMS 1500 Form

See a sample of the CMS 1500 Claim Form and additional information on Provider Connection at https://www.blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/claims/policies_guidelines/claim_forms_guidelines.

Block #	Instructions
1	**Insurance Coverage** Indicate the type of health insurance coverage applicable by placing an X in the appropriate box.
1a	**Insured's ID Number** Enter the subscriber's ID number exactly as on their ID card, including the first three alpha-numeric characters.
2	**Patient's Name** Enter the patient's full last name, first name, and middle initial exactly as on their ID card. If the patient uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name.
3	**Patient's Birth Date, Sex** Enter the patient's 8-digit birth date (MM/DD/YYYY). Enter an X in the correct box to indicate sex (gender) of the patient. If sex is unknown, leave blank.
4	**Insured's Name** Enter the insured's full last name, first name, and middle initial. If the insured uses a last name suffix (e.g., Jr, Sr), enter it after the last name and before the first name. Titles (e.g., Sister, Capt., Dr) and professional suffixes (e.g., PhD, MD, Esq) should not be included with the name.
5	**Patient's Address** Enter patient's complete current address including street address, city, state, and zip code.
6	**Patient Relationship to Insured** Enter an X in the correct box to indicate the patient's relationship to insured.
7	**Insured's Address** Enter insured subscriber's complete address including street address, city, state, and zip code.
8	**Reserved for NUCC Use** Leave blank.

9 **Other Insured's Name**
If there is any other insurance company or insured party who may be responsible for any part of this bill, enter the other insured enrollee's full last name, first name and middle initial.

9a **Other Insured's Policy or Group Number**
Enter the policy or group number of the other insured.

9b **Reserved for NUCC Use**
Leave blank.

9c **Reserved for NUCC Use**
Leave blank.

9d **Insurance Plan Name or Program Name**
Enter the other insured's insurance plan or program name.

10a-c **Is Patient's Condition Related To:**
When appropriate, enter an X in the correct box to indicate whether one or more of the services described in Item Number 24 are for a condition or injury that occurred on the job or as a result of an automobile or other accident. Only one box on each line can be marked. The state postal code where the accident occurred must be reported if "YES" is marked in 10b for "Auto Accident." Any item marked "YES" indicates there may be other applicable insurance coverage that would be primary, such as automobile liability insurance.

10d **Claim Codes (Designated by NUCC)**
When applicable, use to report appropriate claim codes. Applicable claim codes are designated by the NUCC.

11 **Insured's Policy, Group, or FECA Number**
Enter the insured's policy or group number as it appears on the insured's health care identification card.

11a **Insured's Date of Birth, Sex**
Enter the 8-digit date of birth (MM/DD/YYY) of the insured and an X to indicate the sex (gender) of the insured. Only one box can be marked. If gender is unknown, leave blank.

11b **Other Claim ID (Designated by NUCC)**
Enter the "Other Claim ID." Applicable claim identifiers are designated by the NUCC.
When submitting to Property and Casualty payers, e.g., Automobile, Homeowner's, or Workers' Compensation insurers and related entities, the following qualifier and accompanying identifier has been designated for use:
Y4 Agency Claim Number (Property Casualty Claim Number)

11c **Insurance Plan Name or Program Name**
Enter the name of the insurance plan or program of the insured.

11d **Is there another Health Benefit Plan?**
When appropriate, enter an X in the correct box. If marked "YES", complete 9, 9a, and 9d with other health benefit plan information.

12 **Patient's or Authorized Person's Signature**
Not applicable.

Note: Blue Shield will only make payment directly to Physician Members and Participating Health Care Professionals.

13 **Insured's or Authorized Person's Signature**
Not applicable.

Note: Blue Shield will only make payment directly to Physician Members and Participating Health Care Professionals

14 **Date of Current Illness, Injury or Pregnancy (LMP)**
Enter the 8-digit (MM/DD/YYYY) date of the first date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date.
Enter the applicable qualifier to identify which date is being reported.
- 431 Onset of Current Symptoms or Illness
- 484 Last Menstrual Period

15 **Other Date**
If applicable, enter another date related to the patient's condition or treatment.
Enter the date in the 8-digit (MM/DD/YYYY) format.
Enter the applicable qualifier to identify which date is being reported.
- 454 Initial Treatment
- 304 Latest Visit or Consultation
- 453 Acute Manifestation of a Chronic Condition
- 439 Accident
- 455 Last X-ray
- 471 Prescription
- 090 Report Start (Assumed Care Date)
- 091 Report End (Relinquished Care Date) 4
- 444 First Visit or Consultation

16 **Dates Patient Unable to Work in Current Occupation**
If the patient is employed and is unable to work in current occupation, an 8-digit (MM/DD/YYYY) date must be shown for the "from–to" dates that the patient is unable to work. An entry in this field may indicate employment-related insurance coverage.

17 **Name of Referring Provider or Other Source**
Enter the name first name, middle initial, last name followed by the credentials of the professional who referred or ordered the service(s) or supply(ies) on the claim.

If multiple providers are involved, enter one provider using the following priority order:

1. Referring Provider
2. Ordering Provider
3. Supervising Provider

Do not use periods or commas. A hyphen can be used for hyphenated names.

Enter the applicable qualifier to identify which provider is being reported.

DN Referring Provider
DK Ordering Provider
DQ Supervising Provider

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

17a **Other ID#**
The Other ID number of the referring, ordering, or supervising provider is reported in 17a in the shaded area. The qualifier indicating what the number represents is reported in the qualifier field to the immediate right of 17a.

The NUCC defines the following qualifiers used in 5010A1:

0B State License Number
1G Provider UPIN Number
G2 Provider Commercial Number
LU Location Number (This qualifier is used for Supervising Provider only.)

17b **NPI #**
Enter the NPI number of the referring, ordering, or supervising provider in Item Number 17b.

18 **Hospitalization Dates Related to Current Services**
Complete these dates when a medical service is furnished as a result of, or subsequent to, a related hospitalization. Enter the inpatient 8-digit (MM/DD/YYYY) hospital admission date followed by the 8-digit (MM/DD/YYYY)

discharge date (if discharge has occurred). If not discharged, leave discharge date blank.

19 **Additional Claim Information (Designated by NUCC)**
Use this to identify additional information about the patient's condition or the claim.

20 **Outside Lab? $Charges**
Complete this field when billing for purchased services by entering an X in "YES." A "YES" mark indicates that the reported service was provided by an entity other than the billing provider. A "NO" mark or blank indicates that no purchased services are included on the claim. If "YES" is marked, enter the purchase price under "$Charges" and complete Item Number 32. Each purchased service must be reported on a separate claim form as only one charge can be entered.
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.

21 **Diagnosis or Nature of Illness or Injury**
List no more than 12 ICD-10 CM codes in priority order with the primary diagnosis in the #1 position. Do not add any diagnosis description.

22 **Resubmission and/or Original Reference Number**
Not applicable.

23 **Prior Authorization Number**
Enter authorization number from Blue Shield or member's group (IPA), when applicable.

24 **Itemized Services**
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 **Date(s) 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. Monthly rentals must be coded with a date span. Date spans on a single line should not cross months. Date spans on a single claim should not cross years.

24b **Place of Service**
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 **EMG**
Leave blank. Completion of this block is not required.

24d **Procedures, Services, or Supplies**
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.

To report bi-lateral procedures, the services must be billed on two lines of the submitted claim. For example:

19368
19368-50

24e **Diagnosis Pointer**
Enter diagnosis code reference pointer from Block 21 to relate date of service and procedures performed to appropriate diagnosis. Place commas between multiple diagnosis reference pointers on the same line.

24f **Charges**
Enter the charge amount for the service performed. Do not enter dollar signs or decimal points. Always include cents.

24g **Days or Units**
Enter the number of days or units. This field is most commonly used for multiple visits, units of supplies, anesthesia units or minutes, or oxygen volume. If only one service is performed, the numeral 1 must be entered.

Enter numbers left justified in the field. No leading zeros are required. If reporting a fraction of a unit, use the decimal point.

Anesthesia services must be reported as minutes. Units may only be reported for

anesthesia services when the code description includes a time period (such as "daily management").

DME monthly rentals must be coded with 30 units and accompanying date span. See 24a Date(s) of Service for more information.

24h **EPSDT/Family Plan**
Not applicable.

