HMO IPA/Medical Group Procedures Manual

For IPAs/medical groups and their contracted providers

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blue california

blueshieldca.com

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1.1 Blue Shield Introduction

Section 1: Introduction

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Purpose and Organization of the Manual

The *HMO IPA/Medical Group Procedures Manual* describes the policies and operating procedures for IPA/medical groups that contract with Blue Shield of California (Blue Shield) for commercial products, including Access+ HMO®, and our Medicare Advantage – Prescription Drug product, Blue Shield Medicare Advantage plans[1]. It serves as a general reference on topics key to administering the HMO, such as eligibility, contract administration, benefits, and medical management.

This manual is designed to be used in conjunction with the *HMO Benefit Guidelines* (HBG). The HBG explains covered and non-covered services and member copayments for each benefit. It provides answers to specific benefit interpretation questions. *Note: Blue Shield retains the right to make all financial benefit interpretations.*

This *HMO IPA/Medical Group Procedures Manual* replaces and supersedes all previous versions of the manual you may have received or viewed online before this issue date.

This manual is divided into the following six sections, and includes Appendices, if applicable, for each of the sections.

Section 1: Introduction

This section covers the purpose and organization of the manual. The Appendix for this section contains a glossary defining many of the common terms used in this manual.

Section 2: Benefit Plans and Programs

This section describes features of Blue Shield HMO plans as well as benefit programs that Blue Shield offers.

Section 3: Eligibility

This section explains the enrollment process and describes how to verify member eligibility. It also covers enrollment changes and procedures for the transfer or disenrollment of members.

Section 4: Contract Administration

This section includes an overview of the HMO provider network and addresses physician participation and credentialing requirements, as well as contractual responsibilities of both Blue Shield and the IPA/medical group. Member rights and responsibilities and claims administration procedures are also included.

[1] When the manual references Blue Shield Medicare Advantage, it refers to Blue Shield's Medicare Advantage plans; Blue Shield 65 Plus (HMO), Blue Shield 65 Plus Choice Plan (HMO), Blue Shield Trio Medicare (HMO), Blue Shield Inspire (HMO) and Blue Shield Vital (HMO).

Purpose and Organization of the Manual *(cont'd.)*

Section 5: Medical Care Solutions

This section covers Blue Shield HMO Quality Improvement, Delegation Guidelines, and Utilization Management requirements for IPA/medical groups.

Service authorization guidelines, denials and areas relating to quality-of-care review are also highlighted.

Section 6: Blue Shield Medicare Advantage Plan

This section describes the features and operational requirements for Blue Shield's Medicare Advantage Prescription Drug Plan, the Blue Shield Medicare Advantage plan.

Appendices

Most sections are supplemented by an Appendix, located in the back of the manual, which contain charts, forms, lists and/or summaries referenced within the section.

Manual Orders and Updates

Go to Provider Connection at blueshieldca.com/provider, and click on *Guidelines & Resources,* then *Provider Manuals* to view and download a copy of the *HMO IPA/Medical Group Procedures Manual* or the *HMO Benefit Guidelines.*

To order a copy of either manual on CD, email providermanuals@blueshieldca.com or contact your Blue Shield HMO Coordinator.

This manual is updated at least annually, in January.

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 SIU 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.

Provider Audits

The Blue Shield of California 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.

Blue Shield's Code of Conduct and Corporate Compliance Program

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

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

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

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

Blue Shield of California Code of Conduct

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

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2.1 Blue Shield HMO Benefit 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 IFP (on-exchange and mirrored only).

Most groups, such as the Federal Employees' Health Benefits Plan (FEHBP) for example, select the Access+ HMO Plan, which offers a unique self-referral feature called Access+ *Specialist*SM. Blue Shield may also tailor or customize plans for groups with 126+ eligible employees. For example, the California Public Employees Retirement System (CalPERS) HMO consists of two types of plans: a basic CalPERS benefits plan and a Medicare Supplement plan.

The Blue Shield HMO benefit summaries listing the plan-specific benefits and copayments can be found on Provider Connection at blueshieldca.com/provider under *Eligibility & benefits,* then *Benefit summaries*. You can also view and download the Individual Medicare Advantage – Prescription Drug HMO Summary of Benefits under the same link.

The Individual Medicare Advantage – Prescription Drug HMO Summary of Benefits also appears online at www.medicare.gov under the Medicare Plan Finder.

For questions on HMO benefit information, eligibility, claims, and/or billing, call Blue Shield Provider Customer Service at (800) 541-6652.

2.1 Blue Shield HMO Benefit Plans

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Access+ HMO Features

The majority of Blue Shield of California HMO members are covered under the Access+ HMO® program, which allows HMO members direct access to specialists.

The major features of the Access+ HMO program are:

- Access+ *Specialist*SM
- Access+ *Satisfaction*®
- Preventive care at no charge
- Virtually no claim forms for members to complete

Access+ *Specialist*SM

Access+ *Specialist* is a feature that allows HMO members to go directly to a specialist in the same participating IPA/medical group as their primary care physician (PCP), without a referral, for a higher copayment.

IPA/medical groups participate in the Access+ *Specialist/Satisfaction* Program and are considered Access+ Provider Groups for members having an Access+ HMO plan. An Access+ HMO member ID card features the symbol "A+" next to the IPA/medical group name indicating that the member is eligible for Access+ *Specialist* services and that the IPA/medical group is an Access+ Provider Group.

A female member may self-refer to an obstetrician/gynecologist (OB/GYN) or family practice physician in the same IPA/medical group as her PCP for OB/GYN services. This is not considered an Access+ *Specialist* visit. The standard office visit copayment applies.

Access+ *Satisfaction*®

The Access+ *Satisfaction* feature allows HMO members to provide feedback on the service they receive from Access+ HMO primary care physicians during a covered office visit. If they are unhappy with the service, members can request a refund of their standard office visit copayment. Blue Shield monitors the member feedback obtained through this program and uses the information to evaluate the services provided by HMO network physicians.

Access+ HMO Features *(cont'd.)*

Self-Referral for OB/GYN Services

Female members may arrange for obstetrical and/or gynecological (OB/GYN) services by an obstetrician/gynecologist or family practice physician (who is not their designated PCP) without referral from her PCP. However, the obstetrician/gynecologist or family practice physician must be in the same medical group as the primary care physician. Obstetrical and gynecological services are defined as:

- Physician services related to prenatal, perinatal, and postnatal care
- Physician services provided to diagnose and treat disorders of the female reproductive system and genitalia
- Physician services for treatment of disorders of the breast
- Routine annual gynecological examinations/annual well-woman examinations.

The OB/GYN or family practice physician will notify the primary care physician of the results of the examination. If the examination results identify the need for specialty services (for example, mammography, surgery, ultrasound, etc.), the member's PCP must provide or arrange for the additional services.

Provider and Member Participation

Provider Participation

Physicians contracted with IPA/medical groups that participate in the Access+ *Specialist/Satisfaction* Program automatically become participating physicians in the Program. Participating Access+ Provider Groups are listed as such in the *Blue Shield HMO Physician and Hospital Directory*.

Member Participation

The Access+ *Specialist* office visits are available only to members who belong to Access+ HMO plans. An Access+ HMO member ID card has the symbol "A+" next to the IPA/medical group name indicating that the member is eligible for Access+ *Specialist* services and the IPA/medical group is an Access+ Provider Group.

The Blue Shield Medicare Advantage plan (Blue Shield's Medicare Advantage – Prescription Drug HMO plan) and Blue Shield Added Advantage POS SM (point-of-service) plan do not offer the Access+ *Specialist/Satisfaction* feature.

Role of Primary Care Physicians/Specialists in Access+ HMO

Primary Care Physicians (PCPs)

Under the Blue Shield Access+ HMO Plan, primary care physicians maintain their role in coordinating the Access+ HMO member's healthcare needs. However, members access mental health and substance use disorder services through participating providers of Blue Shield's mental health service administrator (MHSA).

Specialists

Access+ HMO members may go to any specialist for a consultation, as long as that specialist is affiliated with the same IPA/medical group as that of his/her PCP.

Specialists agree to see Access+ HMO members who self-refer for Access+ *Specialist* services and to continue to coordinate the healthcare needs of Access+ HMO members with their PCP through the IPA/medical group's authorization process.

Seeing a Member on a Regular Basis

A specialist who has determined that it is medically necessary for the member to see him or her on a continuing basis should contact the member's PCP to discuss the proposed treatment plan or other relevant information and to arrange for a standing referral. Consultation notes and treatment plans should be shared with the member's PCP.

The member's primary care physician may request authorization from his or her IPA/medical group, which may deny or approve the request for a standing referral.

If additional services are authorized, the member may go back to the specialist for the authorized services and pay the usual office visit copayment. If the member elects to self-refer again for additional services, the member is responsible for paying the higher Access+ *Specialist* office visit copayment.

Additional self-referred services are limited to the approved services listed. (For service coverage information, see the Access+ *Specialist* Services subsection on the following pages.)

Referring Members Back to Their Primary Care Physicians

An Access+ HMO member can see a specialist either with a referral from his or her primary care physician or through the Access+ *Specialist* feature with a self-referral to a specialist in the same IPA/medical group as his or her PCP. If an Access+ HMO member self-refers to a specialist who is affiliated with an IPA/medical group that is *not* an Access+ Provider Group, the specialist should refer the member back to his or her PCP or to Blue Shield's Member Services Department for assistance. If the specialist who is not an Access+ Provider renders services without a referral, the member will be liable for all charges.

Using Access+ *Satisfaction*

Access+ HMO members may call Blue Shield's Member Services Department to provide feedback on the service they receive from Access+ HMO physicians and their primary care physician's office staff during covered office visits.

If a Member is dissatisfied with the service provided during an office visit with a Plan Physician, the Member may contact Member Services at the number provided on the back page of the *Evidence of Coverage*.

Procedure for Accessing Care through Access+ *Specialist*

The Access+ *Specialist* feature is utilized only if a member chooses to go to a specialist without a referral from his/her primary care physician. The member can choose to receive services within the HMO benefit plan at lower copayment levels by first seeing his/her Primary care physician and receiving authorization/referral to a specialist.

Described below is the process that explains how an Access+ HMO member accesses care through the Access+ *Specialist* option for other than mental health and substance use disorder services.

Access+ HMO Member Self-Refers Using Access+ *Specialist*

An Access+ HMO member chooses to consult a specialist for Access+ *Specialist* services and self-refers directly to a specialist within the same IPA/medical group as that of his or her primary care physician instead of going to his or her PCP for a referral. The member's Access+ *Specialist* office visit copayment is payable at the time of the visit.

A female member may self-refer to an Obstetrician/Gynecologist (OB/GYN) or Family Practice Physician in the same IPA/medical group as her PCP for OB/GYN services. This is not considered an Access+ *Specialist* visit. The standard office visit copayment applies.

Procedure for Accessing Care through Access+ *Specialist*
(cont'd.)

Specialist Provides Access+ *Specialist* Services

The Access+ HMO member makes an appointment with a specialist and presents the Access+ HMO member ID card.

Before providing Access+ *Specialist* services, the specialist verifies the member's eligibility by checking the member's Access+ HMO member ID card or by calling Blue Shield's Member Services Department.

> *Note: An Access+ HMO member ID card that has the symbol "A+" next to the IPA/medical group name indicates that the member is eligible for Access+* Specialist *services and the IPA/medical group is an Access+ Provider Group.*

The Access+ HMO member consults with the specialist. The specialist's office staff collects the member's Access+ *Specialist* office visit copayment. The specialist provides the member's PCP with the consultation note(s).

If additional services or procedures are recommended, the specialist coordinates care with the member's PCP and follows the IPA/medical group's current authorization procedures.

If additional services or procedures are authorized, the member may go back to the specialist for the authorized services and pay the usual office visit copayment. If the member elects to self-refer again for additional services, the member is responsible for paying the Access+ *Specialist* office visit copayment. Additional self-referred services are limited to the approved services listed. (For service coverage information, see the Access+ *Specialist* Services subsection on the following pages.)

Access+ *Specialist* Services

The Access+ *Specialist* visit includes:

- An examination or other consultation provided to the Access+ HMO member by an IPA/medical group plan specialist without referral from the member's primary care physician
- Conventional X-rays, such as chest X-rays, abdominal flat plates, and X-rays of bones to rule out the possibility of fracture (but does not include any diagnostic imaging such as CT, MRI, or bone density measurements)
- Laboratory services
- Diagnostic or treatment procedures that a plan specialist would regularly provide under the referral from the member's primary care physician

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 primary care physician

Access+ *Specialist* Claims Processing

Specialist Submits Access+ *Specialist* Claims to IPA/Medical Group

Access+ *Specialist* services are included in the IPA/medical group's capitation. Claims should be processed as follows:

- The specialist submits a photocopy of the Access+ HMO member ID card and Access+ *Specialist* claim to his or her IPA/medical group.
- The IPA/medical group processes the Access+ *Specialist* claim and pays the specialist according to its agreement with the specialist. Access+ Specialist services are submitted to Blue Shield as encounters.

For more specific information on *Access+ Specialist* claims processing, refer to your IPA/medical group contract with Blue Shield.

Access+ *Specialist* Encounters - Electronic Encounters

Access+ *Specialist* claims may be submitted electronically. Access+ provider groups must be able to identify an Access+ *Specialist* visit on their electronic encounter submission by one of the following methods:

1. Enter the word(s) "bypass" or "access plus" in the Referring Physician Last Name field of the Western Region HMO/IS format (Record - EA0: Field 22), or

   837P - 2300 CN1 Loop, CN101- 9. CN104-ACCESSPLUS (or BYPASS)

2. Enter the word(s) "bypass", "access" or "access plus" in the Claim Header Record Local Filler field of the Referring Physician Last Name field of the Western Region HMO/IS format (Record - CA0: Field 22), or

   837P – 2300 CN1 Loop, CN101- 9. CN104- ACCESSPLUS (or BYPASS)

3. Enter the word(s) "bypass," "access," or "access plus" in the Referring Physician field of the X12 005010X222A1:837 – Health Care Claim Professional ANSI Format (loop 2010BB REF, or loop 2310A NM103)

   837P – 2300 CN1 Loop, CN101 - 9. CN104 – ACCESSPLUS (or BYPASS)

   BHT06= RP

   2300 Loop CN101=9

   2300 Loop CN104= ACCESSPLUS or BYPASS

Access+ *Specialist* Claims Processing *(cont'd.)*

Access+ *Specialist* Encounters - Electronic Encounters *(cont'd.)*

These are Blue Shield's currently defined indicators for Access+ *Specialist* claims. Once the record is identified as an Access+ *Specialist* visit, the following data elements are required (in addition to the standard required HMO/IS or ANSI data fields):

1. Allowed amount (for example Record FB0: Field 06) or (2430/CAS03) based on 837P implementation guide page 561.
2. Paid amount (for example Record FA0: Field 35) or (2430/CAS03) based on 837I implementation guide page 561.

For additional information, please call Blue Shield's Electronic Data Interchange (EDI) Help Desk at (800) 480-1221 or visit Provider Connection at blueshieldca.com/provider and click on *Claims*, then *Manage electronic transactions.*

2.3 Blue Shield Accountable Care Organizations (ACOs)

Blue Shield's Accountable Care Organizations (ACOs) are alliances formed with physician groups and hospitals who, together with Blue Shield, share responsibility and accountability for the quality, cost, and overall care of a defined group of members. Blue Shield is committed to partnering with selected providers to leverage their expertise and innovative care models to fundamentally change healthcare delivery. Members benefit from collaboration, innovation, stronger coordination between providers, and the sharing of critical information which help to drive better healthcare outcomes.

Underlying each ACO collaboration is a contract that establishes a set of financial incentives that serve to align the parties to work together toward improved healthcare outcomes, cost efficiency and quality improvement. Financial incentives are built on a foundation of shared risk where all parties in an ACO collaboration are motivated to work together toward these goals. Members benefit from lower costs which are passed down to them in the form of lower premiums. Blue Shield provides our ACO groups and hospitals with resources from the Provider Partnerships, Clinical Pharmacy, Quality Improvement, and Actuary teams to support the success of our ACOs.

Trio HMO

The Trio Health Maintenance Organization (HMO) is a product supported by a network of Accountable Care Organization (ACO) providers. In 2017, Trio was newly offered to Covered California with goals of improved patient access, higher quality outcomes and increased cost efficiency. Trio uses an integrated network delivery model across specialties and hospitals that provides coordinated care and leverages relationships with select providers in specific regions.

The name "Trio" represents our ACO program collaboration that creates a community of care to support improved health outcomes for Trio members and helps reduce healthcare costs. As with a traditional HMO plan, members' care is coordinated by a primary care physician. Further, Trio plans are designed to help:

- Link members to the right services
- Create a cross-organizational focus on members with complex needs
- Improve discharge processes and programs to reduce hospital readmissions

Provider Participation

Provider participation in the Trio HMO Network is based on the entire IPA/Medical Group, not on the individual physician's contract with Blue Shield. If your IPA/medical group is participating in the Trio HMO Network, then you are participating as well. To check a physician's participation in the Trio HMO Network, contact your IPA or Medical Group, or go to www.blueshieldca.com and click on *Find a Doctor.*

Trio HMO *(cont'd.)*

Added Benefits

Trio HMO is a family of HMO plans that are focused on delivering choice, coordinated care and affordability. When Blue Shield developed Trio HMO, it was built with members' key concerns in mind. In additional to affordable care, the following unique features are offered.

- Low or no deductibles
- Select local physicians, specialists, and hospitals
- Lifestyle programs to support prevention, treatment, and reversal
- A dedicated customer care line for Trio members, Shield Concierge
- On-demand doctor house calls with Heal™ add in $0 first visit copay and free Rx delivery with Heal visit
- 24/7 virtual consults with Teladoc for $0 copays
- Option to self-refer to specialists within the same medical group

Wellvolution

Included in Trio HMO is Wellvolution, a platform of personalized diet and lifestyle change programs to improve health, lose weight, and feel better.

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 60 programs to choose from, ranging from general well-being, 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.

Weight Loss Programs – Programs specifically designed to help members make changes that fit their lifestyle and promote a healthy weight. Members 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 pounds per week and improvement in their quality of life across the board.

Disease Prevention Programs - Targeting reduction of risk for type 2 diabetes and heart disease, prevention programs provide members with a health coach and an individualized plan that meet the unique needs and address several areas of a member's 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.

Trio HMO *(cont'd.)*

Added Benefits *(cont'd.)*

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.

Shield Concierge

Trio offers a high level of customer service and engagement to members and more flexibility for the member with a choice of local doctors, specialist, hospitals, and pharmacy locations. Trio members have access to Shield Concierge, a team of professionals consisting of customer care representatives, registered nurses, social workers, health coaches, pharmacy technicians, and pharmacists available to provide information to a member regarding benefits, doctors and specialists, coordination of care, case management, and questions on formulary and prescription medication authorizations.

Members who have questions about their benefits should call Shield Concierge at the number listed on the back of the member ID card.

2.3 Blue Shield Accountable Care Organizations (ACOs)

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2.4 Blue Shield Added Advantage POS℠ (Point-of-Service) Plan

Introduction

Blue Shield's Added Advantage POS Plans combine the benefits of the Access+ HMO with access to the Blue Shield Preferred Plan (PPO) provider network. The Added Advantage POS℠ Plan is called a point-of-service plan because the member can decide at the time that healthcare services are needed whether to access benefits under the HMO option or under the "In-PPO Network" or "Out-of-PPO Network" options. These options offer varying degrees of financial responsibility.

Under the HMO option of the Added Advantage POS Plan, members obtain services through their HMO primary care physician and pay a fixed copayment for most covered services, with virtually no claim forms. Or, if they prefer, members may use the "In-PPO Network" option and seek care from a Blue Shield Preferred Provider or from a non-network physician, without consulting their primary care physician. Services received under the "In-PPO Network" and "Out-of-PPO Network" options are subject to a deductible and applicable copayments and coinsurance. Care received from non-network physicians is covered at the lowest benefit level. When members receive services from non-network physicians, members must also file claim forms and pay any difference between the amount Blue Shield allows for those services and the amount billed by a non-network physician. Preventive Services are only covered under the HMO option of the POS Plan.

Note: Mental health and substance use disorder services are accessed through Blue Shield's mental health service administrator (MHSA) utilizing MHSA participating providers and MHSA non-participating providers.

Plan Benefits

Blue Shield's Added Advantage POS Plans are only offered to Core Account employer groups. These plans combine standard Access+ HMO plan benefits with Blue Shield's PPO network of providers at an increased financial responsibility for the member.

Blue Shield's Added Advantage POS Plans benefit coverage is based on benefits available under Blue Shield's HMO plan. When the member elects to use "In-PPO Network" and "Out-of-PPO Network" providers, only the member's level of financial responsibility is changed; benefits available are not changed. However, there may be some benefit exceptions for custom groups (e.g., the Stanford Triple Option Plan). The IPA/medical group will be notified of these exceptions.

The Added Advantage POS Plan does not include the Access+ *Specialist* or the Access+ *Satisfaction* features.

Plan Benefits *(cont'd.)*

Non-Emergency Admissions

Added Advantage POS Plan members who want to access services at their Level I HMO Option must obtain an authorization from the HMO primary care physician for non-emergency hospital admissions. Prior authorization is also required for a non-emergency hospital admission when an Added Advantage POS Plan member accesses services using the Level II or Level III PPO network option. The treating physician should contact Blue Shield's Provider Customer Service at (800) 541-6652 and select the authorizations option, at least five business days prior to the admission.

Emergency Admissions

In the case of an admission for emergency services, Blue Shield should receive Emergency Admission Notification within 24 hours or as soon as reasonably possible following medical stabilization, whichever is later. Blue Shield's Medical Care Solutions will discuss the benefits available, review the medical information provided and may recommend that to obtain the full benefits of this health plan the services must be performed on an outpatient basis.

Information about which Added Advantage POS plan the member belongs to is found on the Blue Shield POS Eligibility Report in the coverage level column.

Claims Submission

Hard Copy or Batched Claims Submission

Claims for in-network services referred or rendered by the physician and outlined as IPA/medical group responsibility in the applicable Division of Financial Responsibility (DOFR), should be submitted electronically to the IPA/medical group for payment determination.

For payment determination, the IPA/medical group must submit directly to Blue Shield the following types of claims:

- In-network institutional services
- Out-of-network institutional services
- Out-of-network professional services
- Point of Service Plan Tier II and Tier III Self-referred Services
- Other Services deemed by the Division of Financial Responsibility (DOFR) to be Plan responsibility.

If the IPA/medical group requires its physicians to submit all claims to the IPA (including those that are for self-referred services), the IPA/medical group should indicate which services were self-referred when submitting the electronic claim using the instructions below before sending them to Blue Shield for payment.

Claims Submission *(cont'd.)*

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 or contact the EDI Help Desk at (800) 480-1221, or email EDI_BSC@blueshieldca.com.

Submitting Self-Referral for Professional Claims:

Loop 2310A NM103 = SELFREFERRAL

Loop 2310A NM104 = BLANK

First Name = SELFREFERRAL

Last Name = Blank

NM1*DN*1*SELFREFERRAL*****1002233777~

Submitting Self-Referral for Institutional Claims:

Loop 2310F NM103= SELFREFERRAL

Loop 2310F NM104= BLANK

First Name = SELFREFERRAL

Last Name = BLANK

Sample: NM1*DN*1*SELFREFERRAL*****XX*1002233777~

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 SELFREFERRAL for NM103 but leave blank NM104
- Use generic NPI for NM109

Sample: SELFREFERRAL

NM1*DN*1*SELFREFERRAL*****xx*1002233777

Note: This electronic billing process for Added Advantage POS Plan claims does not apply to services billed by the member's physician or services rendered to regular Blue Shield HMO members. Independent laboratory providers should continue to enter the ordering physician's name and identification number in the appropriate fields for correct processing.

2.4 Blue Shield Added Advantage℠ POS (Point-of-Service) Plan

Claims Payment Determination

When a provider of service submits a claim directly to Blue Shield, the criteria on the following page is used to determine financial responsibility.

Professional Services Claims

If there is a record that the member has self-referred or "opted-out", Blue Shield will pay the claim at the PPO benefit level.

If there is no record that the member has self-referred, the billing provider will receive an *Explanation of Benefits* (EOB) with the following message:

> *"This patient's Blue Shield plan has self-referral benefits. Claims for services not authorized by the patient's HMO primary care physician (PCP) should be billed to Blue Shield and have 'self-referral' written on the claim. Services provided or authorized by the patient's HMO PCP should be billed to the physician's IPA/medical group. Because these services were provided or authorized by the patient's HMO PCP, this claim has been forwarded to:*
>
> IPA "Name"
> IPA "Address"
> IPA "City, State, Zip"
>
> *Please note this address and submit future claims for this member to this address"*

If the IPA/medical group approves the service, it will pay the professional claim and return it to Blue Shield as an encounter.

If the service is not approved, the billing physician should resubmit the claim to Blue Shield HMO indicating that the member is "self-referring" to access his or her PPO benefits.

Institutional Services Claims

If there is a record of an IPA/medical group or Blue Shield authorization, Blue Shield will pay the claim at the HMO benefit level.

If there is a record of an Added Advantage POS Plan member self-referral or "opt-out', Blue Shield will pay the claim at the PPO benefit level.

If there is no record of a self-referral or an IPA/medical group or Blue Shield authorization, processing of the claim will be suspended while Blue Shield requests the IPA/medical group authorization form from the billing provider. If the provider sends Blue Shield a copy of the authorization form, the claim will be processed at the member's HMO Level I option. If the provider indicates that the member has self-referred, Blue Shield will process the claim at the member's Level II PPO or Level III non-network option.

Claims Payment Determination *(cont'd.)*

Emergency (ER) Services

Standard HMO procedures are used to adjudicate emergency room claims and other claims that may be for emergency services. If the services were rendered to treat a medical or psychiatric emergency (under the reasonable person standard), then the services are covered under the HMO Level I option. If the services are not covered under the HMO option (i.e., non-emergency), they may be covered at Level II or Level III according to Blue Shield policy and are subject to any applicable deductible, copayment, or coinsurance.

Emergency Room Physician Services Note: After services have been provided, Blue Shield may conduct a retrospective review. If this review determines that services were provided for a medical condition that a person would not have reasonably believed was an emergency medical condition, benefits will be paid at Level II or Level III as specified under Outpatient Physician Services Benefit in the Professional (Physician) Benefits in the *Summary of Benefits and Coverage* and will be subject to any calendar year medical deductible.

2.4 Blue Shield Added Advantage℠ POS (Point-of-Service) Plan

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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 under 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.

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.

Ancillary Benefits *(cont'd.)*

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

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

Ancillary Benefits *(cont'd.)*

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.

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 Medical Eye Services of California (MESVision). It covers services for refractions, lenses, and frames. Any questions concerning these benefits may be directed to:

Medical Eye Services (877) 601-9083

2.5 Ancillary Benefits

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Blue Shield's commercial HMO and POS benefit plans have a standard set of exclusions and limitations. Services subject to the standard exclusions under some plans, such as those for vision, infertility, chiropractic, and dental services, may be covered under optional benefits.

Note: For Blue Shield's Medicare Advantage Plan Prescription Drug exclusions and limitations, see Section 6.2.

General Exclusions and Limitations

Unless exceptions to the following exclusions are made elsewhere in the group contract, no benefits are provided for services that are:

1. Routine physical examinations, except as specifically listed under Preventive Health Benefits, or for immunizations and vaccinations by any mode of administration (oral, injection or otherwise) solely for the purpose of travel, or for examinations required for licensure, employment, insurance or on court order or required for parole or probation;

2. For hospitalization primarily for X-ray, laboratory, or any other outpatient diagnostic studies or for medical observation;

3. Routine foot care items and services that are not medically necessary, including callus, corn paring or excision and toenail trimming except as may be provided through a Participating Hospice Agency; over-the-counter shoe inserts or arch supports, or any type of massage procedure on the foot;

4. Inpatient treatment in a pain management center to treat or cure chronic pain, except as may be provided through a Participating Hospice Agency or through a palliative care program offered by Blue Shield;

5. Home services, hospitalization, or confinement in a health facility primarily for rest, Custodial, Maintenance, or Domiciliary Care, except as provided under Hospice Program Benefits;

6. Services in connection with private duty nursing, except as provided under Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, and except as provided through a Participating Hospice Agency;

7. Prescription and non-prescription food and nutritional supplements, except as provided under Home Infusion/Home Injectable Therapy Benefits, PKU Related Formulas and Special Food Products Benefits, or as provided through a Participating Hospice Agency;

8. Hearing aids;

9. Eye exams and refractions, lenses and frames for eyeglasses, and contact lenses except as specifically listed under Prosthetic Appliances Benefits, and video-assisted visual aids or video magnification equipment for any purpose;

10. Surgery to correct refractive error (such as but not limited to radial keratotomy, refractive keratoplasty);

11. Any type of communicator, voice enhancer, voice prosthesis, electronic voice producing machine, or any other language assistive devices, except as specifically listed under Prosthetic Appliances Benefits;

General Exclusions and Limitations *(cont'd.)*

12. For dental care or services incident to the treatment, prevention, or relief of pain or dysfunction of the Temporomandibular Joint and/or muscles of mastication, except as specifically provided under the Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);

13. For or incident to services and supplies for treatment of the teeth and gums (except for tumors, preparation of the member's jaw for radiation therapy to treat cancer in the head or neck, and dental and orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures) and associated periodontal structures, including but not limited to diagnostic, preventive, orthodontic and other services such as dental cleaning, tooth whitening, X-rays, imaging, laboratory services, topical fluoride treatment except when used with radiation therapy to the oral cavity, fillings, and root canal treatment; treatment of periodontal disease or periodontal surgery for inflammatory conditions; tooth extraction; dental implants, braces, crowns, dental orthoses and prostheses; except as specifically provided under Medical Treatment of the Teeth, Gums, Jaw Joints or Jaw Bones Benefits and Hospital Benefits (Facility Services);

14. For cosmetic surgery except for the medically necessary treatment of resulting complications (e.g., infections or hemorrhages. Without limiting the foregoing, no benefits will be provided for the following surgeries or procedures:

    a. Surgery to excise, enlarge, reduce, or change normal structures of any part of the body to improve appearance.

    b. Surgery to reform or reshape skin or bone to improve appearance.

    c. Lower eyelid blepharoplasty.

    d. Upper eyelid blepharoplasty without documentation of significant visual impairment or symptomology.

    e. To correct spider veins.

    f. Services and procedures to smooth the skin (e.g., chemical face peels, laser resurfacing, and abrasive procedures).

    g. Items and services for the promotion, prevention, or other treatment of hair loss, hair growth or hair removal, including hair transplantation.

    h. Reimplantation of breast implants originally provided for cosmetic augmentation.

    i. Surgery to excise or reduce skin or connective tissue that is loose, wrinkled, sagging, or excessive on any part of the body.

    j. Voice modification surgery.

15. For reconstructive surgery where there is another more appropriate covered surgical procedure or when the proposed reconstructive surgery offers only a minimal improvement in the appearance of the member.

    This exclusion shall not apply to breast reconstruction when performed subsequent to a mastectomy, including surgery on either breast to achieve or restore symmetry.

16. For sexual dysfunctions and sexual inadequacies, except as provided for treatment of organically based conditions;

General Exclusions and Limitations *(cont'd.)*

17. Any services related to assisted reproductive technology, including but not limited to the harvesting or stimulation of the human ovum, in vitro fertilization, Gamete Intrafallopian Transfer (GIFT) procedure, artificial insemination (including related medications, laboratory, and radiology services), services or medications to treat low sperm count, services incident to reversal of surgical sterilization, or services incident to or resulting from procedures for a surrogate mother who is otherwise not eligible for covered pregnancy and maternity care under a Blue Shield health plan;

18. Home testing devices and monitoring equipment except as specifically provided in the Durable Medical Equipment Benefits;

19. Genetic testing except as described in the sections on Outpatient X-ray, Pathology and Laboratory Benefits;

20. Mammographies, Pap Tests, or other FDA (Food and Drug Administration) approved cervical cancer screening tests, family planning and consultation services, colorectal cancer screenings, Annual Health Appraisal Exams by Non-Plan Providers;

21. Services performed in a hospital by house officers, residents, interns, and others in training;

22. Services performed by a close relative or by a person who ordinarily resides in the member's home;

23. Services provided by an individual or entity that is not appropriately licensed or certified by the state to provide health care services, or is not operating within the scope of such license or certification, except for services received under the Behavioral Health Treatment benefit under Mental Health and Substance Use Disorder Benefits;

24. Massage therapy that is not physical therapy or a component of a multimodality rehabilitative treatment plan;

25. For or incident to vocational, educational, recreational, art, dance, music or reading therapy; weight control programs; or exercise programs; nutritional counseling except as specifically provided for under Diabetes Care Benefits. This exclusion shall not apply to medically necessary services which Blue Shield is required by law to cover for the treatment of mental health and substance use disorders.

26. Learning disabilities or behavioral problems or social skills training/therapy, or for testing for intelligence or learning disabilities This exclusion shall not apply to medically necessary services which Blue Shield is required by law to cover for the treatment of mental health and substance use disorders.

27. Services which are Experimental or Investigational in nature, except for services for Members who have been accepted into an approved clinical trial as provided under Clinical Trial for Treatment of Cancer or Life-Threatening Condition Benefits;

28. Drugs, medicines, supplements, tests, vaccines, devices, radioactive materials and any other services which cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (the FDA) except as otherwise stated; however, drugs and medicines which have received FDA approval for marketing for one or more uses will not be denied on the basis that they are being prescribed for an off-label use if the conditions set forth in California Health & Safety Code, Section 1367.21 have been met;

General Exclusions and Limitations *(cont'd.)*

29. For non-prescription (over-the-counter) medical equipment or supplies such as oxygen saturation monitors, prophylactic knee braces and bath chairs that can be purchased without a licensed provider's prescription order, even if a licensed provider writes a prescription order for a non-prescription item, except as specifically provided under Preventive Health Benefits, Home Health Care Benefits, Home Infusion/Home Injectable Therapy Benefits, Hospice Program Benefits, Diabetes Care Benefits, Durable Medical Equipment Benefits, and Prosthetic Appliances Benefits;

30. Patient convenience items such as telephone, television, guest trays, and personal hygiene items;

31. For disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, diapers, under pads, and other incontinence supplies, except as specifically provided under the Durable Medical Equipment Benefits, Home HealthCare, Hospice Program Benefits, or the Outpatient Prescription Drug Benefits.

32. Services for which the member is not legally obligated to pay, or for services for which no charge is made;

33. Services incident to any injury or disease arising out of, or in the course of, any employment for salary, wage, or profit if such injury or disease is covered by any worker's compensation law, occupational disease law or similar legislation. However, if Blue Shield provides payment for such services, it will be entitled to establish a lien upon such other benefits up to the amount paid by Blue Shield for the treatment of such injury or disease;

34. For spinal manipulation or adjustment and adjunctive therapy by a chiropractor, except as specifically provided under Professional (Physician) Benefits (other than for Mental Health and Substance Use Disorder Benefits) in the Plan Benefits section;

35. For transportation services other than provided under Ambulance Benefits in the Plan Benefits section;

36. Drugs dispensed by a Physician or Physician's office for outpatient use;

37. For services, including hospice services rendered by a Participating Hospice Agency, not provided, prescribed, referred, or authorized as described herein except for Access+ *Specialist* visits, OB/GYN services provided by an obstetrician/gynecologist or family practice physician within the same medical group/IPA as the primary care physician, Emergency Services or Urgent Services as provided under Emergency Room Benefits and Urgent Services Benefits in the Plan Benefits section.

38. For inpatient and Other Outpatient Mental Health and Substance Use Disorder Services unless authorized by the MHSA except for medical services for the treatment of gender dysphoria, eating disorder and substance use disorder treatment which are the responsibility of the IPA/medical group and Blue Shield.

39. Services not specifically listed as a Benefit.

Medical Necessity Exclusion

All services must be medically necessary. The fact that a physician or other provider may prescribe, order, recommend, or approve a service or supply does not, in itself, make it medically necessary, even though it is not specifically listed as an exclusion or limitation. Blue Shield may limit or exclude benefits for services that are not medically necessary.

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, the member's designated medical group, or Independent Practice Association (IPA) 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, the medical group, or the IPA 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, the member's designated medical group or the IPA 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 IPA/medical group, 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 (COB)

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

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

Determining the Order of Payment

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

The following applies to coverage for dependent children:

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

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

- When the parents are not married, or are divorced or separated and there is no court order which would otherwise establish coverage for the child, primary responsibility is determined in the following order:

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

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

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

Coordination of Benefits (COB) *(cont'd.)*

When Blue Shield is the Primary Plan

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

Upon request, the IPA/medical group 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 IPA/medical group covers a service that would otherwise be the primary group health plan's liability, the IPA/medical group 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* (EOC)

Limitations for Duplicate Coverage (Commercial)

Veterans Administration (VA)

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, who is not on active duty, and who is 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 their 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

Access+ HMO is always primary (unless another group plan is primary) for covered services, even if provided for conditions related to military service, provided 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 by Blue Shield.

Medi-Cal

Medi-Cal is considered a payor of last resort.

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

Medicare Eligible Members

1. Blue Shield will provide benefits **before** Medicare in the following situations:

    a. When the member is eligible for Medicare due to age, if the subscriber is actively working for a group that employs 20 or more employees (as defined by Medicare Secondary Payor laws).

    b. When the member is eligible for Medicare due to disability, if the subscriber is covered by a group that employs 100 or more employees (as defined by Medicare Secondary Payor laws).

    c. When the member is eligible for Medicare solely due to end stage renal disease during the first 30 months that the Member is eligible to receive benefits for end-stage renal disease from Medicare.

2. Blue Shield will provide benefits **after** Medicare in the following situations:

    a. When the member is eligible for Medicare due to age, if the subscriber is actively working for a group that employs less than 20 employees (as defined by Medicare Secondary Payor laws).

    b. When the member is eligible for Medicare due to disability, if the subscriber is covered by a group that employs less than 100 employees (as defined by Medicare Secondary Payor laws).

    c. When the member is eligible for Medicare solely due to end stage renal disease after the first 30 months that the Member is eligible to receive benefits for end-stage renal disease from Medicare.

    d. When the member is retired and age 65 years or older.

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

Services for Members in Custody of the Penal System

Section 1374.11 of the Health & Safety code prohibits health care plans from denying hospital, medical or surgical services for the sole reason that the individual served is confined in a city or county jail, or is a juvenile detained in any facility if the individual is otherwise entitled to receive services. Blue Shield health plans are also required to provide covered services when the member is injured during the act of committing a crime.

HMO plans are responsible for providing non-emergency covered services only to the extent that the justice system allows the IPA to assume responsibility for the member's care (e.g., when the member's emergency condition has been stabilized). No benefits are available if the IPA is denied the right to assume responsibility for the member's non-emergency care. In this case, the IPA should carefully document such refusal.

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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 condition, and the many related issues that may impact their quality of life.

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.

Care Management *(cont'd.)*

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

- 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
- Home visits (as needed)
- Biometric home monitoring (for some members with diabetes, coronary artery disease, COPD, and heart failure)
- Virtual health coaching and cognitive behavioral therapy modules
- Online tools and educational materials

Physician referrals are an important component of Blue Shield's Care Management Programs and may allow for identification of a member more quickly. Blue Shield providers may refer Blue Shield members to our Care Management Programs by submitting the referral form via secure email to bscliaison@optum.com or fax to (877) 280-0179. To download an electronic copy of the referral form, please visit www.blueshieldca.com/provider/guidelines-resources/patient-care/programs.sp. Each referral will be evaluated for eligibility and appropriateness.

In addition to the care management programs described above, the following Maternity Program is offered:

Maternity Program. Blue Shield has teamed up with Maven to offer Maven Maternity to our members. Maven Maternity is a 24/7 virtual care program designed to support Blue Shield members during and after pregnancy. Maven is also available to members who have experienced a pregnancy loss and to partners if they are on an eligible Blue Shield medical plan. 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.

Care Management *(cont'd.)*

Dual Eligible Special Needs Plan Model of Care

For members enrolled in Blue Shield's Medicare Advantage Dual Eligible Special Needs Plan (D-SNP), Blue Shield has developed a D-SNP Model of Care (MOC), in compliance with CMS, which outlines Blue Shield's actions, in coordination with the member's IPA/medical group, to meet the individual needs of D-SNP members.

An individualized care plan (ICP) is developed based on the member's responses to the Health Risk Assessment (HRA) and includes a detailed list of identified problems, interventions, and goals. The ICP is then shared with the member/member's caregiver, the IPA/medical group, and the member's PCP. This care management plan identifies interdisciplinary care team (ICT) members that are needed and appropriate for the individual members to manage the medical, cognitive, psychosocial, and functional needs of the member. Blue Shield's ICT includes social workers; pharmacists; complex case managers; health educators; disease managers; behavioral health providers; and a medical director. The IPA/medical group must have a network of medical, nursing, and allied health professionals who will collaborate with the ICT and provide clinical expertise.

The care management plan is reviewed and revised at least annually, sooner if the member's health status changes, with participation from the IPA/medical group. The IPA/medical group must provide the following ICT members as needed: PCP; specialists; IPA/medical group case manager; and/or IPA/medical group medical director.

The IPA/medical group is responsible for coordinating basic care management services that meet the needs of the member and for implementing the care management plan, with oversight by Blue Shield, by coordinating care and arranging professional and ancillary services proportional to the member's needs. The IPA/medical group must maintain a documented process of how medical professionals and service providers were utilized to coordinate adequate care and achieve individual members' goals.

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.

- **Landmark Home-Based Care.** The Landmark program offers participating chronically ill members 24/7 access to medical professionals and in-home urgent care. Community-based, physician-led medical teams specializing in house calls and home-based care deliver medically needed services to chronically ill patients. Landmark does not replace patients' primary care providers (PCPs), but rather supports the work of patients' existing providers. Landmark clinicians communicate and collaborate with the patients' PCP and specialists to reinforce the PCP's in-office care plan and provide the attention and care that chronically ill patients with complex health needs may require. Blue Shield identifies eligible members for the Landmark program based on their health and the number and type of chronic conditions they have.

Transplant Management Program

Transplants of major organs and bone marrow (excludes cornea, kidney only and skin) are coordinated between the IPA/medical group and Blue Shield. These services are provided through an established network of facilities with expertise in a particular organ or bone marrow transplant. All transplant facilities are evaluated through stringent criteria to determine the safety and appropriateness of their transplant services. After this review, only selected facilities are accepted for the Blue Shield of California Transplant Network. Blue Shield requires Commercial HMO members to have all major organ and bone marrow transplants performed at a facility approved for the specified type of transplant within Blue Shield of California's Major Organ/Bone Marrow Transplant Network. All HMO members should be offered a referral to a Blue Shield of California Major Organ/Bone Marrow Transplant Network facility approved for the specified organ, under their HMO benefit.

All transplant evaluation referrals should be authorized by the IPA/medical group or as otherwise specified and performed by a Blue Shield facility approved for the specified type of transplant. No self-referrals for transplant evaluations will be approved under the POS. All Blue Shield members are entitled to transplant evaluations at any Blue Shield transplant network facility approved for the specified type of transplant, whether or not that facility has a contractual relationship with the IPA/medical group. Members who are in a transplant treatment continuum must be cleared by the Blue Shield of California Transplant Medical Care Solutions Team prior to changing IPA. All requests should be sent via fax to the Transplant Medical Care Solutions Team at (916) 350-8865.

Care Management *(cont'd.)*

Transplant Management Program *(cont'd.)*

Prior written authorization must be obtained from Blue Shield's Transplant Medical Care Solutions Team for all transplants except cornea, kidney only and skin, as these are handled as routine inpatient services. Transplant Medical Care Solutions is a centralized program that is responsible for prior authorization of major organ and bone marrow transplant requests, related admissions, and case management for transplant patients during the transplant process. For members living in California, referrals to an out-of-state transplant facility must be at the referral of a Blue Shield of California's Major Organ/Bone Marrow Transplant Network facility approved for the specified type of transplant based upon medical necessity. For coverage, all referrals for medical necessity to an out-of-state provider must be pre-authorized by a Blue Shield of California Medical Director.

Generally, hospitals within the Blue Shield Major Organ/Bone Marrow Transplant Network assume financial responsibility for all inpatient and outpatient facility, professional, and other services and supplies provided in connection with a major organ or bone marrow transplant during a "global case rate period," when these services are provided at or by the transplant center. If these services cannot be provided at or by the transplant center (i.e., Acute Rehabilitation, Home Health Care, etc.) financial responsibility for professional and facility services are typically allocated between Blue Shield and the IPA/medical group as all other non-transplant related services.

The exact duration of the global case rate period and the specific services and supplies for which the hospital assumes financial responsibility vary based on such things as the specific type of transplant and the terms of the hospital's contract with Blue Shield. Financial responsibility for professional and facility services provided before and after the global case rate period is typically allocated between Blue Shield and the IPA/medical group in the same manner as all other non-transplant-related services.

Please reference the Division of Financial Responsibility (DOFR) that is part of your contract for more information regarding allocation of financial responsibility.

For more information regarding the specific services for which a hospital has assumed financial responsibility during the global case rate period, please contact the Transplant Medical Care Solutions Team at (800) 637-2066, extension 841-1130. You may also contact the Transplant Medical Care Solutions Team for information on Transplant network hospitals and their applicable transplant categories.

Wellness and Prevention Programs

Blue Shield offers member-directed health improvement programs. Blue Shield's mission is to support a member's access to high quality care and facilitate participation in managing his or her own health. Blue Shield actively encourages providers to become familiar with these programs so they can assist members in learning about and taking advantage of these services. Blue Shield offers the following preventive health and wellness initiatives:

CareTips Clinical Messaging

CareTips is a clinical messaging program designed to help improve quality of care and yield cost-of-healthcare savings. Members receive CareTips communications based on nationally recognized clinical practice guidelines and focus on quality improvement topics, many of which are drawn from HEDIS clinical measures. They are sent based on a systematic analysis of Blue Shield's medical, pharmacy, and lab claims that identifies potential gaps in care and medication-related issues. The messages are intended to encourage preventive care and support improvement in treatment outcomes for patients with chronic conditions. We encourage members to bring these communications to their provider for further discussion and possible coaching and follow up.

Diabetes Prevention Program

The Diabetes Prevention Program helps members who are at risk of type 2 diabetes lose weight and adopt healthy habits. The program includes 16 weekly sessions over the span of six months, followed by monthly maintenance sessions during which members will learn new ways to eat healthier, increase activity, and manage challenges with help from a personal health coach and a small support group. The program is embedded in the Wellvolution platform and can be accessed by enrolling in Wellvolution at wellvolution.com.

LifeReferrals 24/7^{SM}

(800) 985-2405

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 can talk to a referrals specialist and set up face-to-face sessions with licensed therapists at no cost to them.
- **Work/life resources –** Members can consult with a specialist who can provide useful information and referrals to a wide range of resources, such as educational programs, 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

(877) 304-0504

Members can access a registered nurse anytime, day or night, seven days a week, 365 days a year at no cost by phone at (877) 304-0504 or online, www.blueshieldca.com. Experienced nurses are ready to answer questions, listen, and provide members with information that can help them choose the most appropriate level of care for their situation. The nurses are trained to offer callers:

- **Health information** – Better understanding of health concerns and chronic conditions, education about possible treatment options to help patients make informed decisions and suggestions for preparing for doctor appointments.
- **Healthcare assistance** – Guidance in understanding and choosing the most appropriate types of health care such as hospital, urgent care center, doctor visit, or home treatment. Assistance with questions about medical tests, medications and living with chronic conditions.
- **Preventive and self-care measures** – Helpful tips for taking care of minor injuries at home, such as a twisted ankle or a common illness like a cold or the flu.
- **Online nurse help** – One-on-one personal Internet dialogue with a registered nurse 24 hours a day, seven days a week. Members get immediate answers to their general health questions and research assistance. The online nurses can also refer members to health information, resources, and member programs on blueshieldca.com.

LifeReferrals 24/7 and NurseHelp 24/7 are designed to complement, not replace the care you provide to your patients.

Preventive Health Guidelines

Blue Shield's Preventive Health Guidelines are based on nationally recommended guidelines for screening examinations, immunizations, and counseling topics for healthy individuals, as well as for individuals at risk for disease. These guidelines are updated and distributed annually to members via blueshieldca.com. Clinical reference sources include the US Preventive Services Task Force (USPSTF) Guide to Clinical Preventive Services, American Academy of Pediatrics, the Advisory Committee on Immunization Practice, and the Health Resources and Services Administration Women's Preventive Services Guidelines.

Guidelines available in both English and Spanish are located on Provider Connection at blueshieldca.com/provider under *Eligibility & benefits*, then *Preventive health guidelines*.

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

Preventive Health Services Policy

Blue Shield has developed a Preventive Health Services Policy as a result of the Affordable Care Act (ACA) of the health reform legislation, adopting United States (US) Preventive Services Task Force (USPSTF) recommendations; the US Department of Health and Human Services, Health Resources and Services Administration (HRSA) recommendations for infants, children, adolescents, and women; immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC); American Academy of Pediatrics/Bright Futures/Recommendations for Pediatric Preventive Healthcare; and additional requirements mandated by the state of California. This policy applies to new and renewing members.

Preventive care services are those provided for the early detection of disease when no symptoms are present. 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.

To view the most updated Preventive Benefit Policy, log on to Provider Connection at blueshieldca.com/provider and click on *Eligibility & benefits*, then *Preventive health guidelines.*

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** – Gives members access to over 10,000 gyms nationwide for a low cost of $25 initiation fee and $25/month. 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.
- **LASIK surgery** – Discounts on LASIK surgery through QualSight LASIK, and LASIK and PRK surgery through NVISION, Inc.
- **Discount Vision Program** – Discounts on vision exams, frames and lenses, contacts lenses, and more.

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

Wellvolution

Wellvolution was designed to give members the tools for obtaining optimal health, whether that means staying fit, preventing disease, or treating existing conditions. Members simply log on to wellvolution.com, create a new account and set their health goals. 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, members get access to easy, customized plans and popular apps, like Betr Health, Monjwell, Platejoy, Weight Watchers, and Yes Health that fit their path. No matter where they are on their health journey, Wellvolution will help members reach their goals.

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.
- **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.
- **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.

Pharmaceutical Benefits

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 meets 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 coverage for different types of outpatient prescription drugs. 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 approved 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) have 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. This includes:
    a. Formulary drugs alternatives are expected to be ineffective or are likely or expected to cause an adverse reaction or physical or mental harm based on the characteristics of the member's known clinical characteristics and history of the member's prescription drug regimen.
    b. Formulary drug alternatives are not clinically appropriate because they are expected to do any of the following:
        i. Worsen a comorbid condition.
        ii. Decrease the capacity to perform daily activities.
        iii. Pose a significant barrier to adherence or compliance.

Pharmaceutical Benefits *(cont'd.)*

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, Prior authorization forms and list,* then *Prior authorization forms.* 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) compiles 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 makes 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.

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.

Pharmaceutical Benefits *(cont'd.)*

Drug Formulary *(cont'd.)*

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. 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.

Mail Service Prescriptions

Members may have their prescriptions for medications taken on a regular basis, for a chronic or long-term medical condition 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 under *Guidelines & resources* and then *Drugs and pharmacy*.

Pharmaceutical Benefits *(cont'd.)*

Drug Formulary *(cont'd.)*

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. A Network Specialty Pharmacy provides up to a 30-day supply of Specialty Drugs by mail or, upon a member's request, at an associated retail pharmacy for pickup.

- The list of Specialty Drugs and information about Network Specialty Pharmacies may be accessed at blueshieldca.com.
- New prescriptions for Specialty Drugs should be sent to a Network Specialty Pharmacy.
- Specialty Drugs may be dispensed by any willing pharmacy for Medicare Part D plans.

Pharmaceuticals in the Medical Benefit

Drugs approved by the Food and Drug Administration (FDA) and covered under a Blue Shield member's medical benefit are generally those that are incident to a medical service, administered by a healthcare professional in a provider office, outpatient facility, infusion center, or by home health/home infusion (not self-administered by the patient). Some medical benefit drugs may require prior authorization and step therapy for coverage based on medical necessity. 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.

For drugs that require prior authorization or an exception to step therapy requirements, coverage decisions are based on the medication coverage policies approved 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 step therapy 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 step therapy drug alternative(s). This includes:
    a. Step therapy drug alternatives are expected to be ineffective or are likely or expected to cause an adverse reaction or physical or mental harm based on the characteristics of the member's known clinical characteristics and history of the member's prescription drug regimen.
    b. Step therapy drug alternatives are not clinically appropriate because they are expected to do any of the following:
        i. Worsen a comorbid condition.
        ii. Decrease the capacity to perform daily activities.
        iii. Pose a significant barrier to adherence or compliance.

Pharmaceutical Benefits *(cont'd.)*

Pharmaceuticals in the Medical Benefit *(cont'd.)*

Blue Shield requires that all delegated IPA/medical groups adhere to Blue Shield Medication Policies which may include step therapy and site of administration criteria. High-cost medications including CAR-T and Gene Therapy are subject to Blue Shield review for coverage according to Blue Shield Medication Policy regardless of if utilization management is delegated to the IPA/medical group. Refer to the Section 5.1 Prior Authorization.

The Blue Shield Pharmacy and Therapeutics Committee (P&T) reviews drugs quarterly and determines medication coverage policies and requirements for drugs requiring prior authorization. Medication coverage policies for medical benefit drugs can be found on Provider Connection at blueshieldca.com/provider. Once you have logged on, select *Authorizations*, *Clinical policies and guidelines*, then *Medical policies & procedures.* For Blue Shield Medicare Advantage HMO plan Members, Blue Shield follows Medicare guidelines for risk allocation, Medicare national and local coverage guidelines, and Blue Shield Medication Policy.

Childhood Immunizations

All childhood immunizations first recommended for use by the Advisory Council on Immunization Practices (ACIP) or the American Academy of Pediatrics (AAP) on or after January 1, 2001 will become the full financial responsibility of Blue Shield unless an IPA/medical group agrees to accept financial responsibility. Childhood immunizations that were part of the ACIP recommendation schedule prior to January 1, 2001 and the cost of vaccine administration are both the financial responsibility of the IPA/medical group. Please note that new combination vaccines of previously recommended immunizations or changes to dosing frequency or age restrictions will not be included in this classification unless they represent a material change in cost under a current contract. Claims must be submitted by the IPA/medical group, not the individual participating providers, for reimbursement regardless of financial responsibility. Please refer to Section 4.4 for encounter and claims processing procedures.

Pharmaceutical Benefits *(cont'd.)*

Pharmaceuticals in the Medical Benefit *(cont'd.)*

Office/Facility-Administered Medications

For some IPA/medical group commercial contracts, Blue Shield identifies and maintains a separate financial risk classification as dictated by the Richman Injectable List for certain (a) office-administered, (b) high-cost, (c) chemotherapy, and (d) chemotherapy and supportive/adjunctive injectable drugs. Medications are updated to these various risk allocation classifications on a quarterly basis. Please refer to your Division of Financial Responsibility (DOFR) for the classification (s) of drugs that are currently contractually carved out to Blue Shield. This policy does not apply to the Medicare Advantage product, as all IPA/medical groups are capitated on a percent of premium methodology, which is presumably self-adjusting and for which we follow Medicare guidelines in risk allocation.

Regardless of financial risk classification, the IPA/medical group is responsible for reimbursing providers for these medications directly. The IPA/medical group shall submit encounters to Blue Shield. When Blue Shield has risk for drugs on the Richman Injectable List, as defined in the IPA/medical group's contract, the IPA/medical group shall submit encounters to Blue Shield for reimbursement at rates set forth in the IPA/medical group's contract with Blue Shield. Encounters for these medications shall be submitted by the IPA/medical group, not the individual participating providers, with the appropriate National Drug Code (NDC) and HCPCS code. Please refer to Section 4.4 Claims for Medical Benefit Drugs for encounter and claims processing procedures.

For reimbursement of medications administered at an outpatient facility, select drugs may require site of service medical necessity authorization for coverage in addition to the authorization of the drug.

The criteria for classification of High-Cost injectables includes those FDA-approved in 1998 or later with an estimated treatment cost per patient at or above $10,000 average wholesale price (AWP) per year. A validation and reconciliation of the high-cost category will be conducted annually based on the previous years' Blue Shield utilization data using updated AWP pricing information and historical claims data to determine average dosing including duration of therapy. A complete list of High-Cost Injectables and corresponding HCPCS Codes that meet the classification criteria is posted quarterly on Provider Connection at blueshieldca.com/provider under *Claims*, then *Policies & guidelines,* then *Medications.* You may also contact your Provider Relations Coordinator for a listing.

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3.1 Enrollment and Eligibility

Section 3: Eligibility

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Introduction

This section describes Blue Shield's HMO enrollment procedures, eligibility criteria and processes for communicating enrollment and eligibility information to IPA/medical groups. It also describes Blue Shield's HMO service delivery rules and the importance of the member's primary care physician (PCP) to follow these rules.

Note: For enrollment and eligibility information on Blue Shield's Medicare Advantage plans, see Section 6.

Initial Enrollment

Eligible members who select the Blue Shield Access+ HMO® or the Blue Shield Added Advantage POS℠ (Point-of-Service) group plan must complete an HMO enrollment application during the initial enrollment period. Each member and each dependent are required to reside or work in Blue Shield's HMO service area to ensure access to care and must include their primary care physician choice on the enrollment application. If an invalid PCP or no PCP is selected, the member will be assigned a PCP.

Blue Shield also offers the HMO Trio Plans for Individuals and Families (IFP). As with our employer sponsored plans, each member of the family must live or work in Blue Shield's HMO service area to ensure access to care. Off-exchange applicants aged 19 or older must meet underwriting criteria in order to enroll in an individual or family plan. All primary care physicians are assigned at the time of enrollment, but the member has the option to change the Blue Shield-designated primary care physician.

If the Commercial Blue Shield Access+ HMO subscriber or dependent no longer lives or works in Blue Shield's HMO service area, they may be subject to a plan change. This can be considered a qualifying event depending on the availability of other group employer plans and eligibility rules set by the employer. Special arrangements may be available for dependents of employer group subscribers who are full-time students or do not live in the subscriber's home. Member Services will assist these dependents to enroll under the BlueCard Away From Home Care Program®.

3.1 Enrollment and Eligibility

Member Eligibility and Coverage

Blue Shield's standard eligibility and coverage requirements for members and dependents are outlined below.

Note: Specific employer groups may have different negotiated eligibility provisions in their health plan.

Members are defined as either a subscriber or dependent and are:

- Employees who are enrolled in an Access+ HMO Group Plan or Blue Shield POS Group Plan after satisfying their employers' eligibility requirements. Spouses, domestic partners, and dependent children who are covered by the subscriber's contract are eligible at the same time. Generally, enrollment becomes effective on the date specified by the employer, which is usually the first day of the month following the group's open enrollment period. Coverage is effective at 12:01 A.M. Pacific Standard Time on the established date.

  Newly hired or transferred employees who become eligible at any time other than during the annual open enrollment must complete the Blue Shield enrollment form within 31 days of becoming eligible. If employees do not enroll themselves or their eligible dependents during an open enrollment period or within 31 days of becoming eligible, they must generally wait until the next open enrollment period to enroll (with some limited exceptions, as mandated by California law or as otherwise permitted in the employer's group health service contract).
- Individuals who are enrolled in the Blue Shield HMO Trio IFP and have been accepted for membership by Blue Shield's Medical Underwriting Department if required. The effective date for coverage under this plan is assigned by Underwriting.

Dependents 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.

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.

Member Eligibility and Coverage *(cont'd.)*

Dependent *(cont'd.)*

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:

        (1) Within 24 months after the month when the dependent would otherwise have been terminated; and

        (2) Annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the dependent child becomes ineligible for coverage under this plan for any reason other than attained age.

Domestic Partners - Blue Shield's Access+ HMO or Blue Shield POS Group plans include spouse-equivalent dependent coverage for domestic partners and their children as required by law. Although not required by law, Blue Shield's HMO Trio Plan for Individuals and Families (IFP) also includes coverage for domestic partners and their children.

Member Eligibility and Coverage *(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.

Member Identification (ID) Cards

Subscribers who are enrolled in a Blue Shield Access+ HMO, HMO Trio, or Added Advantage POS Plan are:

- Notified of their Blue Shield coverage
- Provided an *Evidence of Coverage* (EOC) booklet describing their benefits
- Mailed ID cards or are issued cards electronically, depending on the member's preference

The Blue Shield ID card is generally issued prior to the member's effective date. Additionally, an ID card is reissued each time:

- A member's name or the subscriber's ID number changes
- A group or individual's benefit plan changes or the group number changes
- A new primary care physician is selected or designated
- A dependent is added or deleted
- A primary care physician changes IPA/medical group affiliation
- A change in office visit copayment
- A change in ID card information

The ID card contains the following information:

- Subscriber's name and identification number
- Employer/Individual group number or IFP number
- Member's effective date of coverage in their current benefit selections
- Names of the subscriber's enrolled dependents
- Names, telephone numbers and IPA/medical group affiliation of the primary care physician selected by the subscriber and dependents and their effective dates, including an "A+" designation for IPA/medical groups who participate in Access+*Specialist.*
- Subscriber/Member copayment for office visits
- Subscriber's language preference if other than English
- Blue Shield of California's Members Services phone number

Enrollment Changes

Adding, Deleting, or Transferring Dependents

All employer group plan changes (except primary care physician change requests) affecting the enrollment of employees and their dependents must be submitted by the employee to the employer group before being processed by Blue Shield within 31 days from the date of the following changes:

- A new dependent is added due to marriage or domestic partnership
- A birth or adoption
- A death of a dependent
- A dependent's health benefits are covered by another health plan

IFP members must complete and send a "Member Change Request Form" to Blue Shield.

Terminating Coverage

Refer to *Provider Requests to Transfer or Disenroll Commercial Members* (further in this section), for Blue Shield's policy for involuntary transfer or disenrollment of members.

In general, coverage for group or IFP subscribers and dependents terminates when any of the following occurs:

1. The employer group contract terminates.
2. Group member retires or leaves employment (subject to disability, leave of absence and Consolidated Omnibus Budget Reconciliation Act (COBRA) provisions), unless the employer group purchased retiree coverage.
3. Nonpayment of dues.
4. Dependent ceases to qualify as dependent. Dependent may be eligible for COBRA.
5. Subscriber fails to pay any applicable copayments and continues not to pay after written notice by the plan.
6. Member makes repeated and unreasonable demands for unnecessary medical services and continues to do so after written notice by the IPA/medical group or by plan.
7. Member violates any provision of the service contract, and such violations continue after written notice by the plan.
8. Blue Shield determines that the subscriber or dependent committed fraud or intentionally misrepresented any material facts during or after enrollment after written notice was sent.
9. Member moves out of the Blue Shield of California HMO service area. Members under group employer plans may be able to transition to an applicable out of state plan if available by the employer. Subject to eligibility rules and Blue Shield guidelines.
10. IFP member requests to terminate their coverage.

Enrollment Changes *(cont'd.)*

Coverage After Termination

Group Benefits

A group member may be eligible for one of the following types of continued coverage under the terms of the group health plan when eligibility for group coverage would otherwise terminate:

- Federal COBRA
- Cal-COBRA (for employer groups with less than 20 employees)
- Cal-COBRA for individuals who have exhausted benefits totaling less than 36 months under federal COBRA
- Extension of benefits for a "Totally Disabled" member

The IPA/medical group should contact Blue Shield's Provider Customer Service at (800) 541-6652 for additional information about coverage under these extended benefit options.

Blue Shield will notify and capitate the IPA/medical group for any members with extended benefits. The IPA/medical group will continue to provide all medically necessary services.

> *Note: For members receiving coverage under the extension of benefit for a "Totally Disabled" member, services are limited to only those services necessary to treat the disabling condition.*

Individual Coverage Options

Subscribers and their dependents who are no longer eligible for group coverage may apply for a Blue Shield HMO Trio Plan or a PPO Individual Family Plan (IFP) by completing an IFP application.

3.1 Enrollment and Eligibility

Eligibility Verification

For routine eligibility verification for commercial members, the IPA/medical group may:

- Log onto Provider Connection at blueshieldca.com/provider for current and historical eligibility and benefit information that is updated daily.
- Check the member's ID card; if verifying for Blue Shield Access+ HMO eligibility, check for an "A+" designation next to the name of the IPA/medical group.
- Check the most current monthly eligibility report (see information below).

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*.

In the event the IPA/medical group makes reasonable efforts to confirm eligibility of a member and reasonably relies on the information obtained, the IPA/medical group may seek payment from Blue Shield for these services. For more on procedures to follow when seeking payment under this circumstance, see Section 4.

Monthly Eligibility Reports

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 IPA/medical groups 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 IPA/medical groups no later than the tenth of each calendar month. For details on the file formats, refer to Appendix 3-A and 3-B 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.

Member Primary Care Physician Selection, Assignment, and Change

Member Primary Care Physician Selection

Commercial members must select a primary care physician (PCP) from *Find a Doctor* on blueshieldca.com during enrollment. If an invalid PCP or no PCP is selected, the member will be assigned a PCP. Each family member may select a different PCP, including pediatricians for children. Family members may have the same PCP, different PCPs within the same IPA/medical group, or PCPs from different IPA/medical groups.

Parents are also expected to select a primary care physician for a newborn or newly adopted dependent, preferably prior to birth or placement for adoption, but always within 31 days from the birth or placement for adoption. The PCP must belong to the same IPA/medical group as the mother's primary care physician when the newborn is the natural child of the mother. If the mother or newborn is not enrolled as a member, or if the child has been placed with the subscriber for adoption, the PCP selected must belong to the same IPA/medical group as the subscriber. If a PCP is not selected within 31 days following the birth or placement for adoption, Blue Shield will assign a primary care physician that belongs to the same IPA/medical group as the natural mother or subscriber. This assignment will remain in effect for the first calendar month during which the birth or placement for adoption occurred. To change the primary care physician after the month of birth or placement for adoption, see the section below on member primary care physician changes. If the child is ill during the first month of coverage, see the section below on changing a primary care physician during the course of treatment or hospitalization.

Members are advised to call the primary care physician or go to *Find a Doctor* on blueshieldca.com before submitting their enrollment applications to confirm that the PCP is still accepting new patients. If the selected PCP is not accepting new patients but the member was already a patient of the PCP before becoming a Blue Shield HMO member, the member may be assigned to the PCP pending the PCP's and IPA/medical group's approval.

Member Primary Care Physician Assignment

If a commercial member does not select a primary care physician at enrollment or makes an invalid selection, Blue Shield will designate a PCP based on the member's residence and PCP availability and notify the member of the selection. The member has the option to change the Blue Shield-designated primary care physician.

Member Primary Care Physician Selection, Assignment, and Change *(cont'd.)*

Member Primary Care Physician Change

Commercial and IFP members may change a primary care physician or designated IPA/medical group by calling Blue Shield's Member Services Department at (800) 218-8601 or by logging in to their member page on blueshieldca.com. The hearing impaired may contact Member Services through Blue Shield's toll-free TTY number at (800) 241-1823. These changes are generally effective on the first day of the month following approval by Blue Shield. Members receive an updated Blue Shield ID card that reflects the primary care physician or designated IPA/medical group change.

Once the primary care physician 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 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 PCP, or to any member 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 confined 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 designated IPA/medical groups 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 primary care physician or designated IPA/medical group, as determined by Blue Shield.

> *Note: Exceptions must be approved by the Blue Shield Medical Director. If the Blue Shield Medical Director approves such a change of IPA/medical group, financial responsibility will be determined by the Division of Financial Responsibility (DOFR) detailed in the IPA/medical group contract.*

Provider Requests to Transfer or Disenroll Members

For Commercial Members

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 HMO IPA/medical group 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 DMHC.

For Access+ HMO Members

Reasons for Immediate Disenrollment

A Blue Shield HMO IPA/medical group may request that Blue Shield end its relationship with a member for cause, **IMMEDIATELY** after the member receives written notice for any of the following:

1. Abusive or disruptive behavior that:
    a) threatens the life or well-being of plan personnel, or providers of services;
    b) substantially impairs the ability of Blue Shield to arrange for services to the Member; or
    c) substantially impairs the ability of providers of services to furnish services to the Member or to other patients.
2. Providing false or misleading material information on the enrollment application or otherwise to Blue Shield;
3. Permitting use of a Member identification card by someone other than the Subscriber or Dependents to obtain Covered Services; or
4. Obtaining or attempting to obtain Covered Services under the Group Health Service Contract by means of false, materially misleading, or fraudulent information, acts or omissions.

Blue Shield 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.

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

Procedures for Transfer or Disenrollment

IPA/Medical Group Responsibilities

Before requesting to involuntarily transfer a member for cause, the primary care physician 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 courier service to track that the warning letter was received. (A copy of the letter must also be sent to Blue Shield Member Services Department.) If the behavior or problem continues, the provider may request Blue Shield to take steps to counsel the member and initiate the protocols required for the plan to involuntarily transfer the member to another provider or physician group.

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

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

The physician's or physician group's request for involuntary transfer or disruptive behavior must be complete. All documentation should be submitted to Blue Shield Member Services.

Please provide Blue Shield with sufficient documentation so that Blue Shield will be able to make a decision based on the evidence. Please send the information to the following address:

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

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

Procedures for Transfer or Disenrollment *(cont'd.)*

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

- Decide the evidence is not sufficient to involuntarily transfer the member. The provider or physician group (where applicable) will be notified of the plan's determination.
- Send additional counseling letters to the member describing the behavior that has been identified as disruptive and how it has impacted the plan's ability to manage the individual's care. (Note: If the disruptive behavior ceases after the member receives notice and then later resumes, the 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 (when 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 primary care physician, the call is transferred to the appropriate Member Services Team Leader who will request the written documentation and forward any pertinent information to Provider Relations and Medicare Compliance, as necessary. A verbal request will still require that the provider send Blue Shield all written documentation related to the member's behavior.

Blue Shield sends the provider a written notice of its decision. Please note that Blue Shield considers counseling done by the primary care physician or physician group for Blue Shield 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 can send a formal warning notice to members.

- If the provider does not provide adequate documentation to substantiate an involuntary transfer request, Member Services and/or Provider Relations contacts the provider and advises them that they must provide additional written documentation of the issues or events that led to the transfer request.
- If Blue Shield determines that a member transfer is warranted, the member is notified in writing (certified, return receipt) under the signature of the appropriate Blue Shield Member Services department. The transfer notification letter informs the member of the request made by the primary care physician and that the member can select another primary care physician 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 primary care physician within 30 days of the date the letter was mailed, a new primary care physician 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 if the events leading to the transfer reoccur. An explanation of the member's rights to a hearing under the Blue Shield grievance procedure is also included in the letter.

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

Procedures for Transfer or Disenrollment *(cont'd.)*

- When a member transfers to a new IPA/medical group, the previous provider must supply patient records, reports, and other documentation at no charge to Blue Shield, the new IPA/medical group, provider, or member.
- The existing primary care physician must continue to coordinate care through the date of transfer.

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

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4.1 Network Administration

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4.4 Claims Administration

4.5 Provider Appeals and Dispute Resolution

4.6 Shared Savings Program

Contracting Requirements for Administrative Services Agreements (applies to MSOs or other entities)

Specific contract language requirements apply should an IPA/medical group wish to subcontract with another entity for any administration or management function such as: utilization management, claims processing, or credentialing. The following provisions need to be addressed in the administrative services contracts:

- The person or entity must agree to comply with all applicable state and federal laws, regulations, regulatory guidelines, and accreditation standards.
- The person or entity must agree to comply with all Blue Shield policies and state and federal confidentiality and member record requirements.
- The person or entity must agree to grant Health and Human Services (HHS), the Comptroller General, the General Accounting Office (GAO), or their designees the right to audit, evaluate, inspect any pertinent information related to the contract during the contract term, for up to ten years from the final date of the contract period.
- The contract must clearly state the responsibilities of the administrative services provider and its reporting arrangements.
- The contract must provide that the IPA/medical group have the right to revoke the contract if the entity does not perform the services satisfactorily or if requisite reporting and disclosure requirements are not otherwise fully met in a timely manner.
- The contract must acknowledge that the responsibilities performed by an administrative services entity and/or any delegated administrative service entities are subject to monitoring by the IPA/medical group or Blue Shield on an ongoing basis.
- If the written arrangement provides for credentialing activities the entity must meet all applicable state, federal, and National Committee on Quality Assurance (NCQA) credentialing requirements, including that the credentialing process will be reviewed, pre-approved, and audited by the IPA/medical group and/or Blue Shield on an ongoing basis.
- If the written arrangement provides for the selection of providers, written arrangements must state that Blue Shield retains the right to approve, suspend, or terminate any such arrangement.
- Contracts between the IPA/medical group and the administrative services entity that apply to services for which Blue Shield has granted delegated status to the IPA/medical group must contain provisions specifying delegation requirements consistent with Blue Shield delegation standards.

Contracts between the IPA/medical group and the administrative services entity agrees to hold harmless and protect members from incurring financial liabilities that are the legal obligation of the IPA/medical group or Blue Shield. Provider shall not take any recourse against the member, or a person acting on behalf of the member, for services provided. This does not prohibit collection of applicable coinsurance, deductibles, or copayments, as specified in the *Evidence of Coverage*. This provision also does not prohibit collection of fees for non-covered services, provided the member was informed in advance of the cost and elected to have non-covered services rendered.

4.1 Network Administration

Practitioner Credentialing

See Section 5.2 for delegated credentialing guidelines.

For inclusion in the HMO network, IPA/medical group or direct-contracted practitioners must meet Blue Shield's HMO credentialing criteria. HMO credentialing requires that practitioners:

1. Be board-certified by the American Board of Medical Specialties (ABMS) or have satisfactorily completed a residency in their practice specialty (except for general practitioners, who must complete one year of postgraduate training).

2. Have a current, unrestricted California license to practice.

3. Have staff privileges at a Blue Shield-contracted hospital affiliated with the practitioner's IPA/medical group. (Exceptions may be made for certain physicians who do not require hospital admitting privileges or in instances in which the IPA/medical group uses hospitalists to admit patients). If the physician utilizes the hospitalist program, a letter of the coverage arrangement is required to be on file.

4. Physicians/practitioners must maintain current professional liability insurance in the minimum amount of $1,000,000 per occurrence and $3,000,000 annual aggregate for the practicing specialty. Behavioral Health specialists (Ph.D., M.F.T.s, etc.) must maintain current professional liability insurance in the minimum amount of $1,000,000 per occurrence and $1,000,000 annual aggregate.

5. Complete a Professional Liability Questionnaire on the application.

6. Be free of any Medical Board of California (MBC) restrictions and Medicare/Medicaid sanctions or any restrictions from their issuing licensing board.

7. Have a current, unrestricted Drug Enforcement Agency (DEA) certificate.

8. Participation as a Blue Shield Medicare Advantage plan Physician requires that physicians maintain CLIA certification/waiver certificates for any office lab work performed, participate in the Medicare Program and be free of Medicare sanctions.

Practitioners are formally recredentialed every three years.

Physicians are required to notify their IPA/medical group when there are changes in licensing or certification status (i.e., state probation, liability carrier, accusation, etc.) that could affect their credentialing status.

Provider Status Changes

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

Upon notification of status changes, Blue Shield will update its provider database and directories accordingly. The IPA/medical group is required to notify Blue Shield of changes to its provider network, as follows:

- **Addition of New Providers**

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

  Delegated IPA/medical groups may send new provider profiles directly to the Provider Information & Enrollment team to be added to the network relationship. Non-delegated IPA/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 geographic location is outside the IPA/medical group's service area, as set forth in the Zip Code Table in the HMO IPA/Medical Group Agreement, unless contractually amended.

- **Demographic/Administrative Changes**

  The IPA/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 office location, office hours, office email, telephone numbers, fax numbers, billing address, tax identification number, board status, key contact person, etc.

  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
  - Hospital staff privileges (list hospitals and types of privilege)
  - Languages spoken
  - Wheelchair access
  - IRS number
  - NPI
  - Designation as PCP or specialist or both
  - Panel data including gender, age or patient restriction
  - Identification of the IPA to which the practitioner should be added
  - Where required by law, individuals requiring supervision must also provide the name, NPI and license number of the supervising physician

Provider Status Changes *(cont'd.)*

- **Open/Closed Status Changes**

  The IPA/medical group must notify Blue Shield no less than five days in advance of either of the following:

  - A provider is not accepting new patients.
  - If a provider had previously not accepted new patients, the provider is currently accepting new patients.

- **Termination of Providers**

  Primary care physicians affiliated with more than one Blue Shield IPA/medical group

  If a primary care physician (PCP) terminates from a Blue Shield IPA/medical group and belongs to another Blue Shield IPA/medical group, the PCP will retain his/her current members with their existing IPA/medical group unless prohibited by geographic location. If the PCP's former IPA/medical group authorized medically necessary services for a member that followed the PCP to his/her alternate IPA/medical group, the PCP's existing IPA/medical group will be financially responsible for those services, unless it can be demonstrated that the service authorized by the previous IPA/medical group was not medically necessary. In that case, the new IPA/medical group will not be financially responsible.

  In instances where a primary care physician joins a new IPA/medical group without terminating from his/her present IPA/medical group, member transfers can only be initiated by the member, even if requested by the PCP. Blue Shield does not have the authority to transfer members, at the PCP's request, when the PCP belongs to more than one IPA/medical group. As stated above, Blue Shield will transfer the primary care physician's current membership to a new IPA/medical group in cases where the PCP terminates from one IPA/medical group and is affiliated with or joins another Blue Shield IPA/medical group within the same geographic location. A member may choose to stay with their current IPA/medical group for any number of reasons, including choice of specialists, location, preference for the IPA/medical group, preference for the affiliated hospital, etc.

  Primary Care Physicians affiliated with a single Blue Shield IPA/medical group

  If a primary care physician terminates from a Blue Shield IPA/medical group and is not affiliated with another Blue Shield IPA/medical group, Blue Shield will notify the PCP's members and reassign them to other PCPs within the IPA/medical group. Blue Shield reserves the right to assign members to primary care physicians, hospitals and IPA/medical groups with the members' best interests in mind.

  If the IPA/medical group wants members reassigned to specific primary care physicians, the IPA/medical group must provide that information to Blue Shield at the time of the notification of PCP termination. Blue Shield will strive to accommodate such requests subject to the member's right to make a final PCP selection.

Provider Status Changes *(cont'd.)*

Primary Care Physician Termination Notification Requirements

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

1. 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). Notification should include the termination date, reason for termination, and National Provider Identification Number (NPI) or California license number and the name and NPI of the receiving PCP. Blue Shield will not be able to process the termination request if the required information is not included. Incomplete requests may be returned to the IPA/medical group.

2. Blue Shield provides affected members at least 60 calendar days' advance written notice of their primary care physician's termination which aligns with accreditation and regulatory requirements. The letter to the member includes notification of the PCP's termination, the termination date, their new PCP and/or IPA/medical group and the procedures for selecting another PCP by calling the Member Services toll free number.

3. In very limited circumstances (see number 4 below) the IPA/medical group may be unable to provide advance notice of a primary care physician termination. In such circumstances, Blue Shield must notify the impacted member to expedite a transfer to a new PCP.

4. The limited circumstances or exceptions referenced above include:

    - Death.
    - Revocation of medical license or Medicare sanction and debarment or any other sanction status which results in the practitioner being immediately ineligible to render care.
    - "Grossly unprofessional conduct", which includes any criminal or fraudulent acts (e.g., allegations of molestation or abuse). This requires investigation by Blue Shield's Credentialing and Legal Departments before making a final determination.
    - Physician relocation out of the area without adequate notice.
    - The physician is an employee of a medical group and quits effective immediately. As a result, the physician does not have an office available where he/she may treat patients.
    - The physician is an employee of a group and their employment is terminated effective immediately.

Provider Status Changes *(cont'd.)*

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

5. If an IPA/medical group is unable to provide Blue Shield with the required 90-day notice of a primary care physician termination due to one of the limited circumstances listed in number 4. 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 physician terminates immediately, Medicare Member Services or Medicare Membership will attempt to contact each affected member via telephone (if possible) and/or via a member letter using a Centers for Medicare & Medicaid (CMS) approved letter template to explain the situation and facilitate the member's assignment to a new primary care physician. During these calls, if any issues are identified that involve continuity of care (e.g., pending referrals, hospitalization, necessary immediate primary care physician 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 of termination of a regularly seen specialist or specialty group.

- In accordance with accreditation and state regulatory standards, Blue Shield members are required to receive at least 60 days' prior notice of an upcoming physician termination, including specialist or specialty group termination.

- Federal law, however, requires that members be notified at the time of the provider's contract termination or the employer group's termination of its Blue Shield contract.

Therefore, to comply with all notification requirements, members must receive notices both 60 days prior to the specialist termination and again at the time of termination on a timely basis. Because Blue Shield does not assign members to specialist physicians/specialty groups, but rather relies on the IPA/medical group to coordinate the member's specialty care arrangements, the responsibility to notify the member of specialist terminations rests with the IPA/medical group.

The specifics of the requirements are as follows:

1. All Blue Shield contracting IPA/medical groups must notify members seen regularly by a specialist or specialty group whose contract is terminated at least 60 days prior to the effective termination date. The letter to the member must include notification of the specialist or specialty group's termination, the effective date of termination, and the procedures for selecting or assigning another specialist or specialty group. (Please refer to the Continuity of Care Guidelines in this section for members qualifying for continuity of care).

2. Contracting IPA/medical groups must have policies that define members seen regularly by a specialist or specialty group and which outline the IPA/medical group's implementation plan for notifying members of the specialist/specialty group termination, as well as the procedures they may follow to select another specialist. Ways to identify affected members 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.

3. If the IPA/medical group does not provide Blue Shield affected members with 60 days advance written notice, the IPA/medical group is responsible for ensuring the specialist and/or specialty group continues to provide medical services to affected members until a 60-day advance notice of the termination is given.

Provider Status Changes *(cont'd.)*

Blue Shield Oversight

Blue Shield provides appropriate oversight of each of its contracting IPA/medical groups, including, but not limited to:

- Specialist/Specialty Group Termination Policy and procedures as outlined above;
- Review of member notification letter regarding specialist/specialty group terminations.

As such, Blue Shield's Delegation Oversight Consultant will review each IPA/medical group's policy and procedure and member notification letters during its annual delegation audit process.

The specialist termination notification policy and procedure will outline how your organization will:

1. Identify "affected members" regularly seen by a specialist or specialty group;
2. Inform affected members of the specialist/specialty group termination; and
3. Assign or direct affected members to select another specialist or specialty group.

In addition, the IPA/medical group is required to maintain copies of all notification correspondence between the IPA/medical group and affected members.

Continuity of Care by a Terminated Provider

Members who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; including those who are undergoing a course of institutional or inpatient care; or who are children from birth to 36 months of age; or who have received authorization from a terminated provider for surgery or another procedure as part of a documented course of treatment can request completion of care in certain situations with a provider who is leaving the Blue Shield provider network. The IPA/medical group is required to notify each enrollee who qualifies for continuity of care that they may elect for transitional care from a terminating provider, other than a PCP, from the IPA/medical group.

Continuity of Care for Members by Non-Contracted Providers

Newly covered members who do not have out-of-network benefits, and 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. Provider must agree to Blue Shield pricing by region.

Existing Blue Shield members who are being treated for acute conditions, serious chronic conditions, pregnancies (including immediate postpartum care), or terminal illness; including those who are undergoing a course of institutional or inpatient care; 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 for up to ninety (90) days or completion of care, whichever is sooner.

Provider Status Changes *(cont'd.)*

Continuity of Care for Members by Non-Contracted Providers *(cont'd.)*

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. Members can also request that Blue Shield file the continuity of care request for them by calling the Customer Services number listed on their ID card.

Compliance with Quality Improvement Programs

IPA/medical groups are contractually required to comply with Blue Shield's Quality Improvement (QI) Programs and related activities. Activities include, but are not limited to, the following examples:

1. Adhere to Blue Shield's Medical Policy, Utilization Management (UM) standards, Credentialing/Re-Credentialing standards, and Quality Improvement (QI) responsibilities. These guidelines are discussed in Section 5 of this manual.

2. Review patterns and trends and participate in outcome measurement activities with respect to care and service. Respond to identified adverse outcomes as quality improvement indicators.

3. Pro-actively notify Blue Shield about members whose cases meet catastrophic and targeted case management identification and coordination guidelines, and cooperate with Blue Shield's case management program for catastrophic and targeted cases. For catastrophic and targeted case management identification and coordination guidelines, see Section 2 of this manual.

4. Cooperate with Blue Shield by participating in activities regarding preventive service utilization, quality improvement initiatives, guideline development and monitoring, patient safety activities, clinical pilot studies, and chronic condition management. All Blue Shield providers are required to participate in quality management activities by providing, to the extent allowed by applicable state and federal law, member information and medical records for review of quality of care and service.

5. In order to comply with NCQA accreditation requirements, Blue Shield collects and reports HEDIS® data as it relates to Blue Shield members. Blue Shield HMO-contracted physicians are required to provide medical records requested for HEDIS data collection in a timely manner. The Health Insurance Portability and Accountability Act (HIPAA) includes data collection for HEDIS reporting in the category of health care operations, thus no special patient consent or authorization is required to release this information.

6. Provide health education programs on a routine basis at no charge to members.

7. Participate in provider education/orientation sessions and other activities offered by Blue Shield.

8. Cooperate and participate in all requests for information related to member complaints, grievances and appeals, and quality of care reviews.

Failure to comply may result in administrative action up to and including termination of contract.

Economic Profiling

The California Health & Safety Code requires that every health plan in the state, including Blue Shield, file a description of any policies and procedures related to economic profiling used by the plan and by its IPAs and medical groups with the Department of Managed Health Care (DMHC).

Economic profiling is described as "any evaluation of a particular physician, provider, medical group, or individual practice association based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, medical group or independent practice association."

If an IPA/medical group engages in economic profiling of any kind, it must have a written policy that complies with Section 1367.02 of the Health and Safety Code. Blue Shield will evaluate these policies for compliance and files them with the DMHC. If an IPA/medical group changes its economic profiling policy, the revised policy should be provided to Blue Shield for review and subsequent filing.

Statements filed with DMHC must describe how these policies and procedures are used in:

- Utilization review
- Peer review
- Incentive and penalty programs
- Provider retention and termination decisions

The filed statement must also indicate in what manner, if any, the economic profiling system takes into consideration any enrollee characteristics that may account for higher or lower than expected costs or utilization of services, including risk adjustments that reflect:

- Case mix
- Type and severity of patient illness
- Age of patients

Health plans must demonstrate that medical decisions are rendered by qualified medical providers who are unencumbered by fiscal and administrative management. Plans and IPAs/medical groups must also provide economic profiling information upon request, as delineated in the Health & Safety Code.

Other IPA/Medical Group Responsibilities

The IPA/medical group is responsible for:

- Identifying a Medical Director who will coordinate all matters related to patient care, quality assessment and utilization.
- Providing immediate information to Blue Shield on personnel changes pertaining to contact sheet updates.

Practice Locations and Closures

- If an IPA or medical group has multiple sites/locations, the IPA or medical group will ensure that no group physician practices in more than three practice locations.
- Providers who close their practices to new patients may only remain closed for a maximum of one year. Blue Shield will contact provider semi-annually to confirm changes in status.

IPA/Medical Group Orientations

Blue Shield conducts initial orientations for the administrative staff of newly contracted IPA/medical groups. Subjects covered during these orientations include:

- Blue Shield overview
- Guidelines and Resources
- Communications
- Provider Demographic Updates
- Ancillary Network
- Blue Shield's mental health service administrator (MHSA)
- Pharmacy
- Utilization Management
- BlueCard® Program
- Electronic Data Interchange
- Provider Connection

Contact your group's assigned Provider Relations Representative for further details.

Other IPA/Medical Group Responsibilities *(cont'd.)*

HMO Physician and Hospital Directory

In preparation for inclusion in Blue Shield's *HMO Physician and Hospital Directory* publication, Provider Information & Enrollment will forward quarterly proofing rosters to the IPA/medical groups. The IPA/medical group is responsible for verifying the accuracy of the roster data and returning the roster with any changes/corrections by the requested date.

On an annual basis, Blue Shield will send the IPA/medical group a notification and copy of the roster consistent with California Health & Safety Code §1367.27. The IPA/medical group is responsible, within thirty (30) business days from receipt, for confirming that all of the information is current and accurate or for updating any incorrect information.

If no response is received from the IPA/medical group within the thirty (30)-business-day period, Blue Shield will attempt to contact the IPA/medical group to validate the information or to get required updates. If Blue Shield is unable to verify the information or obtain updates within fifteen (15) business days following the initial thirty (30)-business-day period, Blue Shield will provide IPA/medical group with a ten (10)-business-day advance notice that it will be removed from the provider directory unless the IPA/medical group responds to the request during this time.

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 of Managed Health Care or Department of Insurance to report any inaccuracy with the plan's directory or directories.

Updated rosters will be mailed to each IPA/medical group upon request.

In order to reduce administrative burden on providers, Blue Shield delegates some provider directory maintenance tasks to a vendor. As directed by Blue Shield, the IPA/medical group must work with the vendor in lieu of Blue Shield to complete directory maintenance tasks. This will entail executing a participation agreement with the vendor and taking other reasonably requested steps to ensure smooth exchange of directory data.

Medical Advice Lines

IPA/medical groups or hospitals providing telephone medical advice services to patients may be required to register with the Telephone Medical Advice Services Bureau. All staff must be appropriately licensed, registered or certified and operating within the laws governing their respective scopes of practice in the state in which they provide telephone medical advice services.

Note: IPA/medical groups must advise Blue Shield if they intend to operate or contract with a telephone medical advice service.

Other IPA/Medical Group Responsibilities *(cont'd.)*

Member Referral to Preferred and/or Capitated Ancillary Providers

As appropriate, IPA/medical groups are required to refer Blue Shield members to ancillary providers listed in preferred ancillary provider rosters (Ambulatory Surgery Centers (ASCs), Skilled Nursing Facilities (SNFs), dialysis centers, ambulance providers, home infusion providers, etc.) posted on Provider Connection. To access these rosters, log on to blueshieldca.com/provider and click on *Guidelines & resources*, *Patient care resources*, then *Ancillary provider rosters*.

Apria Healthcare LLC is Blue Shield's capitated provider of home and durable medical equipment for Medicare Advantage HMO members. IPA/medical groups are required to utilize Apria Healthcare LLC for standard home and durable medical equipment items that are not the financial responsibility of the IPA/medical group. If the DME services are not referred to Apria, deductions may occur in the IPA/medical group's capitation payment. IPA/medical groups can access additional information and a comprehensive Apria branch listing at Apria.com or by calling Apria directly at (800) APRIA-88 ((800) 277-4288). Any standard DME item ordered from a DME Provider other than Apria will require Prior Authorization from Blue Shield of California or an authorized agent of Blue Shield.

Except for those services provided in the home, please keep in mind that to ensure appropriate access and availability for our members, referred providers should be located within 15 miles, or 30 minutes, of the member's home or work and have the capacity to render such service(s). If none of the listed providers meet these geographic and capacity requirements, IPA/medical groups may refer providers not listed on the ancillary provider rosters. In this case, authorization must be coordinated with Blue Shield.

Out-of-Network Assessment Program

Blue Shield has implemented an Out-of-Network Assessment Program that charges IPA/medical groups (if allowed for in their contract) when the IPA/medical group authorizes services to non-participating Blue Shield providers without Blue Shield's approval.

The Out-of-Network Assessment Program will specifically target non-urgent/non-emergent services rendered at non-participating ambulatory surgery centers, ambulance companies, dialysis centers, durable medical equipment companies, home health companies, home infusion centers, and skilled nursing facilities.

Blue Shield will supply the IPA/medical group with a quarterly Out-of-Network Assessment Program Report (report). The report will identify which services, provided by an out-of-network provider and referred by the IPA/medical group, are the financial responsibility of Blue Shield. It will exclude services rendered by non-contracted providers on an urgent/emergent basis and/or as approved by Blue Shield.

Other IPA/Medical Group Responsibilities *(cont'd.)*

Out-of-Network Assessment Program *(cont'd.)*

The report will include the following:

- Subscriber's name
- Subscriber's number
- Non-contracted provider's name and address
- Date of service
- Billed amount
- Allowed amount
- Paid amount
- Estimated amount Blue Shield would have allowed for a similar service rendered by a contracted provider within the IPA/medical group's service area
- The difference between the paid amount and the estimated amount Blue Shield would have allowed for a similar service rendered by a contracted provider within the IPA/medical group's service area during the previous calendar year

A determination of the estimated amount Blue Shield would have paid a contracted provider will be based upon the following:

- Twelve (12) months of claims utilization, by provider type (ambulatory surgery center, ambulance company, dialysis center, durable medical equipment company, home health company, home infusion centers, and skilled nursing centers), for HMO members who received services within the IPA/medical group's service area.

- The percentage of charge equivalent to the average allowed amount for a service rendered by a similar provider contracted with Blue Shield and within the IPA/medical group's service area.

Blue Shield will generate the report and send it to the IPA/medical group along with their capitation and eligibility reports. The IPA/medical group will have thirty (30) working days to review the report for feedback and dispute purposes.

If the IPA/medical group does not dispute any of the claims identified in the report the deduction will be applied to the next scheduled capitation payment to the IPA/medical group following sixty (60) calendar days from the date the report was sent. Each deduction will be itemized on the capitation reconciliation report and include a message indicating that the adjustment is due to the Out-Of-Network Assessment Program.

If the IPA/medical group contests or questions any of the claims on the report, Blue Shield will review and respond to objections within thirty (30) days of receiving written notification of such objection. In the event that Blue Shield determines that, despite the IPA/medical group's objections, the IPA/medical group authorized services in violation of their agreement, Blue Shield will inform the IPA/medical group of such determination in writing. Blue Shield's written communication will include information on the IPA/medical group's right to appeal Blue Shield's determination through Blue Shield's Provider Appeals Process.

Other IPA/Medical Group Responsibilities *(cont'd.)*

Out-of-Area Urgent Care Center Utilization

IPA/medical groups are required to provide treatment for out-of-area HMO members presenting for care for urgent care services at their urgent care centers (UCCs). Treatment for out-of-area urgent care does not require a referral or prior authorization. The member is out-of-area when the treating IPA/medical group is located greater than 30 miles from the member's primary care physician location shown on the member's ID card. Eligibility should be first checked using the provider portal or calling the member services phone number shown on the member's Blue Shield HMO ID card.

Financial Responsibility

Blue Shield is financially responsible for the urgent care treatment rendered by an UCC to an out-of-area HMO member. IPA/medical groups can submit claims directly to Blue Shield. The member should not be billed or required to pay at the time of service. Members are only responsible for their office visit copayment as shown on their ID card.

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 Threshold Languages

Blue Shield's threshold languages are:

- Spanish
- Chinese – Traditional
- Korean
- Vietnamese

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

Blue Shield's Language Assistance Program

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

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

Other IPA/Medical Group Responsibilities *(cont'd.)*

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

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. Blue Shield also reports the language preference to the enrollee's IPA/ medical group on monthly eligibility reports.

Providers must inform Blue Shield LEP enrollees 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.

- 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 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.

Other IPA/Medical Group Responsibilities *(cont'd.)*

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

Providing Interpretation Services *(cont'd.)*

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

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

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

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

If the provider does not meet these requirements, they should inform the patient that Blue Shield will make an interpreter available to them 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, the provider should note that in the patient's record.

Blue Shield ensures through quality assurance audits that contracted providers 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:

Other IPA/Medical Group Responsibilities *(cont'd.)*

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

Timeliness Standards for Interpretation Services at Points of Contact *(cont'd.)*

- **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 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 or provider contact Blue Shield to arrange for an interpreter.

Documenting Enrollee Refusal of Language Assistance

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

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

In an emergency situation, 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 member is fully informed in his or her primary/preferred spoken language that a qualified interpreter is available at no charge to the member. If the member refuses the offer of the qualified interpreter, the offer of a qualified interpreter and the member's decision to use the minor as the interpreter shall be documented in the medical record file.

It is important to also document in the patient's medical record the name and contact information of any professionally-trained interpreter whose services were used for a medical visit.

Other IPA/Medical Group Responsibilities *(cont'd.)*

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

Documenting Enrollee Refusal of Language Assistance *(cont'd.)*

It is recommended that providers document all LEP patients' preferred language on paper and/or in electronic medical records. One way to do this is to post color stickers that signal the patient's preferred language and if an interpreter is needed.

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, seek independent medical review (IMR), and obtain oral interpretation in any language. 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 can find appeal and IMR information in their Evidence of Coverage and at blueshieldca.com, as well as on the DMHC website at dmhc.ca.gov. Hard copies of the DMHC notice can also be requested in writing to Department of Managed Care, Attention: HMO Help Notices, 980 9th Street, Suite 500, Sacramento, CA 95814.

Providing Translation Services

Vital Documents

Vital documents are materials deemed critical to accessing the health plan and its benefits. Vital documents may be produced by the plan, a contracted health care service provider, or contracted administrative services provider. The following documents are the "vital documents" produced by Blue Shield. This category includes documents produced or distributed to enrollees by a delegated IPA or medical group:

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

Other IPA/Medical Group Responsibilities *(cont'd.)*

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

Vital documents are divided into two categories:

- **Standard Vital Documents**

  Standard vital documents are translated into Blue Shield's threshold languages in writing and are available upon request by the enrollee.

- **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-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 twenty-one (21) calendar days of that request, with the exception of expedited grievances, as noted below.

Blue Shield's Standard Vital Documents

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

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

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

- Letters containing important information regarding eligibility and participation criteria
- Notices pertaining to the denial, reduction, modification, or termination of services and benefits

Other IPA/Medical Group Responsibilities *(cont'd.)*

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 (ਪੰਜਾਬੀ): ਪੰਜਾਬੀ ਵਿਚ ਮਦਦ ਲਈ ਮਹਰਬਾਨੀ ਕਰ ਕੇ 1-866-346-7198 ਤੇ ਮਫ਼ਤ ਕਾਲ ਕਰੋ.

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.

Other IPA/Medical Group Responsibilities *(cont'd.)*

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 non-standard vital document are instructed to call the Member Services 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.

IPA/Medical Groups

Although not delegated to provide language assistance services, IPA and medical groups are delegated by Blue Shield to issue certain Utilization Management and Claims documents that fall within scope of the regulations. Blue Shield will provide an approved notice offering interpretation and translation services in our threshold languages; this notice must accompany any of the following non-standard vital documents produced and distributed by the IPA/medical group to Blue Shield enrollees:

- UM denial notifications, including denial, modification or delay in service
- UM delay notifications for additional information or expert review
- Claims denial notification that requires a response from the member

To ensure the required information is provided to Blue Shield enrollees, providers responsible for the member notifications will:

- Ensure the enrollee's health plan is correctly identified
- Ensure Blue Shield's approved notice is attached to:
  - Denial letters, including those which modify services or create a delay in delivery
  - Letters about delay or suspension of claims processing due to missing information that requires a response from the enrollee
  - Claims denial notifications that require a response from the enrollee
- Maintain a copy of the notice with the corresponding referral or claims file for review by Blue Shield auditors

Other IPA/Medical Group Responsibilities *(cont'd.)*

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

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. IPA/medical groups must also provide copies of non-standard vital documents, as described above, to Blue Shield, upon request.

A provider who receives a request for a vital document translation should forward it 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:

- Complete Blue Shield's "Language Assistance Form" available at Provider Connection at blueshieldca.com/provider under *Guidelines & resources, Patient care resources*, and then *Language Assistance Program;*
- Attach a copy of the document to be translated;
- Fax the request to (248) 733-6331.

Other IPA/Medical Group Responsibilities *(cont'd.)*

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.

Other IPA/Medical Group Responsibilities *(cont'd.)*

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

Language Assistance at Contracted Facilities

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

Training and Education

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

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

Monitoring Compliance

Blue Shield's LAP annual compliance audit includes:

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

References

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

- American Academy of Family Physicians Cultural Proficient, Health Care
  https://www.aafp.org/about/policies/all/culturally-proficient-health-care.html
- American Medical Association: Delivering Care, Health Equity
  https://www.ama-assn.org/delivering-care/health-equity
- Industry Collaboration Effort (ICE) Cultural and Linguistics Provider Toolkit
  https://www.iceforhealth.org/library.asp?sf=&scid=1284#scid1284
- 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.
  https://www.minorityhealth.hhs.gov

Other IPA/Medical Group Responsibilities *(cont'd.)*

Confidentiality of Substance Use Disorder Patient Records

In 1975, Congress enacted 42 U.S.C. 290dd-2 and its supporting regulations at 42 C.F.R. Part 2. The law is formally referred to as the Confidentiality of Substance Use Disorder Patient Records Act, and informally referred to as "Part 2." The purpose of Part 2 is to protect the privacy of substance use disorder (SUD) patient records by prohibiting unauthorized use and disclosure of SUD patient records except with patient consent and in limited circumstances.

The Substance Abuse and Mental Health Services Administration (SAMHSA) is the agency within the U.S. Department of Health and Human Services (HHS) that regulates and enforces Part 2.

If, as a provider, you are a Part 2 Program, you must comply with all of the applicable legal requirements of the Part 2 laws and regulations.

To assist you in meeting your legal obligations, you may inform Blue Shield that you have the patient's consent to disclose their SUD patient records to Blue Shield when submitting an electronic claim (837 P or I) for Part 2 services by placing an "1" in the CLM09 field.

When submitting an electronic claim (837 P or I) for Part 2 services, under the NTE02 segment, you may include in the free-form narrative one of the following mandatory Part 2 disclaimer language options. The shorter version is preferable.

- 42 CFR part 2 prohibits unauthorized disclosure of these records; or
- This information has been disclosed to you from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of information in this record that identifies a patient as having or having had a substance use disorder either directly, by reference to publicly available information, or through verification of such identification by another person unless further disclosure is expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose (see § 2.31). The federal rules restrict any use of the information to investigate or prosecute with regard to a crime any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65.

To help you determine if you are a Part 2 Program, please refer to:
https://www.samhsa.gov/sites/default/files/does-part2-apply.pdf.

To learn more about the Part 2 laws and regulations, please refer to:
https://www.federalregister.gov/documents/2018/01/03/2017-28400/confidentiality-of-substance-use-disorder-patient-records

To learn more about how Part 2 limits the disclosure of SUD patient records, please refer to:
https://www.samhsa.gov/sites/default/files/how-do-i-exchange-part2.pdf

It is recommended that you consult legal counsel if you are uncertain whether or how these provisions apply to you.

Introduction

Blue Shield has established and approved written policies and procedures that state it does not delegate or sub-delegate any Member Rights and Responsibilities to the IPA/medical groups. This applies to both commercial and Blue Shield Medicare Advantage plans.

All grievances are the responsibility of Blue Shield.

Statement of Member Rights and Responsibilities

Member Rights

All Blue Shield plan members have the right to:

1. Receive considerate and courteous care, with respect for their right to personal privacy and dignity.
2. Receive information about all health services available to them, including a clear explanation of how to obtain them.
3. Receive information about their rights and responsibilities.
4. Receive information about their health plan, the services we offer them, the physicians, and other practitioners available to care for them.
5. Select a primary care physician and expect his/her team of health workers to provide or arrange for all the care that they need.
6. Have reasonable access to appropriate medical services.
7. Participate actively with their physician in decisions regarding their medical care. To the extent permitted by law, members also have the right to refuse treatment.
8. A candid discussion of appropriate or medically necessary treatment options for their condition, regardless of cost or benefit coverage.
9. Receive from their physician an understanding of their medical condition and any proposed appropriate or medically necessary treatment alternatives, including available success/outcomes information, regardless of cost or benefit coverage, so they can make an informed decision before they receive treatment.
10. Receive preventive health services.
11. Know and understand their medical condition, treatment plan, expected outcome and the effect these have on their daily living.
12. Have confidential health records, except when disclosure is required by law or permitted in writing by the member. With adequate notice, members have the right to review their medical record with their primary care physician.
13. Communicate with and receive information from Member Services/Shield Concierge in a language they can understand.
14. Know about any transfer to another hospital, including information as to why the transfer is necessary and any alternatives available.

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

Member Rights *(cont'd.)*

15. Obtain a referral from their primary care physician for a second opinion.
16. Be fully informed about the Blue Shield grievance procedure and understand how to use it without fear of interruption of health care.
17. Voice complaints or grievances about the Blue Shield health plan or the care provided to them.
18. Participate in establishing public policy of the Blue Shield health plan, as outlined in their *Evidence of Coverage* or *Health Service Agreement.*
19. Make recommendations regarding Blue Shield's member rights and responsibilities policy.

Member Responsibilities

Blue Shield health plan members have the responsibility to:

1. Carefully read all Blue Shield plan materials immediately after they are enrolled so they understand how to use their benefits and minimize their out-of-pocket costs. Ask questions when necessary. Members have the responsibility to follow the provisions of their Blue Shield membership as explained in the *Evidence of Coverage* or *Health Service Agreement.*
2. Maintain their good health and prevent illness by making positive health choices and seeking appropriate care when it is needed.
3. Provide, to the extent possible, information that their physician and/or the plan need to provide appropriate care for them.
4. Understand their health problems and take an active role in developing treatment goals with your medical care provider, whenever possible.
5. Follow the treatment plans and instructions they and their Physician have agreed to and consider the potential consequences if they refuse to comply with treatment plans or recommendations.
6. Ask questions about their medical condition and make certain that they understand the explanations and instructions they are given.
7. Make and keep medical appointments and inform the plan physician ahead of time when they must cancel.
8. Communicate openly with the primary care physician they choose so they can develop a strong partnership based on trust and cooperation.
9. Offer suggestions to improve the Blue Shield health plan.
10. Help Blue Shield to maintain accurate and current medical records by providing timely information regarding changes in address, family status and other health plan coverage.
11. Notify Blue Shield as soon as possible if they are billed inappropriately or if they have any complaints.