24i **ID Qualifier**
Enter in the shaded area of 24I the ZZ qualifier identifying the rendering provider Taxonomy number. The Other ID# of the rendering provider should be reported in 24J in the shaded area.

24j **Rendering Provider ID #**
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 **Federal Tax ID Number**
Enter the "Federal Tax ID Number" (employer ID number or SSN) of the Billing Provider.

26 **Patient's Account No.**
Enter the patient's account number.

27 **Accept Assignment?**
Enter an X in the correct box to report "Accept Assignment" for all payors.

28 **Total Charge**
Enter the amount right justified in the dollar area of the field. Do not use commas when reporting dollar amounts. Negative dollar amounts are not allowed. Dollar signs should not be entered. Enter 00 in the cents area if the amount is a whole number.

29 **Amount Paid**
Enter total amount paid by patient on submitted charges in Block 28.

30 **Reserved for NUCC Use**
Leave blank.

31 **Signature of Physician or Supplier Including Degrees or Credentials**
Enter the legal signature of the practitioner or supplier, signature of the practitioner or supplier representative, "Signature on File," or "SOF." Enter either the 6-digit date (MM/DD/YYY), 8-digit date (MM/DD/YYYY), or alphanumeric date (e.g., January 1, 2003) the form was signed.

32 **Service Facility Location Information**
Enter name and full address including the street number, city, state, and zip code 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. 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.

32a **NPI#**
Enter the NPI number of the service facility location in 32a.

32b **Other ID#**
Enter the qualifier identifying the non-NPI number followed by the ID number. Do not enter a space, hyphen or other separator between the qualifier and number.

33 **Billing Provider Info & Ph #**
Enter the provider's or supplier's billing name, full address including the street number, city, state, zip code and phone number.

33a **NPI#**
Enter the NPI number of the billing provider or supplier

33b **Other ID#**
Enter the taxonomy code of the billing provider or supplier.

Where to Send Claims

Providers are asked to submit claims electronically that do not have a record attached. Electronically submitted claims will be acknowledged within 2 days.

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 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 *Claims*, 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 272630
Chico CA 95927-2630
(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

BLUE SHIELD MEDICARE ADVANTAGE
Blue Shield Medicare Advantage plan
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
(Commercial Only)
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 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) 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**

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*, then *How to submit claims.*

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 *Claims*, *Policies and Guidelines*, then *Payment Policies and Rules.*

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List of Office-Based Ambulatory Procedures

CPT	Description
10021	Fna w/o image
10040	Acne surgery
10060	Drainage of skin abscess
10080	Drainage of pilonidal cyst
10120	Remove foreign body
10160	Puncture drainage of lesion
11000	Debride infected skin
11055	Trim skin lesion
11056	Trim skin lesions, 2 to 4
11057	Trim skin lesions, over 4
11200	Removal of skin tags
11201	Remove skin tags add-on
11300	Shave skin lesion
11301	Shave skin lesion
11302	Shave skin lesion
11303	Shave skin lesion
11305	Shave skin lesion
11306	Shave skin lesion
11307	Shave skin lesion
11308	Shave skin lesion
11310	Shave skin lesion
11311	Shave skin lesion
11312	Shave skin lesion
11313	Shave skin lesion
11719	Trim nail(s)
11720	Debride nail, 1-5
11721	Debride nail, 6 or more
11730	Removal of nail plate
11740	Drain blood from under nail
11765	Excision of nail fold, toe
11900	Injection into skin lesions
11901	Added skin lesions injection
11921	Correct skin color defects
11922	Correct skin color defects
11950	Therapy for contour defects
11951	Therapy for contour defects
11952	Therapy for contour defects
11954	Therapy for contour defects
11980	Implant hormone pellet(s)
11981	Insert drug implant device
11982	Remove drug implant device
12001	Repair superficial wound(s)
12002	Repair superficial wound(s)
12004	Repair superficial wound(s)
12011	Repair superficial wound(s)

CPT	Description
12013	Repair superficial wound(s)
12014	Repair superficial wound(s)
12015	Repair superficial wound(s)
15783	Abrasion treatment of skin
15786	Abrasion, lesion, single
15787	Abrasion, lesions, add-on
15788	Chemical peel, face, epiderm
15789	Chemical peel, face, dermal
15792	Chemical peel, nonfacial
15793	Chemical peel, nonfacial
16000	Initial treatment of burn(s)
16020	Treatment of burn(s)
16025	Treatment of burn(s)
16030	Treatment of burn(s)
17000	Destroy benign/premlg lesion
17003	Destroy lesions, 2-14
17004	Destroy lesions, 15 or more
17106	Destruction of skin lesions
17107	Destruction of skin lesions
17108	Destruction of skin lesions
17110	Destruct lesion, 1-14
17111	Destruct lesion, 15 or more
17250	Chemical cautery, tissue
17340	Cryotherapy of skin
17360	Skin peel therapy
17380	Hair removal by electrolysis
17999	Skin tissue procedure
19000	Drainage of breast lesion
19001	Drain breast lesion add-on
20500	Injection of sinus tract
20526	Ther injection, carp tunnel
20527	Inj dupuytren cord w/enzyme
20550	Inj tendon sheath/ligament
20551	Inj tendon origin/insertion
20552	Inj trigger point, 1/2 muscl
20553	Inject trigger points, =/> 3
20555	Place ndl musc/tis for rt
20560	Needle Insert w/o Inj 1 or 2 muscl
20561	Needle Insert w/o Inj 3 or more muscl
20600	Drain/inject, joint/bursa
20605	Drain/inject, joint/bursa
20606	Drain/inj joint/bursa w/us
20610	Drain/inject, joint/bursa
20611	Drain/inj joint/bursa w/us
20612	Aspirate/inj ganglion cyst

List of Office-Based Ambulatory Procedures

CPT	Description
20615	Treatment of bone cyst
20950	Fluid pressure, muscle
20974	Electrical bone stimulation
20979	Us bone stimulation
24640	Treat elbow dislocation
24650	Treat radius fracture
25500	Treat fracture of radius
25530	Treat fracture of ulna
25560	Treat fracture radius & ulna
25600	Treat fracture radius/ulna
25622	Treat wrist bone fracture
25630	Treat wrist bone fracture
25650	Treat wrist bone fracture
26010	Drainage of finger abscess
26340	Manipulate finger w/anesth
26341	Manipulat palm cord post inj
26600	Treat metacarpal fracture
26641	Treat thumb dislocation
26670	Treat hand dislocation
26700	Treat knuckle dislocation
26720	Treat finger fracture, each
26725	Treat finger fracture, each
26740	Treat finger fracture, each
26750	Treat finger fracture, each
26755	Treat finger fracture, each
26770	Treat finger dislocation
27200	Treat tail bone fracture
27220	Treat hip socket fracture
27256	Treat hip dislocation
27899	Leg/ankle surgery procedure
28430	Treatment of ankle fracture
28450	Treat midfoot fracture, each
28470	Treat metatarsal fracture
28475	Treat metatarsal fracture
28490	Treat big toe fracture
28495	Treat big toe fracture
28510	Treatment of toe fracture
28515	Treatment of toe fracture
28530	Treat sesamoid bone fracture
28540	Treat foot dislocation
28570	Treat foot dislocation
28600	Treat foot dislocation
28630	Treat toe dislocation
28660	Treat toe dislocation
29000	Application of body cast
29010	Application of body cast

CPT	Description
29015	Application of body cast
29035	Application of body cast
29040	Application of body cast
29044	Application of body cast
29046	Application of body cast
29049	Application of figure eight
29055	Application of shoulder cast
29058	Application of shoulder cast
29065	Application of long arm cast
29075	Application of forearm cast
29085	Apply hand/wrist cast
29086	Apply finger cast
29105	Apply long arm splint
29125	Apply forearm splint
29126	Apply forearm splint
29130	Application of finger splint
29131	Application of finger splint
29200	Strapping of chest
29240	Strapping of shoulder
29260	Strapping of elbow or wrist
29280	Strapping of hand or finger
29305	Application of hip cast
29325	Application of hip casts
29345	Application of long leg cast
29355	Application of long leg cast
29358	Apply long leg cast brace
29365	Application of long leg cast
29405	Apply short leg cast
29425	Apply short leg cast
29435	Apply short leg cast
29440	Addition of walker to cast
29445	Apply rigid leg cast
29450	Application of leg cast
29505	Application, long leg splint
29515	Application lower leg splint
29520	Strapping of hip
29530	Strapping of knee
29540	Strapping of ankle and/or ft
29550	Strapping of toes
29580	Application of paste boot
29581	Apply multlay comprs lwr leg
29700	Removal/revision of cast
29705	Removal/revision of cast
29710	Removal/revision of cast
29720	Repair of body cast
29730	Windowing of cast