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

Member Responsibilities *(cont'd.)*

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

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

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

15. For all mental health and substance use disorder services, follow the treatment plans and instructions agreed to by the member and Blue Shield's mental health service administrator (MHSA). Members and/or providers are required to obtain prior authorization for all non-emergency mental health and substance use disorder services as required by the applicable plans *Evidence of Coverage* or *Health Service Agreement.* HMO IPA/medical groups are responsible for decisions related to delegated medical services. As such, medical services for the treatment of gender dysphoria, eating disorder, or substance use disorder are the responsibility of the IPA/medical group.

Member Grievance Process

The Blue Shield HMO administers the investigation of member grievances and follows a standard set of procedures for the resolution for both Medicare Advantage and commercial members.

For more information on the member grievance process and complaint resolution procedures for Blue Shield Medicare Advantage plan members, see Section 6.6 of this manual.

Blue Shield has a comprehensive review process to address matters when members wish to exercise their right to file a grievance. The program also encourages communication and collaboration on grievance issues among Blue Shield departments and functional areas. 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.

Grievances are disputes regarding potential quality issues, access to care, or delay/modification/denial of treatment issues. All grievances are researched and investigated by Blue Shield's Appeals and Grievance Department (A&G). Blue Shield requests that IPA/medical groups help identify, process, and resolve all member grievances in a timely manner.

Blue Shield encourages members to informally resolve their grievances with their Blue Shield HMO providers. If this is not possible, members, member representatives, or an attorney or provider on the member's behalf, may call Blue Shield HMO Member Services to initiate a grievance.

Members, member representatives, or an attorney or provider on the member's behalf may file a grievance by contacting Blue Shield's Customer/Member Service Department in writing, by telephone, or by submitting a completed Grievance Form online at blueshieldca.com. Blue Shield provides all IPA/medical groups with an optional member grievance form that is available in the offices for all Blue Shield members. (This form is distributed to all IPA/medical groups through the Provider Relations Department.)

Member Grievance Process *(cont'd.)*

To comply with the Department of Managed Health Care (DMHC), legislative requirements, and National Committee for Quality Assurance (NCQA), Blue Shield resolves all member grievances within 30 calendar days of receipt. Generally, the member must participate in Blue Shield's grievance process for 30 calendar days before submitting a grievance to the DMHC. However, the DMHC can waive this requirement in "extraordinary and compelling cases." In these events, Blue Shield has five days to respond to the grievance.

When it is necessary to coordinate a grievance with the member's provider, Blue Shield will send a copy of the member's grievance to the IPA/medical group and request that the IPA/medical group review it and respond to Blue Shield in writing within ten calendar days from receipt for normal grievances or 24 hours from receipt for urgent or escalated grievances.

The Member Grievance Process ensures that:

- Members are informed of their right to report grievances
- Member grievances are responded to and resolved timely
- No sanctions/penalties or interruption of health care results from using the Grievance Program
- Tracking, analyzing, and reporting of individual and aggregate grievance data
- Identification of systemic quality of care, access to care, and quality of service issues
- Compliance with DMHC, regulatory requirements, and NCQA standards

Resolution Options

The Member Grievance Process is designed to allow the member, member representative or provider on their behalf, a complete and timely review within 30 calendar days of Blue Shield's receipt.

The following options are used to resolve a member grievance:

- Standard Review Process
- Expedited Review
- Independent Medical Review (IMR) (offered through the DMHC)

Blue Shield Grievance Process – Standard, Expedited, and External Review

Standard Review Process

If Member Services cannot resolve the issue, the case is forwarded to the Appeals and Grievance Department (A&G) for review and determination. Clinical grievances may include collaboration with a Blue Shield Medical Director.

Resolution occurs within 30 calendar days of the member's initial request. The written response to the member provides a clear and concise statement of the determination with references to applicable provisions in the *Evidence of Coverage* (EOC). The Blue Shield Grievance Process allows members to file grievances within 180 days following any incident or action that is the subject of the member's dissatisfaction.

The Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If the member has a grievance against Blue Shield, the member should first telephone Blue Shield at the number provided in their EOC 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. Members can contact the DMHC at (888) 466-2219, TDD (877) 688-9891 for the hearing and speech impaired, or through their website at www.dmhc.ca.gov for complaint forms, IMR application forms, and instructions online.

The member may also be eligible for an Independent Medical Review (IMR). If they are eligible for an 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.

If the grievance involves a medical necessity or experimental/investigational issue, the member is notified of his/her right to request an external Independent Medical Review (IMR). A copy of the IMR form and instructions are included in the response.

Expedited Review

Members have the right to an expedited decision when the routine decision-making process might pose an imminent or serious threat to their health, including, but not limited to severe pain, potential loss of life, limb, or major bodily function. Blue Shield will evaluate the request and medical condition to determine if it qualifies for an expedited decision, which will be processed as soon as possible to accommodate the member's condition not to exceed 72 hours from the initial receipt.

Members, member representatives, or an attorney or provider acting on their behalf, may file a verbal or written request, or can submit a Grievance Form online at blueshieldca.com to obtain an expedited decision by specifically stating that the subscriber's health might be seriously jeopardized by waiting for the standard process. The Blue Shield Grievance Process allows members to file grievances within 180 days following any incident or action that is the subject of the member's dissatisfaction.

> *Note: If a Commercial Members employer's health plan is governed by the Employment Retirement Income Security Act (ERISA), they may have the right to bring a civil action under Section 502 (a) of ERISA if all required reviews of their claim have been completed and their claim has not been approved.*

Blue Shield Grievance Process – Standard, Expedited, and External Review *(cont'd.)*

External Independent Medical Review (IMR)

The Knox-Keene Act requires Blue Shield to provide external Independent Medical Review (IMR) when appropriate.

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 calendar days before requesting external review; however, if the matter would qualify for an expedited decision, as described above, or involves a determination that the requested service is experimental/investigational, 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 Department of Managed Health Care (DMHC) 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.

Members may apply for an IMR if:

1. The member's provider has recommended a health care service as medically necessary.
2. The member has received urgent care or emergency services that a provider determined was medically necessary.
3. In the absence of a provider recommendation or the receipt of urgent care or emergency services, the member has been seen by an in-plan provider for the diagnosis or treatment of the medical condition for which the member seeks independent review.

Blue Shield Grievance Process – Standard, Expedited and External Review *(cont'd.)*

External Independent Medical Review (IMR) *(cont'd.)*

Upon receipt of DMHC's notification of approval of the member's request for IMR, Blue Shield forwards requested information directly to the review entity selected by the DMHC within three business days, unless there is an imminent and serious threat to the enrollee's health, in which case, Blue Shield must provide the information within 24 hours.

Information provided must include:

- All medical records that are relevant to the member's condition
- All information provided to the member and contracting providers concerning the condition and care
- All information that was submitted by the member
- All written communications by Blue Shield regarding the grievance
- Copies of any other relevant documents or information regarding the grievance, including any section of the *Evidence of Coverage* relied on by Blue Shield in its denial

IMR will be completed within 30 days or within three days for urgent conditions.

Upon completion of the review, the review entity provides written notice of its decision to the member, the member's provider, Blue Shield and the DMHC. Blue Shield will promptly comply with the decision.

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.

Peer Review

Peer review is the review of cases through the grievance and appeals process where actual or potential quality-of-care issues are identified. Cases requiring investigation may involve components of care delivered by an individual practitioner or a health delivery organization such as a hospital, skilled nursing facility, medical group or independent practice association, or other types of organizations designed to deliver care to Blue Shield members.

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Capitation

For each Blue Shield commercial product in which the IPA/medical group is participating, Blue Shield pays a negotiated age/sex/copay adjusted per member per month (PMPM) capitation amount for each member who selects a primary care physician in that IPA/medical group. (Please refer to the Blue Shield IPA/Medical Group Provider Agreement for actual age, sex, copay-adjusted rates, and percentages.)

Capitation is paid for each member assigned to a primary care physician in the IPA/medical group as of the first of the month. If payments are accepted by the group electronically, such capitation shall be paid for members not enrolled in the Blue Shield Medicare Advantage plan Benefit Program no later than the fifteenth (15^{th}) day of the month.

Each month's capitation payment may include retroactive adjustments.

Financial Reports

Blue Shield supplies the following financial reports electronically via email, or SFTP to the IPA/medical group for the HMO and Point-of-Service (POS) products.

Combined Eligibility/Capitation File

The monthly Combined Eligibility/Capitation File shows capitation details for all IPA/medical groups and their primary care physicians for a specific reporting period. It includes the calculated payment amounts for all currently eligible capitated members. (The file layout for this report appears in Appendix 3.)

This file is the supporting documentation for the Monthly Capitation Reconciliation Report.

Quarterly Financial Performance File

The Quarterly Financial Performance Report is based on a 90-day fund pool performance (for physician organizations participating in a shared savings program). This report itemizes information on member months, capitation paid, institutional fund allocations, depletions, and balances by month and year-to-date. This report is supported by claim detail for all applicable fund pools.

> *Note: If an IPA/medical group has questions regarding the Shared Savings claims, the IPA/medical group can submit the detailed claim records in question to Managed Care Finance, Blue Shield of California. The submitted file should have the same layout format as the claim files that were previously sent to them. A column needs to be added to the end of the file for all comments explaining why the claims are being questioned. In addition, the submitted file should only include the claims that are in question. Please note that this process does not replace or change the DMHC Provider Dispute Process.*

Please refer to Section 6 for Blue Shield Medicare Advantage plan financial reports.

Actuarial Cost Model

The Actuarial Cost Model discloses the projected utilization rate, unit cost and per-member per-month information for each type of service for commercial lines of business. Please refer to Appendix 4-C for the Actuarial Cost Model tables.

Capitation *(cont'd.)*

Retroactive Changes

Retroactive Cancellation/Ineligible Member

If a member is cancelled retroactively, Blue Shield will deduct capitation retroactively from the IPA/medical group not to exceed 90 days for commercial members and 365 days for FEHBP or Medicare Advantage members. Depending on the contract, retroactive cancellation of members may be limited to a predetermined period. (Please refer to the Blue Shield IPA/Medical Group Provider Agreement for the limitation.)

Blue Shield will be financially responsible for all covered services provided by IPA/medical group providers to an ineligible person or a retroactively cancelled member for the period of time for which capitation was retroactively adjusted and who had been previously verified as eligible by Blue Shield, as long as the IPA/medical group has:

- Provided documentation to Blue Shield of the eligibility error or notice of a retroactively terminated member, along with the claim for services. Documentation should include:
    - Member name
    - Member ID number
    - Place, date, and provider of service
    - A claim showing the services provided and the billed/paid amount

If the member is determined to be ineligible or retroactively cancelled, Blue Shield will reimburse the IPA/medical group using the payment methodology described in the Blue Shield contract.

However, if the member 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, the IPA/medical group 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) along with the information described above for payment under eligibility guarantee. If the patient is covered by another health care service plan during the time period involved and the other plan has paid capitation to the IPA/medical group for the patient, no eligibility guarantee payment will be due from Blue Shield.

Retroactive Additions

If a member is added retroactively, Blue Shield will pay capitation retroactively to the IPA/medical group not to exceed 90 days for commercial members and 365 days for FEHBP or Medicare Advantage members. Depending on the contract, retroactive addition of members may be limited to a predetermined period. (Please refer to the Blue Shield IPA/Medical Group Provider Agreement for the limitation.) Any payments collected for covered services by the IPA/medical group and/or its providers from the member must be refunded, minus any applicable copayments. For the period of time beyond which capitation was paid for retroactively added eligible members, Blue Shield shall compensate Group for provided covered services pursuant to the provider's contracted rates.

Claims Processing

This provider manual addresses claims processing, related reporting, and coordination in three separate places:

Section 4.4 Claims Administration

This section covers commercial claims processes including submissions to and coordination with Blue Shield's internal, commercial claims processing operations.

Section 6.4 Blue Shield Medicare Advantage Plan Network Administration

The section on claims administration covers submissions to and coordination with Blue Shield's internal, Medicare claims processing operations.

Appendix 4-A Claims, Compliance Program, IT System Security, and Oversight Monitoring

This appendix covers statutory, regulatory, and Blue Shield requirements to be met for delegated, Medicare Advantage, Group Medicare Advantage, and commercial claims, including: (1) self-monitoring required by the IPA/medical group, (2) monitoring that will be conducted by Blue Shield, and (3) the consequences if deficiencies occur, including formal, written corrective action plans.

Claims for Emergency Room Services

IPA/medical groups must comply with the claims payment and notification requirements of Sections 1371.4 and 1371.5 of the Health & Safety Code and with regulations under 28 CCR 1300.71 for the provision of emergency services and emergency claims payment requirements. California law is consistent with Section 2719A of the federal Patient Protection and Affordable Care Act for coverage of emergency services.

Claims Inquiries

For claims with dates of service less than 30 days old, Customer Service will refer the provider to Provider Connection at blueshieldca.com/provider, where this information is readily accessible.

Claim Review

Blue Shield providers are expected to follow professionally accepted ethical 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 and procedure coding inconsistent with current CPT and HCPCS guidelines.

Blue Shield strives to make its clinical payment policies transparent to providers. Blue Shield has implemented claims editing software systems, based on industry standards, in order to pay professional providers fairly, accurately, consistently, and in a standardized manner. Our claims editing software systems provide additional levels of automated claims adjudication.

Claims Processing *(cont'd.)*

Claims for Medical Benefit Drugs

Childhood immunizations recommended for use on or after January 1, 2001 by the Advisory Committee on Immunizations Practices (ACIP) of the Centers for Disease Control (CDC), including their frequency and patient age recommendations, are the financial responsibility of Blue Shield. For office administered medications, drug claims must include the HCPCS code, National Drug Code, and service units. In some IPA/medical group contracts, certain medications that meet criteria to qualify as shared risk are also reimbursable to the IPA/medical group by Blue Shield (refer to your provider contract to determine if your group qualifies). Qualifying childhood immunizations and office administered medications will be reimbursed and charged to Blue Shield. Shared-risk medications will be reimbursed by Blue Shield and charged against the IPA/medical groups' shared-risk fund. Claims for immunizations and office administered medication services that are payable exceptions to the capitated lines of service(s) submitted electronically will be split off from the encounter and processed accordingly. Instructions for completing the CMS 1500 specific to qualifying childhood immunizations and the shared-risk medication reimbursement are found in Appendix 4-B. If necessary, reports generated that include all of the required data fields can be utilized to substantiate the reimbursement.

Claims for Outpatient Prescription Drugs

Medications that may be safely administered at home by the member or a family member, including those administered subcutaneously or intramuscularly are covered in the member's Outpatient Prescription Drug Benefit. Some may require prior authorization for coverage by Blue Shield.

Note: Some Blue Shield members may have prescription drug coverage through another pharmacy benefit manager.

Commercial Plans: 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, Prior authorization forms and list,* then *Prior authorization forms*. 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.

Medicare Plans: The Centers for Medicare & Medicaid Services (CMS) compiles 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 makes 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.

Claims Processing *(cont'd.)*

Claims for Outpatient Prescription Drugs *(cont'd.)*

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.

HMO and POS members with Blue Shield's Outpatient Prescription Drug Benefit access prescription medications through a participating Blue Shield network retail, mail, or specialty pharmacy that submit electronic prescription claims to Blue Shield. Prescriptions at retail and specialty pharmacies are covered for up to 30-day supplies per prescription, and for up to 90-day supplies at the mail service pharmacy.

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.

For the Blue Shield Medicare Advantage plan, Part D drug coverage and exclusion rules apply.

Incorrect Claims Submissions

Incorrect claims submissions, also known as misdirected claims, are claims for capitated services that providers erroneously submit to Blue Shield for processing/payment instead of submitting appropriate claims and/or encounter reports to the assigned IPA/medical group.

In accordance with Section 1300.71 California Code of Regulations (CCR) Title 28, Blue Shield must forward non-contracted provider claims and/or emergency service claims that are the responsibility of the IPA/medical group to the correct IPA/medical group within ten (10) working days of the original receipt date. For all other claims that are the responsibility of the IPA/medical group, Blue Shield may either send the claimant a notice of denial, with instructions to bill the capitated provider or forward the claim to the appropriate IPA/medical group. Blue Shield has developed a process to allow us to forward applicable claim information, for paper- and electronically submitted claims, to the appropriate IPA/medical group in the form of a facsimile. Facsimiles forwarded to the IPA/medical group must be treated as a viable claim. If additional information is required to make the determination to pay or deny, the IPA/medical group may either develop or contest the claims for the missing information. The claim may only be contested if information is missing that is necessary to process the claim. Claims cannot be contested solely because the claim is submitted on a UB 04 or CMS 1500 facsimile claim form.

Should a claim that is payable by Blue Shield be submitted to the IPA/medical group in error, the IPA/medical group must forward the claim to Blue Shield within ten (10) working days.

As a best practice, Blue Shield recommends that all received commercial provider disputes, that are the responsibility of another payor, be forwarded to the responsible party within ten (10) working days of the original receipt of the misdirected dispute.

Claims Processing *(cont'd.)*

Paper Submission

For faster processing and turnaround, please submit all claims electronically. When paper claim forms must be used, Blue Shield requires accurately completed CMS 1500 (Professional) and CMS-1450 (Institutional) forms to process claims quickly and efficiently. Paper claims will be acknowledged within 15 days. Spreadsheet claim submissions are not admissible unless special arrangements have been made. 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, please ensure:

- 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-9-CM, or ICD-10-PCS codes are sufficient. For drug codes, the CPT, HCPCS and NDC are required.
- No white correction fluid is used.
- Data is not touching box edges.
- No special characters are used (e.g., dollar signs, punctuation marks, parentheses).

Submit paper claims to:

Blue Shield of California
P.O. Box 272550
Chico, California 95927-2550

Claims Processing *(cont'd.)*

Electronic Submission

For faster processing and turnaround, please submit all claims electronically. Electronically submitted claims will be acknowledged within 2 days. Claims/encounters must be submitted in ANSI-5010 837P and -837I formats. Check with your programming staff or vendor to determine whether they have connectivity to Blue Shield.

Providers have several data transfer options to submit their electronic billing. Providers can submit claims to one of the Blue Shield/BlueShield Promise approved clearinghouses, via a secure file transfer protocol (SFTP) or through a web based connection with our approved vendor, Office Ally. Blue Shield pays all transaction fees for selected Electronic Data Interchange (EDI) vendors. Be sure claims are submitted with your Blue Shield/BlueShield Promise-assigned IPA/medical group number.

Call the EDI Help Desk at (800) 480-1221 to obtain a connection or go to blueshieldca.com/provider and click on *Claims* for more information about the options listed above. Providers can also send an email to the EDI Department directly at EDI_BSC@blueshieldca.com.

The Health Insurance Portability and Accountability Act (HIPAA) 5010 went into effect January 1, 2012. This federal regulation requires the use of standard X12 transactions to report and inquire about healthcare services. For questions about 5010, go to Provider Connection at blueshieldca.com/provider and click on *Claims,* then *Manage electronic transactions,* contact the EDI Help Desk at (800) 480-1221, or email EDI_BSC@blueshieldca.com.

Billing for Copayments

With the exception of authorized copayments, billing a member for covered benefits is absolutely prohibited under the Knox-Keene Act for contracted providers of all services and non-contracted providers of emergency services. The provider of services is responsible for collecting the applicable copayments from members. Whenever the provider fails to collect the copayment at the time of service and then later bills the member, the bill should clearly indicate that the amount due is for the copayment only. Copayments may not be waived. Providers or the IPA/medical group must issue a receipt to the member whenever a copayment is collected.

Copayment amounts are detailed in the member's *Evidence of Coverage* (EOC) and *Summary of Benefits and Coverage* documents.

Completing Forms for Members

When a completed form is required for licensure, employment, school, camp, sports or other reasons, and it coincides with a member's scheduled routine physical examination, the provider may not charge the member an additional fee in excess of the member's copayment for completing the form. The Blue Shield IPA/Medical Group Provider Agreement prohibits surcharges to members.

When a member requests a form to be filled out at any time other than their physical exam, it is appropriate to charge an office visit copayment.

Encounter Data Submission

Blue Shield Organization and Procedures

Capitated IPAs and medical groups are required to submit all encounter data to Blue Shield, including encounters for primary care, specialty care, and ancillary services.

For both commercial and Medicare Advantage encounter data, submissions may be made directly to Blue Shield or via a vendor. Regardless of the route of submission, providers may request the professional and facility encounter data specifications and procedures from Blue Shield using the contact information below. Encounter data must be submitted in HIPAA compliant ANSI 837P and 837I formats.

Commercial and Medicare Encounter Data

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

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

Vendors

A list of approved 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.

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. IPAs are required to submit encounter submissions with Maximum Out-of- Pocket "MOOP" for Medicare Advantage members. If cost share information applies to a record, please submit the information. If cost share information is not available, do not submit the information. Refer to the EDI Companion Guides on Provider Connection at blueshieldca.com/provider for additional details.

For Medicare Advantage encounter data submissions to the CMS, there is also a compliance measurement reflecting the data collection period. Benchmarks using Evaluation and Management (E&M) CPT codes are used. The benchmarks are:

Commercial Membership: 3.0 E&M Visits PMPY

Medicare Advantage Membership: 8.0 E&M Visits PMPY

Certain types of denied services are included in calculating each IPA/medical group's annual E&M visit rates.

MEDICARE DENIALS

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

COMMERCIAL DENIALS

Denied *commercial* encounters which should be included with encounter data submissions are encounters for services which are:

1. Denied for payment because they are included in a global fee paid to a provider.
2. Covered benefits which are denied because they lack required prior authorization.

The following types of denied *commercial* encounters should not be submitted to Blue Shield:

1. Encounters denied because of lack of member eligibility.
2. Duplicate encounters.
3. Encounters for shared-risk services.
4. Encounters for services which are Blue Shield or capitated facility payment liability.

Performance - Regular and Complete Submission of Encounter Data *(cont'd.)*

A provider network 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.

In addition, Blue Shield will analyze the completeness of encounter data submissions for specialty and ancillary services.

For the Integrated Healthcare Association (IHA) Pay for Performance (P4P) incentive program, please contact Provider Relations for the most current requirement for encounter data thresholds.

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

Member Billing

Blue Shield Member Services will intervene to prevent members from receiving bills for services other than for deductibles, copayments, coinsurance, or non-covered services. If a member is billed erroneously, Blue Shield Member Services will:

- Research to determine who is financially responsible for the claim.
- Investigate if the delivery rules were followed.
- Verify the payment/process status of the claim.
- Contact and educate the provider and try to obtain the provider's commitment not to bill the member. If unsuccessful, the IPA/medical group is required to ensure that the provider ceases billing the member.
- Work with the IPA/medical group, when the group is financially responsible, to resolve member billing issues, including providing a payment/processing date and check number, if applicable

If a payable claim is not processed within the time period established by the Knox- Keene Act, Blue Shield Member Services may process and pay the claim. These payments, including any required interest, may be deducted from future capitation payments to the IPA/medical group.

In the event a provider continues to bill a member for covered services, Blue Shield and the IPA/medical group shall each take any and all action necessary to protect the member, including but not limited to, paying the provider's claim and taking legal action to enjoin the collection attempts.

A report showing payment for each claim paid and deducted from capitation is sent to the IPA/medical group.

Reciprocity

Reciprocity applies in the following situations:

1. When a Blue Shield IPA/medical group refers a member to a provider assigned to another Blue Shield IPA/medical group;

   or

2. When a Blue Shield IPA/medical group provides Urgent Care Services or Emergency Services to a member assigned to another Blue Shield IPA/medical group.

In such situations, the non-treating IPA/medical group is financially responsible for reimbursing the treating IPA/medical group. Payment shall be made in accordance with the Allowable Rates set forth in the contract between the treating provider and the treating provider's IPA/medical group. If the contract between Blue Shield and the treating IPA/medical group contains rates that the non-treating IPA/medical group can utilize for reciprocity, these rates may be used by the non-treating IPA/medical group to pay the treating IPA/medical group or provider. The payment shall be equal to the Allowable Rate, minus the member's applicable copayment.

If the contract between the treating IPA/medical group and the treating provider is silent with regard to payment for providing services to members not assigned to the treating IPA/medical group, the non-treating IPA/medical group shall work with the treating IPA/medical group or provider of service to determine a reasonable reimbursement rate to be paid by the non-treating IPA/medical group.

Reciprocity applies to Blue Shield associated organizations which include members in the Blue Cross/Blue Shield National network and any equivalent Blue Cross/Blue Shield national network applicable to Blue Shield Medicare Advantage plan members.

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

Bundled Appeal

A written notice to Blue Shield, submitted to the designated provider appeal address, identifying a group of substantially similar multiple claims challenging, appealing or requesting reconsideration of the 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 (ClaimCheck) or allowances, or disputing a request 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 written notice, submitted to the designated provider appeal address, identifying a group of substantially similar contractual appeals that are individually numbered using the section of the contract and sequential numbers that are cross-referenced to a document or spreadsheet. (For example, Section I A #1, Section I A #2, etc.)

Provider Inquiry

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

Receipt Date

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

Appeal Determination Date

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

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

Definitions *(cont'd.)*

Date of Contest, Denial, Notice, or Payment

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

Unjust or Unfair Payment Pattern

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

Unfair Billing Pattern

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

Good Cause for Untimely Submission of Claims

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

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

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

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;
- 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 they had good cause for the delay, will be handled as a provider appeal.

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

Unfair Billing and Payment Patterns

Reporting Unfair Billing Patterns

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

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

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

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

Unfair Payment Patterns

Unjust payment patterns:

- Imposing a claims filing deadline, on three or more claims over the course of any three-month period, or less than 90 days for contracting providers; 180 days for non-contracting provider; 90 days from the primary payors determination, when paying as a secondary/tertiary payor.
- Failing to forward at least 95% of misdirected, capitated claims to the appropriate capitated entity within 10 working days of receipt, over the course of any three-month period.
- Failing to accept at least 95% of late claim submissions, over the course of any three-month period, when the provider submits proof of Good Cause.
- Failing to notify providers at least 95% of the time, in writing and within 365 days of the payment date, of intent to recover an overpayment, over the course of any three-month period.
- Failing to notify providers, at least 95% 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.

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

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

Unfair Payment Patterns *(cont'd.)*

- 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 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.
- 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.

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

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

Explanation of Benefits

Explanations of Benefits (EOB) inform 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 our website, Provider Connection. 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.

Internet: www.blueshieldca.com/provider

The Provider Appeal Resolution Process is available 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 an Initial Appeal

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

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

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

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

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 be submitted in writing and contain the following information:

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

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

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

Appeals Submitted with Incomplete Information

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

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

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

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

Timeframe for Submitting Appeal

Initial appeals must be submitted within 365 days, or the time specified in the provider's contract, whichever is greater, of Blue Shield's date of contest, denial, notice or payment.

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

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

Timely Filing of Appeals

If a contracted provider or capitated entity fails to submit an initial appeal or final appeal within the required timeframes, the provider or capitated entity:

- Waives the right for any remedies to pursue the matter further.
- May not initiate a demand for arbitration or other legal action against Blue Shield.
- May not pursue additional payment from the member.

In instances where the provider's contract specifies timeframes that are greater than the timeframes stipulated in Blue Shield's Provider Appeal Resolution process, the provider's contract takes precedence.

Blue Shield will review the untimely submission of a provider appeal when the provider's contract includes a good cause clause for the untimely submissions of provider appeals.

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

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

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

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

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

Timeframe for Acknowledgement of Appeals

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

Timeframe for Resolving Appeals

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

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

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

Resolution

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

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

Submitting Appeals on a Member's Behalf

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

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

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

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

Final Appeals

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

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

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

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

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

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

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

Arbitration

If after participating in the initial and final levels of the 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.

> *Note: As a best practice, Blue Shield recommends that all received commercial provider disputes that are the responsibility of another payor be forwarded to the responsible party within ten (10) working days of the original receipt of the misdirected dispute.*

Blue Shield Contracts

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

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

Quarterly Reports

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

Each individual appeal in a bundled appeal is reported separately.

Provider Appeal Documentation

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

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.

4.5 Provider Appeals and Dispute Resolution

Provider Appeals of Medicare Advantage Claims

Contracted

Contracted providers have the right to file an appeal related to any initial claim decision by filing a request for redetermination. Medicare Advantage Appeals (for Individual or Group Medicare Advantage members) must be submitted to:

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

Required Information/Appeal

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

- The provider's name
- The provider's identification number – the Blue Shield provider identification number (PIN) 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.)*

Contracted *(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 delegated IPA/medical group 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

CMS requires Medicare Advantage Organizations (MAO) 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 claim (Prescription Drug Plans).

Provider disputes include any decisions where a non-contracted/deemed provider contends that the amount paid by the organization (MAO and/or delegated entity) for a covered service is less than the amount that would have been paid under original Medicare. The disputes may also include instances where there is a disagreement between a non-contracted/deemed provider and the organization about the plan and/or delegated entity's decision to pay for a different service than that billed. An example would include down-coding.

A provider or supplier has the right to dispute a reimbursement decision made by a MAO Plan and/or delegated entity. All Medicare and CMC non contracted zero payment provider appeals must be submitted with a Waiver of Liability (WOL). If there is no WOL submitted, the plan will make three attempts to request the WOL. If the WOL is 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.

After the MAO Plan and/or delegated entity makes its Payment Review Determination (PRD) decision, if a deemed or non-contracted provider or supplier still disagrees with the pricing decision of a MAO Plan and/or delegated entity, non-contracted Medicare/CMC $0 true denials are sent to Maximus. For any case that is dismissed, the provider has a right to go to Maximus within 60 calendar days of the dismissal. For non-contracted Medicare/CMC underpayments, providers can contact 1-800-Medicare. All Medicare non-contracted zero payment denials are auto forwarded to the IRE.

To appeal the provider organization and/or delegated entity's decision upholding initial payment, the provider must submit a written request to:

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

Shared Savings Program and Reports

For certain services not covered under capitation, Blue Shield and the IPA/medical group share financial risk, as defined by the IPA/medical group's contract with Blue Shield.

In most arrangements, the IPA/medical group is allocated a certain percentage of the CMS revenue and a certain percentage of the Employer Group revenue as shared savings budget. Blue Shield administers shared savings claims and the expenses for the IPA/medical group's assigned members are debited from the shared savings budget. Any annual surplus or deficit for the shared savings budget is shared between the IPA/medical group and Blue Shield according to the terms in the IPA/medical group's Blue Shield contract.

Any Blue Shield Medicare Advantage plan services rendered during a particular agreement year, but not reported to Blue Shield Medicare Advantage plan within the predetermined amount of days as stated in the contract after the end of the same agreement year, shall be included in the shared-risk computation for the subsequent agreement year.

If an IPA/medical group has questions regarding a Shared Savings claim, the IPA/medical group can submit the detailed claim records in question to Managed Care Finance, Blue Shield of California. The submitted file should have the same layout format as the claim files that were previously sent to them. A column needs to be added to the end of the file for all comments explaining why the claims are being questioned. In addition, the submitted file should only include the claims that are in question. Please note that this process does not replace or change the DMHC Provider Dispute Process.

Quarterly Financial Performance File

The Quarterly Financial Performance File is based on a 90-day fund pool performance (for physician organizations participating in a shared savings program). This report itemizes information on member months, capitation paid, institutional fund allocations, depletions and balances by year-to-date. This report is supported by claim detail for both current and prior year for all applicable fund pools.

4.6 Shared Savings Program

Shared-Risk Claims

Blue Shield will process all claims for which the IPA/medical group and Blue Shield share financial responsibility. Whenever Blue Shield receives shared-risk claims that contain capitated components, Blue Shield will process its portion of the claim and will forward the capitated service portion to the appropriate IPA/medical group for processing.

> *Example: Blue Shield receives an in-area emergency room (ER) services claim. Blue Shield will process the claim and identify the ER Professional Services as a capitated service on the EOB. The capitated services will be forwarded to the appropriate IPA/medical group for processing.*

Blue Shield will also process all claims for services for which Blue Shield has sole responsibility.

Institutional Services Budget

In an arrangement where hospitals are not capitated for institutional services, Blue Shield maintains an Institutional Services Budget (for physician organizations participating in a shared savings program). The Institutional Services Budget is a shared savings fund in which Blue Shield and IPA/medical groups share any surplus based on a negotiated settlement formula.

In general, Blue Shield provides a quarterly and annual accounting of the shared savings fund and the services paid by Blue Shield from these funds. Each IPA/medical group receives from Blue Shield a quarterly and annual Shared Savings report that contains the Shared Savings statement and the claims detail files.

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Introduction

In most contracts, Blue Shield retains financial responsibility for institutional services. For business reasons, Blue Shield may choose to carve out some services to external vendors. Examples include Disease Management, High-Risk Case Management, Behavioral Health Services, and Organ Transplant. In these cases, the management and coordination of care is not delegated to the IPA/medical groups and providers should contact Blue Shield Medical Care Solutions at (800) 541-6652, Option 6 or the Blue Shield Mental Health Service Administrator (MHSA) for Behavioral Health Services to request authorization. The MHSA only provides authorization for commercial and limited Group MAPD members, not for Individual MAPD members.

Delegation

Delegation is the process by which Blue Shield allows the IPA/medical group to perform certain functions, which are considered the responsibility of Blue Shield, on Blue Shield's behalf for the purposes of providing appropriate and timely care for our members.

Delegated functions are described in Appendix 5 of this manual and can be found under the section for the delegation agreement. If there are any modifications to the standard delegated responsibilities between Blue Shield and the delegated entity, this will be noted within the IPA's specific agreement. For express details regarding delegation status or specific criteria for a delegated function, the IPA/medical group should direct questions to the assigned Delegation Oversight Nurse.

Based on the Health and Safety Code section 1367(i), a health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345. Basic health care services include ambulatory care services, diagnostic and treatment services, physical therapy, speech therapy and occupational therapy services among others.

Health care service plans are authorized to conduct utilization review to determine whether services requested by provider are medically necessary (Health and Safety Code 1367.01(a)). A health care service plan may delegate this authority to its contracted medical groups or independent associations.

As a delegate for Blue Shield, the IPA/medical group is responsible for the delivery of care rooted in evidence-based medicine as defined by health plan medical policy, national guidelines, peer-reviewed literature, and community standards of care. In making utilization management decisions, the IPA/medical group will adhere to all regulatory guidelines and apply criteria as defined in Blue Shield's Utilization Management Program Description.

In addition, IPA/medical groups are responsible for promoting "best practices in care management" through the achievement of performance outcomes in utilization management as determined by Blue Shield and through developing policies, procedures, programs, and processes that demonstrate compliance with NCQA, CMS, DMHC, and applicable regulatory and legislative standards.

Blue Shield expects that IPA/medical groups will incorporate continuous quality improvement methodology such as PDSA[1] process improvement and to have such processes in place at the time of initial delegation. Furthermore, it is expected that IPA/medical groups will maintain their policies, procedures, programs and keep their processes up to date with the most current standards and Blue Shield requirements.

[1] PDSA is the Plan Do Study Act. It is sometimes referred to as the Plan Do Check Act (PDCA).

Delegation *(cont'd.)*

To ensure initial and ongoing compliance, Blue Shield will:

- Conduct a pre-delegation assessment
- Conduct annual reviews
- Conduct annual UM Referral System assessment
- Periodically ask for additional oversight documentation
- Periodically conduct operational reviews to ensure implementation of policy, procedure, and process
- Monitor performance against expected outcomes

Failure to fulfill compliance with delegation standards or to meet expected business outcomes may result in full or partial de-delegation by Blue Shield. Corrective action will be required and may involve additional oversight or co-management of certain functions.

Delegation Oversight

The decision to delegate any function is based upon the IPA/medical group's demonstrated ability to successfully perform specific functions (i.e., Utilization Management, Credentialing, and Recredentialing). Initially, a pre-contractual or pre-delegation audit is conducted to determine if the IPA/medical group has the ability to perform the delegated function to the standards and requirements of Blue Shield and of the various applicable regulatory and/or accreditation agencies. After initial delegation, Blue Shield conducts an annual evaluation and oversight of the IPA/medical group based on the 12-month (no greater than 14th month) requirement set forth by NCQA. Blue Shield's oversight process is conducted through annual evaluation audits for each of the various delegated functions as well as semi-annual reports. The outcome of the evaluation determines if the delegation status will be continued as contracted or if a change in delegation status is indicated, up to, and including, revocation of delegation. Blue Shield may require more frequent or targeted audits or require a Corrective Action Plan in an effort to address any identified issues or deficiencies to avoid revocation of delegation.

Blue Shield retains the right to further assess any aspects of utilization management or legislative compliance for the purpose of determining that they are being conducted in a manner consistent with Blue Shield policies and business goals.

> *Note: A copy of the UM Tool used by Blue Shield during audits can be obtained by contacting your assigned Blue Shield Delegation Oversight Nurse or by emailing the Delegation Oversight Department at: Del_UM_Oversight@BlueShieldca.com.*

Delegation of Utilization Management (UM)

The delegation of UM will be granted only to those IPA/medical groups that meet the standards outlined in the IPA/medical group UM Delegation Standards (see Appendix 5 of this manual).

Blue Shield reviews policies and procedures to evaluate each IPA/medical group when conducting semi-annual performance and outcomes monitoring and the annual audit. Activities, which may be monitored and reviewed for the delegated entity throughout the year, will include:

- UM meeting minutes
- UM Program
- Policies and procedures for UM that demonstrate adherence to Blue Shield Medical & Medication Policies
- Adverse determinations with Medical Records
  - With evidence of Board-Certified Reviewer internal and external if applicable
- Approved authorizations with Medical Records
- Pharmacy authorizations with Medical Records
- Cancelled authorizations with Medical Records
- Standing authorizations with Medical Records
- UM reports
- Evidence of member/provider satisfaction survey with the UM process and results
- UM System Controls review
- UM statistics including, but not limited to:
  - All yearly goals, planned activities, key findings, analysis, and interventions
  - Inpatient metrics: Acute bed days/1000, Acute admits/1000, Acute Readmits/1000, Average Length of Stay
  - Skilled Nursing Facility, Long Term Acute Care & Rehab metrics
  - Referral metrics to include % of medical necessity denials and approvals
  - Emergency room metrics
  - Authorization timeframe compliance for medical necessity, pharmacy, and behavioral health services
  - Over- and under-utilization, including analysis of trends and documented actions to improve performance
  - Documented process to provide access to practitioners and members interested in information about UM decisions and the UM program.
  - Job descriptions for UM staff and physicians require education, training, and professional expertise in clinical medical practice. All clinical staff must have evidence of clinical licensure and an unrestricted California license
  - Interrater Reliability, evaluated annually

5.1 Utilization Management

UM Criteria and Guidelines

Blue Shield requires that all delegated IPA/medical groups adhere to Blue Shield Medical & Medication Policies which may include step therapy and site of administration criteria. IPA/medical groups may use their designated evidence-based criteria for UM decisions where Blue Shield Medical & Medication Policies do not apply, and these criteria have been reviewed and approved by the IPA/medical group's UM Committee. For Blue Shield Medicare HMO and PPO Members, Blue Shield follows 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. UM decision-making is based only on the appropriateness of care and service and existence of coverage. All delegated groups must follow the Blue Shield policy which does not reward practitioners or other individuals for issuing denials of coverage or care. There must be no use of financial incentives to encourage decisions that result in underutilization. All decisions to deny, delay, or modify health care services must identify the criteria or guideline in the denial notification and explain why the service is denied in relation to these criteria. IPA/medical groups must make specific guidelines available to the member or provider upon request.

Medical necessity reviews (for both authorizations and non-authorizations) made by Blue Shield use a hierarchy of criteria. (The specific hierarchy can be found in the Utilization Management Program Description.) These criteria consist of internal medical policies established by the Blue Shield Medical Policy Committee, nationally recognized evidence-based criteria, Milliman Care Guidelines (MCG), National Imaging Associates (NIA) Radiology Clinical Guidelines, Advisory Committee on Immunization Practices (ACIP), and Medication Policies (for non-self-administered drugs such as Injectable and Implantable drugs) established by the Blue Shield Pharmacy & Therapeutics Committee (these criteria and guidelines are adopted with input from network physicians and are regularly reviewed for clinical appropriateness). Where applicable, criteria established by the Center for Medicare & Medicaid Services (CMS) and DME coverage criteria are utilized. 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 reviews utilize 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. and World Professional Association for Transgender Health (WPATH) guidelines. Additional MH/SUD guidelines may be added as they become available from non-profit professional associations in accordance with California law. MH/SUD reviews are the responsibility of the IPA/medical group.

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 (Medically Necessary)**

Benefits are provided only for services which are medically necessary.

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

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

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

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

Medical Necessity *(cont'd.)*

Medical Necessity (Medically Necessary)** *(cont'd.)*

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.

Physician Reviews

Physician Review Process - Participants

Blue Shield's Physician Review process includes a panel of Board-certified physicians affiliated with Blue Shield and the IPA/medical groups. In addition, Blue Shield Medical Directors and IPA/medical group Medical Directors participate in the utilization review process and act as liaisons for administrative matters related to quality and utilization management processes.

Physician Review

Blue Shield Medical Care Solutions and its delegates conduct prospective, concurrent, and retrospective reviews for medical necessity and appropriateness of care and service. A physician review occurs when questions arise about the medical necessity and appropriateness of care provided, or planned to be provided, to a member during the utilization management review process. Physician review is prompted in situations including, but not limited to questions regarding the medical necessity of a service or when services requested or provided do not meet medical necessity criteria/guidelines. The review process consistently applies Blue Shield's medical policy and current community standards of practice to UM review.

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 Reference Panel (BCBSA MPP), 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.

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

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

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

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

Note: Benefit and eligibility criteria supersede medical necessity determinations.

Medical and Medication policy information is accessible through Provider Connection at blueshieldca.com/provider. The IPA/medical groups must adhere to Blue Shield's Medical & Medication Policy and guidelines, including step therapy, biosimilar first requirements, and site of administration requirements where applicable, when prior authorizing medications for coverage. Where Blue Shield Medical & Medication Policy does not address an issue, other evidence-based medicine resources should be consulted such as Hayes Tech Assessment and National Institutes of Health (NIH) consensus statements.

For Blue Shield Medicare HMO and PPO Members, Blue Shield follows 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.

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

Medication Policy *(cont'd.)*

If Blue Shield determines that a previously rendered service 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. If questions arise about Blue Shield Medical Policy or IPA/medical groups require specific guidelines, please contact Provider Information & Enrollment at (800) 258-3091.

For information concerning Member Grievance Process (Appeals and Independent Medical Reviews (IMR)), refer to Section 4.2 Member Rights and Responsibilities.

Ambulance Services

An ambulance is defined as a specifically designed/equipped air or ground vehicle for transporting the sick or injured. Blue Shield considers coverage for related equipment necessary to transport the patient, including stretchers, clean linens, first aid supplies, oxygen, and other safety and lifesaving equipment as included in the ambulance service charge.

Emergency Ambulance

Blue Shield and its delegates authorize emergency ambulance services if immediate medical treatment is required en route to a medical facility or to provide effective medical treatment.

Members who reasonably believe that they have an emergency medical condition which requires an emergency response are encouraged to appropriately use the 911 emergency response system where available.

Emergency ambulance services are covered from the site of the medical emergency to the nearest appropriate facility or between facilities when a higher level of care is required to stabilize and treat an emergency medical condition.

Blue Shield and its delegates determine medical necessity for ambulance transportation independent of medical necessity criteria for emergency room services retrospectively. Payment or denial of emergency ambulance services, including paramedic services rendered at the scene, will be subject to review according to medical necessity and the "reasonable person" standard. Blue Shield defines the "reasonable person" standard to mean that urgent or emergency services are covered when a non-medically trained individual using reasonable judgment would believe that an urgent or emergent situation exists.

For Commercial Members

Refer to the *HMO Benefit Guidelines* located on Provider Connection at blueshieldca.com/provider under *Guidelines & Resources,* then *Provider Manuals* for more information regarding Ambulance benefits.

For Blue Shield Medicare Advantage Plan Members

The Medicare coverage guidelines will be used for Blue Shield Medicare Advantage plan members. Contracted providers who order ambulance transportation where another means of transportation can be safely and effectively used must advise the patient in advance of financial liability for such services. Failure to advise the patient in advance could result in assumption of liability for such transportation.

Ambulance Services *(cont'd.)*

Non-Emergency Ambulance

Non-emergency ambulance services may be authorized to transfer a member from a non-contracting facility to a contracting facility or between contracting facilities, in connection with an authorized confinement and/or admission.

This may be from one hospital facility to another hospital facility, rehabilitation facility, or skilled nursing facility when the patient's condition is such that transportation by ambulance is medically necessary and prior authorization has been obtained.

Depending on the Division of Financial Responsibility in the HMO IPA/Medical Group Agreement and delegation status, the IPA/medical group may be required to obtain prior authorization for non-urgent/emergent ambulance services from the Blue Shield Medical Care Solutions Department.

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.

Ambulatory Surgeries/Procedures

Ambulatory procedures are generally performed in an ambulatory surgery center or an acute care facility on an outpatient basis. Occasionally, the general condition of the member dictates acute inpatient management of a procedure traditionally considered to be ambulatory.

Office-based 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.

Blue Shield provides coverage for all medically necessary surgeries/procedures which can be performed in an ambulatory facility.

Facility-Based Ambulatory Surgeries/Procedures

Depending on the Division of Financial Responsibility (DOFR) in the HMO IPA/Medical Group Agreement and the delegation status, most facility-based procedures and institutional services, referenced under Section 5.1 of this manual require prior service authorization from the IPA/medical group.

Financial responsibility is further described in the DOFR in the HMO IPA/Medical Group Agreement.

Office-Based Ambulatory Surgeries/Procedures

The IPA/medical group is responsible for authorizing office-based surgeries/procedures. Office-based surgical procedures should be performed in a physician's office and are covered under capitation. When it is medically necessary for an office-based procedure to be performed in a facility setting, the IPA/medical group must follow the Facility-Based Ambulatory Surgeries/Procedures, referenced above. Financial responsibility is further described in the Division of Financial Responsibility in the HMO IPA/Medical Group Agreement.

The list of office-based procedures is provided in the *HMO Benefit Guidelines* located on Provider Connection at blueshieldca.com/provider under *Guidelines & resources,* then *Provider manuals.*

Ambulatory Surgeries/Procedures *(cont'd.)*

For Commercial Members

Please refer to the *HMO Benefit Guidelines* for examples of procedures that may be performed in a physician's office or in an outpatient facility. For questions regarding the appropriate setting for a surgery/procedure, call the Blue Shield Medical Care Solutions Department.

For Blue Shield Medicare Advantage Plan Members

All ambulatory procedures for Blue Shield Medicare Advantage plan members are subject to Medicare national and local coverage guidelines. Please contact the Blue Shield Medicare Medical Care Solutions Department if you have questions regarding coverage for a specific surgery/procedure.

UM Authorization Reporting Process ("Authorization Logs")

Approval/Denial Data File Requirements

Approval/denial data files ("Authorization Logs") must be delivered via secure email or SFTP file to Blue Shield. To initiate the delivery of authorization logs by means of a SFTP (Secure File Transfer Protocol) or to obtain the Blue Shield standard file layout and data dictionary, please email Medical Care Solutions at IPAAuths@blueshieldca.com.

Authorization logs must be sent, at minimum, on a weekly basis in order to ensure timely data processing. IPA approvals, denials and partial denials should be delivered together on one file. If sent via email, the data MUST be delivered in a file format that is suitable for data processing such as an Excel spreadsheet or delimited fixed width file. Any data file which does not comply to the format, content requirements and/or delivery frequency will be considered out of compliance, rejected by Blue Shield, and returned to the IPA/medical group for correction and resubmission.

Only shared-risk services for which the IPA/medical group is delegated to perform UM and Blue Shield is responsible for claim adjudication are required on the data file.

Incomplete or inaccurate information may negatively impact claim processing. Please help expedite the processing of authorization/denial files by providing the following required information for each record submitted:

- Subscriber ID #
- Patient Last Name
- Patient First Name
- Patient Date of Birth (mm/dd/yyyy)
- Health Plan/Line of Business (CMC, Medi-Cal, Medicare Advantage or Commercial)
- Request Type (Inpatient, Service or Medication)
- Place of Service (Using CMS Industry Standard Place of Service Code Set and/or Name/Description: POS 11/Office, POS 21/Inpatient Hospital, POS 31/Skilled Nursing Facility)

UM Authorization Reporting Process ("Authorization Logs")
(cont'd.)

Approval/Denial Data File Requirements *(cont'd).*

- Admission Bed Type or Level of Care (Using industry standard descriptions: Acute Rehabilitation, Acute Behavioral Health, ICU, LTAC, Med Surg, NICU, NICU Level 1, Observation, SNF Level 1, Sub-Acute, etc.)
- First date of service or Admit date (mm/dd/yyyy)
- Last date of service or Discharge date (mm/dd/yyyy)
- Diagnosis Code(s) (ICD-10-CM Codes) – Primary code and up to 3 additional codes, if applicable
- Procedure Code(s) (CPT-4/HCPC Codes and for inpatient facility claims only ICD-10-PCS Codes) – Primary code and up to 9 additional codes, if applicable
- Units: Number of procedures, treatments, , days, sessions, or visits
- Servicing Provider Name
- Servicing Provider NPI #
- Facility Name (if applicable)
- Facility NPI # (if applicable)
- Requesting Provider Name
- Requesting Provider NPI #
- Authorization or Decision Reference #
- Blue Shield IPA/Medical Group Provider Identification # (i.e., IPxxxxxxxxxx) – It is highly recommended to include your Blue Shield PIN # to expedite processing. If unknown, the PIN # can be obtained from your Blue Shield Provider Relations representative.
- Receipt Request Date (Date provider requested authorization from IPA/medical group)
- Decision (Approved, denied, partially denied or void)
- Full/Partial Denial Reason (i.e., Not medically necessary, not a benefit, etc.)
- Decision Date (mm/dd/yyyy)
- Discharge Diagnosis (if applicable)
- Discharge Status (i.e., To Home, SNF…., if applicable)

Clinical Trials for Cancer or Life-Threatening Conditions

For Commercial Members

Clinical Trials are covered under the Affordable Care Act (ACA) when it meets the definition of "life threatening." The ACA defines life threatening as a "disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted." (See 42 U.S.C.A. § 300gg-8(e)).

An approved clinical trial is limited to a trial that:

1) Is federally funded and approved by one of the following:

- One of the National Institutes of Health;
- The Centers for Disease Control and Prevention;
- The Agency for Health Care Research and Quality;
- The Centers for Medicare & Medicaid Services;
- A cooperative group or center of any of the entities above; or the federal Departments of Defense or Veterans Administration;
- A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;
    - The federal Veterans Administration, Department of Defense, or Department of Energy where the study or investigation is reviewed and approved through a system of peer review that the Secretary of Health & Human Services has determined to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; or
    - The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration or is exempt under federal regulations from a new drug application.

Benefit Coverage

Benefits are provided for routine patient care for members who have been accepted into an approved clinical trial for treatment of cancer or a life-threatening condition where the clinical trial has a therapeutic intent and when prior authorized by Blue Shield, and:

1. The member's physician or another participating provider determines that the member's participation in the clinical trial would be appropriate based on either the trial protocol or medical and scientific information provided by the Member; or
2. The member provides medical and scientific information establishing that the member's participation in the clinical trial would be appropriate.

The hospital or provider conducting the clinical trial must be in the Blue Shield network unless the protocol is not available through a network provider.

Clinical Trials for Cancer or Life-Threatening Conditions
(cont'd.)

Examples of Non-Covered Services

Routine patient care consists of those services that would otherwise be covered by the plan if the services were not provided in connection with an approved clinical trial, but does not include:

- The investigational item, device, or service, itself;
- Drugs or devices that have not been approved by the federal Food and Drug Administration (FDA);
- Services other than health care services, such as travel, housing, companion expenses, and other non-clinical expenses;
- Any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the direct clinical management of the patient;
- Services that, except for the fact that they are being provided in a clinical trial, are specifically excluded under the plan;
- Services customarily provided by the research sponsor free of charge for any enrollee in the trial; or
- Any service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Financial Responsibility

Approved clinical trial services are paid by Blue Shield. Refer to the Division of Financial Responsibilities in the HMO IPA/Medical Group Agreement for additional information.

Experimental/Investigational Treatments

Blue Shield is responsible for decision-making of experimental/investigational treatments. **IPA/medical groups are not delegated to make determinations for experimental/investigational requests.**

When the IPA/medical group concludes that a requested treatment, therapy, procedure, drug, or usage thereof, may be experimental or investigational, the IPA/medical group must promptly submit the request and IPA/medical group determination to the Blue Shield Prior Authorization Department for a final determination or decision. To facilitate prompt review, the IPA/medical group must send complete information to the Blue Shield Medical Care Solutions Prior Authorization Department. These requests will be referred to the Blue Shield Medical Director for evaluation and determination of authorization. The IPA/medical group is not permitted to issue a denial for any such request. As a rule, Blue Shield does not provide coverage for experimental and/or investigational procedures/treatments.

For commercial members, the Blue Shield Medical Policy Committee determines whether or not certain treatments are experimental or investigational.

For Blue Shield Medicare Advantage plan guidelines on experimental/investigational treatments, see Section 6.

Experimental or investigational services are defined as:

- 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 at issue.
- Services which require approval by the federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered.
- 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.

Blue Shield will make a final determination and provide appropriate written notice to the member, including all required notices of the explanation of the scientific or clinical judgment for the determination (applying the terms of the Plan to the member's medical circumstances), alternate care, and appeal rights.

For Commercial Members

Section 1368.1 of the Health & Safety Code establishes special requirements which health plans must follow for terminally ill members who are denied coverage for experimental/investigational procedures. Those requirements include notification of non-experimental services that the plan will cover and notification of special appeal rights, including the right to an expedited in-person appeal hearing.

Section 1370.4 of the Health & Safety Code and Sections 1300.70.4 and 1300.74.30 of Title 28, CCR establish an optional independent external review process for members with life threatening or seriously debilitating conditions and terminally ill members who meet the criteria established in the law and who have been denied coverage for a recommended or requested drug, device, procedure, or other therapy, on the grounds that the requested service is experimental or investigational.

Experimental/Investigational Treatments *(cont'd.)*

For Commercial Members *(cont'd.)*

Life-threatening means either or both of the following:

- Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.
- Diseases or conditions with potentially fatal outcomes, where the endpoint of clinical intervention is survival.

Seriously debilitating means diseases or conditions that cause irreversible morbidity.

The voluntary external independent medical review process under California law was revised in 2001 to make the external independent medical review available immediately for requests made directly to the DMHC. The DMHC will then submit the review request to an independent agency for external review.

To be eligible for this review process, the member's physician, when contracted with the Blue Shield HMO, must complete the DMHC's Physician Certification Form, certifying that:

- The patient has a life-threatening or seriously debilitating condition, as defined above.
- The patient has been denied coverage for a drug, device, procedure, or other therapy which has been determined to be experimental or investigational.
- Standard therapies have been administered but had no effect in improving the patient's condition or would have been medically inappropriate for the member. The physician must list those therapies tried. If standard therapies have not been administered, the physician must certify that standard therapies would not be more appropriate and indicate the reasons why such therapies have not been tried.
- There is no more beneficial standard therapy covered under the plan other than the therapy proposed.

If the patient's physician *is not contracted with the Blue Shield HMO* but requires a review process, the physician must complete the DMHC's Physician Certification Form as described above. In addition, that physician must submit two documents from the medical and scientific literature, demonstrating that the proposed experimental/investigational therapy is likely to be more beneficial than any standard therapy covered by the Blue Shield HMO.

In addition to submitting the completed Physician Certification Form, the member must include with that form:

- Copies of Blue Shield denials for experimental and investigational services.
- Any related medical or scientific literature.
- A signed DMHC Independent Medical Review Application Form, which authorizes release of medical information to the DMHC and the external independent review agency that will be reviewing the patient's request.

The completed Physician Certification Form should be addressed to the Director of the DMHC.

In addition to the above listed information on the DMHC Physician Certification Form, the following statement must precede the physician's signature:

> *"I certify that the requested therapy is likely to be more beneficial than any standard therapy. The information herein is true and correct."*

Experimental/Investigational Procedures *(cont'd.)*

For Commercial Members *(cont'd.)*

The DMHC will review the request and, if it qualifies for external independent medical review, the DMHC will select an external independent review agency and submit the member's records for independent determination of the case's medically necessity. There is no cost to the member for the external independent medical review. This review is in addition to any other procedure or remedy available to the member and is completely voluntary. However, the member's failure to participate in the review process may result in the member forfeiting his or her statutory right to pursue legal action against Blue Shield regarding the disputed service.

For questions regarding Experimental/Investigational determinations, please call the Blue Shield Medical Care Solutions Department.

For Blue Shield Medicare Advantage Plan Members

Blue Shield Medicare Advantage plan administers requests for experimental and investigational services in accordance with Medicare national coverage guidelines. Requests for experimental and investigational services are not delegated and must be referred to the appropriate Blue Shield Medical Care Solutions department for processing.

Follow-Up Care in a Non-Contracting Hospital

Blue Shield and its delegates may provide authorization for follow-up or continuing care in a non-contracting hospital for only as long as the member's medical condition prevents transfer to a contracting hospital. For out-of-area cases, when the treating physician determines a member's condition is stable and the member is ready for transfer, the Blue Shield UM staff will notify and assist the IPA/medical group, as needed. However, it is a delegated responsibility of the IPA/medical group to identify a receiving physician and a suitable Blue Shield in-network facility and to coordinate the member's transfer back to the appropriate service area/network and contracted facility as soon as the member is identified as stable for transfer. If a bed is not available at the IPA/medical group's affiliated hospital or it does not have the necessary resources, the IPA/medical group must coordinate the transfer to an appropriate Blue Shield in-network facility and provide utilization management. The IPA/medical group is required to convey updates to the Blue Shield Medical Care Solutions staff in a timely manner.

Home Health Care

Home health care must be provided within the Blue Shield network of alternate care providers whenever possible.

Blue Shield provides coverage for home health care services that are medically necessary and authorized by the primary care physician/IPA/medical group and Blue Shield. Blue Shield will authorize a preferred home health agency if the services being requested are out-of-area for the IPA/medical group.

Home visits, or "house calls" by a physician, are covered under capitation and are not applied to the home health care benefits.

Home Health Care *(cont'd.)*

For Commercial Members

The standard group benefit has a combined total limit of 100 visits per calendar year for all home health agency providers. Nursing visits by home infusion agencies do not accumulate against the 100-visit maximum under home health care for group members. Individual plan home health benefits have a combined total limit of 100 visits per calendar year for all home health agency providers and home infusion agency nursing visits.

A maximum of three visits per day, two hours per visit for skilled services may be authorized.

> *Note: Some commercial plan benefits may have specific limitations or an expanded benefit. Refer to the HMO Benefits Guidelines for specific limitations or expanded benefits. For example, the CalPERS HBG for Home Health specify CalPERS members do not have a visit maximum for medically necessary home health services.*

For Blue Shield Medicare Advantage Plan Members

Home health care benefits that are medically necessary and meet Medicare coverage and eligibility requirements are unlimited (for these home health care benefit limitations and eligibility, see Section 6).

For these members, visits are subject to the Medicare national coverage guidelines. Please contact Blue Shield's Medicare Medical Care Solutions Department with questions regarding coverage of home health care visits.

Home health care services include:

- Services by a Registered Nurse (RN), Licensed Vocational Nurse (LVN), Physical Therapist (PT), Occupational Therapist (OT), Speech Therapist (ST), Respiratory Therapist (RT), Certified Home Health Aide (CHHA) in conjunction with RN, LVN, PT, OT, ST, or RT or Medical Social Worker (MSW) for consultation and evaluation of the home health care treatment plan.
- Medical supplies (including disposable medical supplies) and medications administered by the home health agency necessary for the home health care treatment plan.
- Home infusion therapy, including enteral tube feedings and parenteral nutritional services and associated supplies and supplements.
- Related pharmaceutical and laboratory services to the extent the services would have been provided had the member remained in the hospital.

> *Note: Medicare does not cover venipuncture alone as a home healthcare service unless the Blue Shield Medicare Advantage plan member has another covered skilled need (for more on Medicare coverage and limitations on venipuncture, see Section 6).*

Home Health Care *(cont'd.)*

Enteral and Parenteral Nutritional Therapies, Supplies, and Supplements

Enteral and parenteral nutrition therapies, supplies, and supplements are covered for home use when medically necessary and appropriately authorized.

Enteral nutritional therapy is patient feeding via tubes that empty directly into the esophagus, stomach, or intestines. This method is used when the patient's lower gastrointestinal tract is functioning, allowing for adequate digestion and absorption. Enteral nutritional therapy that is not administered through a feeding tube will be denied for coverage.

Parenteral nutritional therapy, also known as Total Parenteral Nutrition (TPN), is intravenous (IV) feeding with a solution rich in nutrients. Patients receiving TPN may have a gastrointestinal dysfunction.

Enteral nutrition and parenteral nutritional therapies, including associated supplies and nutritional solutions, are covered under the home infusion benefit.

For Blue Shield Medicare Advantage plan members, these therapies are covered according to Medicare national and local coverage guidelines. For questions regarding coverage, please contact Medicare Medical Care Solutions.

Hospice Care

Hospice services are specialized interdisciplinary health care services designed to provide palliative care, to alleviate the physical, emotional, social, and spiritual discomforts of an enrollee who is experiencing the last phases of life due the existence of a terminal disease, to provide supportive care to the primary care giver and the family of the hospice member, and which meet all of the following criteria:

- Considers the member and the member's family as the unit of care.
- Utilizes an interdisciplinary team to assess the physical, medical, psychological, social, and spiritual needs of the member and the member's family.
- Requires the interdisciplinary team to develop an overall plan of care and to provide coordinated care, which emphasizes supportive services, including, but not limited to, home care, pain control, and short-term inpatient services. Short-term inpatient services are intended to promote both continuity of care and appropriateness of services for those members who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

For Commercial Members

Hospice services are covered through a Participating Hospice Agency for individual and group members with a terminal illness (expected prognosis of one year or less to live), as certified by their physician.

The member's admission into a Hospice Program by a Participating Hospice Agency requires prior authorization by the IPA/medical group. The Participating Hospice Agency will be requesting the prior authorization from the IPA/medical group directly. A primary care physician authorization is not required for hospice services. IPA/medical groups must notify Blue Shield of authorizations for hospice care and any changes in the levels of hospice care.

Hospice Care *(cont'd.)*

For Commercial Members *(cont'd.)*

Covered services are available on a 24-hour basis to the extent necessary to meet the needs of the member for care that is reasonable and necessary for the palliation and management of the terminal illness and related conditions. Members can receive care for two 90-day periods followed by an unlimited number of 60-day periods. The care continues if the physician re-certifies the member as terminally ill. A member is allowed to change their participating hospice agency only once during each period of care.

> *Note: Members with a terminal illness who have not elected to enroll in a Hospice Program can receive a pre-hospice consultative visit from a Participating Hospice Agency.*

All of the following services must be received from a Participating Hospice Agency:

- Pre-hospice consultative visit regarding pain and symptom management, hospice and other care options including care planning. (Members do not have to be enrolled in the Hospice Program to receive this benefit.)
- Interdisciplinary team care with development and maintenance of an appropriate plan of care and management of terminal illness and related conditions.
- Skilled nursing services, certified health aide services and homemaker services under the supervision of a qualified registered nurse.
- Bereavement services.
- Social services/counseling services with medical social services provided by a qualified social worker. Dietary counseling, by a qualified provider, when needed.
- Medical direction from the medical director for meeting the general medical needs of the members with a terminal illness when these needs are not met by the primary care physician.
- Volunteer services.
- Short-term inpatient care arrangements.
- Pharmaceuticals, medical equipment, and supplies that are reasonable and necessary for the palliation and management of terminal illness and related conditions.
- Physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.
- Nursing care services may be provided to maintain a member at home and achieve palliation or management of acute medical symptoms. Hospitalization is covered when the interdisciplinary team makes the determination that skilled nursing care is required at a level that can't be provided in the home. Either homemaker services or home health aide services or both may be covered on a 24-hour continuous basis during periods of crisis, but the care provided during these periods must be predominantly nursing care.
- Occasional respite care services (no more than five consecutive days at a time). Respite Care Services are short-term inpatient care provided to the member only when necessary to relieve the family members or other persons caring for the member.

Hospice Care *(cont'd.)*

Financial Responsibility

When the IPA/medical group is delegated, and Blue Shield has risk for these services, the in-network hospice will be reimbursed on a per diem basis after IPA/medical group authorization. Under Capitated Hospital arrangements, the Capitated Hospital will be responsible for reimbursing Medicare Certified Hospice Agencies directly for authorized services.

For Blue Shield Medicare Advantage Plan Members

Hospice services for Blue Shield Medicare Advantage plan members must be provided by a Medicare-certified provider. Hospice cases involving Blue Shield Medicare Advantage plan members must be reported to Blue Shield for Centers for Medicare & Medicaid Services (CMS) reporting requirements.

For Blue Shield Medicare Advantage plan members who elect hospice services, only prescriptions that are not related to the terminal illness and covered under the Part D benefit, may be covered. The IPA/medical group should work to coordinate with the Hospice provider to determine what drugs are covered under the Part A Hospice benefit, patient pay, and Part D.

When Blue Shield Medicare Advantage plan members require hospice benefits, the portion of the premium associated with the hospice-qualifying diagnosis and subsequent hospice care reverts to Medicare fee for service and is not the IPA/medical group's financial responsibility. All other medical care is still coordinated and provided through the IPA/medical group and is paid based on the IPA/medical group's agreement with Blue Shield. Refer to Section 6.4 for more information regarding Hospice Billing for Blue Shield Medicare Advantage plan members.

Medical Benefit Drugs

Drugs approved by the Food and Drug Administration (FDA) and covered under a Blue Shield member's medical benefit are generally those that are incident to a medical service, administered by a healthcare professional in a provider office, outpatient facility, infusion center, or by home health/home infusion (not self-administered by the patient). Some medical benefit drugs may require prior authorization for coverage based on medical necessity.

The Blue Shield Pharmacy and Therapeutics Committee (P&T) is the governing committee responsible for oversight and approval of medication coverage policies and requirements for drugs requiring prior authorization. Medication coverage policies for medical benefit drugs can be found on Provider Connection at blueshieldca.com/provider. Once you have logged on select *Authorizations*, *Clinical policies and guidelines*, then *Medical policies & procedures.*

When delegated for utilization management, Blue Shield requires the IPA/medical group to adhere to the Blue Shield's medication coverage policies for Blue Shield Commercial members when administering prior authorizations and follow step therapy and site of administration requirements. Refer to Section 2.8 - Pharmaceutical Benefits in this manual for more details. For Blue Shield Medicare Advantage plan members, Blue Shield follows Medicare guidelines for risk allocation, Medicare national and local coverage guidelines and Blue Shield Medication Policies where applicable. IPA/ medical groups may be subject to audit of medication coverage determinations according to Blue Shield medication policies by their Delegation Oversight Nurse in consultation with a Blue Shield pharmacist.

Medical benefit drugs are typically covered under capitation, unless contracted differently. Certain exceptions to capitation may be included according to financial risk allocation classifications, updated quarterly: (a) office-administered, (b) high-cost, (c) chemotherapy, and (d) chemotherapy and supportive/adjunctive injectable drugs. Please refer to your Division of Financial Responsibility (DOFR) for the classification(s) of drugs that are contractually carved out to Blue Shield. For Blue Shield Medicare Advantage plan members, Blue Shield follows Medicare guidelines for risk allocation and Medicare national and local coverage guidelines. If excluded from capitation, the medication will be subject to Blue Shield review for coverage according to Blue Shield Medication policy. IPA/medical group will be notified of coverage decisions.

High-cost medications including CAR-T and Gene Therapy are subject to Blue Shield review for coverage according to Blue Shield Medication Policy regardless if UM is delegated to the IPA/medical group. Refer to the Section 5.1 Prior Authorization.

Outpatient Prescription Drugs

Medications that may be safely administered at home by the member or a family member, including those administered subcutaneously or intramuscularly are covered in the member's Outpatient Prescription Drug Benefit. Some may require prior authorization for coverage by Blue Shield.

> *Note: Some Blue Shield members may have prescription drug coverage through another pharmacy benefit manager.*

HMO and POS members with Blue Shield's Outpatient Prescription Drug Benefit access prescription medications through a participating Blue Shield network retail, mail or specialty pharmacy that submit electronic prescription claims to Blue Shield. Prescriptions at retail and specialty pharmacies are covered for up to 30-day supplies per prescription, and for up to 90-day supplies at the mail service pharmacy. Commercial group plans also have access to 90-day supplies at retail pharmacies.

Outpatient Prescription Drugs *(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 Prescription Drug Prior Authorization or Step Therapy Exception Request Form 61-211 (Revised 12/2016) to (888) 697-8122. This form is available on blueshieldca.com/provider under *Authorizations, Prior authorization forms and list,* then *Prior authorization forms*. 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 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) compiles 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 makes 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.

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.

Outpatient Prescription Drugs *(cont'd.)*

Medicare Plans *(cont'd.)*

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 an urgent request 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.

For the Blue Shield Medicare Advantage plan, Part D drug coverage and exclusion rules apply.

Institutional Services

Generally, a primary care physician or specialist obtains an authorization for elective institutional services from his or her IPA/medical group, except for the authorization of services not delegated, such as transplant. The IPA/medical group reviews the request and coordinates the authorization with the Blue Shield Medical Care Solutions Department.

Depending on the HMO IPA/Medical Group's Blue Shield Agreement and delegation status, the IPA/medical group is required to request approval from Blue Shield for institutional services. When the IPA/medical group is delegated, and Blue Shield has risk for these services, these services may be reimbursed by Blue Shield under the Institutional Fund. Under capitated hospital arrangements, the capitated hospital will be responsible for reimbursing the providers directly for authorized services. Financial responsibility is further described in the Division of Financial Responsibility in the HMO IPA/Medical Group Agreement.

To facilitate timely authorizations of institutional services, IPA/medical groups should provide Blue Shield with the information outlined in the Authorization Approval and Denial Notifications Process section found above. Institutional services must meet medical necessity requirements as outlined below.

Preoperative Days/Testing

Whenever possible, preoperative testing should be done on an outpatient basis and patients should be admitted on the day of surgery.

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.

The responsibility for authorizing mental health and substance use disorder services for Blue Shield Medicare Advantage plan members remains with the delegated IPA/medical group. If Medicare behavioral health utilization management is not delegated to the IPA/medical group, Blue Shield retains the responsibility for authorizing mental health and substance use disorder services. Mental Health services are covered in accordance with Medicare coverage guidelines.

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 of the diagnostic categories listed in the mental and behavioral disorders chapter 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 members is Human Affairs International of California (HAI-CA). For more detailed information about the services administered by the Blue Shield MHSA and the protocols developed to promote the integration of medical and behavioral health treatment, refer to the *Medical Interface Manual* on Provider Connection at www.blueshieldca.com/provider under *Guidelines & resources* and *Provider manuals*.

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 Mental Health Service Administrator (MHSA) Covered Services and Financial Responsibility below. The MHSA only provides authorization for commercial and limited Group MAPD members, not for Individual MAPD members.

HMO IPA/medical groups are responsible for decisions related to delegated medical services. As such, medical services for the treatment of gender dysphoria, eating disorder, or substance use disorder are the responsibility of the IPA/medical group.

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

Member Self-Referral Number

Blue Shield members can self-refer for behavioral health services by calling the Customer Service or Mental Health Customer Service number on the back of their Blue Shield ID card.

Primary Care Physician Consultation Line

For Commercial and Group Medicare members, the Blue Shield MHSA offers a Primary Care Physician (PCP) Consultation Line at (877) 263-9870 to facilitate PCP 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.

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

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.

Blue Shield Mental Health Service Administrator (MHSA) Covered Services and Financial Responsibility

For fully-insured products, the Blue Shield MHSA will utilize ASAM, LOCUS, CALOCUS, and ECSII for mental health and substance use disorder reviews. Additional MH/SUD 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: *(Note: The MHSA only provides authorization for commercial and limited Group MAPD members, not for Individual MAPD members).*

- Non-emergency mental health or substance use disorder Hospital inpatient admissions, including acute and residential care.
- Other Outpatient Mental Health and Substance Use Disorder Services when provided by a MHSA contracted provider, as listed below:
  - 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).
  - Transcranial Magnetic Stimulation
  - Non-emergency inter-facility transports

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

IPA/Medical Group Covered Services and Financial Responsibility

The IPA/medical group remains responsible for the services listed below even when member's mental health and substance use disorder benefits are being managed by Blue Shield's MHSA:

- Outpatient radiology, laboratory, speech therapy, occupational therapy, and physical therapy services associated with a mental health and substance use disorder diagnosis.
- Medical consultations requested by the MHSA.
- Structured Pain Management Program.
- Nutritional counseling.
- Decisions related to delegated medical services. As such, medical services for the treatment of gender dysphoria, eating disorder, or substance use disorder are the responsibility of the IPA/medical group. In making utilization management decisions, the IPA/medical group will utilize ASAM, LOCUS, CALOCUS, and ECSII for mental health and substance use disorder reviews. Additional MH/SUD guidelines may be added as they become available from non-profit professional associations in accordance with California law.

Blue Shield Responsibility

Blue Shield remains responsible for the services below even when the member's mental health and substance use disorder benefits are being managed by Blue Shield's MHSA.

- Out-of-service area requests.
- Outpatient prescription medications.

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 Major Organ/Bone Marrow transplant referrals must be to a California network transplant facility for benefits to be paid. Please contact the Blue Shield Transplant Team at (800) 637-2066, extension 8411130 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 via fax to the Transplant Medical Care Solutions Department in Rancho Cordova at (916) 350-8865. For members living in California, referrals to an out of state transplant facility must be at the referral of a Blue Shield's Major Organ/Bone Marrow Transplant Network facility approved for the specified type of transplant based upon medical necessity. For coverage, all referrals for medical necessity to an out-of-state provider must be pre-authorized by a Blue Shield Medical Director.

Organ and Bone Marrow Transplants *(cont'd.)*

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 the IPA/medical group only.

> *Note: Charges incurred as a result of cadaver organ donor evaluation, donor maintenance and organ recovery are directly reimbursable by the Organ Procurement Organization (OPO) according to Federal law and therefore are 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 - Both the transplant evaluation and the 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. All Blue Shield members are entitled to transplant evaluations at any Blue Shield transplant network facility approved for the specified organ, whether that facility has a contractual relationship with the IPA/medical group**.**

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 the Blue Shield Transplant Team for the following major organ and bone marrow transplant types:

- Bone marrow
- Stem cell
- CAR-T therapy
- 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)

Organ and Bone Marrow Transplants *(cont'd.)*

Transplant Authorizations *(cont'd.)*

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:

- Corneal
- Kidney only
- Skin

Requests for transplants must include the following:

- Subscriber ID, requesting MD and applicable procedure and diagnosis codes
- 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)
- Complete Transplant evaluation and workup

Fax transplant authorization requests to (916) 350-8865 Attn: Transplant Team.

Other Alternate Care Providers

These services should be provided within the Blue Shield network of alternate care providers:

- Durable Medical Equipment (DME) rental or purchase
- Oxygen
- Prosthetics or orthotics over $50
- Colostomy and ostomy supplies

New technologies must be coordinated with Blue Shield Medical Care Solutions prior to IPA/medical group authorizations for shared risk/savings agreements. IPA/medical groups may contact Blue Shield Medical Care Solutions for questions or issues.

For the Blue Shield Medicare Advantage plan, depending on the IPA/medical group's contract and delegation status with Blue Shield, the IPA/medical group must coordinate authorization with the appropriate Blue Shield Medical Care Solutions Department when these services are required.

Other Alternate Care Providers *(cont'd.)*

Durable Medical Equipment (DME)

Delegated medical groups must refer to and abide by Blue Shield Utilization Management (UM) criteria for authorizations of durable medical equipment (DME). In the absence of any Blue Shield Medical Policy, it utilizes the Centers for Medicare & Medicaid Services (CMS) Coverage Issues Manual for Durable Medical Equipment (section 60). The manual can be found at cms.gov

Durable medical equipment is defined by the following standards:

- Designed for repeated use and is medically necessary to treat an illness or injury, to improve the functioning of a malformed body part, or to prevent further deterioration of the member's medical condition.
- Appropriate for use in the home.

Delivery charges are covered. Durable medical equipment rental is covered only up to the Blue Shield allowance for purchase of the item.

If an emergency room visit is covered, no additional authorization is needed for related DME given to the member in the emergency room. The DME must match services on the ER claim.

When requesting a tracking number for durable medical equipment rental or purchase, the IPA/medical group should specify the:

- Applicable Diagnosis Code
- IPA authorization number
- Specific Procedure Code
- Duration of need

Other Alternate Care Providers *(cont'd.)*

Oxygen

When authorizing a request for oxygen equipment, the IPA/medical group must specify the flow rate at rest, concentration and oxygen saturation.

Oxygen therapy includes professional respiratory therapy services to monitor use of oxygen in the home and supplies needed to administer oxygen.

Professional services associated with administration of oxygen in the home are covered under the Home Health Care benefit.

Apria Healthcare LLC is Blue Shield's Primary Preferred DME provider (including oxygen services) for HMO and PPO members. Apria should be considered the first option when DME services are ordered.

Apria Healthcare LLC is also the capitated provider for Medicare Advantage HMO members. IPA/medical groups are required to utilize Apria Healthcare LLC for standard home and durable medical equipment items that are not the financial responsibility of the IPA/medical group. If the DME services are not referred to Apria, deductions may occur in the IPA/medical group's capitation payment. IPA/medical groups can access additional information and a comprehensive Apria branch listing by visiting Apria.com or by calling Apria directly at (800) APRIA-88 ((800) 277-4288). Any standard DME item ordered from a DME provider other than Apria will require prior authorization from Blue Shield of California or an authorized agent of Blue Shield.

Orthotics and Prosthetics

Orthotics are materials such as an orthopedic appliance used to support, align, prevent, strengthen, or correct deformities or to improve the function of part of the human body. Prosthetics are artificial body parts, appliances, or devices used to replace an absent or missing part of the human body.

For Commercial Members

Financial responsibility is described in the Division of Financial Responsibility in the HMO IPA/Medical Group Agreement.

Orthotics and prosthetics that cost less than a contracted dollar amount (e.g. $50) are generally covered under professional capitation. Orthotics and prosthetics that have a Blue Shield allowed amount more than the contracted dollar amount (for a single item or cumulatively for all items required to make the orthotic or prosthetic) are generally covered as shared-risk under the Shared Risk/Shared Savings Fund, requiring IPA/medical group authorization and coordination with the Blue Shield Medical Care Solutions Department (see the Contact List in Appendix 1 in the back of this manual). Under Capitated Hospital arrangements, the Capitated Hospital will be responsible for reimbursing the providers directly for authorized services**.**

For Blue Shield Medicare Advantage Plan Members

Medicare coverage guidelines for orthotics and prosthetics are applicable for Blue Shield Medicare Advantage plan members. Financial responsibility is specified in the Division of Financial Responsibility in the HMO IPA/Medical Group Agreement with Blue Shield.

Out-of-Area Services

Services that are covered outside the member's primary care physician service area include:

- Non-emergency services referred out-of-area and authorized by the primary care physician/IPA/medical group and/or Blue Shield
- Emergency services (Refer to Emergency Services section)
- Urgent services (refer to the HMO Benefit Guidelines for urgent services benefit information)

Note: A covered exception for renal dialysis is described in the HMO Benefit Guidelines for out-of-area services.

Before approving out-of-area services, the IPA/medical group must confirm whether or not the provider is part of the Blue Shield HMO Provider Network by calling Blue Shield Provider Information & Enrollment at (800) 258-3091.

The IPA/medical group is responsible for all referred out-of-area professional fees and capitated services and for reporting all out-of-area professional referrals as encounter data. Blue Shield is generally responsible for payment of all fees related to out-of-area emergency or urgent care. Financial responsibility is described in the Division of Financial Responsibility in the HMO IPA/Medical Group Agreement with Blue Shield. The Blue Shield Medical Care Solutions Department works with the IPA/medical group to issue authorizations for all out-of-area institutional services. The IPA/medical group must notify the Blue Shield Medical Care Solutions Department of all institutional out-of-area referred services prior to providing those non-emergency services.

Out-of-Plan Services

Out-of-plan services are those services that are not available through the Blue Shield HMO Provider Network.

When providing an authorization for out-of-plan services, the IPA/medical group must contact the Blue Shield Medical Care Solutions Department for a letter of agreement.

The IPA/medical group is financially responsible for all referred out-of-plan professional capitated services and for reporting all out-of-plan professional services as encounter data.

If a letter of agreement for out-of-plan services is not obtained from Blue Shield, then the IPA/medical group is financially responsible for all fees associated to institutional services.

PKU-Related Formulas and Special Food Products

For Commercial Members

Benefits are provided for enteral formulas, related medical supplies, and special food products that are medically necessary for the treatment of phenylketonuria (PKU ICD-9 270.1, ICD-10-CM E70.0-E70.1) to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. These benefits must be prior-authorized by the IPA/medical group and must be prescribed or ordered by the appropriate healthcare professional. Refer to the member's EOC for benefit limitations.

5.1 Utilization Management

Prior Authorization

Except for emergency services, the following services may require prior authorization:

1. Ambulance
2. Colostomy and ostomy supplies
3. IV infusion therapy including high-cost medications such as CAR-T and Gene therapy
4. Facility-based outpatient surgeries/procedures
5. Home health care
6. Durable Medical Equipment (DME) – new technologies
7. Hospice care
8. Non-emergency inpatient hospital admissions
9. Inpatient rehabilitation
10. Skilled nursing facility admissions
11. Out-of-area services
12. Out-of-plan services
13. Oxygen
14. Prosthetics/orthotics – new technologies
15. Parenteral and enteral nutritional supplements
16. In-home physical therapy (PT), occupational therapy (OT), speech therapy (ST), and respiratory therapy (RT)
17. Organ transplants (Refer all transplants except kidney, skin and cornea to the Blue Shield Transplant Team)
18. Cancer clinical trial participation: not delegated to the IPA/medical group, refer to Blue Shield for authorization
19. Experimental/investigational procedures that are not delegated to the IPA/medical group
20. Medication administration at an outpatient hospital facility

Prior authorization for the services listed above is based on medical necessity and clinical criteria, which are guidelines for decisions about coverage of care. Prior authorization information is accessible through Provider Connection at https://www.blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/authorizations/authorization_list#list. Blue Shield uses nationally recognized industry sources selected by Blue Shield, including CMS, Blue Shield Medical Policies, and Medication Policies (Injectable, Implantable, w/ DME) established by the Blue Shield Pharmacy & Therapeutics Committee.

For fully-insured products, the Blue Shield MHSA will utilize ASAM, LOCUS, CALOCUS, ECSII, and World Professional Association for Transgender Health (WPATH) for mental health and substance use disorder reviews. Additional MH/SUD guidelines may be added as they become available from non-profit professional associations in accordance with California law.

Prior Authorization *(cont'd.)*

For those services NOT delegated to the IPA/medical group:

- To obtain a service authorization, the IPA/medical group should call the Blue Shield Medical Care Solutions Department. Requests for service authorization should be made at least five business days in advance of service provision. Blue Shield will issue a determination. Services without an authorization that require an authorization will be denied.
- In addition to contacting Blue Shield by telephone or fax for medical authorizations, providers have the option to use AuthAccel, Blue Shield's online tool for submitting authorization requests. AuthAccel may only be used for services where the division of financial responsibility in the IPA/medical group's contract identifies Blue Shield as responsible for prior authorization. Providers may use AuthAccel to complete, submit, attach documentation, track status and receive determinations for applicable medical and pharmacy prior authorizations. Registered users at Provider Connection may access the tool, in the *Authorizations* section, after logging into the website at www.blueshieldca.com/provider.

To determine service authorizations, the IPA/medical group, in coordination with Blue Shield Medical Care Solutions Department:

- Verifies the patient's eligibility and contract benefits
- Checks the provider's status
- Applies appropriate medical necessity criteria
- Refers the request to a physician advisor or medical director, as appropriate
- Evaluates non-preferred home health care services and DME rentals/purchases

For those services delegated to the IPA/medical group:

- Delegated IPA/medical groups will issue a determination
- Delegated IPA/medical groups will contact the requesting provider(s) by telephone/fax within 24 hours of the decision to inform the physician(s) of the status of the authorization request

If a provider other than the primary care physician's IPA/medical group requests authorization, the provider will be directed to contact the IPA/medical group before the Blue Shield Medical Care Solutions Department reviews the authorization request.

Professional Services

Primary care physicians must follow their IPA/medical group's procedures when requesting authorizations for professional services and referrals.

When referring a member for specialty services, primary care physicians must follow their IPA/medical group's referral guidelines and should also:

- Note the referral in the patient's medical record
- Forward copies of medical records or test results to the specialist
- Coordinate with the attending physician when specialist consultations and services are needed during an inpatient stay

Rehabilitation Services

Rehabilitation services are covered as an inpatient or outpatient benefit when they are deemed medically necessary for the treatment of a single illness, injury or medical condition.

Rehabilitation and habilitation therapies are defined as:

Rehabilitation Therapies – Inpatient or outpatient care furnished primarily to restore an individual's ability to function as normally as possible after a disabling illness or injury. Rehabilitation services include physical therapy, occupational therapy, and/or respiratory therapy. Rehabilitation services will be authorized for an initial treatment period and for any additional medically necessary subsequent treatment periods.

Habilitation Therapies – Medically Necessary services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health care condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Respite care, day care, recreational care, residential care, social services, custodial care, or education services of any kind are not considered Habilitative Services.

Occupational Therapy – Treatment under the direction of a physician and provided by a certified occupational therapist, utilizing arts, crafts, or specific training in daily living skills, to develop, improve and maintain a patient's ability to function.

Physical Therapy – Treatment provided by a physician or when provided by a licensed physical therapist for services diagnosed by a physician or licensed doctor of podiatric medicine. Treatment utilizes physical agents and therapeutic procedures such as ultrasound, heat, range of motion testing, and massage, to develop or improve a patient's musculoskeletal, neuromuscular and respiratory systems.

Respiratory Therapy – Treatment under the direction of a physician and provided by a certified respiratory therapist to develop, preserve or improve a patient's pulmonary function.

Inpatient Rehabilitation

Inpatient rehabilitation benefits will be provided for medically necessary inpatient days of care in an acute hospital rehabilitation unit or skilled nursing facility (SNF) rehabilitation unit.

Depending on the IPA/medical group's Blue Shield contract and delegation status, the primary care physician and/or the IPA/medical group should request authorization for inpatient rehabilitation service from the Blue Shield Medical Care Solutions Department when referring a member for admission or transfer to an inpatient rehabilitation unit or SNF. For Acute Rehabilitation, CMS guidelines should be applied in the absence of a specific Blue Shield medical policy or guideline. The Division of Financial Responsibility is specified in the HMO IPA/Medical Group Agreement.

For Blue Shield Medicare Advantage plan members, rehabilitation benefits are unlimited and are based on medical necessity. For more on Blue Shield Medicare Advantage plan inpatient rehabilitation benefits, see Section 6.

Rehabilitation Services *(cont'd.)*

Outpatient Rehabilitation

Outpatient rehabilitation therapy is covered for as long as continued treatment is medically necessary, pursuant to a written treatment plan and dependent on any EOC benefit limitations. Care must be rendered in the provider's office or outpatient department of a hospital.

A determination of medical necessity can include, but is not limited to, an evaluation of whether or not the member is a reasonable candidate for a rehabilitation program (i.e., the prognosis is such that there is reasonable expectation that rehabilitation efforts will affect greater functionality with respect to the activities of daily living).

Depending on the HMO IPA/Medical Group's Blue Shield Agreement and delegation status, the primary care physician and/or the IPA/medical group should request authorization for outpatient rehabilitation services from the Blue Shield Medical Care Solutions Department. Medically necessary services will be authorized for an initial treatment period and any additional subsequent medically necessary treatment periods. Medical necessity (as defined earlier in this section) is objectively assessed prior to therapy to establish treatment goals and objectives. The Division of Financial Responsibility is specified in the HMO IPA/Medical Group Agreement.

If rehabilitation services are rendered in the home, the visits will be applied to the 100-visits-per-calendar-year limit established for home health care services or according to the member's benefit limitations as shown in their EOC.

For Blue Shield Medicare Advantage plan members, rehabilitation services benefits are unlimited and are based on medical necessity. For more on Blue Shield Medicare Advantage plan outpatient rehabilitation benefits, see Section 6.

Skilled Nursing Facility (SNF) Admissions/Transfers

Note: For Blue Shield Medicare Advantage plan SNF benefit limits, see Section 6.

Blue Shield commercial HMO members may be admitted or transferred to a SNF from any environment. Depending on the HMO IPA/Medical Groups' Blue Shield Agreement and delegation status, IPA/medical groups may be required to obtain prior authorization for SNF admissions/transfers from the Blue Shield Medical Care Solutions Department.

Admission to a SNF is considered appropriate, and may be authorized for care provided by a licensed professional (both nurse and therapist), for the purpose of stabilization, assessment, or preventive care. Medically necessary skilled nursing services, including sub-acute care will be covered when provided in a skilled nursing facility when authorized. The IPA/medical group is required to perform concurrent review for medical necessity at least weekly on SNF patients, or more frequently as circumstances dictate.

Below are examples of services for which SNF admissions may be authorized:

1. Intravenous, intramuscular, or subcutaneous injections and or intravenous feeding.
2. Levine tube feedings and new gastrostomy tube feedings.
3. Nasopharyngeal and tracheostomy aspiration.
4. Insertion, sterile irrigation, and replacement of catheters.
5. Applications of dressings involving prescription medications and aseptic technique.
6. Treatment of extensive decubitus ulcers (stage II or greater) or other widespread skin disorders.
7. Heat treatments that require observation to adequately evaluate progress.
8. Initial phases of a regimen involving administration of medical gases.
9. Rehabilitation nursing procedures (e.g., the institution and supervision of bowel and bladder training programs, diabetic care).

   Note: For commercial members, the standard SNF benefit is limited to 100 days per calendar year, but SNF benefits may differ depending on HMO plan benefits.

Specialist Services

When providing healthcare services, specialists must:

- Render services only with appropriate authorization from the primary care physician or the IPA/medical group.
- Submit all claims for services rendered to the appropriate IPA/medical group affiliated with the referring primary care physician.
- Accept the IPA/medical group’s contracted rates as payment in full, minus applicable member co-payments.
- Provide the primary care physician with the results of any visits, tests, etc.

Specialist Services *(cont'd.)*

Standing Specialist Referrals

Each IPA/medical group must establish and maintain policies and procedures for standing referrals to specialists for members with a condition or disease, including but not limited to HIV and AIDS[2], which requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling. (A standing referral involves more than one appointment with a medical specialist.)

When authorizing a standing referral to a specialist for the purpose of diagnosis or treatment of a condition requiring care by a physician with specialized knowledge of HIV medicine, the delegated IPA/medical group must refer the member to a network HIV/AIDS specialist. A list of qualified HIV/AIDS specialists must be maintained by the IPA/medical group and accessible by the group's membership.

An IPA/medical group does not need to go outside its own network of providers when referring to HIV/AIDS specialists unless the IPA/medical group does not have the appropriate qualified physician, nurse practitioner, or physician assistant under the supervision of an HIV/AIDS provider, in its network.

There is no limitation to utilizing network providers, as long as an appropriate specialist is available within the network. If the IPA/medical group does not contract with a qualified HIV/AIDS provider as defined, the IPA/medical group is required to refer any members needing a standing referral to a physician outside the IPA/medical group's network at their own cost.

It is required that the member's primary care physician, in consultation with the specialist and the Medical Director of the IPA/medical group or designee, determine if the member needs continuing care from a specialist. If it is determined that access to a specialist is medically necessary, then the specialist must be allowed to see the member in his/her area of expertise in the same manner as the member's primary care physician. The IPA/medical group can simply approve the current standing referral order to a specialist or it can require a treatment plan. In the event that a treatment plan is required, all referrals must be made within four business days of the time that the treatment plan is submitted.

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 purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, IPA/medical groups *must* refer the enrollee to an HIV/AIDS specialist.

[2] *Effective Date: January 16, 2003 (Commercial HMO)*

Specialist Services *(cont'd.)*

Standing Specialist Referrals *(cont'd.)*

The Department of Managed Health Care (DMHC) issued a definition of an HIV/AIDS specialist as follows:

(e) For the purposes of this section, an "HIV/AIDS specialist" means a physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California and who meets any one of the following four criteria:
(1) Is credentialed as an "HIV specialist" by the American Academy of HIV Medicine; or
(2) Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; or
(3) Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:
(A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and
(B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; or
(4) Meets the following qualifications:
(A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and
(B) Has completed any of the following:
1. In the immediately preceding 12 months has obtained board certification or re-certification in the field of infectious diseases from a member board of the American Board of Medical Specialties; or
2. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or
3. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV medicine.

(f) When authorizing a standing referral to a specialist pursuant to Section 1374.16(a) of the Act for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, a health care service plan must refer the enrollee to an HIV/AIDS specialist. When authorizing a standing referral to a specialist for purposes of having that specialist coordinate the enrollee's health care pursuant to Section 1374.16(b) of the Act for an enrollee who is infected with HIV, a health care service plan must refer the enrollee to an HIV/AIDS specialist. The HIV/AIDS specialist may utilize the services of a nurse practitioner or physician assistant if:
(1) The nurse practitioner or physician assistant is under the supervision of an HIV/AIDS specialist; and
(2) The nurse practitioner or physician assistant meets the qualifications specified in subsection (e)(4); and
(3) The nurse practitioner or physician assistant and that provider's supervising HIV/AIDS specialist have the capacity to see an additional patient.

Specialist Services *(cont'd.)*

Speech Therapy Services

Medically necessary Speech Therapy services are basic health care services under the Knox-Keene Health Care Service Plan Act of 1975. Health plans must arrange and cover speech therapy services for their enrollees when medically necessary. For the complete Speech Therapy Medical Policy, go to Provider Connection at blueshieldca.com/provider, click on *Authorizations, Clinical policies and guidelines*, then *Medical policies & procedures.*

Initial outpatient benefits for speech therapy are covered when diagnosed and ordered by a physician and services are delivered by a licensed speech-language pathologist that is licensed through the Department of Consumer Affairs, Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board, and performs within the scope of practice pursuant to a written treatment plan, to:

(1) Correct or improve the speech abnormality, or

(2) Evaluate the effectiveness of treatment, and when rendered in the provider's office or outpatient department of a hospital.

Speech therapy is defined as therapy services, including diagnostic evaluation and therapeutic intervention, that are designed to improve, develop, correct, rehabilitate, or prevent the worsening of speech/language communication and swallowing disorders that have been lost, impaired or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries.

Services are provided for the correction of, or clinically significant improvement of, speech abnormalities that are the likely result of a diagnosed and identifiable medical condition, illness, or injury to the nervous system or to the vocal, swallowing, or auditory organs.

Continued Outpatient Benefits will be provided for Medically Necessary Services as long as continued treatment is medically necessary, pursuant to the written treatment plan and likely to result in clinically significant progress as measured by objective and standardized tests and dependent on any limitations in the members EOC benefit plan. The provider's treatment plan and records must be reviewed periodically. When continued treatment is not Medically Necessary, pursuant to the treatment plan, is not likely to result in additional clinically significant improvement, or no longer requires skilled services of a licensed speech-language pathologist, the IPA/medical group must notify the member of this denial determination in writing and benefits will not be provided for services rendered after the date of written notification.

Specialist Services *(cont'd.)*

Speech Therapy Services *(cont'd.)*

The IPA/medical group shall send a denial notice to the member containing the following information:

- Member's name and name(s) of provider(s) who rendered services.
- Date and description of service.
- Clinical reason(s) for the denial.
- UM criteria, guideline, protocol or benefit provisions used in making the decision, including contact information and procedures to follow to obtain a copy.
- Alternative treatment options, as appropriate.
- For employer health plans governed by the Employee Retirement Income Security Act (ERISA), ERISA-required statement notifying member of the right to bring a civil action if all required reviews of the service/claim have been completed and the service/claim has not been approved.
- Appeal information, including the member's right to request an external, independent medical review through the DMHC (only Commercial members may appeal to DMHC, Blue Shield 65 Plus members must appeal directly to the health plan); the member's right to request expedited appeals; the member's right to submit written comments, documents, or other information relevant to the appeal; and the member's right to appeal to Blue Shield.

The IPA/medical group shall also send a copy of the member's denial notice to the member's primary care physician for follow-up regarding appropriate care. The denial letter to the treating provider shall also include the name, title and direct telephone number of the IPA/medical group's Medical Director who oversees the decision.

Note: The following conditions have been removed from Blue Shield's exclusions lists for speech therapy and therefore should not be automatically denied; however, these conditions are still subject to medical necessity review as described above:

- *Psycho-social speech delay including delayed language development*
- *Mental retardation or dyslexia*
- *Syndromes associated with diagnosed disorders attributed to perceptual and conceptual dysfunctions*
- *Developmental articulation and language disorders*

Urgent/Emergent Services

Urgent/emergent services are those 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.

No Prior Authorization Required

State and federal law prohibits requiring prior authorization for emergency services. Blue Shield also does not require prior authorization for urgent services that meet the reasonable person definition.

Urgent or Emergency Services are covered automatically if an authorized Blue Shield representative or authorized representative of the member's assigned IPA/medical group has approved the provision of the urgent/emergent services. Authorized representatives may include, but are not limited to, Advice Nurses, Network Physicians, Physician Assistants, Nurse Practitioners, or Customer Service representatives.

When facing an urgent or emergency situation, the primary care physician should:

- Evaluate the medical necessity of a member's request for urgent or emergency services and determine the appropriate referral for these services, following reasonable person standards.
- If possible, direct out-of-area urgent or emergency services of a member to the IPA/medical group's service area.
- Notify the IPA/medical group or Blue Shield of urgent or emergency admissions.
- Document telephone conversations in the member's centralized medical record, whether the urgent or emergency service is approved or denied by the primary care physician.

For Blue Shield Medicare Advantage plan members, please contact the Blue Shield Medicare Medical Care Solutions Department for a copy of the Emergency Care Treatment Criteria Matrix, also known as the ER Matrix.

Urgent/Emergent Services *(cont'd.)*

Urgent or Emergency Services Denial

The IPA/medical group must adhere to the "reasonable person" standard prior to denying an urgent or emergency services claim.

If an IPA/medical group retrospectively denies an urgent or emergency service, it must document the following denial information and submit it to Blue Shield upon request.

The IPA/medical group shall provide Blue Shield with:

- A clinical reason for the denial based on the reasonable person standards.
- Proof of medical review by a physician.
- Verification that the primary care physician or his/her designee did not refer the member to the emergency room or urgent care provider.
- A copy of the claim with the member's denial notice.

The IPA/medical group shall send a denial notice to the member containing the following information:

- Member's name and name(s) of provider(s) who rendered services.
- Date and description of service.
- Clinical reason(s) for the denial.
- UM criteria, guideline, protocol or benefit provisions used in making the decision, including contact information and procedures to follow to obtain a copy.
- Alternative treatment options, as appropriate.
- For employer health plans governed by the Employee Retirement Income Security Act (ERISA), ERISA-required statement notifying the member of the right to bring a civil action if all required reviews of the service/claim have been completed and the service/claim has not been approved.
- Appeal information, including the member's right to request an external, independent medical review through the DMHC (only Commercial members may appeal to DMHC, Blue Shield Medicare Advantage plan members must appeal directly to the health plan.); the member's right to request an expedited appeal; the member's right to submit written comments, documents, and other information relevant to the appeal and the member's right to appeal to Blue Shield including representation by an attorney.
- The IPA/medical group shall also send a copy of the member's denial notice to the member's primary care physician for follow-up regarding appropriate care. The denial letter to the treating provider shall also include the name, title and direct telephone number of the IPA/medical group's Medical Director who oversees the decision.

Urgent/Emergent Services *(cont'd.)*

Appeal of Denied Urgent or Emergency Services

A Blue Shield Medical Director or physician designee reviews all appeals of denied emergency services.

Blue Shield may reverse the IPA/medical group's decision to deny urgent or emergency services. When this occurs, the Blue Shield Medical Care Solutions Department will coordinate the review of the denial with the IPA/medical group and notify the IPA/medical group and the member of the appeal determination.

Blue Shield retains the right to review and make determinations on appeals of all emergency services.

Urgent and Emergency Services Review

The Blue Shield Delegation Oversight and Appeals and Grievance Departments periodically evaluate an IPA/medical group's performance on urgent and emergency services review by monitoring the:

- Emergency room visits/1000 rate per IPA/medical group.
- Percentage of service denials reversed by Blue Shield based on member appeal.

5.1 Utilization Management

Medical Care Solutions Contact List

Blue Shield Contact	Commercial HMO and Direct Contracted HMO*	Medicare HMO
Call Medical Care Solutions for questions about: • Request for authorization • Blue Shield Medical Policy • Information on referrals • Emergency services • Denials • Hospital admissions and/or discharges • DME/HME & Home Health • Chronic and catastrophic case management	**(800) 541-6652 Option 6** Urgent/ER Inpatient Admits: Fax (844) 295-4637 Prior Authorizations: Fax (844) 807-8997 Prior Authorizations for Office/Infusion/Home Health Administered Medications: Fax (844) 262-5611 *Mailing Address:* Blue Shield of California Medical Care Solutions P.O. Box 629005 El Dorado Hills, CA 95762-9005 To refer patients to a Blue Shield Case Management Program (877) 455-6777 *Direct Contracted HMO **-** Individual providers not affiliated with a Blue Shield HMO IPA/medical group and are contracted to provide benefits directly to HMO members.	**(800) 541-6652 Option 6** Urgent/ER Inpatient Admits: Fax (844) 696-0975 Prior Authorizations: Fax (844) 807-8997 Prior Authorizations for Office/Infusion/Home Health Administered Medications: Fax (844) 262-5611 *Mailing Address:* Blue Shield of California Medicare Medical Care Solutions P.O. Box 629005 El Dorado Hills, CA 95762-9005

Introduction

Blue Shield of California's mission is to ensure all Californians have access to high-quality healthcare at an affordable price. Blue Shield's Quality Management and Improvement Program was established in support of that mission and plays a key role in achieving the organization's goals to:

- Improve the quality and efficiency of health care
- Improve members' experience with services, care, and their own health outcomes
- Delivering an exceptional quality program across the organization

Superior care and service is the force driving the value equation. Blue Shield is committed to an objective, comprehensive, systematic, and multidisciplinary approach to managing and continuously improving the quality of care and service provided to members. Quality Improvement (QI) is an ongoing process of assessing, planning, organizing, directing, coordinating, monitoring, and evaluating the care and service provided to Blue Shield members. Blue Shield is dedicated and committed to the QI process and will strive to produce optimal outcomes by implementing interventions to address identified improvement opportunities to ensure that the quality of care delivered meets national best practice standards.

Quality Management and Improvement

Blue Shield's Clinical Quality Department, in collaboration with Blue Shield's Quality Committees, selects and oversees quality measurement and improvement activities to 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, 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 not but 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 of California maintains Health Plan Accreditation (HPA) with National Committee for Quality Assurance (NCQA). Blue Shield'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 and delegates to participate in Quality Management and Improvement activities as follows:

- Participation in QI Committees and collaborative QI activities
- Expert consultation for credentialing, peer review, and utilization management determinations
- Expert advisers for clinical QI workgroups
- Participation in focus groups
- Partnership in 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.

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

Quality Management and peer review activities are considered privileged communication under California Health and Safety Code Section 1370 and California Evidence Code 1157. As such, neither the proceedings nor record of the review may be disclosed outside of the review process.

Quality Management and Improvement Program Requirements - Delegate Responsibilities

Blue Shield does not delegate Quality Improvement (QI) activities, however; the IPA/medical groups are required to maintain a QI Program that complies with Section 1370 of the California Health and Safety Code.