List of Office-Based Ambulatory Procedures

CPT	Description
29740	Wedging of cast
29750	Wedging of clubfoot cast
29799	Casting/strapping procedure
30300	Remove nasal foreign body
30901	Control of nosebleed
31231	Nasal endoscopy, dx
31298	Nasal sinus endoscopy surgical
31502	Change of windpipe airway
31575	Diagnostic laryngoscopy
32550	Insert pleural catheter
32552	Remove lung catheter
32553	Ins mark thor for rt perq
32562	Lyse chest fibrin subq day
36430	Blood transfusion service
36465	Inj noncompounded foam sclerosant
36466	Inj noncompounded foam sclerosant
36593	Declot vascular device
36598	Inject rad eval central venous device
36680	Insert needle, bone cavity
40800	Drainage of mouth lesion
40804	Removal, foreign body, mouth
40830	Repair mouth laceration
41019	Place needles h & n for rt
42280	Preparation, palate mold
42400	Biopsy of salivary gland
42809	Remove pharynx foreign body
42975	Dise eval slp do brth flx dx
43752	Nasal/orogastric w/stent
43753	Tx gastro intub w/asp
43754	Dx gastr intub w/asp spec
43755	Dx gastr intub w/asp specs
43756	Dx duod intub w/asp spec
43757	Dx duod intub w/asp specs
43761	Reposition gastrostomy tube
44705	Prepare fecal microbiota
45520	Treatment of rectal prolapse
46600	Diagnostic anoscopy
46601	Diagnostic anoscopy
46900	Destruction, anal lesion(s)
46916	Cryosurgery, anal lesion(s)
50391	Instll rx agnt into rnal tub
50686	Measure ureter pressure
51100	Drain bladder by needle
51700	Irrigation of bladder

CPT	Description
51705	Change of bladder tube
51720	Treatment of bladder lesion
51736	Urine flow measurement
51741	Electro-uroflowmetry, first
51784	Anal/urinary muscle study
51792	Urinary reflex study
51797	Intraabdominal pressure test
51798	Us urine capacity measure
53454	Tprnl balo cntnc dev adjmt
53621	Dilate urethra stricture
53660	Dilation of urethra
53661	Dilation of urethra
53860	Transurethral rf treatment
54050	Destruction, penis lesion(s)
54056	Cryosurgery, penis lesion(s)
54200	Treatment of penis lesion
54235	Penile injection
54240	Penis study
54250	Penis study
55000	Drainage of hydrocele
55920	Place needles pelvic for rt
56820	Exam of vulva w/scope
56821	Exam/biopsy of vulva w/scope
57100	Biopsy of vagina
57150	Treat vagina infection
57156	Ins vag brachytx device
57160	Insert pessary/other device
57170	Fitting of diaphragm/cap
57420	Exam of vagina w/scope
57421	Exam/biopsy of vag w/scope
57452	Exam of cervix w/scope
57455	Biopsy of cervix w/scope
57505	Endocervical curettage
58100	Biopsy of uterus lining
58110	Biopsy of uterus lining add on
58300	Insert intrauterine device
58301	Remove intrauterine device
58321	Artificial insemination
58322	Artificial insemination
58323	Sperm washing
59020	Fetal contract stress test
59025	Fetal non-stress test
59050	Fetal monitor w/report
59051	Fetal monitor/interpret only
59200	Insert cervical dilator

List of Office-Based Ambulatory Procedures

CPT	Description
59412	Antepartum manipulation
59425	Antepartum care only
59430	Care after delivery
59899	Maternity care procedure
60100	Biopsy of thyroid
60300	Aspir/inj thyroid cyst
64405	N block inj, occipital
64445	N block inj, sciatic, sng
64454	Inj Aa&/Strd Genicular Nrv Brnch
64455	N block inj, plantar digit
64611	Chemodenerv saliv glands
64615	Chemodenerv musc migraine
64616	Chemodenerv musc neck dyston
64617	Chemodenerv muscle larynx EMG
64624	Destr Neurolytic Agt Genicular Nrv
64632	N block inj, common digit
65205	Remove foreign body from eye
65210	Remove foreign body from eye
65220	Remove foreign body from eye
65222	Remove foreign body from eye
65430	Corneal smear
65778	Cover eye w/membrane
65779	Cover eye w/membrane stent
67500	Inject/treat eye socket
67505	Inject/treat eye socket
67515	Inject/treat eye socket
67700	Drainage of eyelid abscess
67800	Remove eyelid lesion
67805	Remove eyelid lesions
67810	Biopsy of eyelid
68040	Treatment of eyelid lesions
68200	Treat eyelid by injection
68400	Incise/drain tear gland
68761	Close tear duct opening
69000	Drain external ear lesion
69020	Drain outer ear canal lesion
69090	Pierce earlobes
69200	Clear outer ear canal
69209	Remove impacted ear wax uni
69210	Remove impacted ear wax
69220	Clean out mastoid cavity
90867	Tcranial magn stim tx plan
90868	Tcranial magn stim tx deli
92132	Cmptr ophth dx img ant segmt
92133	Cmptr ophth img optic nerve

CPT	Description
92134	Cptr ophth dx img post segmt
92537	Caloric vstblr test w/rec
92538	Caloric vstblr test w/rec
93050	Art pressure waveform analys
93464	Exercise w/hemodynamic meas
97597	Active wound care/20 cm or <
97598	Active wound care > 20 cm
0071T	Focused ultrasnd abl,uterine leiomyomata
0072T	Total leiomyomata vol,200cc tissue
0207T	Clear eyelid gland w/heat
0213T	Njx paravert w/us cer/thor
0214T	Njx paravert w/us cer/thor
0215T	Njx paravert w/us cer/thor
0216T	Njx paravert w/us lumb/sac
0217T	Njx paravert w/us lumb/sac
0218T	Njx paravert w/us lumb/sac
0219T	Plmt post facet implt cerv
0220T	Plmt post facet implt thor
0221T	Plmt post facet implt lumb
0222T	Plmt post facet implt addl
0272T	Interrogate crtd sns dev
0273T	Interrogate crtd sns w/pgrmg
0278T	Tempr
0331T	Heart symp image plnr
0332T	Heart symp image plnr spect
0378T	Visual field assmnt rev/rpt
0379T	Vis Field assmnt tech suppt
0419T	Dstrj Neurofibroma Xtnsv
0420T	Dstrj Neurofibroma Xtnsv
0465T	Supchrdl njx rx w/o supply
0474T	Insj aqueous drg dev io rsvr
0529T	Interrog dev eval iims ip
0530T	Removal complete iims
0563T	Evac meibomian gld using heat bilat
0566T	Autol cell implt adps tiss njx implt
0588T	Rev or Rem isdns post tibial nrv
C7513	Cath/angio dial cir w/aplasty
C7514	Cath/angio dial cir w/stents
C7515	Cath/angio dial cir w/embol
C8929	Transthoracic Echo, w or w/o contrst followd with
C8930	Transthoracic Echo, w or w/o cntrst followd inc record

Table of Contents

Appendix For Section 5

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Table of Contents

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
- Locating other states' Blue plan medical policies and pre-certification requirements
- Requesting and obtaining authorizations
- Submitting BlueCard claims and requesting medical records
- Accessing BlueCard 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 other 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, a mission-driven and nonprofit health plan established in 1939, 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 and creating a sustainably affordable healthcare system that's worthy of our family and friends. 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 other 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), including Blue High Performance Network℠ (Blue HPN℠)
- 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
- 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 other 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 other state Blue plan 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
- A BlueHPN in a suitcase logo with the Blue High Performance Network℠ (BlueHPN℠) name in the upper right or lower left corner, for BlueHPN EPO members

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.