Each IPA/medical group shall:

- Have a written QI Program description that must be reviewed annually, updated as appropriate and approved by the IPA/medical group's Medical Director or appropriate review body. The program description shall include:
    - Program goals and objectives
    - Organizational structure including the role and function of the IPA/medical group's governing body, quality committees and subcommittees, the staff responsible for QI activities, and the frequency of their meetings
    - Scope and content of the QI Program to include the monitoring of quality of care and service
    - Frequency and method of QI Program evaluations
    - Development, implementation and annual evaluation of the QI work plan or schedule of activities, including objectives, scope and planned projects and activities for the year, and planned monitoring of identified issues and requirements according to Section 1370 of the California Health and Safety Code
- Specify a senior physician to be responsible for program implementation, oversight, and accountability
- Indicate the IPA/medical group Medical Director's involvement in QI activities and document the active participation of practicing providers in the quality committee meetings
- Maintain quality committee minutes so as to preserve their confidentiality and immunity from discovery according to Section 1370 of the California Health and Safety Code

Quality Management and Improvement Program Requirements - Delegate Responsibilities *(cont'd.)*

Quality Improvement

In compliance with these minimum program standards, the IPA/medical group shall:

- Provide adequate staff who have the knowledge, skills, and experience to perform quality improvement activities
- Work with Blue Shield to perform quality improvement activities and allow Blue Shield access to its members' medical records
- Develop a plan to evaluate and provide practice feedback to its physicians on:
    - Referral, clinical and utilization performance
    - Use of guidelines, protocols, and appropriate criteria applications/citations
    - Member satisfaction
    - Effective use of preventive screening and education
- Develop and share practice guidelines and explicit review criteria with providers affiliated with the IPA/medical group. These guidelines must be reviewed annually and updated as appropriate.
- Ensure that health services are available and accessible to Blue Shield members as needed and per regulatory/accreditation requirements.
- Take action to improve quality and routinely assess the effect of actions taken
- Evaluate the overall effectiveness of its quality improvement program on an annual basis
- Comply with applicable NCQA standards and guidelines

Quality of Care Activities

Blue Shield requires IPA/medical groups and their participating providers to work with Blue Shield in the following Quality of Care Activities, including, but not limited to:

- Access-to-care monitoring
- Coordination and continuity monitoring
- Investigation of member grievances and quality of care issues (see more below)
- Member satisfaction/disenrollment surveys
- Medical record review
- Office site review
- Healthcare Effectiveness Data and Information Set (HEDIS) data collection
- Disease management programs
- Quality improvement activities/initiatives/monitoring site visit for Utilization Management (UM) and Credentialing Evaluations

IPA/medical groups are responsible for providing copies of their Utilization Management (UM) and credentialing plans, including policies and procedures as necessary, to meet state, federal, NCQA, and Blue Shield requirements. IPA/medical groups must provide Blue Shield annually with information including, but not limited to:

- Process for referring complaints/grievances to Blue Shield
- Process for maintaining confidentiality of member's personal health information
- Nurse practitioner/physician assistant/pharmacist protocols (if applicable)

Quality of Care Reviews

Blue Shield has a comprehensive review system to address quality of care issues. A quality of care issue arising from a member grievance, or an internal department is forwarded to the Blue Shield Quality Management Department where a quality review nurse investigates and compiles a care summary from clinical documentation including, but not limited to, medical records and a provider written response, if available. The case may then be forwarded to a Blue Shield Medical Director for review and determination of any quality of care issues. A case review may also include a review of the care provided by a like-peer specialist and/or review by the Blue Shield Peer Review Committee.

During the review process, information is obtained from an IPA/medical group or directly from the involved provider. Upon review completion, dependent upon the severity of any quality findings identified, follow-up actions may be taken and can include a request for corrective action or an educational letter outlining opportunities for improvement. Patient safety concerns or patterns of poor care may be considered during Blue Shield recredentialing activities or reviewed in more detail by the Blue Shield Credentialing Committee and may result in termination from the Blue Shield network.

Blue Shield providers are obligated to participate in the quality of care review process and must provide documents, including medical records and corrective action plans upon request. Peer review activities are considered privileged communication under California Health and Safety Code Section 1370 and California Evidence Code 1157.

Medical Record Review

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

Primary care physicians are required to maintain a medical record for each member that must include patient records of care provided within the IPA/medical group, as well as care referred outside the IPA/medical group.

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

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

- Identifying information on the member (patient ID on each page)
- Problem list noting significant illnesses and medical conditions
- Allergies and adverse reactions prominently noted
- Preventive Health Services
- 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

IPA/medical groups and physicians 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, IPA/medical groups 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 physician or IPA/medical group must provide one copy of these materials, at no charge, to the member's new physician or IPA/medical group. Upon request, additional copies must be provided to Blue Shield at the IPA/medical group'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 HEDIS documentation requirements. For example, the Child and Adolescent 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 Diabetes Management Flow Sheet (to identify most recent test and results: HbA1C, dilated or retinal eyes exam, and urine microalbumin).

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

The IPA/medical group 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. Controller 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, however, it is Blue Shield's policy to not charge a fee.

Delegation of Credentialing

The decision to delegate any function is based upon the IPA/medical group's demonstrated ability to successfully perform specific functions (i.e., Utilization Management, Credentialing, and Recredentialing). Initially, a pre-contractual or pre-delegation audit is conducted to determine if the IPA/medical group has the ability to perform the delegated function to the standards and requirements of Blue Shield and of the various applicable regulatory and/or accreditation agencies. After initial delegation, Blue Shield conducts an annual evaluation and oversight of the IPA/medical group based on the 12-month (no greater than 14th month) requirement set forth by NCQA. Blue Shield's oversight process is conducted through annual evaluation audits for each of the various delegated functions as well as semi-annual reports. The outcome of the evaluation determines if the delegation status will be continued as contracted or if a change in delegation status is indicated, up to, and including, revocation of delegation. Blue Shield may require more frequent or targeted audits or require a Corrective Action Plan in an effort to address any identified issues or deficiencies to avoid revocation of delegation. The delegation of this function will be granted only to those IPAs/medical groups that meet the standards outlined in the Blue Shield of California Credentialing/Recredentialing Delegation Standards (see Appendix 5-B in the back of this manual).

General Requirements for Credentialing/Recredentialing

Blue Shield is accountable for the credentialing and recredentialing of its practitioners. Blue Shield may delegate these activities but retains accountability for the oversight of the results to ensure that the same standards for participation are maintained throughout its practitioner network. Blue Shield retains the right to approve, suspend, or terminate any of the practitioners, providers, or sites of care.

Credentialing Oversight

Blue Shield will evaluate the IPA/medical group's credentialing program annually, per contractual line of business, based on the 12-month (no greater than 14-month) evaluation requirement set forth by the NCQA. The IPA/medical groups are expected to maintain their policies, procedures, programs and keep their processes up to date with the most current NCQA, DMHC, CMS, CDI, state and federal regulatory standards and Blue Shield requirements.

IPA/medical groups that are delegated for credentialing activities are required to credential and recredential practitioners/providers, mid-level practitioners/providers and non-physician practitioners/providers in accordance with the Blue Shield policies and procedures, NCQA, DMHC, CDI, CMS guidelines and applicable federal and state laws and regulations. Recredentialing is required at least every three (3) years.

Blue Shield retains ultimate responsibility and authority for all credentialing activities. Blue Shield will assess and monitor the IPA/medical group's delegated credentialing activities as follows:

1. The Credentialing Delegation Oversight Auditor will conduct pre-delegation and annual audits in accordance with the Delegated Oversight Policy and Procedure. The audit will include a review of the IPA/medical group's policies and procedures, Credentialing Committee functions and minutes, ongoing monitoring, organizational provider credentialing, sub-delegation oversight activities, quarterly reports, and the IPA/medical group's credentials files, as applicable. The Industry Collaborative Effort (ICE) standardized audit tool will be used to conduct an audit. The IPA/medical group will be required to submit a complete credentialing roster, with specialty, credentialing and recredentialing dates, and board certification name and expiration date, at least two (2) weeks prior to the scheduled audit date.

Delegation of Credentialing *(cont'd.)*

Credentialing Oversight *(cont'd.)*

2. Blue Shield will use one of the following techniques for the file review:
   a. The NCQA 8/30 file review methodology. Prior to the audit, the Blue Shield auditor will provide a list of 30 initial files and 30 recredentialed files to be reviewed at the audit to the IPA/medical group. The Blue Shield auditor will audit the files in the order indicated on the file pull list. If all eight (8) initial files are compliant with all the required elements, the remaining 22 reserve initial files will not have to be reviewed. If any of the first eight (8) files are scored non-compliant for any required element, then the auditor will need to review all 30 initial files.
   b. The NCQA's 5 % or 50 file review methodology of its files, whichever is less, to ensure that information is verified appropriately. At a minimum, the sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits the universe of files rather than a sample.
3. After completion of the initial file review, the auditor will follow the same procedure for the recredentialed files review and performance monitoring review (work history and education/training is not applicable at recredentialing).
4. The IPA/medical group will be required to sign and abide by the credentialing delegation agreement.
5. Results of the credentialing review of the Group's program will be forwarded to the Delegated Oversight Committee for action and approval in accordance with Health Plan policy.
6. To be delegated and to continue delegation for credentialing, the IPA/medical group must meet the minimum standards by scoring at least 95%. If the IPA/medical group scored below 95%, a corrective action plan (CAP) is required. The IPA/medical group must submit all deficiencies to Blue Shield Credentialing Delegation Oversight Department within 30 days of notification is received. After reviewing the CAP, the IPA/medical group will be sent a letter noting acceptance of the CAP or any outstanding deficiencies.
7. The Credentialing Delegation Oversight Department will ensure the CAP meets all regulatory requirements.
8. Failure to fulfill compliance with delegation standards or to meet expected business outcomes may result in full or partial de-delegation by Blue Shield. Corrective action will be required and may involve additional oversight or co-management of certain functions.
9. Delegated credentialing status may be terminated by Blue Shield at any time in which the integrity of the credentialing or recredentialing process is deemed to be out of compliance or inadequate.
10. Blue Shield may terminate this Agreement in the event that the IPA/medical group fails to perform Delegated Activities in accordance with Blue Shield's standards as described in this Agreement. Blue Shield will work with the IPA/medical group to correct the deficiencies. However, if the problem cannot be corrected, then Blue Shield may revoke the delegation status.

Peer Review Process

Peer Review is 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 performance of colleagues by professionals with similar types and degrees of experience. Member complaints/grievances may identify potential quality of care cases. Results of determinations can improve performance levels when issues are identified.

Delegation of Credentialing *(cont'd.)*

Required Submissions/Notifications of Credentialing Program Activity

The IPA/medical group shall keep Blue Shield apprised of credentialing program activity through the following:

- The IPA/medical group will submit reports to Blue Shield twice a year listing those practitioners who have been credentialed, recredentialed, denied, and terminated by their credentialing committee and/or requested a fair hearing (including the outcomes of those determinations). Reports should also include the practitioners' quality improvement activities. The semi-annual reports must also include the practitioners' specialty and board certification status. (Reports may be submitted quarterly to align with other regulatory requirements such as DHCS.)

1st Semi-Annual	August 15th (January 1st – June 30th)	Credentialed Recredentialed Suspensions Resignations Terminations Organizational Providers QI Activities
1st Quarter	May 15th (January 1st – March 30th)	
2nd Quarter	August 15th (April 1st – June 30th)	
2nd Semi-Annual	February 15th (July 1st – December 31st)	
3rd Quarter	November 15th (July 1st – September 30th)	
4th Quarter	February 15th (October 1st – December 31st)	

- The IPA/medical group shall notify Blue Shield of practitioner terminations at least 30 calendar days prior to the effective date of the terminations.
- The IPA/medical group shall notify Blue Shield of changes in the credentialing staff and/or credentialing policies and procedures.
- The IPA/medical group will annually submit a copy of the group's current Credentialing/ Recredentialing Program and/or Policies and Procedures to bsc_cred.delegation@blueshieldca.com or the assigned auditor.

5.2 Quality Management Programs

Submission of Laboratory Results Data

All provider organizations (IPAs and medical groups) contracting with Blue Shield on a capitated basis 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) , disease management programs, and other similar activities. In lieu of direct submission, a contracting provider organization may cause its subcontracted laboratories to submit laboratory results data to Blue Shield in accordance with Blue Shield's specifications and requirements. Direct submission of results data by a laboratory on behalf of a provider organization does not relieve the provider organization of the obligation to ensure that complete, timely, and high-quality data are received by Blue Shield monthly.

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

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

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 of California Quality Committees.

Blue Shield's Clinical Practice Guidelines are available on Provider Connection at under *Guidelines and resources,* then *Guidelines and procedures.*

Service Accessibility Standards

Blue Shield requires that IPAs and medical groups, together with their contracted providers, provide access to health care services within the time periods as established by Blue Shield and Title 28 CCR Section 1300.67.2.2 as specified in this manual.

Blue Shield uses the Consumer Assessment of Health Plans Survey (CAHPS), the Patient Assessment Survey (PAS), Provider Satisfaction Survey, Appointment Availability Survey results, and member appeals and grievances to measure compliance with the applicable access standards. While all of the previously mentioned surveys will be used to demonstrate compliance, an overall rate of compliance by the IPA/medical group will also be calculated based solely on the Provider Satisfaction Survey and Appointment Availability Survey results. Groups that are found non-compliant with the access standards may be required to submit a corrective action plan containing details on how the IPA/medical group will achieve and maintain compliance.

If it is not possible to grant a member an appointment within the 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 wait time will not have a detrimental impact on the health of the enrollee. Such provider must note, in the appropriate record, that it is clinically appropriate and within professionally recognized standards to extend the wait time.

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

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

ACCESS-TO-CARE	STANDARD
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 *See "After Hours Requirements" below for more details on this requirement.*	PCP or covering physician available 24 hours a day, 7 days a week
Emergency Care	Immediate
After Hours Emergency Instructions (telephone answering service or machine) *See "After Hours Requirements" below for more details on this requirement.*	Specific instructions for obtaining emergency care such as directing the member to call 911 or to go to the nearest emergency room.
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.	Member care will not be adversely affected by excessive in-office wait time.
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 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

CATEGORY	ACCESS STANDARDS
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
Urgent Care visits	Within 48 hours
Care for an Emergent Non-Life-Threatening Situation	Within 6 hours

Behavioral Health Geographic Access Standards

CATEGORY	ACCESS STANDARD	COMPLIANCE TARGET
Geographic Distribution of Behavioral Health including: Psychiatrists Psychologists Licensed Clinical Social Workers Substance Abuse and Addiction Specialists	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 including: Inpatient Facility Residential & OP Treatment Facility	Urban: 1 within 15 miles of each member Suburban: 1 within 30 miles of each member Rural: 1 within 60 miles of each member	Urban: 90% Suburban: 85% Rural: 75%
Behavioral Health Member Ratio including: Top 3 HVS Substance Abuse practitioner	1 provider: 20,000 members	Urban100% Suburban: 100% Rural: 100%

After Hours Requirements for Commercial and Medicare Members

IPA/medical groups should abide by the following standards for after-hours emergency instructions and after-hours access to care guidelines.

After Hours Emergency Instructions

Note: The IPA/medical group must ensure that its contracted physicians 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 advice/triage nurse.
	7. No emergency instructions given.

After Hours Access-to-Care Guidelines

Note: The IPA/medical group should ensure that its contracted physicians or health care professionals 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 and high-volume specialty practitioners that is sufficient in number and geographic distribution for applicable commercial products. Please refer to the provider availability standards below.

Geographic Distribution

CATEGORY	PRODUCT TYPE*	STANDARD
Geographic Distribution (PCPs)	HMO/POS PPO – DOI & DMHC IFP ePPO CCSB HMO/PPO	One PCP within 15 miles or 30 minutes of each member
Geographic Distribution (SPCs)	HMO/POS PPO – DOI & DMHC IFP ePPO CCSB HMO/PPO	One of each type of High Volume and High Impact Specialists and OB/GYN (commercial only) within 30 miles of each member
PCP To Member Assignment Ratio	HMO	Maximum of 2,000 members assigned per PCP
SPC to Member Ratio	HMO PPO – DMHC IFP ePPO	1 OB/GYN to 10,000 (commercial members only) 1 HVS to 20,000 members
Geographic Distribution (Acupuncturist)	PPO	Urban/Suburban: 1 of each specialty within 20 miles of each member's residence or workplace or equivalent to 30 minutes. Rural: 1 of each specialty within 45 miles of each member's residence or workplace or equivalent to 60 minutes.
Provider to Member Ratio (Acupuncturist)	PPO	1 Acupuncturist per 5,000 members
Ethnic/Cultural and Language Needs	HMO/PPO	1 PCP speaking a threshold language to 1,200 members speaking a threshold language**
Geographic Distribution Hospitals	HMO/POS PPO – DOI & DMHC IFP ePPO CCSB HMO/PPO	One hospital within 15 miles of each member
Availability of Ancillary Care Providers	HMO/POS PPO – DOI & DMHC IFP ePPO CCSB HMO/PPO	Pharmacy: 1 in 15 miles DME: 1 in 15 miles Radiology/Lab/ASC/SNF: 1 in 30 miles Urgent Care/Dialysis: Urban 1 in 15 miles, Suburban 1 in 20 miles, Rural 1 in 30 miles

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

Geographic Distribution *(cont'd.)*

CATEGORY	PRODUCT TYPE*	STANDARD
Non-physician medical practitioner to physician **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.

*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, 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/Rad	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)

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

IPA/medical groups are required to be in compliance with the standards stipulated by CMS. If any IPA/medical group is unable to provide primary or specialty care services according to the requirements of CMS outlined above, the IPA/medical group is required to do one of the following to meet compliance:

1. Have a Medicare fee-for-service provider who meets both the driving time and driving distance requirements render services to the member, or

2. Contact Blue Shield and utilize one of Blue Shield's PPO providers who is also contracted for the Medicare line of business and meets both the driving time and driving distance requirements render services.

In selecting either one of the options, the financial responsibility for professional services rendered under this circumstance will rest with the IPA/medical group.

Linguistic and Cultural Requirements

MEASURE	STANDARD	COMPLIANCE TARGET
Ethnic/ Cultural and Language Needs	1 PCP speaking a threshold language to 1,200 members speaking a threshold language	100%

The top 4 Medicare threshold languages are Spanish, Chinese, Korean, and Japanese.

Additional Measurements for Multidimensional Analysis for Commercial Products

METRICS	PRODUCT	STANDARD	FREQUENCY
Access 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 Semi-Annually against Standard
Availability-related PCP Transfers	HMO	Rate of PCP transfers 1.68 per thousand members per month (Medicare)	Assessed Quarterly against Standard
PCP, Specialist and Hospital Network Change Analysis	IFP ePPO	10% (change)	Assessed Quarterly against Standard
PCP to Member Ratio	IFP ePPO	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	85%	Assessed Semi-Annually against Standard
Member Satisfaction	HMO/POS PPO	HMO – Patient Assessment Survey at IPA/MG level HMO/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
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

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6.1 Blue Shield Medicare Advantage Plan Program Overview

Introduction

Sections 1 through 5 of this provider manual contain information that may be applicable to Blue Shield Commercial Plans, Blue Shield Medicare Advantage plans (Individual and Group product)[1], and Blue Shield Medicare prescription drug plans (PDP Individual and Group product). In those instances where information or a process is different for Blue Shield Medicare Advantage plan members and Blue Shield Medicare prescription drug plan (PDP) members, you are referred to this section for more details.

This section contains information applicable only to Blue Shield IPA/medical groups that are contracted to provide benefits for Blue Shield Medicare Advantage plan members. It includes a general overview of the plan and administrative activities unique to delivering care to these Medicare Advantage members.

Blue Shield Medicare Advantage Plan 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 Medicare Advantage plans that are open to all Medicare beneficiaries, including those under age 65 who are entitled to Medicare on the basis of Social Security disability benefits, who meet all of the applicable eligibility requirements for membership, have voluntarily elected to enroll in 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 plan is offered to individual Medicare beneficiaries and to group Medicare beneficiaries retired from employer groups/unions who have selected the product as an option. Blue Shield also offers a Dual Eligible Special Needs Plan (D-SNP) for those members who are fully eligible for both Medicare and Medi-Cal.

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

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

1 When the manual references Blue Shield Medicare Advantage plan, it refers to Blue Shield's Medicare Advantage-Prescription Drug plans: Blue Shield 65 Plus (HMO), Blue Shield 65 Plus Choice Plan (HMO), Blue Shield Inspire (HMO) and Blue Shield Vital (HMO).

6.1 Blue Shield Medicare Advantage Plan Program Overview

Blue Shield Medicare Advantage Plan Service Areas

The definition of a service area, as described in the Blue Shield Medicare Advantage plan *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 Advantage plan. The Blue Shield Medicare Advantage plan has multiple service areas within the state. The specific service area in which the member permanently resides determines the Blue Shield Medicare Advantage plan(s) in which the member may enroll. More than one Blue Shield Medicare Advantage plan may be offered in a service area. 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. There are different service areas for Individual Blue Shield Medicare Advantage plan and Group Blue Shield Medicare Advantage plan, as follows:

Individual Blue Shield Medicare Advantage Plan Service Areas

Alameda County	San Bernardino County
Fresno County	San Diego County
Kern County	San Luis Obispo County
Los Angeles County	San Joaquin County
Madera County	San Mateo County
Merced County	Santa Barbara County
Orange County	Santa Clara County
Riverside County	Stanislaus County
Sacramento County	Ventura County

Group Blue Shield Medicare Advantage Plan Service Areas

Alameda County	San Bernardino County
Contra Costa County (partial county coverage)	San Diego County
Fresno County	San Francisco County
Kern County	San Joaquin County
Los Angeles County	San Luis Obispo County
Madera County (partial county coverage)	San Mateo County
Merced County	Santa Barbara County (partial county coverage)
Nevada County (partial county coverage)	Santa Clara County
Orange County	Santa Cruz County
Riverside County	Stanislaus County
Sacramento County	Ventura County

Blue Shield Medicare Advantage Plan Service Areas *(cont'd.)*

Dual Eligible Special Needs Plan (D-SNP) Service Areas

Fresno County	San Bernardino County
Los Angeles County	San Diego County
Merced County	San Joaquin County
Orange County	Stanislaus County

Blue Shield Medicare Advantage Plan Provider Network

Most Blue Shield Medicare Advantage plan IPA/medical groups participate in the Blue Shield commercial HMO provider network. However, some contracted IPA/medical groups are strictly Blue Shield Medicare Advantage plan providers. The Blue Shield Medicare Advantage plan group plan offers more service area coverage than the Blue Shield Medicare Advantage plan individual plan; therefore, providers in some areas are only providing coverage to group members at this time.

The requirements for provider participation in the Blue Shield Medicare Advantage plan network are generally the same as those for the commercial HMO provider network. All first tier and downstream entity contracts must contain all CMS-required contract provisions.

Medicare Part D Prescriber Preclusion List

The Centers for Medicare & Medicaid Services (CMS) compiles 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 makes 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.

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.

6.1 Blue Shield Medicare Advantage Plan Program Overview

Blue Shield Medicare Advantage Plan 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 possess a compliance program through which the organization establishes and maintains compliance with all federal and state standards. Moreover, provisions in the Affordable Care Act (ACA) require that the compliance program be "effective" in preventing and correcting non-compliance with Medicare Program requirements and fraud, waste, and abuse.

The compliance program must include:

- Written policies, procedures, and standards of conduct
- Compliance Officer, Compliance Committee, and high level oversight
- Effective training and education
- Effective lines of communication
- Well publicized disciplinary actions
- Effective system for routine monitoring, auditing, and identification of compliance risks
- Procedures and system for prompt response to compliance issues

Blue Shield 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 our company values. Blue Shield's values 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.

Blue Shield Medicare Advantage Plan Compliance Program
(cont'd.)

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

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

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

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

Blue Shield Medicare Advantage Plan Compliance Program
(cont'd.)

CMS requirements, but also to improve the quality of care and service provided to our Medicare Advantage and Medicare Part D members. The overall compliance structure incorporates the Code of Conduct and the Compliance Program to promote ethical behavior, equal opportunity, and anonymity in reporting of any improprieties within the Medicare product or elsewhere within the organization.

Blue Shield has and enforces a strict non-retaliation policy for reporting actual or suspected legal, policy or Code violations, or any other misconduct, in good faith. Key compliance indicators or benchmarks, as well as concerns raised through internal and external monitoring activities, are reviewed by the Medicare Compliance Committee to help proactively identify potential issues and facilitate internal corrective actions or policy changes, as indicated. These elements of the Blue Shield Medicare Compliance Program provide examples of policies and programs that providers might wish to establish within their own organizations.

Auditing and Monitoring

Blue Shield has various departments, e.g., Provider Claims Compliance and Delegation Oversight, that audit first-tier entities for compliance with CMS Program requirements. However, IPAs and medical groups are tasked with the oversight and audit of the entities with which they contract to ensure compliance with Medicare Program requirements. Upon request, IPAs and medical groups 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) maintain sanction lists 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 lists 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, IPAs and medical groups must provide evidence that they are checking their employees, temporary workers, and Board of Directors against the excluded provider databases upon hire, contracting, or election to the Board, and monthly thereafter.

Blue Shield Medicare Advantage Plan Compliance Program
(cont'd.)

Fraud, Waste, and Abuse

The Medicare Prescription Drug benefit was implemented by 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 Contractors (MEDICs). In California, the MEDIC is Qlarant Integrity Solutions, LLC. Qlarant Integrity Solutions, LLC is responsible for monitoring 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 and Part 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 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 has been 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 Part D drug than their doctor ordered.

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 by fax at (410) 819-8698 or on their website at qlarant.com Reports may also be submitted anonymously directly to Blue Shield's Special Investigations Unit at (855) 296-9092 or the Medicare Compliance Department at (855) 296-9084. For information on Fraud Prevention, Special Investigations, and Provider Reporting, please refer to Section 1.1 of this manual.

6.1 Blue Shield Medicare Advantage Plan Program Overview

Blue Shield Medicare Advantage Plan Compliance Program
(cont'd.)

Medicare Compliance and Fraud, Waste, and Abuse Training Requirements

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

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 an 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. 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 accessed at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining.

Model of Care

In compliance with CMS requirements, Blue Shield has developed a specific model of care (MOC) to help address the complex health care needs of members enrolled in the dual eligible special needs plan (D-SNP). Blue Shield's MOC is a written document that describes Blue Shield's responsibilities, the IPA/medical group's responsibilities, and reporting requirements.

The program also includes training for Blue Shield's employees, Blue Shield's provider network, the IPA/medical group employees and downstream providers. The training can be face-to-face; interactive (e.g., web-based, audio/video conference), or self-study (e.g., printed materials, electronic media). A statement of attestation is required annually by all IPAs/medical groups contracted with Blue Shield for the D-SNP. The compliance statement of attestation indicates that the IPA/medical group, staff and downstream providers have completed the D-SNP training. To access the MOC training and complete your annual attestation, please go to https://www.blueshieldca.com/bsca/bsc/wcm/connect/sites/sites_content_en/bsp/providers/programs/snp-model-of-care.

6.2 Blue Shield Medicare Advantage Plan Benefits and Exclusions

Blue Shield Medicare Advantage Plan Benefits

Blue Shield Medicare Advantage individual and group plans provide all the inpatient and outpatient care covered by Medicare Parts A and B services, Medicare Part D prescription drug coverage, plus additional benefits not covered by Medicare, such as routine vision care. Blue Shield has submitted a formulary to the Centers for Medicare & Medicaid Services (CMS) for the Part D benefit.

Like other Blue Shield HMO plans, the Blue Shield Medicare Advantage individual and group plans emphasize health promotion and offer a health improvement program for Blue Shield Medicare Advantage plan members that includes health risk assessment, information and assistance services, health education, and a variety of wellness resources. Blue Shield Medicare Advantage plan individual and group members also have direct access to certain preventive services, including annual mammograms and influenza vaccinations.

Blue Shield Medicare Advantage plan benefits vary by service area. Blue Shield Medicare Advantage group plans include base level plans and benefits filed with CMS and include copay and co-insurance ranges, buy-ups/optional benefits, and services which allow for a wide range of flexibility to closely match an employer group/union's current active or other Medicare Advantage-Prescription Drug plan offering.

Blue Shield provides each IPA/medical group with a copy of the Summary of Benefits for Blue Shield Medicare Advantage plan individual members. Providers also may use the Blue Shield Medicare Advantage Automated Voice Eligibility and Benefit Information System (Fast Track) at (800) 442-6665 or may contact Blue Shield Medicare Advantage Member Services to confirm eligibility and benefits at (877) 654-6500 (for Providers), (800) 776-4466 (for Members) [TTY 711].

Blue Shield files benefits with CMS on an annual basis. The benefits for contract year 2022 are effective January 1, 2022 through December 31, 2022 for individual Blue Shield MA-PD and PDP plans only. A base level benefit plan is filed with CMS for group Blue Shield MA-PD and PDP plans. Custom benefit plans are then developed and built off the "base" plan filed with CMS. These custom benefit plans are effective for the entire group contract year which can run on a calendar basis (January 1, 2022 through December 31, 2022) or on an off-calendar basis (for example, July 1, 2021 through June 30, 2022).

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

Blue Shield Medicare Advantage Plan Benefits *(cont'd)*

Medication Therapy Management Program

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

- Have two of the following conditions:
  - Chronic Heart Failure (CHF)
  - Diabetes
  - Hypertension
  - Osteoporosis
  - Respiratory Disease
- 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.

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

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

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

Blue Shield Medicare Advantage Plan Benefits *(cont'd)*

Premiums and Copayments or Coinsurance

Medicare Premiums

All Blue Shield Medicare Advantage plan 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

For the 2022 contract year, some of the Blue Shield Medicare Advantage individual plans have a monthly plan premium. Please refer to the *Blue Shield Medicare Advantage Plan Individual Summary of Benefits* for additional plan premium information.

For the 2022 contract year, the monthly plan premium for Blue Shield Medicare Advantage 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 Advantage plan members must pay a copayment or coinsurance for certain services. Please refer to the *Blue Shield Medicare Advantage Plan 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 Advantage 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.

6.2 Blue Shield Medicare Advantage Plan Benefits and Exclusions

Blue Shield Medicare Advantage Plan Benefits *(cont'd.)*

Inpatient Benefits

Blue Shield Medicare Advantage 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 Advantage individual and group plans provide coverage according to Medicare guidelines, if the member's Blue Shield Medicare Advantage plan primary care physician (PCP) authorizes care at a Blue Shield Medicare Advantage plan hospital.

In addition to hospital care, Blue Shield Medicare Advantage plan 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 Advantage Plan Summary of Benefits* for the number of days covered for care provided by a skilled nursing facility.

Outpatient Benefits

Blue Shield Medicare Advantage 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 Advantage Plan Summary of Benefits* (sent separately to IPA/medical groups) for a list of covered outpatient services.

Outpatient Prescription Drugs

Blue Shield Medicare Advantage individual and group plans provide coverage for plan-approved generic and brand name prescription medications included in the Blue Shield Medicare Advantage Plan 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. The Blue Shield Medicare Advantage plan benefit for Outpatient Prescription Drug coverage can be found on Provider Connection at blueshieldca.com/provider under *Authorizations, Clinical policies and guidelines*, and then *Drug formularies & policies*. Some formulary medications may require prior authorization. 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 Pharmacy & Therapeutics (P&T) Committee makes 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 practicing 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.

Blue Shield Medicare Advantage Plan Benefits *(cont'd.)*

Outpatient Prescription Drugs *(cont'd.)*

In general, outpatient prescription drugs are covered under Blue Shield Medicare Advantage plan when they are:

- Included in the Blue Shield Medicare Advantage Plan 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.
- Filled at a Blue Shield Medicare Advantage plan 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*; and for cancer the *National Comprehensive Cancer Network, Clinical Pharmacology*, *Lexi-Drugs,* 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 Advantage plan individual or group drug formulary, the prescriber or member may contact Blue Shield Medicare Advantage Member Services to confirm the drug's coverage status.

If Member Services confirms that the drug is not part of the Blue Shield Medicare Advantage plan 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 Advantage plan individual or group drug formulary.

- The prescriber on behalf of the member can request that Blue Shield make a Formulary Exception (a type of Coverage Determination) to cover the specific drug.

Blue Shield Medicare Advantage Plan Benefits *(cont'd.)*

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

If a member recently joined Blue Shield and is taking a drug not listed in the Blue Shield Medicare Advantage Plan 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.

Transition Policy

New Blue Shield members may be taking drugs not listed in the Blue Shield Medicare Advantage plan 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 for one month (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 one month 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.

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 Advantage Plan Benefits *(cont'd.)*

Vision Services

Blue Shield Medicare Advantage individual and group plans cover vision services that meet Medicare guidelines.

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

Note: The IPA/medical group has no financial responsibility for these services.

Hearing Services

Blue Shield Medicare Advantage individual and group plans cover hearing exams in accordance to Medicare guidelines. Members should get a referral from their PCP to go to a Blue Shield Medicare Advantage plan provider. Please refer to the member's *Blue Shield Medicare Advantage Plan Summary of Benefits* for additional information. For select plans, hearing aid examinations and fittings are provided by EPIC Hearing Healthcare.

Optional Buy-Up Services (Group Members Only)

Blue Shield Medicare Advantage plan also offers optional buy-up benefits for hearing, 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 Advantage plan GMAPD members within that employer group/union**.** (There are also optional buy-up dental plans being offered to Blue Shield Medicare Advantage individual plan members.)

Note: The IPA/medical group has no financial responsibility for these services.

6.2 Blue Shield Medicare Advantage Plan Benefits and Exclusions

National Medicare Coverage Determinations

For Blue Shield Medicare HMO and PPO Members, Blue Shield follows Medicare national and local coverage determination. For Blue Shield Medicare PPO Plans, Blue Shield Medication Policies and Step Therapy requirements may also apply for select medications.

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

Exclusions to Blue Shield Medicare Advantage Plan 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 Advantage plan, effective January 1, 2022:

- 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.

  Note: This determination is to be based on current National (NCD) or Local Coverage Determinations (LCD). National guidelines from a recognized specialty society or governmental body or health plan policy can be applied if the member's individual circumstances are supported by literature referenced in the guidelines or policy. National guidelines from a recognized specialty society or governmental body or health plan policy are appropriately used to support a medically appropriate decision if the member's individual circumstances are consistent with the literature cited in the guidelines or policy.
- 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 Advantage plan in which the member is enrolled.

Exclusions to Blue Shield Medicare Advantage Plan Benefits
(cont'd.)

General Benefit Exclusions *(cont'd.)*

- Unless the member has enrolled in the optional supplemental dental HMO or PPO benefit, routine dental care, such as cleanings, fillings or dentures, unless specifically indicated as covered by the Blue Shield Medicare Advantage 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 Advantage 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 Advantage 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 Advantage 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 Advantage 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.

Exclusions to Blue Shield Medicare Advantage Plan 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 Advantage plan prescription drug benefits:

- Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- 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*, and 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) unless offered as supplemental coverage as specified by your plan
  - Drugs that are prescribed for medically accepted indications approved by the FDA other than sexual or erectile dysfunction (such as pulmonary hypertension) are eligible for Part D coverage. However, ED drugs will not meet the definition of a Part D drug when used off-label, even when the off-label use is listed in one of the compendia found in section 1927(g)(1)(B)(i) of the Act: American Hospital Formulary Service Drug Information and DRUGDEX® Information System
  - 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

6.2 Blue Shield Medicare Advantage Plan Benefits and Exclusions

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6.3 Blue Shield Medicare Advantage Plan Enrollment and Eligibility

Blue Shield Medicare Advantage Plan Eligibility Criteria

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

In general, an individual is eligible to elect a Medicare Advantage Prescription Drug (MA-PD) plan when each of the following requirements is met:

1. The individual is entitled to Medicare Part A and enrolled in Part B, provided that he or she will be entitled to receive services under Medicare Part A and Part B as of the effective date of coverage under the plan.
2. The individual has not been medically determined to have ESRD prior to completing the enrollment request.
3. The individual or his or her legal representative complete an enrollment request form and includes all the information required to process the enrollment or meets alternative conditions for enrollment specified by CMS.
4. The individual is fully informed of and agrees to abide by the rules of the MA-PD organization that were provided during the enrollment request.
5. The individual makes a valid enrollment request that is received by the plan during an election period.
6. The individual permanently resides in the service area of the MA-PD plan (Individual or Group).
7. An individual who is living abroad or is incarcerated is not eligible for Part D as he or she cannot meet the requirement of permanently residing in the service area of a Part D plan.
8. The individual cannot be concurrently enrolled in Blue Shield Medicare Advantage plan and a PDP plan at the same time, nor can the individual be enrolled in Blue Shield Medicare Advantage plan and another MA plan at the same time.

In addition to the above, the following applies to Group retirees:

9. The individual is a retiree from an employer group/union and meets the group's definition of an "eligible" retiree.
10. The individual must not be actively working.

All Blue Shield Medicare Advantage plan individual or group plan changes (except primary care physician (PCP) change requests) affecting the enrollment of members must be submitted by the member to Blue Shield and approved by the Centers for Medicare & Medicaid Services (CMS) before Blue Shield will process the change. Blue Shield follows Medicare guidelines and adjusts Blue Shield Medicare Advantage plan individual and group member eligibility consistent with CMS reporting.

Member eligibility may be verified using many different resources. Blue Shield Medicare Advantage plan encourages providers to use the steps detailed in this section to expedite this process.

6.3 Blue Shield Medicare Advantage Plan Enrollment and Eligibility

Lock-In Election Rules

The rules for when and how often Medicare Advantage (MA) members can switch Medicare health plans were changed by Congress in an effort to help MA Plans manage health care costs and payments and plan for the members' care. The Centers for Medicare & Medicaid Services (CMS) refers to these rules as "Lock-in."

A Medicare beneficiary may make one change during the Annual Election Period (AEP), which is October 15 through December 7 of every year. In addition, during the MA OEP, MA plan enrollees may enroll in another MA plan or disenroll from their MA plan and return to Original Medicare. Individuals may make only one election during the MA OEP. For Group Medicare members, Blue Shield advises them to first follow their former employer group/union's open enrollment period for making any enrollment changes. With a few exceptions, a Medicare beneficiary cannot enroll in or disenroll from an MA plan, or return to Original Medicare, at any other time of the year. Refer to Chapter 2-Medicare Advantage Enrollment & Disenrollment of the *CMS Medicare Managed Care Manual* (Pub. 100-16), located at cms.hhs.gov/manuals.

In order for a Medicare Advantage organization to accept an election, the individual must make the enrollment request during an election period. An enrollment period is the time during which an eligible individual may elect an MA plan or Original Medicare. The type of enrollment period determines the effective date of MA coverage. Following are the types of election periods during which individuals may make enrollments. Group plan members must follow the open enrollment dates established by their former employer group/union, unless they are aging-in to Medicare or otherwise fall under a Special Election Period (SEP).

- The Annual Election Period (AEP);
- The Initial Coverage Election Period (ICEP);
- The Initial Enrollment Period for Part D (IEP for Part D);
- The Open Enrollment Period for Institutionalized Individuals (OEPI);
- All Special Election Periods (SEP); and
- The Medicare Advantage Open Enrollment Period (MA OEP).

Unless a CMS-approved capacity limit applies, all MA organizations must accept requests to enroll in their MA plans (with the exception of Medicare MSA plans) during the AEP, an ICEP, an IEP for Part D (MA-PD plans only), and any SEP that allows enrollment into the specific plan. When an MA plan is closed due to a capacity limit, the MA plan must remain closed to all prospective enrollees (with the exception of reserved vacancies) until the limit is lifted.

Enrollment Periods

Annual Election Period (AEP)

During the AEP, MA eligible individuals may enroll in or disenroll from an MA plan. The last enrollment request made, determined by the application date, will be the enrollment request that takes effect.

The AEP is referred to as the "Fall Open Enrollment" season and the "Open Enrollment Period for Medicare Advantage AND Medicare prescription drug coverage" in Medicare beneficiary publications and other tools and runs October 15 through December 7 of every year.

An employer group/union sponsored Medicare Advantage (MA) plan may have an "open enrollment" as determined by the employer group/union. This may or may not correspond with the MA annual election period. Therefore, organizations are not required to accept enrollment requests into employer group/union plans during the AEP (unless the AEP and open season occur simultaneously); however, organizations must accept valid requests for disenrollment.

Initial Coverage Election Period (ICEP)

The ICEP refers to the period beginning three months immediately before an individual's first entitlement to both Medicare Parts A and B and ends on the later of:

- The last day of the month preceding entitlement to both Part A and Part B; or
- The last day of the individual's Part B initial enrollment period. The initial enrollment period for Part B is the 7-month period that begins 3 months before the month an individual meets the Part B eligibility requirements and ends 3 months after the month of eligibility.

Once an ICEP enrollment request is made and enrollment takes effect, the ICEP enrollment has been used.

Initial Enrollment Period for Part D (IEP for Part D)

The IEP for Part D is the period during which an individual is first eligible to enroll in a Part D plan. In general, an individual is eligible to enroll in a Part D plan when he/she is entitled to Part A OR enrolled in Part B, AND permanently resides in the service area of a Part D plan.

Generally, individuals will have an IEP for Part D that is the same period as the Initial Enrollment Period for Medicare Part B, which is the 7-month period that begins three months before the month an individual meets the eligibility requirements for Part B and ends three months after the month of eligibility.

Individuals not eligible to enroll in a Part D plan at any time during their initial enrollment period for Medicare Part B have an IEP for Part D that is three months before becoming eligible for Part D, the month of eligibility, and the three months following eligibility for Part D.

Individuals eligible for Medicare prior to age 65 (such as for disability) will have another IEP for Part D based upon attaining age 65.

Enrollment Periods *(cont'd.)*

Open Enrollment Period for Institutionalized Individuals (OEPI)

The OEPI is continuous for eligible individuals. For purposes of enrollment under the OEPI election period, an institutionalized individual is defined as an individual who moves into, resides in, or moves out of a:

- Skilled nursing facility (SNF) as defined in §1819 of the Act (Medicare);
- Nursing facility (NF) as defined in §1919 of the Act (Medicaid);
- Intermediate care facility for the mentally retarded (ICF/MR) as defined in §1905(d) of the Act;
- Psychiatric hospital or unit as defined in §1861(f) of the Act;
- Rehabilitation hospital or unit as defined in §1886(d)(1)(B) of the Act;
- Long-term care hospital as defined in §1886(d)(1)(B) of the Act; or
- Hospital which has an agreement under §1883 of the Act (a swing-bed hospital).

The OEPI ends two months after the month the individual moves out of the institution.

Special Election Periods (SEP)

Special election periods (SEPs) constitute periods outside of the usual IEP, AEP or MADP when an individual may elect a plan or change his or her current election. There are various types of SEPs, including SEPs for dual eligibles and for individuals whose current plan terminates, who change residence, and who meet "exceptional conditions" as CMS may provide. Depending on the nature of the particular SEP, an individual may:

- Discontinue an enrollment in an MA plan and enroll in Original Medicare
- Switch from Original Medicare to an MA plan
- Switch from one MA plan to another MA plan

It is generally the responsibility of Blue Shield to determine whether an individual is eligible for an SEP. The exception to this requirement would be enrollment and disenrollment requests completed or approved by CMS staff. To make this determination, the organization may need to contact the individual directly.

For specific details on each type of SEP, refer to Chapter 2 - Medicare Advantage Enrollment and Disenrollment of the *CMS Medicare Managed Care Manual*.

Enrollment Periods *(cont'd.)*

Medicare Advantage Open Enrollment Period (MA OEP)

During the MA OEP, MA plan enrollees may enroll in another MA plan or disenroll from their MA plan and return to Original Medicare. Individuals may make only one election during the MA OEP.

This chart outlines who can use the MA OEP and when:

Who can use the MA OEP:	**MA OEP occurs:**
Individuals enrolled in MA plans as of January 1	January 1 – March 31
New Medicare beneficiaries who are enrolled in an MA plan during their ICEP	The month of entitlement to Part A and Part B – the last day of the 3rd month of entitlement

Individuals may add or drop Part D coverage during the MA OEP. Individuals enrolled in either MA-PD or MA-only plans can switch to:

- MA-PD
- MA-only
- Original Medicare (with or without a stand-alone Part D plan)

The effective date for an MA OEP election is the first of the month following receipt of the enrollment request.

The MA OEP does not provide an opportunity for an individual enrolled in Original Medicare to join a MA plan. It also does not allow for Part D changes for individuals enrolled in Original Medicare, including those enrolled in stand-alone Part D plans. The MA OEP is not available for those enrolled in Medicare Savings Accounts or other Medicare health plan types (such as cost plans or PACE).

6.3 Blue Shield Medicare Advantage Plan Enrollment and Eligibility

Effective Date of Coverage

With the exception of some SEPs and when election periods overlap, generally beneficiaries may not request their enrollment effective date. The effective date is generally not prior to the receipt of a complete enrollment request by Blue Shield. An enrollment cannot be effective prior to the date the beneficiary or their legal representative signed the enrollment form or completed the enrollment request. To determine the proper effective date for individual members, Blue Shield must determine which election period applies to each individual before the enrollment may be transmitted to CMS. The election period may be determined by reviewing information such as the individual's date of birth, Medicare card, a letter from SSA, or by the date the completed enrollment request is received by the MA organization. Once the election period is identified by Blue Shield, Blue Shield must determine the effective date.

The effective date of group MA-PD plan coverage (coverage for Medicare-eligible group retirees) is based on the specific plan contract renewal date of the employer group/union. For example, most groups renew their plan contract for an effective date of January 1; however other groups may renew their plan contracts at other times during the year. For each employer group/union, the plan contract date will be different. As such, group members must follow the open enrollment period established by their former employer group/union when making plan changes unless they are aging-in to Medicare or, for another reason, fall under the exception of special circumstance. In these instances, the effective date of coverage would be based on the special circumstance and would be the first of the month following the completed enrollment request. Effective dates are as follows:

Election Period	Effective Date of Coverage	Are MA organizations obligated to accept enrollment elections in this election period?
Annual Election Period (AEP)	January 1 of the following year.	Yes, unless capacity limit applies.
Initial Coverage Election Period (ICEP) and Initial Enrollment Period (IEP) for Part D	First day of the month of entitlement to Medicare Part A and Part B. – or – The first of the month following the month the enrollment request was made if after entitlement has occurred.	Yes, unless capacity limit applies. IEP for Part D is applicable only to MA-PD enrollment requests.
Open Enrollment Period for Institutionalized Individuals (OEPI)	First day of the month after the month the MA organization receives an enrollment request.	No. The MA organization can choose to be "open" or "closed" to accept enrollments during this period.
Special Election Periods (SEP)	Varies (refer to Chapter 2 - Medicare Advantage Enrollment & Disenrollment of the Medicare Managed Care Manual (Pub. 100-16), as outlined in §30.4).	Yes, unless capacity limit applies.
Medicare Advantage Open Period (MA OEP)	Individuals enrolled in MA plans as of January 1 (MA OEP January 1 – March 31)	Yes, unless capacity limit applies.
Employer Group/Union Open Enrollment Period	Based on the employer group/union contract renewal.	Yes.

Monthly Eligibility Reports

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

Blue Shield sends these eligibility reports via Blue Shield secure email or SFTP to all IPA/medical groups no later than the 10th calendar day of each month. For details on the file formats, refer to Appendix 3 in the back of this manual. The *Blue Shield Medicare Advantage Plan Product ID and Physician Office Copayment Guide* is also forwarded to IPA/medical groups each month.

Both electronic files include the member's name and ID, the member's PCP's name and ID, as well as the transaction code for all member status changes. The files also include the member's group number and Product ID, which identifies member's standard office visit copayments.

6.3 Blue Shield Medicare Advantage Plan Enrollment and Eligibility

Blue Shield Medicare Advantage Coordination of Benefits (COB)

When an individual enrolls with Blue Shield Medicare Advantage Individual or Group Plan, Blue Shield will ask the member whether he or she has healthcare insurance other than Blue Shield Medicare Advantage plan. If so, this information will appear on the IPA/medical group eligibility list. IPA/medical groups should always inquire whether a member has other health insurance coverage. For those members who are over 65 years of age and retired, Blue Shield Medicare Advantage plan will generally be the primary payor.

When Blue Shield Medicare Advantage plan is the primary payor, the IPA/medical group may bill the secondary carrier for usual and customary fees and receive compensation in addition to that received from Blue Shield Medicare Advantage plan.

Note: Under no circumstances may a member be billed for any balance due.

Blue Shield Medicare Advantage plan will be the secondary payor in the following situations:

1. The member is age 65 or older and has coverage under an employer group health plan through an employer with 20 or more employees, either through the member's own employment or the enrollee's spouse's employment.
2. The member is under age 65 and is entitled to Medicare due to disability other than ESRD, and the member has coverage under a large employer (100 or more employees) group health plan, either through the enrollee's own employment or the enrollee's spouse's employment.
3. The member is being treated for an accident or illness that is work-related or otherwise covered under Workers' Compensation.
4. The member has ESRD and an employer group health plan. Blue Shield Medicare Advantage plan will be secondary for up to 30 months; Medicare will be the primary payor after 30 months.
5. The member is being treated for an injury, ailment, or disease caused by a third party and automobile or other liability insurance is available.

Questions regarding the Blue Shield Medicare Advantage plan COB can be directed to the Blue Shield Medicare Advantage Member Services Department at (800) 776-4466 (for Members) or (800) 541-6652 (for Providers) [TTY 711].

IPA/Medical Group Responsibilities

Access to Medical Services

Centers for Medicare & Medicaid Services (CMS) regulations require that Blue Shield Medicare Advantage plan members be able to obtain the following services without getting prior approval from their primary care physician (PCP) or IPA/medical group:

- Routine women's health care, which includes breast exams, screening mammograms, Pap tests, and pelvic exams (as long as members get them from a network provider)
- Flu shots, Hepatitis B vaccinations, and pneumonia vaccinations (as long as members get them from a network provider)
- Emergency services from network providers or from out-of-network providers
- Urgently needed care from in-network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible (i.e., when the member is temporarily outside of the plan's service area)
- Kidney dialysis services at a Medicare-certified dialysis facility when the member is temporarily outside the plan's service area

The IPA/medical group must at all times furnish current names, addresses, and telephone numbers of specialists, clinics, or centers that provide services referenced above to facilitate an accurate Blue Shield listing of such providers in the provider directory and on Blue Shield's website at https://www.blueshieldca.com/fap/app/find-a-doctor.html thereby enabling access for members.

Note: The IPA/medical group is required to comply with any regulatory updates pertaining to access to care and services. For example, if direct access requirements change, the IPA/medical group must provide such required direct access.

IPA/Medical Group Responsibilities *(cont'd.)*

Provider Requests to Transfer or Disenroll Blue Shield Medicare Advantage Plan Members

Blue Shield has established procedures, based on 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.

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 the Blue Shield Medicare Advantage plan's 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, the 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.

- 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 disenrollment, 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 Member Services staff can assist by contacting the member in such a circumstance. Since such litigation demonstrates a breakdown in the patient/physician relationship, Member Services can verify if the member wishes to voluntarily transfer to a new 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.

IPA/Medical Group Responsibilities *(cont'd.)*

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

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 courier service to track that the warning letter was received (a copy of the letter must also be sent to Blue Shield Medicare Advantage Member Services Department). If the behavior or problem continues, the provider may request Blue Shield to take steps to counsel the member and initiate the protocols required for the plan to involuntarily transfer the member to another provider or physician group.

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

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

The physician's or physician group's request for involuntary transfer or disruptive behavior must be complete. All documentation should be submitted to Blue Shield Medicare Advantage Member Services.

IPA/Medical Group Responsibilities *(cont'd.)*

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

Procedure *(cont'd.)*

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

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

- Send additional counseling letters to the member (CMS requires the plan to send an official warning letter for 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 individual's care. *(Note: If the disruptive behavior ceases after the member receives notice and then later resumes, the involuntary disenrollment process must begin again.)*

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

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

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

Blue Shield sends the provider a written notice of its decision. Please note that CMS considers counseling done by the PCP or physician group for Blue Shield 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 Member Services department. The transfer notification letter informs the member of the request made by the PCP and that the member can select another PCP in the same IPA/medical group or (if warranted) in another IPA/medical group. The letter clearly outlines the reasons why the request is being made and informs the member that if they do not select a new PCP within 30 days of the date the letter was mailed, a new PCP will be selected for them.

IPA/Medical Group Responsibilities *(cont'd.)*

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

Procedure *(cont'd.)*

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.

- 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.

IPA/Medical Group Responsibilities *(cont'd.)*

Exclusion of Providers from the Network

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. These sanction lists identify those individuals found guilty of fraudulent billing, misrepresentation of credentials, etc. The Medicare Advantage (MA) organizations employing or contracting with health providers have a responsibility to check the sanction list with each new issuance of the list, as they are prohibited from hiring, continuing to employ, or contracting with individuals named on that list. Below are links to the List of Excluded Individuals and Entities (LEIE), which can also be downloaded, and the Excluded Parties List System (EPLS). Simply enter the name of an individual or entity and determine whether they are currently excluded.

- https://www.oig.hhs.gov/exclusions/exclusions_list.asp
- https://sam.gov/content/home

CMS requires that all entities review the list for all employees and at least once a year thereafter to ensure that its employees, board members, officers, and first tier entities, downstream entities, or related entities that assist in the administration or delivery or Part D benefits are not included on such lists. If the Sponsor's employees, board members, officers, managers or first tier entities, downstream entities, or related entities are on such lists, the Sponsor's policies shall require the immediate removal of such employees, board members, or 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.

Federal regulations prohibit Blue Shield Medicare Advantage plan from paying capitation to, or including in its provider network, any provider that has entered into a private contract with a member for the provision of covered services. The exclusion of such a provider is to be for a period of two years, beginning at the time that any direct contracts between the provider and member were entered into. Because such providers must be excluded from the network, Blue Shield will reduce the IPA/medical group's capitation fees by the amount of any reimbursement that was paid either directly or indirectly to such providers.