How to Identify Members *(cont'd.)*

Member ID Cards *(cont'd.)*

The BlueHPN EPO product includes a BlueHPN in a suitcase logo on the ID card. Members must obtain services from BlueHPN providers to receive full benefits. If you are a BlueHPN provider, you will be reimbursed for covered services in accordance with your contract with Blue Shield of California. If you are not a BlueHPN provider, it is important to note that benefits for services incurred with non-BlueHPN providers are limited to emergent care within BlueHPN product areas, and to urgent and emergent care outside of BlueHPN product areas. For these limited benefits, if you are a PPO provider, you will be reimbursed according to Blue Shield of California PPO provider contract, just like you are for other EPO products.

Some Blue ID cards do not have any suitcase logo on them. Those ID cards include 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.

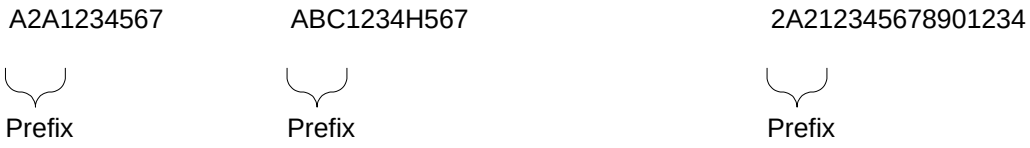
How to Identify Members *(cont'd.)*

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 that require medical records 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.

Examples of member IDs:



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 to which the member belongs. It is critical for confirming a patient's membership and coverage.

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

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

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

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

Currently, Blue Shield does not offer a BlueCard PPO Basic network to local Blue Shield members. However, you may see patients with BlueCard PPO Basic coverage by another state Blue Plan. Providers will be reimbursed for covered services in accordance with your PPO contract with Blue Shield of California.

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.

Sample ID Card

How to Identify Members *(cont'd.)*

How to Identify BLueHPB Members

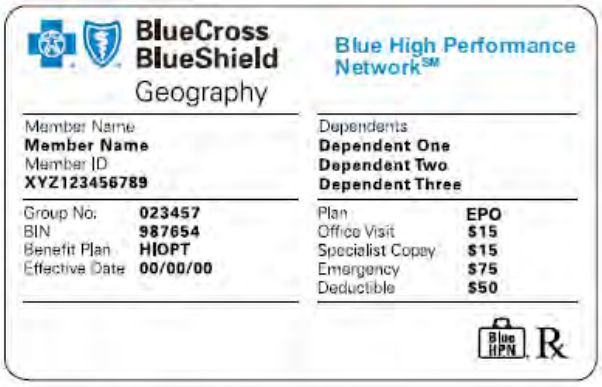
The Blue High Performance Network℠ (BlueHPN℠) is a new network that is available to members that live in key metropolitan areas. BlueHPN members must access BlueHPN providers in order to receive full benefits. If you are a BlueHPN provider, you will be reimbursed for services provided to BlueHPN members according to your contract with Blue Shield of California. If you are not a BlueHPN provider, it is important to note that benefits for services incurred with non-BlueHPN providers are limited to emergent care within Blue HPN product areas, and to urgent and emergent care outside of BlueHPN product areas.

You can recognize BlueHPN members by the following:

- The Blue High Performance Network name on the front of the member ID card
- The BlueHPN in a suitcase logo in the bottom right-hand corner of the member ID card

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

Sample ID Card



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.

Illustration A - Sample ID Card

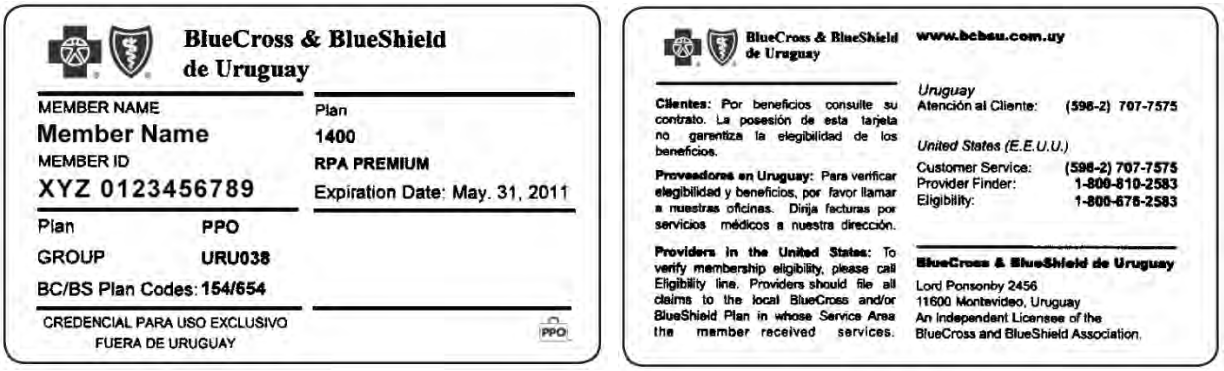


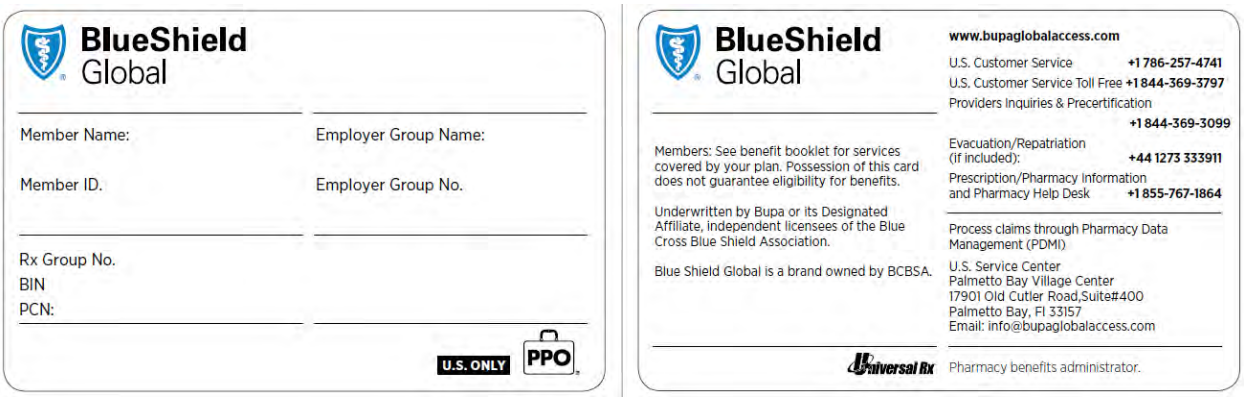
Illustration B – Blue Cross Blue Shield Global portfolio:

How to Identify Members *(cont'd.)*

How to Identify International Blue Plan Members *(cont'd.)*

Illustration C – 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

How to Identify Members *(cont'd.)*

Consumer Directed Health Care and Healthcare Debit Cards

Consumer Directed Health Care (CDHC) is a 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 paperwork 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

How to Identify Members *(cont'd.)*

Consumer Directed Health Care and Healthcare Debit Cards *(cont'd.)*

Sample of Combined Healthcare Debit Card and Member ID Card

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

Another new product and benefit type in the healthcare market is the limited benefit products for 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 local Blue Shield 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

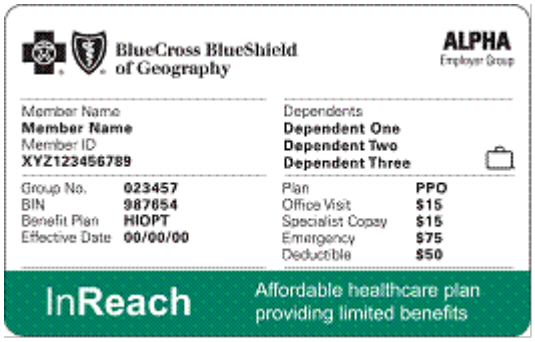
Members with Blue limited benefits coverage (that is, annual benefits limited to $50,000 or less) carry ID cards that may have one or more of the following indicators:

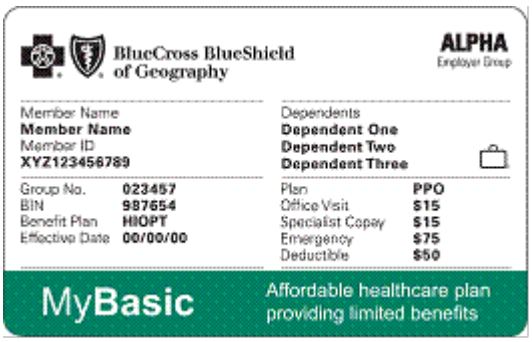
- Product name will be listed such as **InReach** or **MyBasic**
- A **green stripe** at the bottom of the card
- A statement either on the front or the back of the ID card stating this is a limited benefits product
- A **black cross and/or shield** to help differentiate it from other identification 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 treatments might be member's liability. We recommend that you inform patients of any potential liability they might have as soon as possible.

Coverage and Eligibility Verification

Provider Connection, our provider website at blueshieldca.com/provider, gives you direct access to current, reliable information for other state Blue plan members' eligibility, benefits, claims mailing address, and share of cost. You can receive more detailed benefit information when searching for other state Blue plan 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 onscreen or sent to the Provider Connection Message Center.

You can also verify other 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 zone 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.

Eligibility and Benefits for BlueHPN EPO Members:

BlueHPN EPO members will be identified as such within the eligibility and benefits result response. If you are a Blue Shield of California contracted provider within BlueHPN network, submit your claim to Blue Shield. If you are not a contracted BlueHPN provider with Blue Shield of California, you should be aware that the only services that are covered for BlueHPN EPO members are urgent and emergent care outside of BlueHPN product areas. Benefits are determined by Blue plan the member is insured with.

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, 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, which may result in a payment delay or post-payment adjustment.

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 unit 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.

Coordination of Benefits (COB) Information on Blue Plan Members *(cont'd.)*

When other 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 other state Blue plan as soon as possible.

Refer to the COB Questionnaire on the following pages or on blueshieldca.com/provider under *Guidelines & resources,* then *Forms,* then *Patient care forms.*

Coordination of Benefits Questionnaire

Coordination of Benefits Questionnaire

BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

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 appreciates your prompt and accurate reply. If any of the information below changes, please contact your Blue Cross and/or Blue Shield Plan immediately.

Provider Name:	NPI (Give Tax ID if no NPI Number):

Policyholder Name:	
Group Number:	Member ID Number with Three Letter Prefix:

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 If No, please complete Section D, sign, date and return this questionnaire to us, indicating "No other insurance."

☐ Yes If Yes, please complete all the fields below that pertain to the member(s) that has the other coverage.

Mark those that apply: ☐ Other Health Insurance ☐ Other Dental Insurance

What type of policy is this? ☐ Group ☐ Individual Policy ☐ Student Policy ☐ Medicare Supplemental

Other Insurance Carrier's Name

Address

Address | State | Zip | Phone Number

Dependent(s) listed on the other insurance

Other Insurance Policyholder's Name | Policyholder's Date of Birth | ID Number

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: _____

Policyholder's Employer

Address

City | State | Zip | Phone Number

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 relation 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

Name	Relationship	Date of Birth	Sex	Social Security Number (Optional)
Name	Relationship	Date of Birth	Sex	Social Security Number (Optional)
Name	Relationship	Date of Birth	Sex	Social Security Number (Optional)

Policy Holder Signature **Date**

Other -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 other state Blue plan members. You can view medical policies and general pre-certification/prior authorization requirements applicable to other 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:

1. Log onto blueshieldca.com/provider.

2. Click on the *Pre-service review for out-of-area members* link within the *Authorizations* section of Provider Connection.

3. Enter the other 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 other state Blue plan members' benefits, eligibility and share of costs, directly from the member's Blue plan.

Prior Authorization

Prior authorization of medical services for other state Blue plan members is provided by the member's Blue plan. Providers can request authorization for an other 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 another Blue plan's provider website to request authorization.

To access the EPA tool, log onto Provider Connection at blueshieldca.com/provider, click on the *Pre-service review for out-of-area members* link 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 regarding authorizations for Blue plan members needing for clinical lab, DME/HME, and specialty pharmacy services should be directed to the member's Blue 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 chronic condition 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).

General information on pre-certification/preauthorization information can be found by clicking on the *Pre-service review for out-of-area members* within the *Authorization* section of blueshieldca.com/provider.

When obtaining pre-certification/preauthorization, please provide as much information as possible, to minimize potential claims issues. Providers are encouraged to communicate immediately with a member's Blue Plan if any changes in treatment or setting occur to ensure an existing authorization is modified or a new one is obtained, if needed. Failure to obtain approval for 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 other state 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 other state member's Blue plan provider portal, through a secure routing mechanism. Once in the Blue plan provider portal, the other state 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

Log onto blueshieldca.com/provider, click on *Pre-service review for out-of-area members* link 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, which 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 are 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 other 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 other 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 other 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.
- Submitting an ANSI 278 electronic transaction to Blue Shield.
- Calling the BlueCard Eligibility toll-free phone number at (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 otherstate Blue plan members and the providers who serve them.

Medical records related to your otherstate 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, to help us 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 of their receipt, please include the medical records request letter with all supporting documentation.
- 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 other 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. Claims with incorrect or missing prefixes and member identification numbers cannot be filed correctly.

> **Ancillary providers who Blue Shield categorizes them in their contract as Independent Clinical Laboratory, Durable/Home Medical Equipment, orthotic and prosthetics 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.

You may now submit claims online through clearinghouse vendor Office Ally. Once at the EDI clearinghouse's website, you will 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, click on *Claims*, then click on the *Submit claims for free* box in the claims tool area.

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

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

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 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 the three-character prefix) and avoid unnecessary claims payment delays.
- Check eligibility and benefits electronically at blueshieldca.com/provider or by calling (800) 676-BLUE (2583). Be sure to provide the member's three-character prefix.
- 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. 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 have 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).

BlueCard Claim Tips *(cont'd.)*

- If medical records are requested, send them to the claims address listed on the request letter you received from Blue Shield.
- 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 272630
Chico, CA 95927-2630

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, access additional information within Resources section of BlueCard Program or contact Blue Shield's dedicated BlueCard Customer Service Unit at (800) 622-0632 or access our online Chat feature at www.blueshieldca.com/provider.

Submitting BlueCard Claims

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. The following are tips on how to submit claims:

1) Access our Claims Routing Tool on Provider Connection at blueshieldca.com/provider by clicking on the *Claims Routing Tool* link within the *Claims* section. 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 will 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 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.

Submitting BlueCard Claims *(cont'd.)*

5) To facilitate the obligation outlined in 4) above, Blue Shield provides clearinghouses and EDI partners* with tools that improve claims processing accuracy and reduce turnaround time. These are collectively known as the BlueCard Prefix Code Routing Table Edit ("BlueCard Edit" or simply, "Edit"). Unless otherwise noted in the Provider Contract; the provider has authorized the implementation and use of these tools for their BlueCard claims in all transmission formats.

   The purpose and functionality of the BlueCard Edit is to direct and route all BlueCard transactions where Blue Shield is eligible to process said claims. This includes all BlueCard transactions that are related to a healthcare member whose healthcare payer is a licensed affiliate of the Blue Cross Blue Shield Association ("BCBSA"). It does not include transactions from prefixes noted in the tables that are (i) exclusive to another licensee of the Blue Cross Blue Shield Association in the State of California,; or (ii) from those licensed affiliates of BCBSA that designates another licensee of the Blue Cross Blue Shield Association in the State of California exclusively to process transactions for its members.

   Other state independent licensee(s) of the Blue Cross Blue Shield Association may select Blue Shield of California or another licensee of the Blue Cross Blue Shield Association in the State of California as the preferred processor of their BlueCard claims in California for particular accounts, groups, procedures and/or other circumstances. Submitting claims to the wrong processor or payor can cause substantial delays in processing. Blue Shield and its agents will provide best effort to review claims submitted to California processor(s). In the event a claim is submitted to a non-preferred processor, Blue Shield may re-route claims as needed. Re-routing of BlueCard claims may occur in accordance to Blue Shield's agreement(s) with another licensee of the Blue Cross Blue Shield Association. Where other state independent licensee(s) of the Blue Cross Blue Shield Association has selected another independent Blue Cross and Blue Shield licensee in California, as their processor for accounts or groups, Blue Shield will provide best effort to re-route claims to that licensee. This claim review process is integral to our claims processing and claims routing systems and cannot be selectively enabled by Provider. While Blue Shield and its agents will provide best effort; we cannot ensure that 100% of all claims are reviewed prior to Payor delivery. Blue Shield is not responsible for any delays or liability from the provision or non-provision of this service or subsequent re-routing or non re-routing.