If, according to CMS, a provider is excluded from participating in Medicare, then the IPA/medical group is prohibited from employing or contracting with that provider for the provision of healthcare services, utilization review services, medical social work services and administrative services for Blue Shield Medicare Advantage plan and its members. In the event the IPA/medical group fails to comply with this prohibition, Blue Shield reserves the right to impose upon the IPA/medical group any sanctions that CMS may impose upon Blue Shield for violation of this prohibition.

(Reference: Code of Federal Regulations, 42 CFR 422.220 and 42 CFR 422.752)

IPA/Medical Group Responsibilities *(cont'd.)*

Exclusions from Medicare and Limitations on Medicare Payment

According to the Code of Federal Regulations, 42 CFR 411.12, charges imposed by an immediate relative or member of the beneficiary's household are excluded from coverage. The regulations are outlined below:

(a) Basic rule. Medicare does not pay for services usually covered under Medicare if the charges for those services are imposed by:

(1) An immediate relative of the beneficiary; or

(2) A member of the beneficiary's household

(b) Definitions. As used in this section "Immediate relative" means any of the following:

(1) Husband or wife

(2) Natural or adoptive parent, child, or sibling

(3) Stepparent, stepchild, stepbrother, or stepsister

(4) Father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law

(5) Grandparent or grandchild

(6) Spouse of grandparent or grandchild

Member of the household means any person sharing a common abode as part of a single-family unit, including domestic employees and others who live together as part of a family unit, but not including a mere roomer or boarder.

Professional corporation means a corporation that is completely owned by one or more physicians and is operated for the purpose of conducting the practice of medicine, osteopathy dentistry, podiatry, optometry, or chiropractic, or is owned by other health care professionals as authorized by state law.

(c) Applicability of the exclusion. The exclusion applies to the following charges in the specified circumstances:

(1) Physicians' services.

(i) Charges for physicians' services furnished by an immediate relative of the beneficiary or member of the beneficiary's household, even if the bill or claim is submitted by another individual or by an entity such as a partnership or a professional corporation.

(ii) Charges for services furnished incident to a physician's professional services (for example by the physician's nurse or technician), only if the physician who ordered or supervised the services has an excluded relationship to the beneficiary.

(2) Services other than physicians' services.

(i) Charges imposed by an individually owned provider or supplier if the owner has an excluded relationship to the beneficiary; and

(ii) Charges imposed by a partnership if any of the partners has an excluded relationship to the beneficiary.

(d) Exception to the exclusion. The exclusion does not apply to charges imposed by a corporation other than a professional corporation.

IPA/Medical Group Responsibilities *(cont'd.)*

Continuation of Benefits

Per CMS regulations, for continuity of care purposes and for a limited amount of time (as determined on a case-by-case basis), the IPA/medical group and its physician members must continue to provide benefits to members in the event Blue Shield becomes insolvent or terminates the contract. Benefits must continue through the period for which capitation has been paid or until the discharge from an inpatient facility, whichever time is longer.

Transition of Care / Financial Responsibility Upon Enrollment / Disenrollment

1. Prospective Payment System (PPS) Participating Hospitals

a. Members hospitalized prior to their effective date with Blue Shield Medicare Advantage plan

- If a member is an inpatient in a PPS participating facility on his or her effective date of enrollment in Blue Shield Medicare Advantage plan, Blue Shield is not required to provide nor assume responsibility to pay for any inpatient services covered under Medicare Part A during the inpatient stay. Part B or physician services become an IPA/primary care physician responsibility as of the member's effective date with Blue Shield Medicare Advantage plan.

- Under the above circumstances Blue Shield Medicare Advantage plan network providers will assume responsibility for inpatient hospital services under Part A on the day after the date of discharge from the inpatient stay. Discharge to a skilled nursing facility is considered as an inpatient hospital discharge.

  Caution: Under the above rules, CMS has viewed a "transfer to an in-plan hospital" as a discharge in the past. This makes the Health Plan liable for the admission from the date of the transfer and Medicare pays the "transfer payment" to the facility to which the member was an inpatient at the time of admission.

b. Coverage Terminates While Blue Shield Medicare Advantage plan Member is Hospitalized

- If Blue Shield Medicare Advantage plan coverage terminates while the member is hospitalized, regardless of the reason for the termination, and the admission was authorized by the member's IPA/PCP, Blue Shield's liability for inpatient hospital services will continue until the member is discharged. Blue Shield's responsibility for coverage or payment of Part B/physician services ends as of the member's effective date of disenrollment.

  (Reference: Code of Federal Regulations, 42 CFR 422.318)

IPA/Medical Group Responsibilities *(cont'd.)*

Transition of Care / Financial Responsibility Upon Enrollment / Disenrollment *(cont'd.)*

2. Non-Prospective Payment System (PPS) Hospitals

In cases where the member is in a non-PPS hospital or unit, Skilled Nursing Facility (SNF), Home Health Agency (HHA), etc., Blue Shield is responsible for payment of services on and after the day of enrollment up through the day disenrollment is effective.

To determine if a facility is subject to or excluded from the prospective payment system, refer to the Code of Federal Regulations §412 Subpart B – Hospital Services Subject to and Excluded From the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs.

(References: Code of Federal Regulations §422.268 Source of payment and effect of election of the MA plan election on payment; §422.318 Special rules for coverage that begins or ends during an inpatient hospital stay; Code of Federal Regulations Part 412—Prospective Payment Systems for Inpatient Hospital Services; and Medicare Intermediary Manual, Section 3654.2 Patient is a Member of HMO for Only Part of Billing Period).

Refer to Section 4.1 Network Administration – Provider Status Changes for more information.

Member Billing

At no time may a provider bill a Blue Shield Medicare Advantage plan member in connection with covered services, except for plan cost-sharing amounts. Such billing is in violation of CMS federal regulations. Should a member be billed for covered services that are the responsibility of the IPA/medical group, Blue Shield will notify the IPA/medical group.

If a Blue Shield Medicare Advantage plan member contacts Member Services about a bill received, Blue Shield will instruct the member to mail the claim directly to us. Blue Shield Medicare Advantage plan will review the claims and fax the claims to the IPA/medical group, with instructions to respond to Blue Shield within 2 weeks. If the IPA/medical group does not respond within that time period, or if the response is invalid, an appropriate payment will be made by Blue Shield to the provider of the services and that amount may be deducted from the IPA/medical group's capitation. Any overpayment created as a result of the IPA/medical group's subsequent payment to the provider will be the IPA/medical group's responsibility to collect. It is not necessary that the claim be paid by the IPA/medical group within the 2-week period described above, unless the member's account has been sent to collections; but the response indicating the date that the claim will be paid or written-off must be returned to Blue Shield within that time.

Once notified by Blue Shield that the assigned member is being billed for a service that is the IPA/medical group's financial responsibility, the IPA/medical groups must take whatever steps are necessary to prevent the member from receiving further bills for a covered service. If the provider billing the member is capitated by the IPA/medical group for the services being billed, the IPA/medical group must contact that provider and ensure that the account balance is fully written-off and that the member is not billed again. If the member receives a second bill from a provider that the IPA/medical group has told Blue Shield is capitated, Blue Shield will pay the claim and that amount thus paid may be deducted from the IPA/medical group's capitation.

IPA/Medical Group Responsibilities *(cont'd.)*

Hospice Billing

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

Covered Services

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

(1) Hospice services covered under the Medicare hospice benefit if billed by a Medicare hospice;

(2) Services of the enrollee's attending physician if the physician is not employed by or under contract to the enrollee's hospice;

(3) Services not related to the treatment of the terminal condition while the beneficiary has elected hospice; or

(4) Services furnished after the revocation or expiration of the enrollee's hospice election until the full monthly capitation payments begin again. Monthly capitation payments will begin on the first day of the month after the beneficiary has revoked their hospice election.

Billing of Covered Services

Medicare hospices will bill the 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 bills 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, effective April 2002, 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.

IPA/Medical Group Responsibilities *(cont'd.)*

Hospice Billing *(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 was revoked.

Timely Filing

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

Physician Billing Instructions For Non-Hospice Services

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

1. Services are 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 (i.e., 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 GW modifier and should denote that the treatment is not for the CHF condition, which is coded as covered under hospice.

Resources: *Medicare Hospice 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.

IPA/Medical Group Responsibilities *(cont'd.)*

Subcontracting Requirements

Providers that subcontract with IPA/medical groups for the treatment of Blue Shield Medicare Advantage plan members are subject to additional requirements, as outlined in the Medicare Advantage (MA) Provider Contracting Guidelines found in Appendix 6 of this manual.

Division of Financial Responsibility

Depending on Blue Shield Medicare Advantage plan contract, the IPA/medical group will be financially responsible for certain medical/pharmacy services. The Division of Financial Responsibility (DOFR) in the Blue Shield contract outlines who is financially responsible for specific services.

Note: It is not possible to list all medical/pharmacy services that may be provided to members. Financial responsibility for medical/pharmacy services not listed in the DOFR found in the Blue Shield contract shall follow Medicare guidelines for all product lines. Accordingly, medical/pharmacy services covered under Medicare Part A are the Capitated Hospital or Shared Savings financial responsibility and medical/pharmacy services covered under Medicare Part B are the group's financial responsibility.

Once a member formally elects Hospice status through CMS, financial responsibility for Hospice services will revert to CMS.

IPA/Medical Group Reimbursement

CMS pays managed care organizations based upon a risk-adjustment methodology. Risk adjustments are member-specific and are based upon diagnosis data submitted to CMS by Blue Shield Medicare Advantage plan for dates of services occurring in the prior period. CMS adjusts this date range in an attempt to reflect a most accurate measurement of the members' current health status. Inpatient hospital, physician, and outpatient encounter data is utilized to determine the risk adjustment calculation.

Because IPA/medical group capitation payments are based on a percentage of CMS revenue, Blue Shield passes a portion of the CMS revenue on to the IPA/medical group, in accordance with the terms and conditions of their contract, to pay for services designated as the IPA/medical group responsibility.

Note: It is imperative that IPA/medical groups send Blue Shield all encounter data for capitated Blue Shield Medicare Advantage plan members. If Blue Shield is unable to forward to CMS a comprehensive reporting of the utilization, it is very likely that the CMS reimbursement will be significantly reduced, resulting in reduced capitation payment.

Blue Shield Medicare Advantage Plan Claims Administration

Refer to Appendix 4-A: Claims, Compliance Program, IT System Security, and Oversight Monitoring in this manual for information and requirements regarding the IPA/medical group's responsibility in claims payment. It describes Blue Shield's auditing and monitoring role and outlines the IPA/medical group's performance for complying with CMS requirements, including timeliness and best practices.

Medicare Regulations and Payment to Non-Contracted Providers

Any provider who is not contracted with Blue Shield and approved or certified to participate in the Medicare program must accept as payment in full the Medicare fee schedule rate if they agree to see a Blue Shield Member. They are further obligated to see patients in the case of a medical emergency.

Providers who have been sanctioned by Medicare or who have opted out of the Medicare program are not eligible to see Blue Shield members. (Again, an exception would be if they are an emergency room physician on staff and emergency stabilization care is needed).

Blue Shield or delegated providers would be able to access the Medicare fee schedules if a specialty referral or some other situation occurs with a non-contracted provider according to the regulations.

Federal regulations address the amount which MAO's must pay a non-contracting supplier of services. Section 4001 of the BBA added Social Security Act Section 1852k (42 USC § 1395w-22(k)), which states:

> *A physician or other entity …that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a Medicare Advantage organization…shall accept as payment in full for covered services under this title that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled…*

This provision was implemented by Federal Regulation 42 CFR § 422.214 *Special Rules for Services Furnished by Non-Contract Providers*.

The preamble to the regulatory provision states, in relevant part, as follows:

> *Special Rules for Services Provided by Non-Contract Providers*
>
> *Consistent with Section 1852(k) and Section 4002(e), the regulations in § 422.214 require any healthcare provider that does not have a contract establishing payment amounts for services furnished to a beneficiary enrolled in an MA coordinated care plan to accept as payment in full, the amounts that could have been collected if the beneficiary were enrolled in original Medicare. An MA organization (other than an MA MSA plan) satisfies its liability for Medicare covered services if the provider receives the total amount that would have been received if the beneficiary were enrolled in original Medicare. This amount equals the total of Medicare's payment (including any applicable deductible and coinsurance amounts) and any balance billing amount that would have been allowed by original Medicare. In the case of a participating physician or supplier, this amount would equal the Medicare fee schedule amount for the service…Of these amounts, the provider could collect from the MA plan enrollee the cost sharing amount required under the MA plan, approved by MCFA…and the remainder from the MA organization.* (63 FR 34968-01, 35002; June 26, 1998) (emphasis added.)

Blue Shield Medicare Advantage Plan Claims Administration *(cont'd.)*

Medicare Regulations and Payment to Non-Contracted Providers *(cont'd.)*

In addition, SSA Section 1852(a)(2)(A) (42 USC § 1395w-22(a)(2) states that a MA Plan satisfies its obligations with respect to services beneficiaries obtain from non-contracting suppliers:

> *If the plan provides payment in an amount so that – (i) the sum of such payment amount and any cost sharing provided for under the plan, is equal to at least (ii) the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B of [Medicare] including any balance permitted under such parts.*

CMS supports this position of payment of non-contracted physicians, hospitals, and other providers according to the Medicare fee schedule and prohibit a non-contracted Medicare provider from balance billing a member for services in excess of the Medicare allowable amount, except for the applicable copayment, coinsurance, or if the service is considered to be a non-covered item. In the case of a contracted provider, the contract terms that are in place with the provider would prevail and they would be obligated to accept the contract terms, except for the applicable copayment, coinsurance, or if the service is non-covered.

Blue Shield notifies all non-contracted Medicare providers that they have been paid at the Medicare allowable charges, and if that provider continues to balance bill the member, Blue Shield will take the following steps:

- Notify the member that the claim has been paid in full according to Medicare allowable charges and that no payment is due from the member.
- Similarly advise the provider.
- Advise the member and provider that if there is additional balance billing or attempts to collect the funds, the case will be forwarded to CMS for action against the provider.

Professional Stop-Loss Requirements for Blue Shield Medicare Advantage Plan Members

For Blue Shield Medicare Advantage plan members, CMS Physician Incentive Plan requirements mandate specific stop-loss coverage requirements for providers who are placed at substantial financial risk. The definition of substantial financial risk includes but is not limited to the passing of risk through capitation payments. Annual reporting and compliance with CMS regulations is required. Non-reporting may result in Blue Shield procuring stop-loss coverage on your behalf to comply with federal law and deducting the cost of the stop-loss coverage from capitation.

Blue Shield Medicare Advantage Plan Medical Care Solutions Program

Refer to Section 2.8 for a list of all Medical Care Solutions benefit programs.

Health Risk Assessment

A Health Risk Assessment Survey is mailed to all new Blue Medicare Advantage plan members. This survey is designed to identify members who may be among the frail elderly, who require reminders for preventive health services, who may require assistance with activities of daily living, and those with certain chronic diseases. Those whose results show five or more identified risks are forwarded to IPA/medical group Medical Directors on a quarterly basis for dissemination to these members' primary care physicians and/or IPA/medical groups' case management programs. For Dual Special Needs Plan members, the Health Risk Assessment results are sent to the IPA/medical group and primary care providers with each completed Health Risk Assessment.

Individualized Care Plan for Dual Eligible Special Needs Plan (D-SNP Members)

Based on member-specific responses to the Health Risk Assessment, Blue Shield creates an Individualized Care Plan (ICP), which is stratified, that includes an itemized list of identified problems, interventions, and goals. The ICP is shared with the member or member's caregiver, the member's PCP, and the medical group. At least annually, and sooner if a member's health status changes, Blue Shield will review and revise, as applicable, the ICP.

The medical group must utilize the ICP to manage the member's care in coordination with pertinent providers and the interdisciplinary care team to provide coordinated care and services proportionate to the member's needs and stratification level, which include care coordination, basic case management, and collaboration with Blue Shield. Care records must be maintained and coordinated among the providers to ensure access in accordance with HIPAA and professional standards.

The member and/or member's caregiver should be involved, whenever feasible, through various ways of communication.

6.5 Blue Shield Medicare Advantage Plan Medical Care Solutions

Medical Care Solutions Guidelines

Emergency Services

The Centers for Medicare & Medicaid Services (CMS) Region IX office has approved an emergency services automatic payment diagnosis list for Blue Shield Medicare Advantage plan members. This list is available by contacting the Blue Shield Medicare Advantage Provider Customer Service Department at (800) 541-6652.

Skilled Nursing Facility (SNF) Admissions/Transfers

Blue Shield Medicare Advantage plan members may be admitted or transferred to a Medicare-certified SNF from any environment. The SNF benefit is limited to 100 days per benefit period.

A benefit period begins on the first day of a covered inpatient SNF stay and ends when the member has been out of the SNF or rehabilitation hospital for 60 consecutive days, including the day of discharge. A benefit period is a way of measuring the use of services under Medicare Part A. A SNF benefit period begins on the first day of a Medicare-covered skilled nursing facility stay. The benefit period ends when a member has been out of the SNF for 60 consecutive days, including the day of discharge. There is no limit to the number of benefit periods per benefit year. A member may be discharged from and readmitted to a hospital or SNF several times during a benefit period and still be in the same benefit period if 60 days have **not** elapsed between discharge and readmission. The stay does not have to be for related physical or mental conditions.

If a member is discharged from a SNF after receiving post-hospital SNF care, the member is not covered for an additional SNF admission or SNF services in the same benefit period, unless the member is hospitalized again, or their condition deteriorates and meets Medicare coverage guidelines for readmission. Re-admissions within the same benefit period continue to accrue toward the 100-day limit.

When a network provider coordinates the member's admission, Blue Shield Medicare Advantage plan waives the 3-day hospital stay required by Medicare to qualify for coverage. If the admission to an out-of-area SNF is not authorized or approved by the member's network provider, the Medicare required 3-day hospital stay applies.

Second Opinions

In keeping with current legislation, second opinion consultations must be provided when requested by a Blue Shield Medicare Advantage plan member or the participating healthcare provider who is treating the member.

According to Blue Shield Medicare Advantage plan policy, a second opinion for surgery or major procedures (see below) requested by a member is to be provided by an appropriately qualified healthcare professional from within the member's assigned IPA/medical group. Second opinions are only for recommendations about the medical need for surgery or for major nonsurgical diagnostic and therapeutic procedures (e.g., invasive diagnostic techniques such as cardiac catheterization and gastroscopy). Payment for the second opinion consultation is drawn from the capitation amount paid to the IPA/medical group for that member. If the recommendation of the first and second physician differs regarding the need for surgery (or other major procedure), a third opinion is also covered.

IPA/Medical Group Responsibilities

IPA/medical groups that are fully delegated for Blue Shield Medicare Advantage plan utilization management activities must perform the following functions:

- Authorize referrals in accordance with CMS regulatory requirements.
- Issue a timely notice to the member containing CMS-required appeal rights in accordance with CMS regulatory requirements.
- Authorize inpatient admissions and outpatient procedures in accordance with Medicare coverage guidelines.
- Perform authorization, prospective, concurrent, and retrospective review of services.
- Provide retrospective review of emergency room visits and emergency admissions not reviewed concurrently using the prudent layperson criteria.
- Provide out-of-plan concurrent review via telephone and arrange transfer of medically stable patients to in-network facility when appropriate.
- Use CMS' national or local coverage determinations guidelines, or in the absence of such guidelines, Blue Shield's Medical Policies or Medication Policies when applicable for referrals/hospital authorizations. When such guidelines/policies are not applicable, use nationally recognized evidence- based UM criteria approved for use by the IPA/medical group's UM Committee.
- Submit members' grievances (in writing) or requests for appeal or direct verbal complaints to the Blue Shield Medicare Advantage Provider Customer Service Department at (800) 541-6652 or Member Customer Services at (800) 776-4466.
- IPAs that are delegated for UM are responsible to authorize/provide only those benefits covered by Medicare and Blue Shield Medicare Advantage plan. If non-covered benefits are authorized or non-covered services are provided on referral from a delegated plan provider, the IPA assumes financial responsibility for those services as a capitated medical expense.
- Notify Blue Shield Medicare Advantage Plan Medical Care Solutions at (800) 786-7474, or fax to (916) 350-8928, of the following:
    - Hospitalizations, within one working day of the admission for urgent /emergent admits and five business days prior to a scheduled or elective admission.
    - Services provided more than 30 miles from the member's primary hospital or more than 30 miles out-of-area.
    - Ambulatory surgeries.
    - Invasive procedures requiring the use of a facility other than a physician office.
    - Out-of-area admissions (as appropriate, the IPA/medical group should facilitate and coordinate an enrollee's transfer to a participating primary hospital).
    - All admissions/transfers to Skilled Nursing Facility/Transitional Care Unit (SNF/TCUs) within 24 hours or one business day of admission or transfer.

IPA/Medical Group Responsibilities *(cont'd.)*

- Notify Blue Shield Medicare Advantage Plan Medical Care Solutions of the denial of any requested service or treatment for Blue Shield Medicare Advantage plan members by submitting:
  - A copy of the shared risk authorization log on a weekly basis directly to the MCS department email address at IPAauths@blueshieldca.com
- As part of the annual Delegation Oversight audit, submission of the denial letter and authorization request will be required. This information may also be requested for third party audits or appeal reviews and will need to be submitted to Blue Shield within the timeframe required to meet regulatory or expedited appeal timeframes.
- All denial letters must be CMS-approved. Blue Shield Medicare Advantage plan has developed CMS-approved letters and tools that may be used as templates. Blue Shield also accepts Industry Collaborative Effort (ICE) approved letters, unless otherwise indicated. For electronic or hard copies of these letter templates, contact the Blue Shield Utilization Management Delegation Oversight Nurse Auditor. ICE-approved letters may be found on the ICE website at iceforhealth.com.

  The following service denial letter templates are available:
  - Home health care discontinuation.
  - SNF continued stay (Acknowledgement of Receipt of Notice must be signed and attached for all facility denials).
  - SNF benefits exhausted.
  - Hospital pre-admission/admission denial.
  - Initial organization determination pre-service denial.
- Coordinate Expedited Initial Determinations (EID)
  - Any Blue Shield Medicare Advantage plan member has the right to ask that a request for services be processed as an expedited initial determination (EID). An EID is defined as an expedited (no longer than 72 hours) decision on a request for service. A member, or a physician acting on a member's behalf, may make a request to expedite a determination if he/she feels that a delay in obtaining the service would cause further harm or injury, or is life-threatening. An EID is distinct from an appeal where an initial determination to deny a service has already been rendered. EIDs are not delegated to the IPA/medical group.
  - Request that an initial review be expedited by one of the following entities:
    - All Blue Shield Medicare Advantage plan members have the right to request an expedited initial determination.
    - A member's representative may request an expedited initial determination.
    - Any physician, contracted or not contracted, may request an expedited initial determination on behalf of the member.

IPA/Medical Group Responsibilities *(cont'd.)*

- Follow the guidelines below to process a request for an expedited initial determination:
  - Immediately notify the Blue Shield Medicare Advantage Member Services Department when the IPA/medical group receives a request for an expedited initial determination. The tracking of these requests is not a delegated function.
  - Blue Shield Medicare Advantage plan members are instructed to contact Member Services to request an EID. Should a member request an EID from the IPA/medical group, the group should instruct the member to contact Member Services.
  - Blue Shield's Medicare Appeals and Grievances Department will contact the IPA/medical group to facilitate the IPA/medical group's decision making upon receipt of the request from the group and Appeals and Grievances will ensure that the request is processed within the required timeframe. As required by regulations, the health plan is responsible for the tracking of these requests.
  - All requests for EIDs are expedited in the interest of member satisfaction. Blue Shield will keep the IPA/medical group informed of the deadline for making the decision.
  - If the IPA/medical group does not reach a decision within the required timeframe, a Blue Shield medical director will make the decision to approve or deny the request based on available information. Blue Shield's Medicare Appeals and Grievances Department is also responsible for notifying the member of the determinations on behalf of the IPA/medical group. The IPA/medical group is responsible for issuing any necessary denial notices in the event that the IPA/medical group denies the requested service.
  - Blue Shield's Medicare Member Services notifies all members who request an EID of the initial determination via telephone and provides assistance with filing appeals, as necessary.

IPA/Medical Group Responsibilities *(cont'd.)*

- Adhere to reporting requirement timeframes as outlined below:

Medicare Advantage Plan Reporting Requirements

IPA/Medical Group Reporting Requirements	Entities' Responsibilities	Reporting Frequency	Submit To
UM Program Description and selected supporting Policies and Procedures as necessary to meet federal, state, NCQA, and plan requirements.	Must be consistent with federal, state, NCQA, and Blue Shield guidelines.	**Annually**	Delegation Oversight Nurse

UM Work Plan to include
Medicare Reporting on:
• Acute, SNF & BH
  • Bed Days/1000
  • Admits/1000
  • Average LOS
  • Readmits/1000
• Total number of processed Referrals
• Total number of Denials
• Denial Rate
• ER visit & Denial rate
• Special Needs Plan metrics
• Turn Around Time (TAT)
  • Total # of decisions compliant with TAT & % compliant (UM, BH, Pharmacy)
  • Total # of notifications compliant with TAT & % compliant (UM, BH, Pharmacy)
• % of Referrals that exceed TAT
• Member and Provider Satisfaction Results
• IRR results
• Updates to UM Program
	Must be consistent with federal, state, NCQA, and Blue Shield guidelines.
	
	Maintain documentation of analysis and actions taken. Reports submitted must be Blue Shield specific.
		Semi-Annually	Delegation Oversight Nurse

UM Annual Evaluation	Must be consistent with federal, state, NCQA, and Blue Shield guidelines.	**Annually**	Delegation Oversight Nurse
UM Criteria and Guidelines	Must be consistent with federal, state, NCQA, and Blue Shield guidelines.	**Annually** (can be reviewed at time of annual delegation audit)	Delegation Oversight Nurse
Behavioral Health Reporting • Assessment of under-and over-utilization of UM data related to behavioral health	Maintain documentation of analysis and actions taken.	**Semi-Annually**	Delegation Oversight Nurse
Medicare Shared Risk Authorizations (for groups with shared risk contracts ONLY)	Includes all services that delegated entities approve and deny that are paid out of shared risk pool. These include:	**Concurrently**	Call or email Blue Shield Medicare Advantage Plan Medical Care Solutions: Phone (800) 786-7474 IPAauths@blueshieldca.com

IPA/Medical Group Reporting Requirements	Entities' Responsibilities	Reporting Frequency	Submit To
	Acute and skilled admits: med/surg/ rehab/mental health /detox /DME/Home Health. Check your individual group shared risk matrix for additional details.		
All acute inpatient admissions		**Within 24 hours** to for urgent/emergent admits or five (5) business days prior to a scheduled/ elective admission.	Call or fax Blue Shield Medicare Advantage Plan Medical Care Solutions: Phone: (800) 786-7474 IPAauths@blueshieldca.com
All catastrophic cases		**Concurrently**	Email Blue Shield Medicare Advantage Plan Medical Care Solutions at IPAauths@blueshieldca.com
All Skilled Nursing Facility (SNF) admissions		**Within 24 hours**	Email Blue Shield Medicare Advantage Plan Medical Care Solutions at IPAauths@blueshieldca.com
Prior Authorizations and Denials	Required to use Plan denial letter templates for Medicare denials	**Weekly** submission of auth & denial logs showing 100% of all denials	Email Blue Shield Medicare Advantage Plan Medical Care Solutions at IPAauths@blueshieldca.com
Information on any denial or authorization which has been made. Including but not limited to the regulatory or appeals process.	Make available to Blue Shield all information requested on the denial.	**As needed**	Email Blue Shield Medicare Advantage Plan Medical Care Solutions at IPAauths@blueshieldca.com
Medicare Member Expedited Initial Determinations (EIDs)	**NOT DELEGATED** for tracking or determination of EID status	Forward to Plan **Immediately** for determination of whether or not the case meets EID criteria	Phone (800) 786-7474 Fax (844)696-0975
Requests for Investigational/Experimental Services	**DELEGATED** See Section 6.2 General Benefit Exclusions	Forward to Plan **Immediately** for determination	Phone (800) 786-7474 Fax (844) 696-0975
Request for Cancer Clinical Trials- Commercial HMO only; Medicare Clinical Trials are handled by the Intermediary and not Blue Shield. (For Commercial HMO, upon enrollment or renewal of member's group or IFP coverage after 1/1/02)	**NOT DELEGATED**	Forward to Plan **Immediately** for determination	Phone (800) 786-7474 Fax (844) 696-0975
Medicare Clinical Trials Routine costs are paid for by regular Medicare. The medical group is responsible for difference between original Medicare cost-sharing and the member's cost sharing under their MAPD plan. The group also covers any preparticipation evaluations per the DOFR.	**DELEGATED**	Forward to Plan **Immediately** for determination	Phone (800) 786-7474 Fax (844) 696-0975

6.5 Blue Shield Medicare Advantage Plan Medical Care Solutions

IPA/Medical Group Reporting Requirements	Entities' Responsibilities	Reporting Frequency	Submit To
Investigation Device Exemption (IDE)	**DELEGATED**	Forward to Plan **Immediately** for determination	Phone (800) 786-7474 Fax (844) 696-0975
Encounter data		**Monthly**	Email Medicare Revenue Improvement & Recovery Team at MRIRIT@blueshieldca.com
Patients with ESRD		**Monthly**	Email Blue Shield Medicare Advantage Plan Medical Care Solutions at IPAauths@blueshieldca.com
Patients who remain institutionalized in SNF		Preferred **concurrently**, at minimum **weekly**	Email Blue Shield Medicare Advantage Plan Medical Care Solutions at IPAauths@blueshieldca.com
Patients who are receiving hospice benefits		**Monthly**	Email Medicare Claims Team at ClaimsAnalystMedAdv@blueshieldca.com
Change in key IPA/medical group management and/or professional staff		**Monthly**	Blue Shield Provider Relations

Medicare Dual Eligible Special Needs Plan (D-SNP) Reporting Requirements

IPA/Medical Group Reporting Requirements	Entities' Responsibilities	Reporting Frequency	Submit To
Evidence of IPA/Medical Group annual training for SNP Model of Care (MOC): • Training materials • Dates of training • IPA/Medical Group attestation of participation • Internal staff training	Use Blue Shield's training materials to educate employees and downstream providers initially and annually	**Annually – 1st quarter**	Email proof of completion to providerexperience@blueshieldca.com *or* Complete the training module via the Learning Management System located on the provider portal and no additional submission is required
Ambulatory/basic case management logs: • Member's Name and ID number • Date of Birth • Referral Source • Reason for Referral to CM • Case Status • Case Open Date • Diagnosis (ICD – 10/Description) • Problems/Issues Identified • Goals Identified • Interventions Documented • Care Plan sent to PCP (notification) • Communications with Member Documented • Case Closure Date • Reason for Closure/Case Outcome		**Quarterly**	MCSPromiseTriageComplexCaseManagement@blueshieldca.com

IPA/Medical Group Reporting Requirements	Entities' Responsibilities	Reporting Frequency	Submit To
Interdisciplinary Care Team (ICT) Meetings: • Membership of the ICT • Evidence of member/caregiver participation or refusal to participate		**Quarterly**	MCSPromiseTriageComplexCaseManagement@blueshieldca.com
Evidence of Medical Group/IPA Care and Service Coordination as Delineated in Health Plan Complex Case Management Care Plan Interventions • Record of authorization • Verification of date service(s) provided • Coordination/exchange of medical information with the plan		**Monthly**	MCSPromiseTriageComplexCaseManagement@blueshieldca.com
Member data for performance and health outcomes measurement		**Quarterly**	MCSPromiseTriageComplexCaseManagement@blueshieldca.com

IPA/Medical Group Responsibilities *(cont'd.)*

Reporting End Stage Renal Disease (ESRD) Members

As a reminder, in order to be eligible for participation in the Blue Shield Medicare Advantage plan program, a person must be entitled to Medicare Part A and enrolled in Medicare Part B and live within the Blue Shield Medicare Advantage plan service area. Beginning January 1, 2021, patients diagnosed with End Stage Renal Disease (ESRD) prior to signing an enrollment application, or who have ongoing dialysis, are eligible to join the Blue Shield Medicare Advantage plan.

The IPA/medical group should verify that the Dialysis facility that they have authorized or referred their members to files the CMS form (2728-U3) "ESRD Medical Evidence Report" with the local Social Security Office to register a Member as an ESRD Member. A copy of the form (CMS 2728-U3) should also be sent to the ESRD Network Organization. (Refer to the CMS website at cms.hhs.gov/center/esrd.asp for a copy of the ESRD Medical Evidence Report form.)

The following is a general description of Medicare eligibility when ESRD is involved:

ESRD coverage begins:

- When a person with ESRD has a transplant or is on maintenance dialysis, they become entitled to Medicare benefits. Eligibility typically begins on the first day of the fourth month of maintenance dialysis, however, if the person has a transplant or is on self-dialysis at home, coverage begins the first month.

- If the individual is employed or a dependent of an employed person, Medicare would be secondary to the Employer Group Health Plan (EGHP) during the first 30 months after becoming eligible. After the initial 30 month "coordination period," Medicare automatically becomes primary and the EGHP becomes the secondary payor.

ESRD coverage ends:

- Medicare ESRD coverage ends 12 months after maintenance dialysis ends or 36 months after a kidney transplant. At that time, the member would revert to standard Medicare coverage or to the Employer Group Health Plan. If, at any time, maintenance dialysis must be resumed or another transplant becomes necessary, Medicare coverage will be continued or reinstated without any waiting period.

  Note: If this were to occur, the Dialysis Facility will need to submit a new CMS form (2728-U3), ESRD "Medical Evidence Report" with the new information.

The monthly Eligibility/Capitation report will indicate the member's status, if they are classified with CMS as ESRD. If the report does not show the correct status, the IPA/medical group should contact the Dialysis Facility to verify they have correctly completed and submitted the CMS form (2728-U3) "ESRD Medical Evidence Report" with the local Social Security Office.

Blue Shield Medicare Advantage Plan Responsibilities

Blue Shield is responsible for:

- Establishing a formal mechanism to consult with the physician regarding the Blue Shield Medicare Advantage Plan Medical Care Solutions procedures.
- Providing technical assistance to facilitate IPA/medical group UM activities.
- Providing supplementary UM/oversight responsibilities for members of delegated IPA/medical groups. Daily selection of inpatient acute cases meeting identified criteria will be reviewed by the Medical Care Solutions UM. The Utilization Care Manager will provide coordination and collaboration with the IPA/medical group case management staff for discharge planning and/or transitions to lower levels of care as needed. Cases that appear to lack medical necessity or indicate possible quality of care issues will be escalated to the Blue Shield Medical Director for clinical review, peer to peer communication, or communication with the IPA/Medical Group Medical Director as indicated. This activity will ensure that the delegated medical groups and IPAs are providing quality and appropriate care for Blue Shield MAPD members.
- Providing concurrent and/or retrospective review for out-of-area emergent care.
- Coordinating communication between the primary care physician (PCP) and the treating physician if Blue Shield Medicare Advantage plan learns of an out-of-area admission before the IPA/medical group.
- Contacting the PCP to:
    - Clarify medication orders on the patient's behalf.
    - Coordinate care and expedited initial determination requests.
    - Obtain medical records when appropriate.
    - Respond to customer service issues.
    - Facilitate discharge planning.

6.5 Blue Shield Medicare Advantage Plan Medical Care Solutions

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Member Rights and Responsibilities

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

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

To get information from us in a way that works for you, please call Member Services at (800) 776-4466 [TTY 711] 8 a.m. to 8 p.m. seven days a week, from October 1 through February 14, and 8 a.m. to 8 p.m., weekdays, from February 15 through September 30.

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in large print, or other alternate formats if you need it. If you are eligible for Medicare because of disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call (877) 486-2048.

We must treat you with fairness and respect at all times.

Our plan must obey laws that protect you from discrimination or unfair treatment. We do not discriminate based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' Office for Civil Rights (800) 368-1019, TTY (800) 537-7697, or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call Member Services. If you have a complaint, such as a problem with wheelchair access, Member Services can help.

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 Member Services 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.

Member Rights and Responsibilities *(cont'd.)*

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 of the EOC for details on how to make a complaint about quality of care, waiting times, and other concerns.

We must protect the privacy of your protected health information.

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 Practices" that tells about these rights and explains how we protect the privacy of your health information.

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 consider your request and 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 Member Services.

Member Rights and Responsibilities *(cont'd.)*

We are always committed to protecting the privacy of your personal and health information. Our Notice of Confidentiality and 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.
2. Call the Member Services phone number on your Blue Shield member ID card to request a copy.
3. Call the Blue Shield 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 Medicare Advantage plan, 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 performance ratings, including how it has been rated by plan members and how it compares to other Medicare Advantage 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 Member Services or visit *Find a Doctor* on blueshieldca.com.
- Information about your coverage and the rules you must follow when using your coverage.
    - 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 Member Services.
- Information about why something is not covered and what you can do about it.

Member Rights and Responsibilities *(cont'd.)*

- 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. 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 about how to ask the plan for a decision about your coverage and 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.

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.

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 choices. 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.

Member Rights and Responsibilities *(cont'd.)*

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.

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, a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. There are several organizations in California that can provide information about advance directive forms, including the California Coalition for Compassionate Care and Physician Orders for Life-Sustaining Treatment California (POLST). You can also contact Member Services for this form.

- 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.

Member Rights and Responsibilities *(cont'd.)*

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.

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 Member Services.

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 Member Services.
- You can call the State Health Insurance Assistance Program (HICAP) at (800) 434-0222 [TTY 711].
- 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 *(cont'd.)*

You have the right to receive information about your rights and responsibilities, and to make recommendations regarding our member rights and responsibilities policy.

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

- You can call Member Services.
- You can call the State Health Insurance Assistance Program (HICAP) at (800) 434-0222 [TTY 711].
- You can contact Medicare in one of the following ways:
    - You can visit the Medicare website at medicare.gov to read or download the publication "Your Medicare Rights & Protections."
    - 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.

What are the member's responsibilities?

- **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 Member Services 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 7.)
- **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.

Member Rights and Responsibilities *(cont'd.)*

- **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. For that reason, some plan members must pay a premium for Medicare Part A and 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 of this booklet 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.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services.
    - **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 Member Services 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 Member Services 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 Procedures

Blue Shield investigates Blue Shield Medicare Advantage plan member complaints, grievances, and appeals and follows a standard set of procedures for their resolution. All grievances and appeals are handled by Blue Shield. If the member asks the IPA/medical group about filing a complaint, the member should be referred to Blue Shield Medicare Advantage Plan Member Services. If the IPA/medical group receives a written complaint from a member, the complaint should be immediately forwarded to:

Blue Shield Medicare Advantage Plan Appeals & Grievances
P.O. Box 927
Woodland Hills, CA 91365-9856
Fax: (916) 350-6510

Blue Shield Medicare Advantage plan encourages questions and suggestions regarding any and all aspects of Blue Shield Medicare Advantage plan and the care received by its members. Comments are utilized to help improve the service provided. The Blue Shield Medicare Advantage Plan Member Services Department may be contacted with any problems or questions including those concerning coverage, procedures, physicians, hospitals, medical care, or reimbursement. If the problem or complaint cannot be resolved informally to the member's satisfaction, a member may file a grievance with Blue Shield Medicare Advantage plan. The grievance should include information about the complaint, specific facts relating to the complaint, and the reasons for lack of satisfaction.

Once the member files a grievance:

- Blue Shield Medicare Advantage plan must acknowledge receipt of the complaint within five calendar days and provide the name of the person who is working on the grievance; and

- Blue Shield Medicare Advantage plan will resolve the grievance within 30 calendar days of receipt.

If the member is not satisfied with the resolution of the 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 Plan Appeals and Grievances Department.

The member will be invited to attend, and representatives of the involved parties will have the opportunity to present their position. Following the hearing, all parties will receive a proposed resolution from the panel.

To resolve member issues more expeditiously, the Blue Shield Medicare Advantage Plan Appeals and Grievance Resolution Department has implemented the following process to research and respond to member grievances.

Member Grievance Procedures *(cont'd.)*

The following summarizes the Blue Shield Medicare Advantage plan grievance categories:

1. Complaints (grievances which do not involve quality-of-care issues) such as:
    - Wait time in medical office
    - Telephone access
    - No return telephone call
    - Misplaced medical records
    - Access to providers (scheduling difficulties)

All complaints are tracked and trended for future quality assurance purposes. The IPA/medical group will receive a Provider Notification Memorandum that may require a response within five business days or is informational only. The member receives a written response from Blue Shield Medicare Advantage plan concerning such issues.

2. Grievances (include but are not limited to):
    - Inappropriate behavior of provider personnel
    - Delay in referral
    - Referral denials resulting in care being adversely affected (also could be considered an appeal)
    - Quality of care issues
    - Miscommunication between member and provider regarding care/benefits

Grievances are member complaints that require research and response to the member. Grievances involving care issues require medical records. The IPA/medical group will be sent a Provider Notification Memorandum that requests medical records and a written response within five working days. Upon receipt of this information, a Blue Shield Medicare Advantage plan Medical Director will review it.

All Requests for Assistance (RFA) received from the Department of Managed Health Care (DMHC) on behalf of the member must be filed as a grievance, if not already done so, on behalf of the member and must have a written letter of response to the member. A personalized written response from Blue Shield Medicare Advantage plan will be sent to the member within 30 days from the date the RFA notification was received by the health plan. The purpose of the letter to the member is to explain how his/her grievance was resolved and to educate the member as to how he or she may prevent similar incidents from occurring in the future.

IPA/medical groups must comply with the DMHC and Medicare Advantage requirements by responding to all requests for information to be used for grievance resolution as outlined on the previous page. In accordance with the detailed Provider Notification Memorandum request, the IPA/medical group needs to respond to each request within five working days from the date the Provider Notification Memorandum is sent.

Member Grievance Procedures *(cont'd.)*

All information provided by the IPA/medical group, as part of a response to a grievance, is considered confidential and is protected under peer review confidentiality provisions, according to state regulations.

Blue Shield Medicare Advantage plan retains the responsibility for resolving its members' grievances and does not delegate that responsibility to the IPAs/medical groups. The IPAs/medical groups agree to cooperate with Blue Shield Medicare Advantage plan in resolving member grievances related to the IPA/medical group or IPA/medical group physicians.

Blue Shield Medicare Advantage plan will bring to the IPA/medical group's attention all member complaints involving IPA/medical group physicians. The IPA/medical group will, in accordance with its procedures, investigate such complaints and use its best efforts to resolve them in a fair and equitable manner. Any action taken or proposed action by the IPA/medical group, with respect to the resolution of such complaints and the avoidance of similar complaints in the future, should be reported promptly to Blue Shield Medicare Advantage plan.

Member Complaint and Appeals Resolution

A Blue Shield Medicare Advantage plan member may appeal any denials, termination, reduction of services, or payment for services. This includes denial of services or denial of payment after service has been rendered. An appeal may also be requested for services rendered for non-plan providers or suppliers that the member believes should have been provided, arranged for, or reimbursed by Blue Shield Medicare Advantage plan. An appeal may also include any adverse initial determination for treatment or services the member believes he/she is entitled to receive, which includes any delays in providing, arranging, or approving health services. Following the submission of a member appeal, Blue Shield Medicare Advantage plan will request that the IPA/medical group provide the necessary medical records and a copy of the initial determination mailed to the member within five business days to thoroughly evaluate the member appeal. In instances where the member has sought or obtained services from a non-contracted provider, Blue Shield Medicare Advantage plan will obtain the medical records directly from the provider.

Should a member not agree with an initial determination (denial of service or denial of claim), the member may request an appeal. The member must file the appeal in writing to Blue Shield Medicare Advantage plan.

> *Note: All Medicare appeals must be processed by Blue Shield Medicare Advantage plan. Medicare appeals are not delegated to IPA/medical groups.*

IPA/Medical Group Responsibility

When the initial determination is made by the IPA/medical group or hospital, the IPA/medical group or hospital will be responsible for sending the member an Initial Determination Letter containing the appropriate CMS-approved appeals language and denial reason.

Member Complaint and Appeals Resolution *(cont'd.)*

Blue Shield Medicare Advantage Plan Responsibility

Blue Shield is responsible for:

1. Acknowledging receipt of filed appeals within five calendar days.

2. Ensuring that a proper Initial Determination Letter was sent to the member by the appropriate party. If not, Blue Shield Medicare Advantage plan will request that the appropriate letter be issued by the responsible party. Through the delegation oversight process, a corrective action plan may be requested, if there is a failure to comply with this request.

3. Requesting a response from the IPA/medical group or hospital within nine (9) calendar days from the receipt of an appeal for all medical information used in making the determination. If additional medical records, in conjunction with the clinical information used in making the determination, are required for Blue Shield Medicare Advantage plan to properly evaluate the member appeal, Blue Shield will request that the IPA/medical group provide this additional information.

4. Either making a determination that is in the member's favor and informing the member, IPA/medical group, or hospital of the fully favorable determination within 30 calendar days from the receipt of an appeal for a pre-service denial or 60 calendar days for a claims denial; or, if the request is denied or partially denied, submitting the appeal request to Maximus Federal Services (Maximus) for external review. Maximus is an independent CMS contractor that reviews appeals by members of Medicare managed care plans, including Blue Shield Medicare Advantage plan.

   Maximus will either uphold or overturn the Initial Determination. If Maximus chooses to uphold the denial, Maximus will inform Blue Shield and the member. If Maximus overturns the Initial Determination, it will inform the member and copy Blue Shield Medicare Advantage plan, which will inform the IPA/medical group or hospital of the overturn.

   If the decision is favorable to the member, for standard service denials, Blue Shield Medicare Advantage plan will authorize within 72 hours of Maximus' decision or provide the service in question as quickly as the member's health requires, but no later than 14 days following the receipt of Maximus' decision. For expedited service denials, Blue Shield Medicare Advantage plan will authorize or provide the service in question as quickly as the members health requires but no later than 72 hours following the receipt of Maximus' decision.

   In instances where Maximus overturns a claim denial, Blue Shield Medicare Advantage plan will process the claim(s) either at contracted rates or Medicare allowable charges, whichever is applicable. The IPA/medical group or hospital is given the opportunity to respond within 10 days whether or not the claim(s) should be processed at a fee schedule different than the Medicare allowable rate.

   Maximus decisions are final and binding on all parties. If a member is unsatisfied with the Maximus' resolution, he/she may request a hearing before an Administrative Law Judge (ALJ) of the Social Security Administration if the amount in question is $100 or more. Maximus will be responsible for arranging the ALJ hearing and will notify Blue Shield Medicare Advantage plan.

Expedited Appeals

The Center for Medicare & Medicaid Services (CMS) requires an Expedited Appeal process be made available to all members. Expedited appeals apply to denied services/referrals or discontinuation of service or referral. When a member believes that his/her health or ability to function could be seriously harmed by waiting the 30 days for a standard appeal, he/she may request an Expedited Appeal. Medicare regulations require expedited requests be processed within 72 hours (including weekends). The expedited request may be filed by the member, a member representative, or by a physician on behalf of the member, and must be filed within 60 days of the denial of or discontinuation of the services.

A Blue Shield Medicare Advantage plan Medical Director will determine within 72 hours if the request meets criteria for an Expedited Appeal. Those requests which do not meet the criteria will be automatically transferred to the standard 30-day appeal process. Expedited Appeals may be requested by contacting the Blue Shield Medicare Advantage Plan Member Service Department at (800) 541-6652 (for providers), (800) 776-4466 (for members) [TTY 711]. A request may be faxed to (800) 303-5828 during business hours, 8 a.m. to 5 p.m., Monday through Friday.

Expedited Initial Request for Services

Section 422.562(a) of the Balanced Budget Act of 1997 requires that providers adhere to Medicare's procedures for expedited requests for treatment and expedited appeals for all MA Organization (MAO) enrollees, including gathering/forwarding information on appeals to MAO.

CMS has established that beneficiaries in MAOs (like Blue Shield Medicare Advantage plan) are entitled to the review of any request for a service or treatment within specific timeframes. CMS further requires MAOs to ensure that any delegated functions meet federal guidelines.

Regulations require that MAOs (and contracted delegated provider organizations) process standard requests to approve a service or referral within 14 calendar days. If a member (or physician) believes that a member has a condition that is "time sensitive" and requires urgent attention, an "expedited or 72-hour" review may be requested. Any service or referral that a member feels requires medical treatment that cannot wait for the standard 14-day timeframe may be requested to be handled as "urgent, speedy, or expedited." If a service request is requested to be expedited, that request must be reviewed as soon as medically indicated, but no longer than 72 hours from the time of the request.

Expedited Appeals *(cont'd.)*

Expedited Initial Request for Services *(cont'd.)*

CMS Definitions related to Expedited Initial Requests

Time Sensitive - Situations where the time frame of the regular decision-making process could seriously jeopardize the life or health of the enrollee or jeopardize the enrollee's ability to regain maximum functioning.

> *Note: If any physician requests a review be expedited, that review must be expedited on behalf of the member.*

Expedited Handling - As soon as medically appropriate, not to exceed 72 hours (including weekends and holidays). The 72 hours is measured from the time the request is received until notification (telephonic notice) to the member of a decision on the request. Should an expedited request be denied, a written notice must be mailed within three calendar days of the telephonic notification. Section 422.572(e)(2) further indicates written approval must follow for full or partial approvals within three calendar days of the oral approval of any expedited appeal. If medical information or medical records from outside the health plan are necessary in order to determine whether a request should be expedited, then the 72 hours begins when those records are received.

An extension of up to 14 calendar days is allowed if requested by the member or if the plan finds that it is in the member's best interest to have additional information, consultation or testing done. Extensions are not allowable for gathering information that should already be available from plan providers.

Blue Shield's Role in Handling Expedited Initial Requests

Should a Blue Shield Medicare Advantage plan member feel that his or her health could be jeopardized if an expedited decision is not made, the member is requested to contact Blue Shield Medicare Advantage Plan Member Services Department to request an expedited initial determination. Blue Shield will document the member's request and immediately forward the request to the contact person in the Medicare Appeals and Grievance Department for processing. All requests for expedited initial determination will be processed according to the CMS guidelines, within 72 hours. Blue Shield will monitor that expedited requests are completed according to the mandatory timeframes and will notify the members of any adverse initial decisions. If a group is unable to meet the mandatory timeframes and does not make a timely initial determination on an expedited request, a Blue Shield medical director will make the decision whether to approve or deny the request. Blue Shield will advise the member of his or her right to appeal.

Blue Shield will advise the member of the IPA/medical group or decision and send the approval letter or denial notice to the members within three calendar days of the decision. All expedited initial requests will be logged and tracked by Blue Shield. If an MAO denies a request for an expedited initial determination, in addition to notifying the member within three calendar days, the MAO must inform the member of the right to submit a request for an expedited reconsideration with any physicians' support.

> *Note: The above process may be extended up to 14 calendar days if it is in the member's interest.*

Expedited Appeals *(cont'd.)*

Expedited Initial Request for Services *(cont'd.)*

IPA/Medical Group Role in Handling Expedited Initial Requests

Members are requested to make all expedited initial requests through Blue Shield. However, if the IPA/medical group receives a request for an "urgent, expedited or 72-hour" review that has not already been forwarded to the IPA/medical group by Blue Shield, the IPA/medical group should contact Blue Shield Medicare Advantage Plan Appeals and Grievance Department directly at (800) 894-5487.

> *Note: Immediately notify Blue Shield Medicare Advantage plan Member Services of any request for an expedited initial determination. Do not delay review of an expedited initial request. Blue Shield will log the request as received as of the date the expedited request is made, as this is in the member's best interest, should an urgent medical issue need to be resolved.*

Blue Shield will assist IPA/medical groups by monitoring that all expedited requests are closed according to federal guidelines. This process also allows Blue Shield to provide CMS with documentation to demonstrate oversight and compliance with the federal requirements.

6.6 Blue Shield Medicare Advantage Plan Member Rights and Responsibilities

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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* (see definitions below).

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* SM

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. (See Access+ *Specialist* above).

Accountable Care Organization (ACO)

An accountable care organization is an alliance formed with physician groups and hospitals who, together with Blue Shield, share responsibility and accountability for the quality, cost, and overall care of a defined group of patients with the goal of improving healthcare quality and lowering healthcare costs. As with a traditional HMO plan, a member's care is coordinated by a primary care physician.

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*.

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.

Allowed Amount

The total amount Blue Shield pays for covered services rendered, or the provider's billed charge for those covered services, whichever is less.

Alternate Care Services Provider

Home health care agencies, pharmacy home infusion suppliers, home infusion suppliers, and home medical equipment suppliers.

Glossary

Ambulatory Surgery Center (ASC)

Any ambulatory surgical center that is certified to participate in the Medicare program under Title XVIII (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."