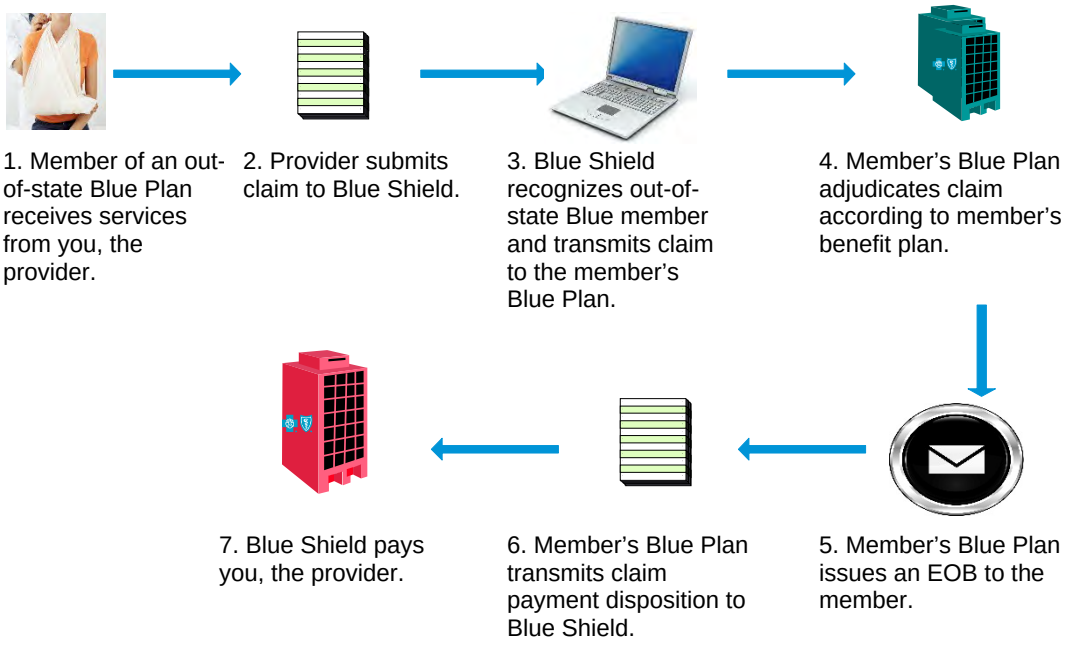
6) If submitting a claim for ancillary services (independent clinical lab, DME/HME, or specialty pharmacy), please refer to the Ancillary Claims Filing Guidelines section of this appendix.

Submitting BlueCard Claims *(cont'd.)*

7) If you have any questions about electronic claims submission, contact our EDI Help Desk at
(800) 480-1221. 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.

*If requested, Blue Shield will provide to the provider or their agents or claims clearinghouse (collectively known as the "SUBMITTER") its proprietary BlueCard Prefix Code (also known as the Interplan Teleprocessing System, or "ITS") tables ("Tables") which shall at all times remain the Confidential Information of Blue Shield. Upon provision of the Tables, the Submitter shall develop, implement, and maintain in production the software functionality or program known as the BlueCard Prefix Code Routing Table edit ("BlueCard Edit" or simply, "Edit"). Where such capability currently exists, the provider hereby authorizes and directs their Submitter to make use of said Edit or similar capability. To inquire about the BlueCard Edit, email BlueCardMarketing@blueshieldca.com.

Below is an example of how claims flow through BlueCard



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 alpha-numeric 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.

Traditional Medicare-Related Claims *(cont'd.)*

- 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.

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 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 272630 , Chico, CA 95927-2630

Ancillary Claims Filing Requirements

Ancillary providers include Independent Clinical Laboratory, Durable/Home Medical Equipment and Supplies (D/HME), Orthotics & Prosthetics (O&P), and Specialty Pharmacy providers. File claims for these providers as follows:

- Independent Clinical Laboratory (Lab)
  - File to the BCBS Plan in whose service area the referring provider is located.
- Durable/Home Medical Equipment and Supplies (D/HME) and Orthotics & Prosthetics (O&P)
  - File to the Plan in whose service area the equipment/supplies was shipped to or purchased at a retail store.
- Specialty Pharmacy
  - File to the Plan in whose service area 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.

Provider Type	How to File (Required Fields)	Where to File	Example
Independent Clinical Laboratory (any type of non-hospital based laboratory) Types of Service include, but are not limited to: blood, urine, samples, analysis, etc.	**Referring Provider**: - Field 17B on CMS 1500 Health Insurance Claim Form or - Loop 2310A (claim level) on the 837 Professional Electronic	File the claim to the Plan in whose service area the ***referring provider is located***. **Note**: • Claim must be processed based on information submitted on the claim. • The referring provider NPI, as submitted on the claim, must be used to determine where service was rendered. • Claims for the analysis of a lab must be filed to the Plan in whose service area the referring provider is located. • BlueCard rules for claims incurred in an overlapping service area and contiguous county apply.	Blood is drawn in lab or office setting at the request of a referring provider located in **[enter Plan X service area].** Blood analysis is done in **[enter Plan Y service area**]. *File both portions of the claim to:* **[enter Plan X service area].**

Ancillary Claims Filing Requirements *(cont'd.)*

Provider Type	How to File (Required Fields)	Where to File	Example
Durable/Home Medical Equipment and Supplies (D/HME) and Orthotics/Prosthetics Types of Service include, but are not limited to: Hospital beds, oxygen tanks, crutches, equipment to correct deformities or to preserve and restore the function of the skeletal system, etc.	**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 to the Plan in whose service area the equipment was ***shipped to or purchased in a retail store.*** **Note**: • Claim must be processed based on information submitted on the claim. • The Place of Service code, as submitted on the claim, must be used to determine where service was rendered (e.g. member home/equivalent setting, retail, office, etc.). • BlueCard rules for claims incurred in an overlapping service area and contiguous county apply.	A. Wheelchair, Ankle foot orthotic, etc, is purchased at a retail store in [**enter Plan Y service area**]. *File to:* [**enter Plan Y service area**] B. Wheelchair, Ankle foot orthotic, etc,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 Y service area**] C. Wheelchair, Ankle foot orthotic, etc, 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**]

Ancillary Claims Filing Requirements *(cont'd.)*

Provider Type	How to File (Required Fields)	Where to File	Example
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.	**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***. **Note**: • Claim must be processed based on information submitted on the claim. • The ordering physician NPI, as submitted on the claim, must be used to determine where service was rendered. • BlueCard rules for claims incurred in an overlapping service area and contiguous county apply.	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**]

Ancillary Claims Filing Requirements *(cont'd.)*

- 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 Blue 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 *Claims* section, click on the *Policies and guidelines* and then select the *Ancillary claims filing* box.

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 Blue plan in a state for the same product type (i.e., PPO or Traditional), you may file the claim with either Blue plan.

Service Rendered	How to File (Required Fields)	Where to File	Example

Air Ambulance Services	**Point of Pickup ZIP Code**:
	– 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.
		File the claim to the Blue plan in whose service area the point of pickup ZIP code is located*.
		
		*BlueCard rules for claims incurred in an overlapping service area and contiguous county apply.
			• The point of pick up ZIP code is in Blue plan A service area.
			• The claim must be filed to Blue plan A, based on the point of pickup ZIP code.

If you have questions about the claims filing for Air Ambulance Services for other state Blue plan member, please contact Blue Shield's BlueCard Customer Service Unit at (800) 622-0632.

Medical Records

Under what circumstances may the provider get requests for medical records for other Blue plan 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 and a copy of the medical records request letter, to Blue Shield's dedicated BlueCard Customer Service team at: Blue Shield of California, BlueCard Program, P.O. Box 272630, Chico, CA 95927-2630
- 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 medical records request letter you received with the request when submitting the medical records. This is necessary to make sure the records are routed properly once received by Blue Shield.
- 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 local 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 with 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.

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

Blue plans have value-based care delivery arrangements in place with their providers. Each Blue plan has created their own arrangement with their provider(s), including reimbursement arrangements. Due to the unique nature of each Blue 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 Blue plans.

Claim Adjustments

Contact the Blue Shield's BlueCard Customer Service Unit 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 Customer Service Unit at (800) 622-0632.

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

How it works

You will need the claim number to get started:

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

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 within claims section. Simply enter the member's three-character prefix and date of service to instantly learn where to send your BlueCard claim.

BlueCard Video

Blue Shield offers a video online at our Provider Connection website that describe the core processes of the BlueCard Program.

Access our online BlueCard video by logging onto blueshieldca.com/provider, clicking on the *Find BlueCard Program resources* link within the BlueCard section, then selecting video on the webpage that appears.

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

Log onto Provider Connection at blueshieldca.com/provider and click on the *BlueCard Program home page* link within the BlueCard Program section on the opening landing page and select the *Tutorials* 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 BlueCard claims.

To attend one of our monthly webinars, access our *Webinars* link on the BlueCard Program webpage on Provider Connection for the date and time. To receive notification about BlueCard webinars, request more information by emailing BlueCardMarketing@blueshieldca.com.

BlueCard Frequently Asked Questions (FAQ) Page

Visit our BlueCard FAQ page to see the most asked questions from providers about the BlueCard Program and their detailed answers. To access this informative page, log onto blueshieldca.com/provider, click on the *BlueCard Program* home page link, select the *Resources* link, and then choose the *BlueCard Program FAQs* box.

BlueCard Program Educational Resources

A wide variety of BlueCard educational flyers, brochures, and other resources are available on the BlueCard Program webpage on Provider Connection.

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 1.800.676.BLUE (2583) 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.

Types of Medicare Advantage Plans *(cont'd.)*

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.

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 Blue 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.
- Submit your MA PFFS claims to Blue Shield.

Types of Medicare Advantage Plans *(cont'd.)*

Medicare Advantage Medical Savings Account (MSA)

A Medicare Advantage MSA plan is made up of two parts. One part is a Medicare MSA Health Insurance Policy with a high deductible. The other part is a special savings account where Medicare deposits money to help members pay their medical bills.

Medicare Advantage PPO Network Sharing

What is BCBS Medicare Advantage PPO Network Sharing?

All BCBS MA PPO Plans participate in reciprocal network sharing. This network sharing allows all BCBS MA PPO members to obtain in-network benefits when traveling or living in the service area of any other BCBS MA PPO Plan as long as the member sees a contracted MA PPO provider.

What does the BCBS Medicare Advantage (MA) PPO Network Sharing mean to me?

If you are a contracted MA PPO provider with Blue Shield and you see MA PPO members from other BCBS Plans, these members will be extended the same contractual access to care and will be reimbursed in accordance with your negotiated rate with your Blue Shield contract. These members will receive in-network benefits in accordance with their member contract.

If you are not a contracted MA PPO provider with Blue Shield of California and you provide services for any BCBS MA members, you will receive the Medicare allowed amount for covered services. For urgent or emergency care, you will be reimbursed at the member's in-network benefit level. Other services will be reimbursed at the out-of-network benefit level.

How do I recognize an out-of-area member from one of these Plans participating in the BCBS MA PPO network sharing?

You can recognize a MA PPO member when their member ID card has the following logo.

The "*MA*" in the suitcase indicates a member who is covered under the MA PPO network sharing program. Members have been asked not to show their standard Medicare ID card when receiving services; instead, members should provide their Blue Cross and/or Blue Shield member ID.

Types of Medicare Advantage Plans *(cont'd.)*

Do I have to provide services to Medicare Advantage PPO members from other Blue Cross Blue Shield Plans?

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 Blue Shield MA PPO 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 BCBS Plans but you are not required to do so. Should you decide to provide services to BCBS 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.

What if my practice is closed to new local Blue Cross Blue Shield Medicare Advantage PPO members?

If your practice is closed to new local BCBS MA PPO members, you do not have to provide care for BCBS 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.

What will I be paid for providing services to these out-of-area Medicare Advantage PPO network sharing members?

If you are a MA PPO contracted provider with Blue Shield, benefits will be based on your contracted MA PPO rate for providing covered services to MA PPO members from any MA PPO Plan. Once you submit the MA claim, Blue Shield will work with the other Plan to determine benefits and send you the payment.

What will I be paid for providing services to Medicare Advantage out-of-area members not participating in the Medicare Advantage PPO Network Sharing?

When you provide covered services to other BCBS MA out-of-area members', benefits will be based on the Medicare allowed amount. Once you submit the claim, Blue Shield will send you the payment. However, these services will be paid under the member's out-of-network benefits unless for urgent or emergency care.

Types of Medicare Advantage Plans *(cont'd.)*

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, co-payment, 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.

What is the member cost sharing level and co-payments?

Member cost sharing level and co-payment is based on the member's health plan. You may collect the co-payment amounts from the member at the time of service. To determine the cost sharing and/or co-payment amounts, you should call the Eligibility Line at 1.800.676.BLUE (2583).

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 billed for any deductibles, co-insurance, and/or co-pays.

What if I disagree with the reimbursement amount I received?

If there is a question concerning the reimbursement amount, contact Blue Shield at 1.800.622.0632.

What is BCBS Medicare Advantage PPO Network Sharing?

Network sharing allows MA PPO members from MA PPO BCBS 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 MA PPO provider. MA PPO shared networks are available in 39 states and one territory:

Alabama	Kentucky	Nebraska	Puerto Rico
California	Kansas	Nevada	Rhode Island
Colorado	Louisiana	New Hampshire	South Carolina
Connecticut	Maine	New Jersey	Tennessee
Florida	Massachusetts	New Mexico	Texas
Georgia	Michigan	New York	Utah
Hawaii	Minnesota	Ohio	Virginia
Idaho	Missouri	Oklahoma	Washington
Illinois	Montana	Oregon	Wisconsin
Indiana	North Carolina	Pennsylvania	West Virginia

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:

Member ID cards for Medicare Advantage products will display one of the benefit product logos shown here:	MEDICARE ADVANTAGE | HMO	Health Maintenance Organization
	MEDICARE ADVANTAGE | MSA	Medical Savings Account
	MEDICARE ADVANTAGE | PFFS	Private Fee-For-Service
	MEDICARE ADVANTAGE | POS	Point of Service
	MA | PPO MEDICARE ADVANTAGE	Network Sharing Preferred Provider Organization

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 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.

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.

Reimbursement for Medicare Advantage PPO, HMO and POS *(cont'd.)*

If you are a provider who accepts Medicare assignment, has a Blue plan contract to provide services for all Medicare Advantage enrollees, and you render services to out-of-area Blue Medicare Advantage members, you will be reimbursed at the contracted rate.

Providers should make sure they understand the applicable Medicare Advantage reimbursement rules and their individual Blue 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).

If you have rendered services for a Blue out-of-area Medicare Advantage PFFS member and you are obligated to provide services to such member under a contract with a Blue plan, you will generally be reimbursed at your contracted rate.

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.

Reimbursement for Medicare Advantage Private Fee-For-Service (PFFS) *(cont'd.)*

Medicare Advantage Coordination of Care Program

A new national Coordination of Care program to support Blue MA members was launched on January 1, 2020. The program aims to increase the quality of members' care by enabling Blue MA PPO group members to receive appropriate care, wherever they access care.

To better support all Blue MA PPO group members residing in California, Blue Shield is working with providers to improve these members' care through:

- Supporting providers with additional information about open gaps in care
- Requesting medical records to give Plans a complete understanding of member health status

MA PPO group members participating into this program can be identified as having a member address in California and based on the following logo included on their Blue Cross and/or Blue Shield ID Cards:

What does this new program to support Blue Medicare Advantage members mean to me?

This program will result in some changes, including a number that will be beneficial to you, your practice and your patients. The program serves all MA PPO group members that reside in Blue Shield's service area, and some of the benefits that you may see include:

- You will receive consolidated information on gaps in care and risk adjustment gaps, as well as medical record requests for all Blue MA PPO members enrolled with Blue Shield and other Blue Plans and residing in California through local communication practices.
- The MA PPO group members that you see may come into your practice setting more frequently for care due to Blue Shield's requesting care gap closures, allowing for greater continuity in care.

Reminder: As outlined in your contract with Blue Shield, you are required to respond to requests in support of risk adjustment, HEDIS and other government required activities within the requested timeframe. This includes requests from Blue Shield related to this program.

Section 6

Health Insurance Marketplaces (Exchanges)

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 *Guidelines & resources* at the top of the landing page, then *Healthcare reform* in the top right.