Appeal (Member)

A request for reconsideration of an initial decision to deny a request for service, a claim payment or a requested service or procedure.

Appeal (Provider)

A written statement from a provider disputing the decision to reduce, delay, or deny services or benefits, requesting the original decision be altered or overturned.

AuthAccel

An online tool for submitting authorization requests to Blue Shield. This tool may only be used to request authorizations for services where the division of financial responsibility in the IPA/medical group's contract identifies Blue Shield as responsible for prior authorization. Requesting providers may use AuthAccel to complete, attach documentation, submit, track status, and receive determinations for applicable medical and pharmacy prior authorizations. Registered users at Provider Connection may access the tool, in the Authorizations section, after logging into the website at www.blueshieldca.com/provider.

For medical authorizations, AuthAccel is an option, in addition to calling or faxing, for submitting authorization requests to Blue Shield.

For pharmacy authorizations, providers may fax or submit through AuthAccel. 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 required information is built into the tool.

Authorization

The procedure for obtaining Blue Shield's and/or the IPA/medical group's prior approval for all services, except primary care physician, Access+ *Specialist,* and emergency services, provided to members under the terms of their health services contract.

Balanced Budget Act of 1997 (BBA)

Signed into law in August 1997, this legislation enacts the most significant changes to the Medicare program since its inception.

Benefits

Covered health care services, pursuant to the terms of the member's health services contract. For Blue Shield Medicare Advantage, basic benefits include all healthcare services that are covered under the base Blue Shield Medicare Advantage plan, but do not include services provided under the Premium Plan (i.e., Complementary Care).

Benefit Period (Blue Shield Medicare Advantage plan – Individual and Group)

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.

Biosimilar

A biosimilar is a biologic medical product highly similar to another already approved biological medicine.

Blue Shield Medicare Advantage HMO Network

A group of physicians, hospitals, and other healthcare providers that contract with Blue Shield to provide medical 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 network is different from the Access + HMO network.

Blue Shield Medicare Advantage HMO Plans

Blue Shield's Medicare Advantage plans: Blue Shield 65 Plus (HMO), Blue Shield Plus Choice Plan (HMO), Blue Shield Inspire (HMO) and Blue Shield Vital (HMO). 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 a 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 Web

Blue Cross and Blue Shield Association's website at https://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 Medi-Care program.

Capitation

A prepaid monthly fee paid to the IPA/medical group for each Blue Shield member in exchange for the provision of comprehensive health care services.

Case Rate

The all-inclusive rate, paid in accordance with the hospital contract Exhibit C, for specified types of care that are paid regardless of the type or defined duration of services provided by the hospital. For specified care/diagnoses, Blue Shield pays the stated Case Rate in lieu of the Per Diem rate.

Glossary

Centers for Medicare & Medicaid Services (CMS)

An agency within the U.S. Department of Health and Human Services which administers the Medicare Program and with whom Blue Shield has entered into a contract to provide healthcare and Medicare prescription drug coverage to Medicare beneficiaries.

Chronic Care

Care (different from acute care) furnished to treat an illness, injury, or condition, which does not require hospitalization (although confinement in a lesser facility might be appropriate), that may be expected to be of long duration without any reasonably predictable date of termination, and which may be marked by a recurrence requiring continuous or periodic care as necessary. See *Acute Care*.

COBRA

Consolidated Omnibus Budget Reconciliation Act. It provides for the continuation of group health benefits for certain employees and their dependents (applies to groups of 20 or more employees). A member may elect to continue coverage under COBRA if coverage would otherwise terminate as a result of a "qualifying event." (A qualifying event may be termination of employment or reduction of hours, etc.)

Coinsurance

The percentage amount that a Member is required to pay for covered services after meeting any applicable Deductible. Specific coinsurance information is provided in the member's *Summary of Benefits*.

Coinsurance (Blue Shield 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 and government-sponsored programs.

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 provides 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.

Contract Year (Blue Shield Medicare Advantage HMO and PPO Plans)

The contract year for Medicare beneficiaries begins on January 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 (e.g., July 1st or October 1st) and continues for a 12-month period.

Coordination of Benefits

A term used to describe a process to determine carrier responsibility when a plan member is covered by more than one group health plan. One of the carriers is considered the primary carrier and its benefits are paid first. Any balance is then processed by the secondary carrier, up to the limit of its contractual liability.

Copayment

The fixed dollar amount that a member is required to pay for covered services after meeting any applicable Deductible. Specific copayment information is provided in the member's *Evidence of Coverage* or *Summary of Benefits.*

Cosmetic Procedure

Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic within the broad range of normal.

Covered Services

Those medically necessary services and supplies which a member is entitled to receive pursuant to the terms of the group or individual health services contract.

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 reasonable likelihood that the disability will be so reduced.

Delegation

The process by which Blue Shield allows the IPA/medical group to perform certain functions that are considered the responsibility of Blue Shield, for the purpose of providing appropriate and timely care for Blue Shield members.

Dependent (Commercial Only)

A dependent is an individual who is enrolled and maintains coverage in the Plan, and who meets one of the following eligibility requirements, as:

1. A dependent spouse is an individual who is legally married to the Subscriber, and who is not legally separated from the Subscriber.
2. A Dependent Domestic Partner is an individual who meets the definition of Domestic Partner in the member's plan.
3. A Dependent child is a child of, adopted by, or in legal guardianship of the Subscriber, spouse, or Domestic Partner, and who is not covered as a Subscriber. A child includes any stepchild, child placed for adoption, or any other child for whom the Subscriber, spouse, or Domestic Partner has been appointed as a non-temporary legal guardian by a court of appropriate legal jurisdiction. A child is an individual less than 26 years of age (or less than 18 years of age if the child has been enrolled as a result of a court-ordered non-temporary legal guardianship. A child does not include any children of a Dependent child (i.e., grandchildren of the Subscriber, spouse, or Domestic Partner) unless the Subscriber, spouse, or Domestic Partner has adopted or is the legal guardian of the grandchild.
4. If coverage for a Dependent child would be terminated because of the attainment of age 26, and the Dependent child is disabled and incapable of self-sustaining employment, benefits for such Dependent child will be continued upon the following conditions:
    a. the child must be chiefly dependent upon the Subscriber, spouse, or Domestic Partner for support and maintenance;
    b. the Subscriber, spouse, or Domestic Partner must submit to Blue Shield a Physician's written certification of disability within 60 days from the date of the Employer's or Blue Shield's request; and thereafter, certification of continuing disability and dependency from a physician must be submitted to Blue Shield on the following schedule:
        i. within 24 months after the month when the Dependent child's coverage would otherwise have been terminated; and
        ii. annually thereafter on the same month when certification was made in accordance with item (1) above. In no event will coverage be continued beyond the date when the Dependent child becomes ineligible for coverage for any reason other than attained age.

Direct Contract

An executed agreement between Blue Shield and an individual or group of individual providers for the purpose of providing health care services to Blue Shield enrollees.

Domestic Partner (California Family Code)

An individual who is personally related to the Subscriber by a registered domestic partnership. Both persons must have filed a Declaration of Domestic Partnership with the California Secretary of State. California state registration is limited to same sex domestic partners and only those opposite sex partners where one partner is at least 62 and eligible for Social Security based on age. The domestic partnership is deemed created on the date the Declaration of Domestic Partnership is filed with the California Secretary of State.

Downstream Entity

All participating providers or other entities contracted or subcontracted with the IPA/ medical group, including but not limited to individual physicians, ancillary providers, subcontracted administrative services vendors, third party administrators or management companies, as defined by CMS and the Medicare Advantage regulations.

Durable Medical Equipment (DME)

Equipment designed for repeated use, which is Medically Necessary to treat an illness or injury, to improve the functioning of a malformed body member, or to prevent further deterioration of the patient's medical condition. Durable Medical Equipment includes wheelchairs, hospital beds, respirators, and other items that the Plan determines are Durable Medical Equipment including oxygen, ostomy, and incontinence supplies.

Durable Power of Attorney

See Advance Directives.

Electronic Data Interchange (EDI)

A computer-to-computer exchange of information between businesses. Blue Shield 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 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. The ERA replaces the paper Explanation of Payment (EOP).

Electronic Claim Submission

Electronic claim submission is the paperless submission of claims generated by computer software that is transmitted electronically to Blue Shield. Claims are submitted in the ASC X12 837 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.

Evidence of Coverage and Disclosure Form

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.

Exclusion

An item or service that is not covered under the Blue Shield health services contract.

Expedited Appeals

A member, a member representative, or a physician on behalf of the member may request an expedited appeal of a denied prior authorization request because a member is experiencing severe pain or a member's health or ability to function could be seriously harmed by waiting for a standard appeal decision. Blue Shield will make a decision on an expedited appeal as soon as possible to accommodate the patient's condition not to exceed 72 hours from receipt of the request.

A request for a 72-hour/fast appeal consideration of a prior authorization request denial in which the health plan determines a member's health or ability to function could be seriously harmed by waiting for a standard appeal decision. A member, member representative, or physician on behalf of the member may request an expedited appeal.

Expedited Initial Determination

When Blue Shield's routine decision making process might pose an imminent or serious threat to a member's health, including, but not limited to severe pain, potential loss of life, limb, or major bodily function, Blue Shield will make a decision on prior authorization requests relating to admissions, continued stays, or other healthcare services, as soon as medically indicated but no longer than 72 hours.

Expedited Review or Decision

The Knox Keene Act requires and provides for an expedited review (initial determination) and appeal process. When a member believes that his/her health and ability to function could be seriously harmed by waiting the 30 days for a standard appeal, he/she may request an expedited review (initial determination) or appeal. NCQA standards, CMS, 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 at issue.

- 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 plans.

External Review

An option provided to commercial members for consideration of:

- A medical necessity decision following an appeal; or
- An appeal under the Friedman/Knowles Experimental Treatment Act in which care for a member has been denied on the grounds that the treatment is experimental; or
- 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 which doctors, hospitals and other providers are paid for each service performed.

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 brand-name, generic, and biologic drugs.

Grievance

An expression of dissatisfaction by a member, member representative or provider on the member's behalf, and categorized as quality of care, access to care, appeal (see Appeals), or complaint.

Health Maintenance Organization (HMO)

A health care service plan that requires its members, except in a medical emergency, to use the services of designated physicians, hospitals, or other providers of medical care. HMOs have a greater control of utilization and typically use a capitation payment system.

Health Services Contract

The contract for health coverage between Blue Shield and the employer group or individual 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 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) is the main regulatory agency responsible for implementing the provisions of HIPAA. The provisions related to portability were effective July 1997. The provisions relating to Administrative Simplification will be effective at various times during 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.

HMO Benefit Guidelines (HBG)

The *HBG* supplements the *HMO IPA/Medical Group Procedures Manual* and provides Blue Shield HMO basic plan benefit interpretations and policies.

Home Health Care

Medically necessary healthcare services, including services provided by a home health agency, PKU related formulas and special food products, and home infusion/home injectable therapy at the patient's home, as prescribed by the primary care 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 HMO primary care physician's service area.

Individual Family Plan (IFP)

A health plan purchased by an individual subscriber to cover an individual or family.

Infertility

The member who has a current diagnosis of infertility and who is actively trying to conceive and has either:

1) The presence of a demonstrated bodily malfunction recognized by a licensed Doctor of Medicine as a cause of not being able to conceive; or

2) For women age 35 and less, failure to achieve a successful pregnancy (live birth) after 12 months or more of regular unprotected intercourse; or

3) For women over age 35, failure to achieve a successful pregnancy (live birth) after 6 months or more of regular unprotected intercourse; or

4) Failure to achieve a successful pregnancy (live birth) after six cycles of artificial insemination supervised by a physician (The initial six cycles of artificial insemination are not a benefit of this plan); or

5) Three or more pregnancy losses.

Initial Decision/Initial Determination

When a physician group, hospital or Blue Shield makes an initial determination for a requested service or a claim for services rendered.

Inpatient

An individual who has been admitted to a hospital as a registered bed patient and is receiving services under the direction of a physician.

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 Advantage will pay for these services.

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

The beneficiary's maximum dollar liability amount for a specified period. For Blue Shield Medicare Advantage plan members, the maximum out-of-pocket 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.

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.

Medically Necessary

Benefits are provided only for covered services that are medically necessary. Medically necessary services include only those which have been established as safe and effective and are furnished in accordance with generally accepted professional standards to treat an illness, or injury or medical condition, and which, as determined by Blue Shield, are:

- Consistent with Blue Shield medical policy; and,
- Consistent with the symptoms or diagnosis; and,
- Not furnished primarily for the convenience of the patient, the attending physician or other provider; and,
- Furnished at the most appropriate level that can be provided safely and effectively to the patient.

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

Hospital inpatient services which are Medically Necessary include only those services which satisfy the above requirements, require the acute bed-patient (overnight) setting, and which could not have been provided in a Physician's office, the outpatient department of a hospital, or in another lesser facility without adversely affecting the patient's condition or the quality of medical care rendered.

Inpatient services which are not Medically Necessary include hospitalization:

- For diagnostic studies that could have been provided on an outpatient basis;
- For medical observation or evaluation;
- For personal comfort;
- In a pain management center to treat or cure chronic pain; or
- For inpatient rehabilitation that can be provided on an outpatient basis.

Blue Shield reserves the right to review all services to determine whether they are Medically Necessary.

Medicare Advantage Organization (MAO)

A public or private entity that contracts with CMS to offer a Medicare Advantage plan. Blue Shield of California is 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 Part D vaccine administration.

Under Medicare guidelines, drugs may be covered under Medicare Part B or Medicare Part D depending upon the characteristics of the beneficiary and/or medical use of the drug. Unless otherwise indicated in the Division of Financial Responsibilities, Medicare Part B Covered Services are Group responsibility and Medicare Part D Covered Services are Blue Shield responsibility. Group is delegated for authorization of Medicare Part B drugs. If a drug does not meet LCD Medicare Part B coverage guidelines, Blue Shield will review for potential coverage under Part D, using the LCD Medicare guidelines and Blue Shield prior authorization coverage criteria.

An LCD, as established by Section 522 of the Benefits Improvement and Protection Act, is a decision by a fiscal intermediary or carrier whether to cover a particular service on an intermediary-wide or carrier-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the service is reasonable and necessary).

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.

Non-Covered Services

Health care services that are not benefits under the terms of the group or individual health services contract.

National Drug Code (NDC)

The 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 is issued by CMS to all eligible health care individual practitioners, groups and facilities. The NPI is required on all HIPAA compliant standard electronic transactions.

Opt-Out

The act of a member seeking care without a referral from the primary care physician. Depending upon with type of HMO plan involved, opt-outs might or might not be covered. If covered, members who opt out are responsible for higher out-of-pocket costs. Also called "Self-referral."

Out-of-Area Follow-up Care

Out-of-area services which are non-emergent and medically necessary in nature to evaluate the member's progress following an initial emergency or urgent service.

Out-of-Pocket Maximum

The highest deductible, copayment and coinsurance amount an individual or family is required to pay for designated covered services each year as indicated in the Summary of Benefits. Charges for services that are not covered and charges in excess of the allowable amount or contracted rate do not accrue to the Out-of-Pocket Maximum.

> *Note: Members are financially responsible for any services which are not covered by the Plan. This may result in total member payments in excess of the out-of-pocket maximum.*

Outpatient

An individual receiving services under the direction of a plan provider but not requiring hospital admission.

> *Note: For Blue Shield Preferred Plans, a length of stay past midnight is considered an inpatient admission.*

Outpatient Facility

A licensed facility, not a physician's office or a hospital, that provides medical and/or surgical services on an outpatient basis.

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

A monthly premium paid (usually deducted from a person's Social Security check) to cover Part B services in fee-for-service Medicare. Members of Blue Shield Medicare Advantage plans must continue to pay this premium to receive full coverage and be eligible to join and stay in a 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, or 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 credentialed health care professional or facility that has an agreement with Blue Shield or an IPA/medical group to provide 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 may obtain services through their HMO primary care physician or may use the PPO network option and seek care from a Blue Shield participating provider or from a non-participating provider, without consulting their primary care physician. Services received under the PPO network options are subject to applicable deductibles, copayments, and coinsurance. Services received from non-network providers are covered at the lowest benefit level. When members receive services from non-network providers they are financially responsible for the difference between the amount Blue Shield allows for those services and the amount billed by the non-network physician. Mental health and substance use disorder services are provided at the HMO and PPO non-participating levels of care.

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.

Premium Plan Benefits (Blue Shield Medicare Advantage HMO and PPO Plans)

Additional benefits beyond Medicare covered benefits. There is a plan premium associated with premium plan benefits.

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 through an IPA/medical group to provide benefits to members and to refer, authorize, supervise, and coordinate the provision of all benefits to members in accordance with their health services contract and the Plan service delivery guidelines. primary care physician is the terminology used in Blue Shield HMO/POS plans.

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 Inquiry

A telephone 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 Connection

Blue Shield's provider website at http://www.blueshieldca.com/provider.

Provider Manual

The Blue Shield *HMO IPA/Medical Group Procedures Manual*, which sets forth the operational rules and procedures applicable to Blue Shield HMO IPA/medical groups, and which is, amended and updated by Blue Shield at least annually. The Provider Manual shall include the rules, regulations or policies adopted by Blue Shield, including Blue Shield's medical policy, which may, from time to time, be communicated to physicians and providers.

Psychiatric Emergency

A mental disorder that manifests itself by acute symptoms of sufficient severity that it renders the patient as being either of the following:

- An immediate danger to himself or to herself, or to others.
- Immediately unable to provide for, or utilize, food, shelter, or clothing due to the mental disorder.

Quality Improvement Organization (QIO)

A Quality Improvement Organization (QIO) is 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 Person

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

Referral

The process by which a member obtains authorization for covered services rendered by providers other than the member's primary care physician. In the Access+ HMO program, an HMO member may self-refer, for an increased copayment, to a specialist in the same IPA/medical group for Access+ *Specialist* services.

Referred Services

A covered health service, performed by a referred-to provider, that is:

- Authorized in advance by the primary care physician and/or the IPA/medical group
- Limited in scope, duration or number of services, as authorized

Referred-To Provider

A provider to whom a member is referred for services.

Rehabilitation Service

Inpatient or outpatient care furnished to an individual disabled by injury or illness, including mental health and substance use disorders, 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.

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.

Service Area (Blue Shield Medicare Advantage HMO and PPO Plans)

The geographic area in which a person must permanently reside for initial or continued eligibility as a member of a Blue Shield Medicare Advantage plan. Blue Shield Medicare Advantage has multiple service areas within California. The specific service area in which the member permanently resides determines the Medicare Advantage plan(s) in which they may enroll. More than one Blue Shield Medicare Advantage plan may be offered in a service area.

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.

Stop-Loss

An agreement limiting the financial liability of an IPA/medical group for any given member to a specific threshold.

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.

Trio HMO

The Trio Health Maintenance Organization (HMO) is a product supported by a network of Accountable Care Organization (ACO) providers. Trio uses an integrated network delivery model across specialties and hospitals that provides coordinated care and leverages relationships with select providers in specific regions. As with a traditional HMO plan, members' care is coordinated by a primary care physician.

Urgent Services

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.

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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Appendix For Section 2

There is no appendix for Section 2.

Appendix for Section 2

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Appendix for Section 3

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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		3
ClassId		4
LineOfBusinessId		4

Blue Shield Combined Eligibility/Capitation Report

FIELD NAME	NOTES	FIELD LENGTH
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

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Appendix for Section 4

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Claims, Compliance Program, IT System Security, and Oversight Monitoring

A Supplement to the HMO IPA/Medical Group Manual

July 2022

Claims, Compliance Program, IT System Security, and Oversight Monitoring

This supplement has been written as a guide for a Delegated Entity. A Delegated Entity refers to IPA/medical groups, hospitals, specialty plans/vendors, medical service organizations, third party administrators (TPAs) or others who process claims delegated by Blue Shield of California (Blue Shield). Blue Shield hopes the information and procedures in this supplement will assist in meeting delegated requirements for Claims, Compliance Program, IT System Security, and other Regulatory Oversight Monitoring. For any questions or further assistance, please contact your assigned Delegated Oversight Auditor(s). This supplement includes the following sections:

- **Claims Introduction**
- **Key Terms and Definitions**
- **Measuring Timeliness and Accuracy**
- **Best Practices and Claim Adjudication**
    - Audits and Audit Preparation
    - Balance Billing
    - Date Stamping
    - Disbursement of Payments
    - Forwarding Claims (Misdirected)
    - Reopenings
    - Monitoring of a Subcontractor (this includes MSO) for a delegated function-offshore/onshore
    - Reporting
- **Compliance Program/Fraud, Waste, and Abuse**
    - Fraud
    - Abuse
    - Compliance Program
    - Reporting
- **IT System Security**
- **Oversight Monitoring**
- **Claims Delegate Reporting Instructions**
    - Reports

Claims, Compliance Program, IT System Security, and Oversight Monitoring

Claims Introduction

This supplement to the Blue Shield *HMO IPA/Medical Group Procedures Manual* is for the Delegated Entity that 1) processes its own claims, 2) contracts with a management company or Third-Party Administrator (TPA) to process claims on its behalf, or 3) sub-capitates (sub-delegates) some or all of its claims processing responsibilities. If the Delegated Entity is currently not processing their claims, the IPA/medical group must share this supplement with their TPA or management company or otherwise ensure that they have the latest version of this specific update. If the Delegated Entity sub-capitates claims processing, or ever contemplates doing so, please carefully read the "Sub-Capitated (Sub-Delegated) Claims Monitoring" section of this appendix below. It explains the additional responsibilities you assume when you sub-capitate the claims processing function.

By means of this supplement, Blue Shield seeks to describe and follow sound operating principles. This supplement will guide you in providing superior service to our beneficiaries and in applying industry best practices in your claims operations. It will help you to verify that you are successful in meeting all applicable requirements. Please do not hesitate to contact your assigned Blue Shield Delegated Claims Oversight Auditors directly for further information or assistance.

Based on the available data, the information in this supplement conforms to all CMS, DMHC and DOL requirements. Should information in this supplement fail to reflect any existing or newly enacted statutory requirements, these new or additional requirements will supersede the information contained herein. Blue Shield will notify the Delegated Entity of any changes in requirements through supplemental revisions or by other written communications. Throughout this document, wherever possible, Blue Shield distinguishes between Medicare Advantage (HMO) requirements and DMHC ("commercial") requirements or citations by displaying them side-by-side.

This supplement only describes claims, compliance program, IT system security and oversight monitoring. Information on other claims-related topics (i.e., claims operations coordination with Blue Shield; submission of encounter claims or data; claims appeals or grievances; Medicare Secondary Payment (MSP); and coordination of benefits (COB)) are covered in other parts of the *HMO IPA/Medical Group Procedures Manual.*

Key Terms and Definitions

Affiliated/Contracted Provider

A provider with whom the plan and/or a Delegated Entity has a signed contractual agreement in place on the date of service. A contractual agreement can be an actual written contract, a one-time letter of agreement (LOA), a memorandum of understanding (MOU), or a provider rendering services while on-call or covering for a contracted provider.

Claims Operations

Blue Shield monitors compliance and deficiencies across all aspects of Delegated Entity's claims operations: receipt and related handling, processing/adjudication, and payment. The claim operation begins when the claim is first received from the US Postal Service, electronically or by any other means and ends when the check or disbursement, explanation of benefits (EOB) or notice of denial is electronically transmitted or deposited in the US mail. These operations are defined to include computer systems and their reports, as well as utilization review, and any other ancillary operations in the workflow needed to fully process a claim and deliver the payment and/or denial.

Clean Claim

A clean claim is defined as "one which can be paid and/or denied as soon as it is received, because it is complete in all aspects, including complete coding, itemization, dates of service, billed amounts, and identification of the billing provider including tax identification number (TIN)" and the national provider identifier (NPI).

Emergency services or out-of-area urgently needed services do not need authorization to be considered "clean," providing that the presenting ICD-10-CM diagnoses codes or accompanying medical records substantiate that they qualify as emergent, urgent under the reasonable person standard.

Complete Claim

A complete claim is one that includes all necessary information to determine payor liability. Information necessary to determine payor liability for the claim includes, but is not limited to, reports or investigations concerning fraud and misrepresentation, necessary consents, releases and assignments, or other information necessary for the delegated claims operation to determine the medical necessity for the health care services provided.

Emergency services or out-of-area urgently needed services do not need authorization to be considered "complete," providing that the diagnoses codes or accompanying medical records substantiate that they qualify as emergent, urgent under the reasonable person standard.

Compliance

Compliance means conforming to a rule, such as a specification, policy, standard or law**.** Regulatory compliance describes the goal that organizations aspire to achieve in their efforts to ensure that they comply with relevant laws, policies, and regulations.

Key Terms and Definitions *(cont'd.)*

Date of Payment

The date of postmark or electronic mark accurately setting forth the date when the payment was electronically transmitted or deposited in the U.S. Mail or another mail or delivery service, correctly addressed to the claimant's office or other address of record.

Date of Receipt

Commercial

The working day when a claim, by physical or electronic means, is first delivered to either the plan's specified claims payment office, post office box, or designated claims processor or to the plan's contracted Delegated Entity for that claim. In the situation where a claim is sent to the incorrect party, the "date of receipt" shall be the working day when the claim, by physical or electronic means, is first delivered to the correct party responsible for adjudicating the claim.

Medicare Advantage

The working day when a claim, by physical or electronic means, is first delivered to either to the plan's specified claims payment office, post office box, clearing house, or to the plan's contracted Delegated Entity. For Medicare Advantage, the earliest date, either from Blue Shield or any of the Blue Shield's Delegated Entities, determines the received date of the claim unless documentation can be provided to validate that the earliest stamp(s) does not belong to the Blue Shield network.

Delegated Entity

Any party who enters into a legal agreement by which an organization gives another entity the authority to perform certain functions on its behalf. Although an organization may delegate the authority to perform a function, it may not delegate the responsibility for ensuring that the function is performed appropriately.

HMO

Health Maintenance Organization. A type of health insurance plan that usually limits coverage to care from doctors who work for or contract with the HMO. Generally, an HMO will not cover out-of-network care except in an emergency or when authorized.

Incomplete Claims

A claim or portion thereof, if separable, including attachments and supplemental information or documentation, which does not provide: "reasonably relevant information" and "information necessary to determine payor liability.

Key Terms and Definitions *(cont'd.)*

Medicare Advantage

The product line offered to enrolled members who have Medicare Part A and Part B and reside within the plan's service area.

Member Denial

An adverse benefit determination in which a claim, or any line item(s) on a claim, will not be paid and the member is responsible for payment of the service. Non-eligibility not authorized non-contracted, and/or excluded services are examples of potential member liability denials.

Closing a claim without issuing a payment is not a member denial unless the member is responsible to pay for the service rendered. A second denial notice may not be mailed to the member for the service provided.

Monitoring

Federal and state law specifically requires monitoring of compliance over Delegated Entities. Monitoring for compliance assesses the Delegated Entity's claims operation's ability to meet timeliness and accuracy requirements. Blue Shield reviews both the monthly and quarterly claims timeliness reports, conducts annual/periodic auditing as part of our compliance monitoring program and expects every Delegated Entity to monitor itself. Blue Shield expects the delegated claims operation to maintain a complete program of "continuous quality improvement" (CQI) to detect deficiencies early and implement corrective actions.

Principal Officer

Each Delegated Entity that has claims delegated must designate a Principal Officer for claims and provider disputes. These officers are responsible for attesting to compliant operations and for reporting the timeliness of those operations. The Principal Officer is the president, vice-president, secretary, treasurer, or chairman of the board of a corporation, a sole proprietor, the managing general partner of a partnership, or a person having similar responsibilities or functions.

The Principal Officer must sign the quarterly timeliness reports for both claims and provider disputes and Disclosure of Emerging Claims Payment Deficiencies. To designate an individual as Principal Officer or report a change of Principal Officer, request a form from the Blue Shield assigned claims auditor or retrieve the form from the ICE website and submit an original copy with original signatures to Blue Shield. The Principal Officer form should be submitted by email to ClaimsDelegateReport@blueshieldca.com.

Key Terms and Definitions *(cont'd.)*

Provider Dispute Resolution (PDR)

A written provider dispute that includes all information required under state regulations:

(1) Clear identification of the disputed item(s).

(2) The date of service(s)

(3) Clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, denial, or other action is incorrect.

Provider Dispute Resolution (PDR) Process - Commercial

A formal process for receiving, resolving, and reporting provider disputes for commercial claims relating to billing, claims, contracts, and utilization management is mandated for delegated payors.

Provider Dispute Resolution (PDR) Process - Medicare Advantage

A formal process for receiving, resolving, and reporting provider disputes for Medicare Advantage claims relating to payment non-contracted provider claims only.

Unaffiliated/Non-Contracted Provider

Commercial

A provider with whom the plan and/or its contracted Delegated Entity does not have a signed contractual agreement in place on the date of service (often referred to as a non-contracted or out of network provider). A contractual agreement can be an actual written contract, a one-time letter of agreement (LOA), a memorandum of understanding (MOU), or a provider rendering services while on-call or covering for a contracted provider. Delegated Entities may not utilize Blue Shield reciprocity and/or PPO rates without the written consent of the health plan. Commercial non-contracted provider claims must be adjudicated within 45 working days of the received date to be considered compliant.

Medicare Advantage

A provider with whom the plan and/or its Delegated Entities does not have a signed contractual agreement in place on the date of service (often referred to as a non-contracted or out of network provider). A non-contracted/unaffiliated provider claim must be adjudicated within 30 calendar days from the earliest date received to be considered compliant.

Unclean Claims - Medicare Advantage

An "unclean claim" is defined as an incomplete claim, a claim that is missing any of the above information, or a claim that has been suspended in order to get more information from the provider.

Key Terms and Definitions *(cont'd.)*

Contested Claims - Commercial

A contested claim is defined as a claim or portion thereof that is reasonably contested where the delegated claims operation has not received the completed claim and all information necessary to determine payor liability or has not been granted reasonable access to information concerning provider services. When appropriate, claims may need to be contested for additional information, e.g., medical records and chart notes. Contested claims include provider denials and claims pended or closed before a coverage determination can be made. Commercial contested claims must be adjudicated within 45 working days of the received date to be considered compliant.

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

Measuring Timeliness and Accuracy

Timeliness for claims and disputes is measured from the date the claim or provider dispute is received to the date the check or disbursement, explanation of benefits, denial notice, or dispute resolution correspondence is mailed.

Acknowledgement of Receipt

Commercial

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

Commercial Provider Dispute Resolution (PDR)

The Delegated Entity must acknowledge receiving electronic provider disputes within two (2) working days of receipt and paper provider disputes within 15 working days of receipt.

Check Cashing Timeliness

Blue Shield accepts the check or electronic transfer date as reasonable evidence of mailing, provided no operational or systematic delays are documented via a formal Policy and Procedure. As evidence that the check has been mailed, the Delegated Entity can provide a check mail log that has been signed by a Principal Officer or CFO who is attesting to checks being mailed on the dates reported. Blue Shield will confirm the date the check or electronic transfer was cleared to the Delegated Entity's bank account during the audit process. Blue Shield requires that a minimum of 70% of all checks be presented for deposit within 14 calendar days of the date the check is reported to have been mailed. If the check clearing timeliness is below 70%, Blue Shield requires the Delegated Entity to submit a check cashing attestation to be completed by each provider. The attestation can be requested from your assigned claims delegation oversight auditor.

Measuring Timeliness and Accuracy *(cont'd.)*

Fee Schedule Accuracy

Commercial

Contracted providers must be paid accurately at contracted rates. During a claims delegation audit this is demonstrated by the Delegated Entity providing the header page and the signature page of the provider contract with the fee schedule and evidence of the system configuration.

Non-contracted providers may be paid at a reasonable and customary (R&C) fee schedule which requires the Delegated Entity as mandated by Title 28 CCR 1300.71(a)(3):

(B) For contracted providers without a written contract and non-contracted providers, except those providing services described in paragraph (C) below: the payment of the reasonable and customary value for the health care services rendered based upon statistically credible information that is updated at least annually and takes into consideration: (i) the provider's training, qualifications, and length of time in practice; (ii) the nature of the services provided; (iii) the fees usually charged by the provider; (iv) prevailing provider rates charged in the general geographic area in which the services were rendered; (v) other aspects of the economics of the medical provider's practice that are relevant; and (vi) any unusual circumstances in the case; and

(C) For non-emergency services provided by non-contracted providers to PPO and POS enrollees: the amount set forth in the enrollee's Evidence of Coverage.

Medicare Advantage

Title 42, Part 422, Section 214 mandates that "Any provider that does not have in effect a contract establishing payment amounts for services furnished to a beneficiary enrolled in a Medicare Advantage private fee-for-service plan must accept, as payment in full, the amounts that the provider could collect if the beneficiary were enrolled in original Medicare."

Blue Shield will accept the following in determining accuracy on non-contracted 30-day claims based on the location of where the services were rendered:

(1) "Participating" providers are paid at a published Medicare fee schedule less any standard copayment amount,

(2) "Non-participating" providers who accept assignment are paid 95% of a published Medicare fee schedule less any standard copayment amount, and

(3) "Non-participating" providers who do not accept assignment are paid at the "Limiting Charge," This charge is the amount that non-participating providers are "limited" to charge for that service. The amount is 115% of the non-par fee allowance service.

Measuring Timeliness and Accuracy *(cont'd.)*

Interest Accuracy

Commercial

Interest is applicable for contracted and non-contracted providers claims paid later than the statutory deadline. Interest must be paid beginning with the first day after deadline through the day the payment/ check is mailed.

Interest is due on adjustments found in favor of the provider (in whole or in part) when the Delegated Entity was at fault with the original claim process. Interest would be calculated from the original received date of the claim through the date of the mailing of the adjustment payment.

The interest rate is fixed at a 15 percent annual rate. The amount of interest is calculated by multiplying the daily rate times the number of calendar days late, times the dollar amount paid. The interest should be included with the claim payment except as noted below.

To avoid a mandated $10.00 per claim penalty, the interest must be paid "automatically." Automatically means that the full amount of interest warranted must be included with the claim payment or mailed within five working days of the original claim payment. If the warranted amount of interest is underpaid, the mandated $10.00 per claim penalty must be paid along with the additional interest due.

If the interest amount is less than $2.00 the interest may be paid on that claim along with interest on other such claims within ten (10) calendar days of the close of the calendar month in which the claim was paid as long as a statement identifying the specific claims for which the interest being paid is included.

For claims involving emergency services, the minimum amount of interest due is the greater of either $15.00 for each 12-month period or 15 percent per annum calculated as described above.

Medicare Advantage

Clean claims from unaffiliated/non-contracted providers, including adjustments, in which the payor was at fault on the initial determination that are paid later than the statutory deadline requires interest to be paid. Interest is to be calculated beginning on the thirty-first calendar day through the day the check is mailed.

Interest is due at the current Federal Prompt Payment Interest Rate, which is updated each January and July. The current interest rate can be found at https://www.fiscal.treasury.gov/prompt-payment/rates.html. Interest is to be calculated based on (1) the number of calendar days over thirty (30), (2) the current Medicare interest rate and (3) the amount paid. The daily rate is the result of dividing the interest rate in effect at the time the claim was paid by 365 or 366 in the case of a leap year.

The amount of interest is calculated by multiplying the daily rate, times the number of calendar days over 30, times the dollar amount paid. The interest should be included with the claim payment.

Measuring Timeliness and Accuracy *(cont'd.)*

Measuring Timeliness

Commercial Claims

Claim processing begins when a claim is first delivered to delegated payor's office. The number of days measured are "working" days. The time limit to make payment – 45 working days – applies to all claims, without regard to whether the billing provider is contracted or non-contracted. If a claim is to be contested, the notice to that effect must be mailed within 45 working days.

Member denial notices must be mailed within 30 calendar days of receipt of the claim to fulfill the ERISA regulations. This policy blends requirements from ERISA regulations and the California Health and Safety Code. To fulfill the state regulations all denial notices must be mailed within 45-working days.

Commercial Provider Dispute Resolution

Resolution and a written determination must be completed within 45 working days after the date of receipt of the provider dispute or the amended provider dispute. If the provider dispute is overturned in favor of the provider, payment is due within five (5) working days of the issuance of the written determination. If the payment is issued prior to the written determination, the written determination is due to the provider within five (5) working days of the issuance of the payment. Interest and penalties on disputes which result in determination in favor of the provider should be calculated beginning 45 working days following the date of receipt of the original complete claim.

Medicare Advantage Claims

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

Measuring Timeliness and Accuracy *(cont'd.)*

Measuring Timeliness *(cont'd.)*

Medicare Advantage Provider Dispute Resolution/Appeals

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

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

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

Member Denial Notice

Commercial

A denied claim is a claim where (1) one or more services will not be paid by the Delegated Entity's claims operation and (2) payment is the financial responsibility of the member.

Member denied claims are reported and monitored separately from paid and "contested" claims. Provider-denials are reported and audited along with other contested claims.

Examples of claims that are not member denials and should not be reported, submitted, or presented to Blue Shield as member liability "denied" claims include:

- Patients who remain enrolled with the health plan but have transferred from one Delegated Entity to another must be forwarded to the health plan or the other entity for processing;
- Duplicates to claims already paid or denied must be denied as duplicates, a second denial notice may not be mailed to the member;
- Encounter only, and capitated claims;
- Denials to a contracting provider who must write off the unpaid claim (unless the provider has written evidence that the member understood and accepted payment responsibility); or
- Reduced payment amounts due to contract terms, or correction of billing errors such as bundling or inaccurate coding.

Measuring Timeliness and Accuracy *(cont'd.)*

Member Denial Notice *(cont'd.)*

Medicare Advantage

A denied claim is a claim where (1) one or more services will not be paid by the provider claims operation and (2) payment is the financial responsibility of the member.

Examples of claims that are not member denials and should not be reported, submitted, or presented to the health plan as member liability "denied" claims include:

- Patients who remain enrolled with the Health Plan but have transferred from Delegated Entity to another and you are just forwarding the claim to the health plan or the other entity for processing;
- Patients who remain capitated to your organization, but payment responsibility belongs to another contracting entity (health plan or hospital) and you are forwarding the claim;
- Duplicates to claims already paid or denied;
- Encounter only, and capitated claims;
- Denials to a contracting provider who must write off the unpaid claim (unless the provider has written evidence that the member understood and accepted payment responsibility); or
- Correction of billing errors such as bundling or inaccurate coding.

Member Denial Notice – Standards

Commercial

When health plans and Delegated Entities make decisions to deny claims that result in liability for the enrollee, those decisions must be in accordance with DMHC and DOL law and regulations (ERISA), including required coverage for emergency care taking the "reasonable person" standard into account. The member must be given clear information including phone numbers and mailing addresses to assist them in contacting the health plan, the delegated claim operations, or the consumer assistance agencies for more information or to appeal the denial decision.

Once a denial notice has been sent, no further adverse notices may be sent to the member for the service provided.

All member denial and emergency service denial letters must include the diagnosis code and treatment with the corresponding meaning for each.

Denial letters sent to members should include Section 1557 of the Affordable Care Act of 2010 which prohibits discrimination based on race, color, national origin, sex, age, or disability in certain health programs and activities. Members must be notified about their rights under Section 1557. Specifically, delegated entities must include a nondiscrimination notice in English and taglines in at least the top 15 non-English languages spoken by individuals with limited English proficiency with every member liability denial notice.

Measuring Timeliness and Accuracy *(cont'd.)*

Member Denial Notice – Standards *(cont'd.)*

Medicare Advantage

Federal law, regulations and CMS guidelines govern initial coverage determinations that are adverse to a Medicare beneficiary (i.e., denials that result in financial liability for the beneficiary).

These requirements apply to health plans and thereby to any entity in which authority to make coverage determinations has been delegated. When an adverse determination has been made, the current CMS approved Integrated Denial Notice (IDN) letter format must be sent to the member.

Any changes to Integrated Denial Notices will be sent out annually as applicable.

Each IDN letter should include Section 1557 of the Affordable Care Act of 2010 which prohibits discrimination based on race, color, national origin, sex, age, or disability in certain health programs and activities. Members must be notified about their rights under Section 1557. Specifically, covered entities must include a nondiscrimination notice in English and taglines in at least the top 15 non-English languages spoken by individuals with limited English proficiency with every Integrated Denial Notice.

All Integrated Denial Notices (IDN) must contain the Blue Shield Medicare Advantage plan CMS material identification number along with the CMS approved expiration date. The most current IDN letter may be obtained through the Blue Shield's Delegated Oversight Department - Claims.

If identified that the member is eligible with Blue Shield but assigned to another Delegated Entity, the claim must be forwarded to the appropriate payor or denied to the provider of service informing them that another payor is responsible. It is not a member liability.

Medicare Advantage - Opt Out

Any provider that has chosen not to participate with the CMS Medicare program may not provide services to a Medicare member without notifying the member in advance that they have elected to opt out of the CMS Medicare program. Upon advanced notification, the member would be responsible for the payment of the services rendered.

Measuring Timeliness and Accuracy *(cont'd.)*

Overpayment

Commercial

The Delegated Entity has a total of 365 calendar days from the date of payment to initiate an overpayment request. The request must be in writing and allow the provider of service a minimum of 30 working days to contest and/or refund the overpayment. The Delegated Entity may only offset an uncontested notice of reimbursement of the overpayment of a claim against a provider's current claim submission when (1) the provider fails to reimburse within the 30-working day timeframe and (2) the provider has entered into a written contract specifically authorizing the Delegated Entity to offset an uncontested notice of overpayment of a claim from the contracted provider's current claims submissions.

Medicare Advantage

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

Payment Accuracy

Commercial

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

Medicare Advantage

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

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

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

Measuring Timeliness and Accuracy *(cont'd.)*

Timely Filing

Commercial

The Department of Managed Health Care enacted regulations related to claims settlement and dispute resolution practices of health plans and their delegated IPA/medical groups ("AB 1455 Regulations"). Among other things, the AB 1455 Regulations provide timely filing limitations for commercial claims depending on the provider's status. Timeframes for filing claims for contracted and non-contracted providers are as follows:

- Contracted – A deadline of less than ninety (90) days after the date of service may not be imposed.
- Non-contracted – A deadline of less than one hundred eighty (180) days after the date of service may not be imposed

Medicare Advantage

- Claims with dates of service January 1, 2010 and later received more than one calendar year beyond the date of service will be denied as being past the timely filing deadline.

Medicare Advantage Provider Dispute Resolution (PDR)/Appeal

The submission of a first level provider dispute/appeal must be filed within a minimum of 120 calendar days after the notice of initial determination (i.e., explanation of benefits, remittance advice, and/or letters). Additional filing requirements are as follows:

- Payor may allow an additional 5 calendar days for mail delivery
- The payor may extend the time limit for filing a provider dispute/appeal if good cause is shown

Unclean or Contested Claims (Affiliated or Unaffiliated Providers)

Commercial (Contested)

The Delegated Entity may contest incomplete claims and disputes for missing information. The claim may either be pended and/or contested to the provider and may include a statement that it will receive no further attention if no reply is received. Contested claims are not to be reported as member denials. The contested or pended claims must be closed prior to the 45th working day. No denial notice should be sent to a member when "closing" a claim pending receipt of additional information.

Medicare Advantage (Unclean)

For Medicare Advantage claims, two separate attempts are recommended to obtain missing information allowing sufficient time for the provider to respond to each request and indicating the claim will be denied by the 60th calendar day if no response is received. By the 55th calendar day post receipt of the claim, an initial determination to pay or deny the claim must be made based on the information available.

Best Practices and Claim Adjudication

In this section as well as prior sections, the terms "our" or "your" refer both to health plans and to the Delegated Entity. Best practices are recommended for everyone involved in claims processing. When the word "must" is used, Blue Shield regards the standard as the requirement to be met.

Audits and Audit Preparation

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

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

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

Regulatory Audit

In the event CMS or the DMHC require that Blue Shield conduct additional compliance oversight, Blue Shield will require the Delegated Entity to participate within the regulator-specified time schedules or deadlines and provide the material in the format requested in the timeframe as stipulated by the regulators. Refusal to do so will result in an escalation to the Delegation Oversight Committee

Best Practices and Claim Adjudication *(cont'd.)*

Balance Billing

Commercial

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

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

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

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

AB 72

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

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

Medicare Advantage

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

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

Best Practices and Claim Adjudication *(cont'd.)*

Date Stamping

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

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

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

Disbursement of Payments

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

Best Practices and Claim Adjudication *(cont'd.)*

Forwarding Claims (Misdirected)

Billing providers often submit claims and disputes to the incorrect payor. It is a requirement that the Delegated Entity forward claims directly to the financially responsible entity, if known, otherwise deny with a remit message informing the provider the Delegated Entity is not financially responsible for processing of the claim.

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

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

Commercial Forwarding Timeliness

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

Medicare Advantage Forwarding Timeliness

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

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

Reopenings

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

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

Reference Materials for Reopenings

- 42 CFR 405.980
- MLN Matters Number SE 1426
- Medicare Manual Chapter 34
- Medicare Managed Care Manual Part C & D Enrollee Grievances, Organization/Coverage Determinations and Appeals Guidance
- https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS018912
- https://www.cms.gov/Medicare/Appeals-and-Grievances/MMCAG/ORGDetermin

Best Practices and Claim Adjudication *(cont'd.)*

Monitoring of a Subcontractor (this includes MSO) for a delegated function-offshore/onshore

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

The Delegated Entity is expected to require the sub-delegated claims organization to meet all regulatory requirements and criteria discussed in this supplement. The Delegated Entity must perform the same tasks, e.g., delegation oversight of claims processing, that Blue Shield carries out as the Health Plan, including obtaining timely monthly reporting from them, and include their statistics in the Delegated Entities reports to Blue Shield. The Delegated Entity must audit the sub-delegated organization annually/periodically and require corrective action plan implementation when their performance results are not compliant. If the sub-delegated organization fails to achieve compliance, the Delegated Entity needs to take the appropriate actions to achieve compliance. If the Delegated Entity sub-delegates claims functions, they will need to demonstrate and provide evidence of their oversight of that entity during the on-site audit. If the Delegated Entity outsources claims functions, that will also need to be monitored.

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

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

Reporting

Claims Reports

Monthly/Quarterly self-reports must be submitted on the ICE industry-standard templates. Report templates and detailed instructions can be found in this appendix under **Claims Delegate Reporting Instructions.**

Compliance Program/Fraud, Waste, and Abuse

Blue Shield requires the Delegated Entity to have a compliance program. It is a best practice that the Delegated Entity models the compliance plan requirements as established by the Centers for Medicare & Medicaid Services (CMS) which requires the health plan and its Delegated Entities to have a compliance program that includes code of conduct, reporting of compliance incidents, monitoring of operational compliance and internal controls and that guards against potential fraud, waste, and abuse. The compliance program must include requirements/elements from both state and federal regulations. The compliance program must include continual education, monitoring and annual training completed by December 31st of each year.

Blue Shield will perform review of Delegated Entity's Compliance Program including assessment of the compliance material (program, P&Ps, etc.), organizational structure, training of staff, performance of internal control audits, etc. This oversight is performed either via shared audit through ICE or individually on an annual basis.

Fraud

Fraud is the intentional deception or misrepresentation that an individual knows, or should know, to be false, or does not believe to be true, and makes, knowing the deception could result in some unauthorized benefit to himself or some other person(s). An example of fraud is when a provider purposely bills for services that were never given or bills for a service that has a higher reimbursement than the service provided

Abuse

Abuse includes, but is not limited to, the following improper behaviors or billing practices:

- Billing for a non-covered service;
- Misusing codes on the claim (i.e., the way the service is coded on the claim does not comply with national or local coding guidelines or is not billed as rendered);
- Inappropriate allocating costs on a cost report; or
- Payment for items or services that are billed by mistake by providers but should not be paid for by Medicare. This is not the same as fraud.

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

Compliance Program

Key components of a strong compliance program should include but are not limited to:

1. Written policies, procedures, and standards of conduct articulating the organization's commitment to comply with all applicable federal and state standards.
2. The designation of a compliance officer and compliance committee accountable to senior management.
3. Procedures for conducting claims compliance/internal control audits.
4. The procedures that will be taken to report the suspected fraud to Blue Shield.
5. Effective training and education between the compliance officer and the employees, managers, directors, and the downstream and related entities.
6. Effective lines of communication between the compliance officer, members of the compliance committee, the employees, managers and directors, and the downstream and related entities.
7. Enforcement of standards through well-publicized disciplinary guidelines.
8. Procedures for effective internal monitoring and auditing.
9. Procedures for ensuring prompt responses to detected offenses and development of corrective action initiatives relating to the organization's contract.
10. Respond to and initiate corrective action to prevent similar offenses including a timely responsible inquiry.
11. Conduct timely and reasonable inquiries.
12. Conduct appropriate corrective actions in response to the potential violation.
13. Include procedures to voluntarily self-report potential fraud or misconduct to the health plan, state, and federal regulators.
14. Development and implementation of regular, effective education, and training that occurs annually.
15. Retain records of the annual training of employees, including attendance logs and material distributed at training sessions.
16. Policies to consistently enforce standards and addresses dealing with individuals or entities that are excluded or precluded from participating in CMS programs.
17. Include a system to receive, record, and responds to compliance questions, or reports of potential or actual non-compliance, while maintaining confidentiality. The Delegated Entity will report compliance concerns and suspected or actual misconduct without retaliation when reporting in good faith to Blue Shield.
18. Policy shall allow any state, federal government, or CMS to conduct on-site audits.
19. Performance of data analysis of procedures codes, diagnostic codes, utilization, quantity, etc., to detect fraud.

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

20. Ensure program includes the monitoring of claims for accuracy which includes ensuring coding reflects services provided.
21. Be able to produce proof to show compliance with all requirements.
22. Check the Office of Inspector General (OIG) and the General Services Administration (GSA) exclusion lists for all new employees and on a regular basis or at least once a year thereafter to validate that employees and other entities that assist in the administration or delivery of services are not included on such lists.
23. Check the Office of Inspector General (OIG) and the General Services Administration (GSA) exclusion lists for all providers on a regular basis to validate that the providers that assist in the administration or delivery of services are not included on such lists.

Reporting

Please use one of the following ways to report fraud, waste, and abuse to Blue Shield:

- Call the Blue Shield 24-hour Anti-Fraud Hotline at (800) 221-2367. This hotline is managed by Blue Shield's Special Investigations Unit.
- Send an email to MedicareStopFraud@blueshieldca.com.
- Submit an inquiry via the internet at blueshieldca.com/fraud-report.

CMS and DMHC mandates that each health plan and its Delegated Entities have a Compliance, Fraud, Waste, and Abuse program in place and further mandates that all employees are required to take the training, at a minimum, annually. To ensure Blue Shield is meeting all CMS and DMHC requirements, Delegated Compliance Oversight will perform an annual review of each Delegated Entity's Compliance Program, including a Fraud, Waste, and Abuse program and assurance that all employees have taken Compliance Program training.

IT System Security

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

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

Oversight Monitoring

Delegated Entity shall implement controls to ensure internal processes are monitored for integrity of mechanisms and procedures to promote accountability and prevent fraud.

- Group shall not allow the same person or departments to have the ability to pay claims and enter or update new providers, vendors and/or eligibility;
- Group shall provide staffing levels and organizational capacity to ensure operations are consistent and maintained at all times;
- Group shall maintain a compliance program, and that the program is independent of fiscal and administrative management;
- Group shall ensure personnel have appropriate access to data, consistent with their job requirements; and
- Group shall ensure that any and all changes made to data contained in entities; databases are logged and audited.

Claims Delegate Reporting Instructions

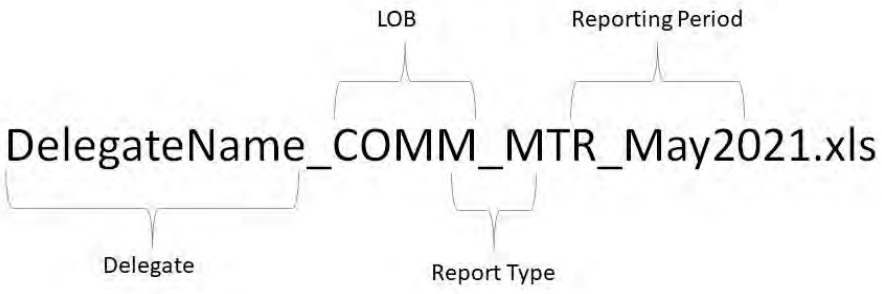
Please email reports to the following contacts:

Report Type	Contact
Disclosure of Emerging Claim Deficiencies	ClaimsDelegateReport@blueshieldca.com
MTR	ClaimsDelegateReport@blueshieldca.com
ODAG	ClaimsDelegateReport@blueshieldca.com
PDR	ClaimsDelegateReport@blueshieldca.com
Principal Officer Form	ClaimsDelegateReport@blueshieldca.com
SARAG	ClaimsDelegateReport@blueshieldca.com

Report files should be named to identify the Group, LOB, Report Type, and Reporting Period. Following this naming convention will uniquely identify the report and help streamline the reporting process.