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 (Blue 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.

Health Insurance Marketplaces Overview *(cont'd.)*

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 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.

1. Eligibility and Benefits
2. Care Management
    1. Pre-Service Review
    2. Medical Policy
3. Claim Pricing and Processing
    1. Contracting
    2. Claim Filing
    3. Pricing
    4. Claim Processing
    5. Medical Records
    6. Payment
    7. Customer Service

Health Insurance Marketplaces Overview *(cont'd.)*

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 *Guidelines & resources* at the top of the landing page.

2) Click on *Healthcare reform* in the top right.

3) On the next page, click on the link *Products and Networks Available through Covered California.*

Here, you will find a wide variety of provider and member resources to enhance your understanding of Health Insurance Marketplaces.

Who do I contact if I have a question about Health Insurance Marketplaces (Exchanges)?

If you have any questions regarding the Health Insurance Marketplaces, please contact Blue Shield's Provider Customer Service Unit at (800) 541-6652.

Section 7

Glossary of BlueCard Program Terms

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.
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.
Ancillary Services	Ancillary services include independent clinical laboratory services, durable/home medical equipment and supply services, and specialty pharmacy services.
bcbs.com	Blue Cross and Blue Shield Association's website, which contains useful information for providers.
BlueCard Access	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.

BlueCard Doctor and Hospital Finder	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 *Find a Doctor* and then click on the *Providers outside of CA* link on the bottom of the page.
BlueCard *Eligibility®*	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.
BlueCard PPO	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.
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 this identifier on 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 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 High-Performance Network (BLUEHPN)	A national network of providers offered in key geographies that provides national accounts enhanced quality and cost savings.
Blue Shield Global Core®	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.
Consumer Directed Health Care/Health Plans (CDHC/CDHP)	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.
Coinsurance	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.

Coordination of Benefits (COB)	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.
Copayment	A specified charge that a member incurs for a specified service at the time the service is rendered.
Deductible	A flat amount the member incurs before the insurer will make any benefit payments.
Electronic Provider Access	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 onto Provider Connection at blueshieldca.com/provider and click on *Pre-service review for out-of-area members* in the *Authorizations* section on the opening landing page. 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.
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.
Exclusive Provider Organization (EPO)	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.
FEP	The Federal Employee Program.

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.
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.
Preferred Provider Organization (PPO)	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.
Prefix	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.
Provider Connection	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.
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.
Small Business Health Options Program (SHOP)	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.

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.
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.

Table of Contents

Appendix For Section 6

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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 Medicare Advantage plan 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.

Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

- 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.

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.

Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

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.)

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.

Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

Regulatory Changes & the Centers for Medicare & Medicaid Services *(cont'd.)*

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.

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(l) 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.

Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

Regulatory Changes & the Centers for Medicare & Medicaid Services *(cont'd.)*

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.

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

#	Responsible Party	Activity	Time Requirement
	MSO	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.	No less than 2 days prior to termination of services
1.	SNF, HHA, CORF	Issues NOMNC and obtains member's signature. SNF- at least 2 days prior to termination If < 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.	2 days prior to termination of services
2.	Enrollee	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.	No later than noon the day after receipt of notice
3.	QIO = Health Services Advisory Group, Inc.	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.	Day 1 begins
4.	MA (Medicare Advantage) = Medicare Advantage plan	Receives notice of appeal from Health Services Advisory Group, Inc. (by phone & 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.	Day 1

#	Responsible Party	Activity	Time Requirement
5.	Blue Shield Medicare Advantage plan	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 Medicare Advantage plan. Also contact should be made to SNF requesting records & NOMNC be faxed to Health Services Advisory Group, Inc. for review with confirmation of this to Blue Shield. Health Services Advisory Group, Inc. needs the detailed chart notes that SNF's have for review.	Day 1
6.	Blue Shield Medicare Advantage plan	If IPA/MSO is unable to make Day 1 submission requirement, notify Manager, Director or Medical Director.	Day 1
7.	Blue Shield Medicare Advantage plan	Manager, Director or Medical Director then contacts IPA Director of UM/QM & or Medical Director to obtain documents.	Day 1
8.	IPA/MSO	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.) Member/representative: Mails DENC. Upon request, all documents sent to Health Services Advisory Group, Inc.	Day 1
9.	Blue Shield Medicare Advantage plan	IPA makes decision to rescind the termination date and send new letter to member Fax copy of letter to Health Services Advisory Group, Inc.	Resolved Go to step 14
10.	Health Services Advisory Group, Inc.	Reviews documents Renders decision to uphold or overturn Notifies Blue Shield Medicare Advantage plan of decision by phone or fax. Mails letters of determination to Blue Shield Medicare Advantage plan and enrollee	Day 1 If Resolved Go to step 14
11.	Health Services Advisory Group, Inc.	If documents not received by Health Services Advisory Group, Inc., on Day 2, Health Services Advisory Group, Inc. sends to Blue Shield Medicare Advantage plan , "Notice: Failure to Comply" requesting documents again.	Day 2

Blue Shield Medicare Advantage Plan
Required Billing Elements

#	Responsible Party	Activity	Time Requirement
12.	Blue Shield Medicare Advantage plan	Call IPA/MSO contact again to ensure all documents are faxed to Health Services Advisory Group, Inc. for review.	Day 2
13.	Health Services Advisory Group, Inc.	Review documents Render decision to uphold or overturn Notifies IPA & Blue Shield Medicare Advantage plan of decision by phone or fax. Mails letters of determination to Blue Shield Medicare Advantage plan and enrollee	Day 2
14.	Blue Shield Medicare Advantage plan	Logs all actions, dates & times in Notes document 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	Real time
15.	Blue Shield Medicare Advantage plan	Cases are filed away in a locked cabinet alphabetically	Conclusion

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.

Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

Contractual & Billing Requirements *(cont'd.)*

- **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.

- **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/forms-notices/beneficiary-notices-initiative/ffs-ma-nomnc-denc. 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.

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: **OMB Approval No. 0938-1019**
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:

  _____
  {insert specific managed care policies}

  ____Other

_____
{insert other applicable 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)

Blue Shield Medicare Advantage Plan
Required Billing Elements

(Attachment B – CMS Model Letter – **SAMPLE -** Must be 12 point font)
OMB Approval No. 0938-0953

{Insert provider contact information here}
NOTICE OF MEDICARE NON-COVERAGE

Patient name: **Patient number:**

The Effective Date Coverage of Your Current {insert type}
Services Will End: {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.

See page 2 of this notice for more information.

Form CMS 10123-NOMNC (Approved 12/31/2011) OMB approval 0938-0953
H0504_12_095B File & Use 05052012

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 Medicare Advantage Plan
  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.

Signature of Patient or Representative Date

Form CMS 10123-NOMNC (Approved 12/31/2011) OMB approval 0938-0953

Optional Attachment to assist with documentation

Blue Shield Medicare Advantage Plan
Required Billing Elements

Please fax completed (signed) Notice of Medicare Non-Coverage (NOMNC) to:

_____

CONFIRMATION OF NOTICE BY TELEPHONE

(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.)

Name of person contacted:

Date of contact: Time: ☐AM ☐PM

_____

_____

Signature of Health Plan/SNF/HHA/CORF/Medical Group Representative Date

CONFIRMATION OF FOLLOW-UP NOTICE BY MAIL

(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.)

Mailing address:

_____

_____

_____

_____

Date sent: _____Via: ☐ US Mail ☐ Certified Mail ☐ FedEx ☐ Priority Mail

Tracking # (if applicable): _____

CONFIRMATION OF REFUSAL TO SIGN

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.

Name of person receiving notice:

Date of delivery: Time: ☐AM ☐PM

_____
_____
Signature of Person Delivering Notice Date

Guidance Checklist When Issuing NOMNC to Other Than Member (See Medicare Managed Care Manual, Chapter 13, Section 60.1.3)	Responsible Party		Initial Completed	Date	Time
	SNF	BSC/MG /IPA			
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.					

Blue Shield Medicare Advantage Plan
Required Billing Elements

Guidance Checklist When Issuing NOMNC to Other Than Member (See Medicare Managed Care Manual, Chapter 13, Section 60.1.3)	Responsible Party		Initial Completed	Date	Time
	SNF	BSC/MG /IPA			
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.					