File Naming Convention	Description
Delegate	The delegated entity's name or an acronym which represents the group.
LOB	Commercial (COMM) Medicare (MCR)
Report Type	Disclosure of Emerging Claim Deficiencies (DECD) MTR (MTR) ODAG (ODAG) PDR (PDR) Principal Officer Form (POF) SARAG (SARAG)
Reporting Period	Identify the period being reported on, i.e., Jan2021, 2021Q1, etc.

Below is an example of the file name for the Comm MTR report for group "DelegateA", covering the month of May 2021.



Reports

Review all the Monthly/Quarterly report requirements. Please submit the Excel/Word report in addition to the signed document. Reports that do not meet reporting standards or have issues will be returned with a request to correct the inconsistencies. Prompt submission is expected to ensure timely reporting.

1. Disclosure of Emerging Claim Deficiencies

In accordance with the California Code Regulation (Title 28, Section 1300.71-Claims Settlement Practices), delegated entities that report claims deficiencies, must complete a Disclosures of Emerging Claims Payment Deficiencies form. The delegated entity will identify the reason for such reported deficiencies by selecting series of check mark boxes, which explain the lack or thereof compliance during the reporting period.

For quarterly reports, the delegated payor's Principal Officer(s) must sign this form. As each report includes a statement attesting to the accuracy of the information provided, it is the responsibility of the signer to ensure the information provided is accurate.

Line of Business (LOB)	Due Date	Report Template (double click icon)
Commercial	Claims Settlement Practice reports are submitted quarterly. The reports are due by the last day of the month following the end of the reported quarter. If the last day of the month falls on a weekend or holiday, the reports are due the next business day. • Q1 report due April 30th • Q2 report due July 31st • Q3 report due October 31st • Q4 report due January 31st of the following year.	AB1455 Claims Settlement Practices

2. Monthly Timeliness Report (MTR) (Commercial)

Claims must be processed within 45 working days.

For quarterly reports, the delegated payor's Principal Officer(s) must sign this form. As each report includes a statement attesting to the accuracy of the information provided, it is the responsibility of the signer to ensure the information provided is accurate.

Line of Business (LOB)	Due Date	Report Template (double click icon)
Commercial	Reports are submitted monthly. The reports are due by the 15th of the month following the end of the reported month. If the 15th of the month falls on a weekend or holiday, the reports are due the next business day. At the end of each reporting quarter, submit a report for the full quarter. The reports are due by the last day of the month following the end of the reported quarter. If the last day of the month falls on a weekend or holiday, the reports are due the next business day. • January report due February 15th • February report due March 15th • Q1 report due April 31st • April report due May 15th • May report due June 15th • Q2 report due July 31st • July report due August 15th • August report due September 15th • Q3 report due October 31st • Oct report due November 15th • November report due December 15th • Q4 report due January 31st of the following year	 ICE_Claims_Comm_ MoQtr_Final_rev_01

3. Monthly Timeliness Report (MTR) (Medicare)

Note: CMS Contract Numbers H0504 and H5928 are reported together under Blue Shield.

The Claims Monthly Timeliness Report is designed to report, without duplication, actions completed (i.e., claims finalized during each month). It includes claims finalized during the month being reported. Plans are to report requests for payment and services, as described in the Part C Technical Specifications, for non-contracted providers and enrollee representative. Do not include:

- Adjustments to previously paid claims
- Interest-only payments
- Claims forwarded to the financially responsible entity for payment
- Duplicate claims
- Encounter-only claims for services sub-capitated to other providers, or claims paid solely as a means of allocating capitation (and the member could never be liable for a denial)

For quarterly reports, the delegated payor's Principal Officer(s) must sign this form. As each report includes a statement attesting to the accuracy of the information provided, it is the responsibility of the signer to ensure the information provided is accurate.

Line of Business (LOB)	Due Date	Report Template (double click icon)
Medicare	Reports are submitted monthly. The reports are due by the 15th of the month following the end of the reported month. If the 15th of the month falls on a weekend or holiday, the reports are due the next business day. At the end of each reporting quarter, submit a report for the full quarter, include the "ClaimSource", "EnrolleeSource" and "ReopeningSource" tabs. The reports are due by the last day of the month following the end of the reported quarter. If the last day of the month falls on a weekend or holiday, the reports are due the next business day. • January report due February 15th • February report due March 15th • Q1 report due April 31st • April report due May 15th • May report due June 15th • Q2 report due July 31st • July report due August 15th • August report due September 15th • Q3 report due October 31st • October report due November 15th • November report due December 15th • Q4 report due January 31st of the following year	ICE_CMS_MA_MTR_revised_09_2020.xlsx

4. Payment Dispute Resolution (PDR) (Commercial)

For quarterly reports, the delegated payor's Principal Officer(s) must sign this form. As each report includes a statement attesting to the accuracy of the information provided, it is the responsibility of the signer to ensure the information provided is accurate.

Line of Business (LOB)	Due Date	Report Template (double click icon)
Commercial	At the end of each reporting quarter, submit a report for the full quarter. The reports are due by the last day of the month following the end of the reported quarter. If the last day falls on a weekend or holiday, the reports are due the next business day. • Q1 report due April 31st • Q2 report due July 31st • Q3 report due October 31st • Q4 report due January 31st of the following year	ICE_Claims_ComlQtrProvDisputesRpt_10

5. Payment Dispute Resolution (PDR) (Medicare)

Note: CMS Contract Numbers H0504 and H5928 are reported together under Blue Shield.

For quarterly reports, the delegated payor's Principal Officer(s) must sign this form. As each report includes a statement attesting to the accuracy of the information provided, it is the responsibility of the signer to ensure the information provided is accurate.

Line of Business (LOB)	Due Date	Report Template (double click icon)
Medicare	At the end of each reporting quarter, submit a report for the full quarter. The reports are due by the last day of the month following the end of the reported quarter. If the last day falls on a weekend or holiday, the reports are due the next business day. • Q1 report due April 31st • Q2 report due July 31st • Q3 report due October 31st • Q4 report due January 31st of the following year	CMS_Qtr_ProvDispute_Rpt_Final_012019

6. Principal Officer Form

The Principal Officer is the president, vice-president, secretary, treasurer, or chairman of the board of a corporation, a sole proprietor, the managing general partner of a partnership, or a person having similar responsibilities or functions.

Line of Business (LOB)	Due Date	Report Template (double click icon)
All LOBs	Reports are due by the end of September each year (annually). Also, submit updated reports whenever changes occur to Principal Officer(s) at the delegated entity.	PrincipalOfficerForm.docx

7. Organization Determinations, Appeals, and Grievances (ODAG)

- Include all requests processed as both contract and non-contract provider denied claims and only non-contract provider paid claims.
- Exclude all requests processed as direct member reimbursements, dismissals, duplicate claims and payment adjustments to claims, reopenings, claims denied for invalid billing codes, denied claims for beneficiaries who are not enrolled on the date of service, withdrawn requests and claims denied due to recoupment of payment.
- Submit payment organization determinations (claims) based on the date the claim was paid, or should have been paid, or the notification date of the denial, or the date the denial notification should have been sent (the date the request was initiated may fall outside of the review period).
- If a claim has more than one line item, include all of the claim's line items in a single row and enter the multiple line items as a single claim.

Line of Business (LOB)	Due Date	Report Template (double click icon)
Medicare	At the end of each reporting quarter, submit a report for the full quarter. The reports are due by the 5th of the month following the end of the reported quarter. If the 5th falls on a weekend or holiday, the reports are due the next business day. • Q1 report due April 5th • Q2 report due July 5th • Q3 report due October 5th • Q4 report due January 5th of the following year	

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Qualifying Medical Benefit Drug Claims Submission Instructions

Box #	Instruction
1-24 C	Follow CMS 1500 Claim Form Instructions.
24 D	Provide the appropriate Blue Shield HCPCS or CPT Code based on the drug and dosage being billed. Include the National Drug Code (NDC), description, and total dosage provided for drugs. Please contact your Provider Relations Coordinator for the most up-to-date listing.
24 E – 24 F	Follow CMS 1500 Claim Form Instructions.
24 G	Provide the total units provided per date of service and procedure code billed. Example: If 1000 mgs of Rituxan was provided on 09/01/00, then procedure J9310 (Rituxan 100 mg) would be billed with 10 units of service.
24 H – 24 J	Follow CMS 1500 Claim Form Instructions.
25	Enter the IPA's Federal Tax Identification Number.
26 – 32	Follow Sample CMS 1500 Claim Form Instructions.
33	Enter the IPA's Name, Address, Phone Number, and five-digit IPA Number preceded by IPA0. Example: Name of IPA, 123 Any Street, Any Town, CA 12345, 999-999-9999, IPA012345

Note: Claims for qualifying immunizations and injectables must not be combined with any other services on the claim form and must be submitted separately from encounter data.

Qualifying Medical Benefit Drug Claims Submission Instructions

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Development of Actuarial Cost Model

Actuarial Cost Model discloses the projected utilization rate, unit cost, and per-member per-month (pmpm) information for each type of service for commercial lines of business. These assumptions were developed based on actuarial projections and supplemented with Blue Shield actual experience. The actual experience for each medical group will deviate from these tables. Models were developed to reflect the costs for calendar year 2022 and are inclusive of services that the IPA/Group and/or Blue Shield of California bear responsibility for.

Individual and Group Plans are combined for reporting purposes since for most IPAs Individual members account for less than 1% of the overall commercial membership. Blue Shield is providing the following Actuarial Cost Models:

Attachment 1 :	Individual and Group Plans, Northern California 2022
Attachment 2 :	Point of Service Plans, Northern California 2022
Attachment 3 :	Individual and Group Plans, Southern California 2022
Attachment 4 :	Point of Service Plans, Southern California 2022

Source of Data

The fee-for-service claim experience data is extracted from Blue Shield of California's claims database. It reflects the overall claims experience incurred for each market segment and is trended to the center date 7/1/22 for calendar year 2022.

Actuarial Methodology

The projected utilization rates, unit cost and allowed pmpm costs for hospital inpatient, hospital outpatient and prescription drugs were developed based on the actual fee-for-service incurred claims. The allowed pmpm costs in the attachments are prior to member cost share. Appropriate trend factors were used to estimate claims for calendar year 2022. For professional services and other ancillary services such as home health, ambulance, or DME, the utilization rates and unit cost were estimated based on the commercial fee-for-service population and adjusted to reflect Blue Shield members' age/sex mix, geographical distribution, provider reimbursement, and benefit structure. The overall pmpm was reconciled to Blue Shield overall capitation paid in year 2020 and trended to 2022.

2022 Actuarial Cost Model

Attachment 1

Actuarial Cost Model - BSC Standard HMO
Individual & Group Plans, North Region
Center Date: 07/01/2022

Service Category	Annual Admits per 1,000	Length of Stay	Annual Util. per 1,000	Average Cost Per Service	*Per Member Monthly Claim Cost*
Inpatient Hospital					
Medical	15.89	5.115	81.25	$ 9,236.57	$ 59.42 - $ 65.67
Surgical	11.88	5.304	63.02	16,183.71	80.75 - 89.25
Maternity	7.96	2.703	21.52	7,563.51	12.89 - 14.24
Psychiatric	2.09	6.669	13.92	2,459.93	2.71 - 3.00
Alcohol/Drug - Detox	2.06	2.727	5.62	5,687.72	2.53 - 2.80
SNF	-	-	6.08	2,783.14	1.34 - 1.48
Other	1.94	4.896	9.52	9,993.55	7.53 - 8.32
Subtotal					**$ 167.16 - $ 184.76**
Outpatient Hospital					
Emergency Room			145.46	$ 4,421.23	$ 50.91 - $ 56.27
Outpatient Surgery (Hosp & ASC)			89.35	7,948.50	56.22 - 62.14
Radiology			245.75	1,788.94	32.97 - 40.30
Pathology			394.11	356.82	10.55 - 12.89
PT/OT/ST			158.05	335.40	3.98 - 4.86
Other			241.83	1,590.13	30.44 - 33.65
Subtotal					**$ 185.07 - $ 210.11**
Physician					
Inpatient Surgery			108.47	$ 876.34	$ 7.13 - $ 8.71
Outpatient Surgery			1,281.70	275.33	26.47 - 32.35
Inpatient Visits			349.26	213.25	5.59 - 6.83
Office Visits & Misc.			5,823.87	107.31	46.87 - 57.29
Therapeutic Injections			331.78	668.75	16.64 - 20.34
Prof ER Visits			249.71	244.23	4.57 - 5.59
Radiology			923.04	166.53	11.53 - 14.09
Pathology			4,526.73	35.78	12.15 - 14.85
Immunizations			1,149.04	79.47	6.85 - 8.37
Speech / Hearing Exams / Vision Exams			1,101.86	86.10	7.12 - 8.70
Physical Exams / Well Baby Exam			1,403.77	100.60	10.59 - 12.95
Podiatrist			-	-	- - -
Outpatient MHCD			1,465.52	108.10	12.54 - 13.86
Maternity			67.21	1,131.40	5.70 - 6.97
Other			3,695.05	46.68	12.94 - 15.81
Subtotal					**$ 186.68 - $ 226.70**
Prescription Drugs			12,843.59	$ 134.86	**$ 137.13 - $ 151.56**
Other					
PDN / Home Health			-	$ -	$ - - $ -
Ambulance			48.12	1,589.33	5.74 - 7.01
DME			405.11	140.56	4.27 - 5.22
Prosthetics			4.13	926.46	0.29 - 0.35
Other			851.88	168.57	10.77 - 13.16
Subtotal					**$ 21.06 - $ 25.74**
Total Claims/Benefit Cost					**$ 697.10 - $ 798.87**

Attachment 2

Actuarial Cost Model - BSC Standard HMO
Point of Service, North Region
Center Date: 07/01/2022

Service Category	Annual Admits per 1,000	Length of Stay	Annual Util. per 1,000	Average Cost Per Service	*Per Member Monthly Claim Cost*
Inpatient Hospital					
Medical	21.49	3.291	70.72	$ 4,280.52	$ 23.97 - $ 26.49
Surgical	8.23	2.645	21.76	26,041.19	44.86 - 49.58
Maternity	6.27	2.039	12.79	3,540.61	3.58 - 3.96
Psychiatric	1.85	6.631	12.24	2,383.53	2.31 - 2.55
Alcohol/Drug - Detox	1.48	2.524	3.73	5,477.12	1.62 - 1.79
SNF	-	-	-	-	- - -
Other	2.09	7.103	14.83	5,254.08	6.17 - 6.82
Subtotal					**$ 82.51 - $ 91.19**
Outpatient Hospital					
Emergency Room			194.08	$ 2,462.66	$ 37.84 - $ 41.82
Outpatient Surgery (Hosp & ASC)			71.09	3,633.58	20.45 - 22.60
Radiology			116.01	1,777.44	15.46 - 18.90
Pathology			189.31	354.47	5.03 - 6.15
PT/OT/ST			74.52	334.38	1.87 - 2.28
Other			117.77	3,321.49	30.97 - 34.23
Subtotal					**$ 111.62 - $ 125.99**
Physician					
Inpatient Surgery			73.24	$ 889.87	$ 4.89 - $ 5.97
Outpatient Surgery			881.66	278.78	18.43 - 22.53
Inpatient Visits			232.50	215.47	3.76 - 4.59
Office Visits & Misc.			4,042.56	108.10	32.78 - 40.06
Therapeutic Injections			218.21	683.52	11.19 - 13.67
Prof ER Visits			172.52	241.07	3.12 - 3.81
Radiology			532.22	166.55	6.65 - 8.13
Pathology			2,602.10	36.25	7.08 - 8.65
Immunizations			835.60	80.11	5.02 - 6.14
Speech / Hearing Exams / Vision Exams			766.68	88.42	5.08 - 6.21
Physical Exams / Well Baby Exam			1,014.90	100.31	7.64 - 9.33
Podiatrist			-	-	- - -
Outpatient MHCD			1,295.13	108.30	11.10 - 12.27
Maternity			48.90	1,158.54	4.25 - 5.19
Other			2,583.91	47.77	9.26 - 11.32
Subtotal					**$ 130.24 - $ 157.88**
Prescription Drugs			9,136.66	$ 82.11	**$ 59.39 - $ 65.64**
Other					
PDN / Home Health			-	$ -	$ - - $ -
Ambulance			26.97	1,544.82	3.12 - 3.82
DME			236.62	140.68	2.50 - 3.05
Prosthetics			2.21	968.80	0.16 - 0.20
Other			509.27	155.73	5.95 - 7.27
Subtotal					**$ 11.73 - $ 14.34**
Total Claims/Benefit Cost					**$ 395.49 - $ 455.04**

2022 Actuarial Cost Model

Attachment 3

Actuarial Cost Model - BSC Standard HMO
Individual & Group Plans, South Region
Center Date: 07/01/2022

Service Category	Annual Admits per 1,000	Length of Stay	Annual Util. per 1,000	Average Cost Per Service	*Per Member Monthly Claim Cost*
Inpatient Hospital					
Medical	10.87	5.057	54.95	$ 6,760.40	$ 29.41 - $ 32.51
Surgical	7.05	4.885	34.43	11,864.47	32.34 - 35.74
Maternity	6.18	2.615	16.15	5,834.48	7.46 - 8.24
Psychiatric	1.26	5.246	6.63	3,940.43	2.07 - 2.28
Alcohol/Drug - Detox	3.52	-	9.92	3,431.86	2.70 - 2.98
SNF	0.55	7.200	3.99	2,242.21	0.71 - 0.78
Other	1.47	7.254	10.69	8,012.62	6.78 - 7.50
Subtotal					**$ 81.46 - $ 90.03**
Outpatient Hospital					
Emergency Room			108.42	$ 3,078.65	$ 26.43 - $ 29.21
Outpatient Surgery (Hosp & ASC)			49.60	4,928.55	19.35 - 21.39
Radiology			146.05	1,766.86	19.35 - 23.65
Pathology			219.07	333.49	5.48 - 6.70
PT/OT/ST			79.04	319.03	1.89 - 2.31
Other			103.70	1,152.53	9.46 - 10.46
Subtotal					**$ 81.96 - $ 93.72**
Physician					
Inpatient Surgery			79.50	$ 702.81	$ 4.19 - $ 5.12
Outpatient Surgery			1,062.54	198.70	15.83 - 19.35
Inpatient Visits			285.73	185.25	3.97 - 4.85
Office Visits & Misc.			4,147.47	90.01	28.00 - 34.22
Therapeutic Injections			331.44	689.99	17.15 - 20.96
Prof ER Visits			135.62	267.68	2.72 - 3.33
Radiology			733.52	132.25	7.28 - 8.89
Pathology			3,866.62	31.66	9.18 - 11.22
Immunizations			878.98	79.35	5.23 - 6.39
Speech / Hearing Exams / Vision Exams			850.89	68.50	4.37 - 5.34
Physical Exams / Well Baby Exam			999.37	73.28	5.49 - 6.71
Podiatrist			-	-	- - -
Outpatient MHCD			1,519.45	102.12	12.28 - 13.58
Maternity			47.15	898.25	3.18 - 3.88
Other			3,814.83	32.80	9.38 - 11.47
Subtotal					**$ 128.26 - $ 155.33**
Prescription Drugs			10,650.33	$ 121.93	**$ 102.81 - $ 113.63**
Other					
PDN / Home Health			-	$ -	$ - - $ -
Ambulance			26.41	998.79	1.98 - 2.42
DME			214.39	158.79	2.55 - 3.12
Prosthetics			1.71	635.86	0.08 - 0.10
Other			634.14	229.73	10.93 - 13.35
Subtotal					**$ 15.54 - $ 18.99**
Total Claims/Benefit Cost					**$ 410.03 - $ 471.70**

Attachment 4

Actuarial Cost Model - BSC Standard HMO
Point of Service, South Region
Center Date: 07/01/2022

Service Category	Annual Admits per 1,000	Length of Stay	Annual Util. per 1,000	Average Cost Per Service	*Per Member Monthly Claim Cost*
Inpatient Hospital					
Medical	9.68	5.331	51.58	$ 6,303.21	$ 25.74 - $ 28.45
Surgical	6.10	4.991	30.46	9,728.75	23.46 - 25.93
Maternity	8.39	2.404	20.17	5,938.63	9.48 - 10.48
Psychiatric	1.24	4.802	5.94	4,182.07	1.97 - 2.17
Alcohol/Drug - Detox	2.60	2.560	6.67	3,451.02	1.82 - 2.01
SNF	0.51	11.175	5.65	1,762.02	0.79 - 0.87
Other	1.84	6.496	11.93	8,304.29	7.84 - 8.67
Subtotal					**$ 71.10 - $ 78.58**
Outpatient Hospital					
Emergency Room			110.88	$ 2,763.85	$ 24.26 - $ 26.82
Outpatient Surgery (Hosp & ASC)			48.54	4,921.05	18.91 - 20.90
Radiology			125.11	1,838.06	17.25 - 21.08
Pathology			192.59	341.47	4.93 - 6.03
PT/OT/ST			68.05	326.46	1.67 - 2.04
Other			105.10	1,393.27	11.59 - 12.81
Subtotal					**$ 78.61 - $ 89.67**
Physician					
Inpatient Surgery			67.21	$ 713.31	$ 3.60 - $ 4.39
Outpatient Surgery			939.67	204.38	14.40 - 17.60
Inpatient Visits			233.35	193.01	3.38 - 4.13
Office Visits & Misc.			3,709.00	92.34	25.69 - 31.40
Therapeutic Injections			268.47	731.53	14.73 - 18.00
Prof ER Visits			119.37	265.47	2.38 - 2.90
Radiology			618.44	134.73	6.25 - 7.64
Pathology			3,270.18	32.81	8.05 - 9.84
Immunizations			818.61	81.18	4.98 - 6.09
Speech / Hearing Exams / Vision Exams			749.92	72.26	4.06 - 4.97
Physical Exams / Well Baby Exam			909.81	75.34	5.14 - 6.28
Podiatrist			-	-	- - -
Outpatient MHCD			1,404.70	101.10	11.24 - 12.43
Maternity			43.15	931.16	3.01 - 3.68
Other			3,448.93	33.92	8.78 - 10.73
Subtotal					**$ 115.69 - $ 140.08**
Prescription Drugs			11,382.35	$ 123.30	**$ 111.11 - $ 122.80**
Other					
PDN / Home Health			-	$ -	$ - - $ -
Ambulance			20.96	999.43	1.57 - 1.92
DME			183.38	159.09	2.19 - 2.67
Prosthetics			1.38	656.22	0.07 - 0.08
Other			525.67	222.12	8.76 - 10.70
Subtotal					**$ 12.58 - $ 15.38**
Total Claims/Benefit Cost					**$ 389.08 - $ 446.52**

2022 Actuarial Cost Model

“Disclaimers:

The information presented herein regarding cost and utilization is provided by way of example only and is based broadly on historical data in Blue Shield’s possession. It is not a statement of fact or opinion of what will actually occur and is not offered as an accurate predictor of the experience of any specific IPA/medical group. It is not intended to reflect the actual cost or utilization incurred by any specific IPA/medical group, does not predict the actual costs to any specific group or patient mix, and has not been risk adjusted in any way (capitation adjustments for age, sex, and benefit plan design are reflected in Exhibit C of the Agreement). Each IPA/medical group recognizes that its actual utilization and unit costs will likely differ from the examples given and could be higher or lower. Each IPA/medical group should not rely on this information in evaluating its own financial risk, but, rather, should review its own patient mix, utilization, and cost information as well as other available information, consult with its own financial and actuarial advisors in evaluating the information contained herein, and make its own independent business judgment in deciding to enter into the financial risk arrangements under the Agreement based on its own independent assessment.”

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Utilization Management Delegation Standards

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Utilization Management Delegation Standards Overview

Blue Shield of California (Blue Shield), as the Managed Care Organization (MCO), is responsible for the management and provision of care to all contracted members. Much of this health care is provided through contractual arrangements with Independent Provider Association/Medical Groups (IPA/medical groups) throughout California. Additionally, contractual arrangements have been established with other entities such as Managed Behavioral Health Organization (MBHO) and other specialty health plans (e.g., for chiropractic services). These entities, based on our monitoring of their demonstrated performance to comply with the requirements of the Blue Shield of California UM Program, will be delegated for certain Utilization Management (UM) administrative functions.

When a group is delegated for UM, it is responsible for all UM functions delegated to them for all Blue Shield members assigned to them, unless the services are excluded from delegation by the Delegation Agreement or Contract.

IPA/medical groups are not delegated for appeals, experimental and investigational procedure determinations, cancer clinical trials, specific major organ transplants, and any prescriptions, which require prior authorization from the Blue Shield Pharmacy Department.

In order for the entities to qualify for initial delegation status, pre-delegation audits are performed. Blue Shield's standards for delegated UM will comply with NCQA Standards, CMS guidelines when applicable, and incorporate relevant state and federal regulatory standards and specific Blue Shield requirements. These standards are updated and approved on an annual basis by the Blue Shield Delegation Oversight Committee in order to meet new regulatory requirements and quality monitoring agencies.

Delegation status, whether in total or in part, is renewable annually but can be revoked upon Blue Shield's determination that the entities are no longer able to meet the delegation requirements. In addition, the group may qualify for delegation with corrective actions. These corrective actions can include changes by the IPA and may involve Blue Shield managing or co-managing various functions. Revocation of delegation may include deducting from group's capitation payment an amount commensurate (as spelled out in the services contract) with the reduced obligations required of the group.

Continued delegation or reestablishment of a delegated function is contingent on achieving compliance, as determined by a reevaluation similar to the initial delegation audit, of the entities' processes, UM Program, associated structure, and performance outcomes which demonstrate successful management of the delegated function. Underpinning these audit measures is the expectation that the IPA/medical group demonstrate a commitment to applying evidence-based medicine (EBM) to the delivery of care to Blue members. This commitment must be in evidence through educational outreach to their network physicians regarding the practice of EBM, application of EBM to the prior authorizations process for elective procedures, and the delivery of acute care in an inpatient setting. As a part of this annual evaluation, the entities must comply with all reporting requirements per the attached schedule and with any legislative mandates or regulatory requirements that are mandated and communicated to the group.

Additional auditing and review of compliance is conducted at least annually in conjunction with other oversight measures, and more often as appropriate, to evaluate the entity's ability to continue in the delegated status. In addition, Blue Shield shall use other measures as appropriate to oversee the entity's management of Blue Shield patients. This may include, but is not limited to: surveys, reports, personal interviews with staff, system control review and chart reviews. The following outlines the Utilization Management Standards and Reporting Requirements Blue Shield expects of its delegated entities.

Evaluation for Delegation

An evaluation of the entities' abilities to perform delegated utilization management activities is conducted within twelve months prior to contracting, or prior to delegation for entities already contracted with Blue Shield, and at least once annually thereafter. The outcome of the evaluation determines the delegation status. This process ensures that the standards set by Blue Shield and all appropriate governing regulatory agencies are met.

As part of the ongoing oversight, the entities must comply with reporting requirements, submitting required documentation per the schedule outlined in these standards. Blue Shield's Delegation Oversight Nurses review the submitted documentation for compliance twice a year prior to the annual evaluation. Entities will be evaluated for their compliance with legislative, CMS and NCQA standards for delegation of utilization management functions using Blue Shield of California's Standardized Utilization Management Audit Tool and Scoring Guidelines. This tool includes Blue Shield and NCQA standards, CMS guidelines, as well as federal and state legislative requirements. The entities may wish to use this tool prior to their delegation evaluation to self-audit their preparedness. A copy of this tool will be sent to the IPA prior to their annual audit and can be obtained from the assigned Delegation Oversight Nurse. The tool may be modified or updated during the year if regulations are changed or laws are enacted. Blue Shield may elect to conduct periodic surveys to assess the IPA/medical group's medical management infrastructure and capabilities. These must be completed by the IPA/medical group within two weeks of the request.

Entities' Timely Submission of Corrective Action Plans

Blue Shield's approach to delegated entities' correction of deficiencies is based on a commitment to continuous quality improvement (CQI) and is educational and consultative in nature in an effort to promote collaboration and mutual success.

Upon identification of deficiencies, Blue Shield will outline the deficiencies in writing and send a "Audit results letter follow up needed" letter to the IPA/medical group. The entities are required to submit a response to the written Corrective Action Plan (CAP) for approval within 30 calendar days. The submitted CAP will include supporting documentation to demonstrate that measurable actions are taken to remediate identified deficiencies and identify key staff responsible for the implementation and information will be tracked by Blue Shield. In the event a CAP is issued for a file review, the group will need submit evidence of training when applicable, to all UM staff within 30 days of the initial CAP notification.

Blue Shield will review the implementation of the CAP to ensure correction of the deficiencies within 10 calendar days or an agreed timeframe from the date of receipt of the CAP response. If the CAP is in compliance with the Blue Shield requirements, a letter will be sent to the group confirming receipt and approval. If the CAP is not in compliance with Blue Shield requirements, a follow-up letter will be sent outlining the areas of deficiency and further requirements for compliance. Failure to correct deficiencies within stated timeframes will lead to further action, including additional audits or monitoring and revocation of specific delegated functions. Revocation of specific delegated functions may be required until the entity can demonstrate the ability to perform the function in compliance with Blue Shield standards.

Standards for Program Structure and Processes

Review of Written UM Program Documentation, Policies & Procedures, and Review Criteria

The delegated entity must have a well-structured UM program and make utilization decisions affecting the health care of members in a fair, impartial, and consistent manner. The UM Program Description may be contained in a separate document or included in the *UM/Case Management Policies and Procedures Manual*. Evidence that the UM Program, Policies & Procedures, and Review criteria are being followed may be requested.

The UM Program Description or the Policies and Procedures (P&P) should include the following elements for all activities performed:

- Approval date and signature by the appropriate senior management or the chairperson of the group's Utilization Review/Quality Management Committee.
- Program description must be organized and written so that staff members and others can understand the program's structure, scope, processes, and information sources used to make UM determinations.
- Confidentiality statement.
- Structure and accountability outlined.
- Defined scope of program, processes, and information sources to make appropriate benefit coverage and medical appropriateness determinations.
- Designated senior physician involvement. There must be evidence that this physician has a California license with no restrictions.
- Description of the specific behavioral health aspects of the UM program. This description should include the processes for centralized triage and referral, as applicable.
- Description of how a designated behavioral healthcare physician or a doctoral-level behavioral healthcare practitioner is involved in implementing and evaluating the behavioral health aspects of the UM program. The behavioral healthcare practitioner must be a physician or have a clinical PhD or PsyD, and may be a medical director, clinical director, participating practitioner from the organization or behavioral healthcare delegate (if applicable).
- Clearly defined staff responsibilities and qualifications.
- Appropriately licensed health professionals supervise all the review decisions, including a physician review of any medical necessity denial determination. Medical necessity denials must be reviewed by either a psychiatrist with an unrestricted California license or a doctoral-level clinical psychologist with an unrestricted California license for any denial of behavioral health care based on medical necessity. The group must be able to provide evidence of medical necessity review either with electronic or written documentation.
- Qualified licensed health professionals assess the clinical information used to support UM decisions.
- Description of authorization/review process.

Standards for Program Structure and Processes *(cont'd.)*

Review of Written UM Program Documentation, Policies & Procedures, and Review Criteria *(cont'd.)*

- Written utilization management (UM) decision-making criteria that are objective and based on medical evidence. Involves appropriate practitioners in developing, adopting and reviewing criteria. Criteria is reviewed annually by the UM Committee.
- Description of criteria for Length of Stay (LOS) and Medical Necessity, including:
    - The process by which the criteria are developed or chosen including the involvement of practitioners in the development or adoption of criteria and in the review of procedures for applying the criteria.
    - The procedures for applying criteria based on the needs of individual patients and assessment of the local delivery system.
    - The process by which criteria are reviewed, updated and modified, at specified intervals and appropriate.
    - The evidence that the Health Plan's criteria, as defined in Blue Shield's Utilization Management Program Description, have been reviewed and adopted.
- A description of the process by which the medical necessity of inpatient admissions (including LOS) and outpatient services is determined, including those staff members who have the authority to deny coverage.
- Concurrent care shall not be discontinued until the treating provider has been notified of the health plan delegate's decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of the patient. The member and provider are informed in writing of the decision.
- Inpatient reviews should include: pre-admission, concurrent, discharge planning, case management (if appropriate) and retrospective review.
- Outpatient reviews should include, but not be limited to: ambulatory, diagnostic procedures, specialty referrals, referrals to non-contracted providers, retrospective review.
- Emergency services policy and procedures.
- A description of the data and information used in making determinations.
- Process for redirecting requests for non-delegated functions, including cancer clinical trials, specific major organ transplants, non-formulary drugs or any prescriptions which require prior authorization from the Blue Shield Pharmacy Department, appeals.
- A description of the procedures by which the entities facilitate the ability of a member and practitioner to appeal to the health plan and Department of Managed Health Care (DMHC) or Centers for Medicare & Medicaid Services (CMS) for a determination.

Standards for Program Structure and Processes *(cont'd.)*

Review of Written UM Program Documentation, Policies & Procedures, and Review Criteria *(cont'd.)*

- A description of the process of how practitioners and members can obtain the UM criteria and how the criteria is made available upon request.
- Disclosure of the general processes and criteria used to approve or deny care, to anyone, upon request.
- Guidelines, criteria, or substantiated documentation of rationale must be used for making utilization review (UR) decisions. That criteria and source of the criteria must be described in the denial letter sent to the member with documentation of what criteria was not met.
- Description of case management program.
- Documentation of referral process to notify the Health Plan about authorization requests for services which are investigational or experimental for Health Plan determination.
- Description of denial process, and the use of Blue Shield-approved denial letter language including DMHC or CMS appeal language informing the member of the right to appeal and referring the member to Blue Shield's Member Services department.
- Method for implementing corrective action.
- Process for communicating information back to the Health Plan.
- Process for determining inter-rater reliability IRR (consistency of review decision making) regarding the application of clinical review criteria, including (at a minimum):
    - Annual performance goals for inter-rater reliability (IRR) of at least 90% should be achieved. When threshold is not met, remediation plan will need to be provided by the delegate.
    - All new staff must meet 90% threshold prior to conducting independent utilization reviews without supervision
    - Review of physician and non-physician staff involved in UM decision-making.
    - Documented evidence that the entities have evaluated conformity with Health Plan medical policy, including conformity with Health Plan clinical practice guidelines, preventive health guidelines and other published policy

Review Committees are strongly encouraged to utilize nationally developed evidence-based, acceptable review criteria; e.g., Milliman Care Guidelines and InterQual®. Blue Shield Medicare Advantage HMO participants must utilize the Centers for Medicare & Medicaid Services (CMS) national and local coverage guidelines.

On an exception basis only, entities may also develop their own criteria with the involvement of participating practitioners. Such criteria must be based on documented scientific medical evidence that covers the broad scope of services provided and approved by the IPA/medical group UM Committee. In addition, there must be evidence that criteria were reviewed by physicians with sufficient expertise in the criteria being adopted and the criteria must encompass a full scope of services. The medical group's own criteria must be available to Blue Shield for review.

Standards for Program Structure and Processes *(cont'd.)*

Review of Written UM Program Documentation, Policies & Procedures, and Review Criteria *(cont'd.)*

The entities' Review Committee must use Blue Shield's Medical Policy for decision-making when available. These Medical Policies includes the application of Clinical Practice and Preventive Health Guidelines, as well as findings by the Blue Shield Medical Policy Committee. For Blue Shield Medicare Advantage plan participants, Medicare national and local coverage guidelines must be the first guidelines used whenever available for Blue Shield Medicare Advantage plan patients.

Blue Shield may request that evidence of criteria, policies, procedures, and UM program descriptions are being followed.

Use of Qualified Professionals in Decision Making

The entities must utilize qualified health professionals to assess the clinical information used to support UM decisions. The entities must have written procedures requiring:

- Appropriately licensed health professionals to supervise all medical necessity decisions.
- Description of the personnel responsible for each level of UM decision-making.
- Written job description, with qualifications, for physicians who review medical necessity denials that requires:
    - Education, training, or professional experience in medical practice.
- Behavioral healthcare medical necessity denials are reviewed by a physician or appropriate behavioral healthcare practitioner, with an unrestricted California license, UM Medical Directors must hold an active unrestricted California medical license.
- Written procedure for using board-certified internal and external consultants to assist in making medical necessity determinations.
    - Evidence of Board-Certified consultants in making decisions on adverse determinations
- Evidence that compensation plans for individuals who provide utilization review services do not contain financial incentives, direct or indirect, for those individuals who are making review decisions.

Standards for Program Structure and Processes *(cont'd.)*

Entities' Utilization Management Committee Meetings

Utilization Management Committee Charter/Mission Statement

UM Committee responsibilities, processes, and activities must be delineated through a written charter or committee mission statement. This document must include:

- Term of membership
- Committee composition (including specialties represented)
- Voting rights
- Definition of quorum of voting members
- Provision for Health Plan representatives to attend Committee meetings
- Frequency and schedule of meetings
- Committee / Subcommittee reporting relationship
- Outline of Committee responsibilities

Standards for Program Structure and Processes *(cont'd.)*

Entities' Utilization Management Committee Meetings *(cont'd.)*

Entities' Utilization Management Committee Meeting Minutes

The entities' UM Committee meeting minutes must reflect the following:

- Oversight of the UM process (as outlined in previous sections).
- Approval of UM policies/procedures and standards.
- Results/reports of clinical data and UM statistics.
- Evidence of feedback/ongoing education of physicians/practitioners by the committee.
- UM information relevant to quality improvement activities is identified and reported to the entities' Quality Improvement/Peer Review committee.
- The delegated entities' written Utilization Management (UM) Program Description, work plan, UM/Case Management policies and procedures and utilization review decision protocols (review criteria) must be reviewed and approved on an annual basis by the entities' UM Committee, which will recommend changes to the entities' Board of Directors as necessary.

The Committee's minutes must be on file and available for Health Plan reviewers.

Health Plan Attendance at Review Committee Meetings

The review process conducted by each entities' UM Committee will be carried out by participating physicians who will be the only voting members on the Committee. However, a Health Plan representative may attend any meeting of the UM Committee that deals with utilization of services provided to Blue Shield members. The Blue Shield representative will generally be a member of the Blue Shield's Delegation Oversight Staff or Medical Director who will contact the entities to request attendance at the meeting. The representative will monitor the process used by the entities to conduct review, provide technical assistance, and provide data summaries or other information as needed to facilitate the operation of the UM Committee.

Member and Practitioner Communication Services Regarding Utilization Management Process and Authorization of Care Standards

The entities must have processes in place to provide access to staff for members and practitioners seeking information about the UM process and authorization of care. The process for areas outlined below must be evidenced by a written description that outlines the delegated entity's system of operation and may include policies and procedures, process flow charts, protocols, and other methods that describe the actual process used by the delegated entity.

Staff Availability During Normal Business Hours

- Staff must be available at least eight hours a day during normal business days and business hours to receive inbound collect or toll-free calls and outbound communications regarding UM issues.
- Staff must respond to general UM inquiries which may include speaking directly with practitioners and members by telephone, including voicemail, electronically, or fax.
- Staff must document inbound and outbound communications and their response.
- Staff must triage and refer specific UM communications to UM staff.
- Staff must identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.
- TTD/TTY are available for members who may need them.
- Language assistance for member to discuss UM issues.

Staff Availability After Normal Business Hours

Staff must be able to receive inbound communications after normal business hours either by directly speaking with practitioners and members by telephone, voicemail, electronically, or fax.

Initial Organization Determinations (Treatment Authorization Request Decisions) Standards

Evidence That Determinations of Coverage Are Based On Medical Necessity, Are Appropriate and Are Based on Sound Clinical Evidence

The entities must obtain relevant clinical information and consult with treating physicians, take into consideration the individual needs of patients and characteristics of the local delivery system, and consult with treating physicians before making a determination of coverage. This process must be evidenced as indicated below:

- A written description (policy) that identifies information collected to support UM decision making.
- Evidence that relevant clinical information is collected to support UM decisions and documented appropriately.

Overturned Initial Determinations by Health Plan

Blue Shield may overturn any entity's decision that does not meet Blue Shield approved medical policy or recommended medical necessity review criteria. A decision to overturn the determination of the entities will be made by the Blue Shield Medical Director or a designated physician advisor, involving discussion with and/or notification to the entity's Medical Director. Groups are required to submit any information that is related to a denial when it is requested by Blue Shield.

Second Opinions (California Health and Safety Code 1383.15)

- Second opinion authorizations for members will be approved, when requested, as appropriate. Second opinion requests regarding care from the assigned PCP shall be provided by an appropriately qualified health care professional of the member's choice *within the entity's network* and within the entity's scope and practice.
- A second opinion authorization process for care from specialists and other licensed health care providers inside the member's IPA/medical group is the responsibility of the IPA/medical group.
- Second opinions will be rendered within 72 hours when the member faces an imminent or serious threat to life or health.
- Authorization process takes into account the member's ability to travel to the practitioner rendering the second opinion.
- If the second opinion differs from the initial, coverage for third opinion is available if requested.
- The above types of second opinion authorization requests are a delegated function.
- Considerations of requests for second opinions by non-contracted providers are not delegated and are referred to Blue Shield for approval or denial.

Medicare is excluded from this legislation.

Organ Transplants (Commercial HMO)

All transplant evaluations and transplant authorization decisions for kidney, cornea and skin are the responsibility of the IPA/medical groups that are delegated for UM. Members needing transplant evaluations should be directed to a Blue Shield transplant center.

Initial Organization Determinations (Treatment Authorization Request Decisions) Standards *(cont'd.)*

Non-Delegated Initial Determinations

There are certain initial authorization determinations that Blue Shield does not delegate. Please refer to the Blue Shield *HMO IPA/Medical Group Procedures Manual* or contact Blue Shield Performance Improvement for questions regarding non-delegated utilization management activities or non-delegated initial determinations. Non-delegated initial determination activities include the following:

- **Major organ transplant for Commercial HMO** – Transplant authorizations for other than kidney, cornea, and skin are Blue Shield's responsibility and will be coordinated with the IPA/medical group. All evaluations for transplant and transplantation are performed by a designated facility identified as part of Blue Shield's Transplant Centers of Excellence as specified by product line. (Call your Blue Shield Medical Care Solutions Transplant Case Manager or your Delegation Oversight Nurse for information.)

- **Major organ transplant for Blue Shield Medicare Advantage plan** – All transplant evaluations and transplant authorizations are the responsibility of Blue Shield Medicare Advantage Plan Medical Care Solutions. Blue Shield Medicare Advantage plan members must receive organ transplants from Medicare-designated transplant facilities. (Information regarding location of these facilities may be obtained by contacting Blue Shield Medical Care Solutions Transplant Case Manager.)

- **Hip or knee replacement surgery for CalPERS Commercial HMO** – Referrals for hip or knee replacement surgery for commercial HMO CalPERS members are the responsibility of Blue Shield. Commercial HMO CalPERS members must have these surgeries performed at a Blue Shield Preferred Center, unless otherwise authorized by Blue Shield.

- **Prescriptions which require prior-authorization through the Blue Shield Pharmacy Department** – (Examples include non-formulary, some self-injectable medications.)

- **Experimental/Investigational care/services** – If an experimental/investigational treatment is not approved by Blue Shield Policy, or there is no Blue Shield policy regarding requested services, the entity is not delegated for determination and a request must be submitted to Blue Shield for determination. If groups are unable to determine whether the services are or are not experimental/investigational, they should forward their request to Blue Shield for determination.

- **Cancer Clinical Trials** – Blue Shield is responsible for making decisions of coverage for commercial cancer clinical trials.

- **Second Opinions Outside the Member's IPA/medical group** – Second opinion authorization process for care from specialists and other licensed health care providers for care *outside the member's IPA/medical group* is the responsibility of Blue Shield. Specialist second opinions can be with any specialist or other licensed health care providers within Blue Shield's HMO network. Medicare second opinions must be within the group network if available.

Initial Organization Determinations (Treatment Authorization Request Decisions) Standards *(cont'd.)*

Triage and Referrals for Behavioral Health Care

If the delegated IPA/medical group has a centralized triage and referral process to address a member's needs, including crisis or clinically emergent situations, the entity must have the following program elements in place:

- Evidence of the entities' protocols for mental health and substance abuse triage and referral and process to define the level of urgency and appropriate setting of care. Implementation of current, clinically based triage and referral guidelines/protocols represent currently acceptable practices for behavioral health care (including mental health and substance abuse).
- Protocols define level of urgency and appropriate setting of care.
- Protocols used by staff have been reviewed or revised within the past two years.
- Decisions not requiring clinical judgment are made by appropriately trained triage and referral personnel (e.g., providing information on whether a specific provider is in the network) with evidence that they have received the necessary education and training regarding protocol use.
- Appropriately licensed behavioral health care practitioners must make triage and referral decisions that require clinical judgment. These licensed staff must be supervised by a licensed master's-level practitioner. In addition, evidence must show that a licensed psychiatrist or doctoral-level clinical psychologist with experience in clinical risk management oversees all triage and referral decisions (within the scope of his/her license to practice).

UM Decision Timeliness Standards – Commercial

The entities make timely UM decisions, as follows, based upon state and federal regulatory requirements, NCQA Standards and the clinical urgency of the situation. Decisions should be made as expeditiously as possible, in the least time needed based on member's condition.

Web Portal Notification/Provider

If a practitioner web portal is used to provide electronic denial notifications, the entity must:

- Inform practitioners of the notification mechanism and their responsibility to check the portal regularly.
- Document the date and time when the information was posted in the portal.
- Provide alternative notification method for practitioners who do not have web portal access.
- Ensure a process is in place for notifying a practitioner of a denial notification via the web portal.

Web Portal Notification/Member

The organization must document the member's agreement to receive electronic notifications via the portal. The entity must:

- Document the date and time when the information was posted in the portal.
- Members receive notification that a new document or update is available in the portal when posted.
- Provide alternative notification method for members who do not have access to the web portal access or do not agree to receive notifications via the web portal.
- Ensure a process is in place for notifying a member of a denial notification via the web portal.

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Urgent Pre-Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition **not to exceed 72 hours after receipt of the request.**	Practitioner: Within 24 hours of the decision, not to exceed 72 hours of receipt of the request (for approvals and denials). Member: Within 72 hours of receipt of the request (for approval decisions). Document date and time of oral notifications.	Within 72 hours of receipt of the request. ***Note:*** If oral notification is given within 72 hours of receipt of the request, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.

UM Decision Timeliness Standards – Commercial *(cont'd.)*

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Urgent Pre-Service - Extension Needed • Additional clinical information required	Additional clinical information required: Notify member and practitioner within 24 hours of receipt of request & provide 48 hours for submission of requested information.		
	Additional information received or incomplete: If additional information is received, complete or not, decision must be made within 48 hours of receipt of information. ***Note:*** Decision must be made in a timely fashion appropriate for the member's condition not to exceed 48 hours after receipt of information.	*Additional information received or incomplete* Practitioner: Within 24 hours of the decision, not to exceed 48 hours after receipt of information (for approvals and denials). Member: Within 48 hours after receipt of information (for approval decisions). Document date and time of oral notifications.	*Additional information received or incomplete* Within 48 hours after receipt of information. ***Note:*** If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.
	Additional information not received: If no additional information is received within the 48 hours given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 48 hours. ***Note:*** Decision must be made in a timely fashion appropriate for the member's condition not to exceed 48 hours after the deadline for extension has ended.	*Additional information not received* Practitioner: Within 24 hours of the decision, not to exceed 48 hours after the timeframe given to the practitioner & member to supply the information (for approvals & denials). Member: Within 48 hours after the timeframe given to the practitioner and member to supply the information (for approval decisions). Document date and time of oral notifications.	*Additional information not received* Within 48 hours after the timeframe given to the practitioner & member to supply the information. ***Note:*** If oral notification is given, written or electronic notification must be given no later than 3 calendar days after the initial oral notification.

UM Decision Timeliness Standards – Commercial *(cont'd.)*

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Urgent Concurrent - (i.e., inpatient, ongoing/ambulatory services) Request involving both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved and the request is made at least 24 hours prior to the expiration of prescribed period of time or number of treatments. **Exceptions:** • If the request is not made at least 24 hours prior to the expiration of prescribed period of time or number of treatments, and request is urgent, default to *Urgent Pre-service* category. If the request to extend a course of treatment beyond the period of time, or number of treatments previously approved by the Health Plan/PMG/IPA does not involve urgent care, default to *Non –urgent Pre-service* category.	Within 24 hours of receipt of the request.	Practitioner: Within 24 hours of receipt of the request (for approvals and denials). Member: Within 24 hours of receipt of the request (for approval decisions).	Within 24 hours of receipt of the request. ***Note:*** If oral notification is given within 24 hours of request, written or electronic notification must be given no later than 3 calendar days after the oral notification.
Standing Referrals to Specialists / Specialty Care Centers - All information necessary to make a determination is received	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 3 business days of receipt of request. ***Note:*** Once the determination is made, the referral must be made within 4 business days of the date the proposed treatment plan, if any, is submitted to the plan medical director or designee.	Practitioner and Member: Refer to appropriate service category (urgent, concurrent, or non-urgent) for specific notification timeframes.	Practitioner and Member: Refer to appropriate service category (urgent, concurrent, or non-urgent) for specific notification timeframes.
Non-urgent Pre-Service - All necessary information received at time of initial request	Decision must be made in a timely fashion appropriate for the member's condition not to exceed 5 business days of receipt of request.	Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	Within 2 business days of making the decision.

UM Decision Timeliness Standards – Commercial *(cont'd.)*

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Non-urgent Pre-Service - Extension Needed • Additional clinical information required • Require consultation by an Expert Reviewer	*Additional clinical information required*: Notify member and practitioner within 5 business days of receipt of request & provide at least 45 calendar days for submission of requested information.		
	Additional information received or incomplete: If additional information is received, complete or not, decision must be made in a timely fashion as appropriate for member's condition not to exceed 5 business days of receipt of information.	Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	Within 2 business days of making the decision.
	Additional information not received If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available in a timely fashion as appropriate for member's condition not to exceed an additional 5 business days.		
	Require consultation by an Expert Reviewer: Upon the expiration of the 5 business days or as soon as you become aware that you will not meet the 5-business day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		
	Require consultation by an Expert Reviewer: Decision must be made in a timely fashion as appropriate for the member's condition within 5 business days of obtaining expert review, not to exceed 15 calendar days from the date of the delay notice to the practitioner and member.	*Require consultation by an Expert Reviewer:* Practitioner: Within 24 hours of the decision (for approvals and denials). Member: Within 2 business days of the decision (for approval decisions).	*Require consultation by an Expert Review* Within 2 business days of making the decision.
Post-Service - All necessary information received at time of request (decision and notification are required within 30 calendar days from request)	Within 30 calendar days of receipt of request.	Practitioner: Within 30 calendar days of receipt of request (for approvals). Member: Within 30 calendar days of receipt of request (for approvals).	Within 30 calendar days of receipt of request.

UM Decision Timeliness Standards – Commercial *(cont'd.)*

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of Denial to Practitioner and Member**
Post-Service - Extension Needed • Additional clinical information required Require consultation by an Expert Reviewer	Additional clinical information required: Notify member and practitioner within 30 calendar days of receipt of request & provide at least 45 calendar days for submission of requested information.		
	Additional information received or incomplete If additional information is received, complete or not, decision must be made within 15 calendar days of receipt of information.	*Additional information received or incomplete* Practitioner: Within 15 calendar days of receipt of information (for approvals). Member: Within 15 calendar days of receipt of information (for approvals).	*Additional information received or incomplete* Within 15 calendar days of receipt of information.
	Additional information not received If no additional information is received within the 45 calendar days given to the practitioner and member to supply the information, decision must be made with the information that is available within an additional 15 calendar days.	*Additional information not received* Practitioner: Within 15 calendar days after the timeframe given to the practitioner & member to supply the information (for approvals). Member: Within 15 calendar days after the timeframe given to the practitioner and member to supply the information (for approval decisions).	*Additional information not received* Within 15 calendar days after the timeframe given to the practitioner & member to supply the information.
	Require consultation by an Expert Reviewer: Upon the expiration of the 30 calendar days or as soon as you become aware that you will not meet the 30-calendar day timeframe, whichever occurs first, notify practitioner and member of the type of expert reviewer required and the anticipated date on which a decision will be rendered.		
	Require consultation by an Expert Reviewer: Within 15 calendar days from the date of the delay notice.	*Require consultation by an Expert Reviewer:* Practitioner: Within 15 calendar days from the date of the delay notice (for approvals). Member: Within 15 calendar days from the date of the delay notice (for approval decisions).	*Require consultation by an Expert Reviewer:* Within 15 calendar days from the date of the delay notice.

UM Decision Timeliness Standards – Commercial *(cont'd.)*

		Notification Timeframe	
Type of Request	**Decision Timeframes & Delay Notice Requirements**	**Practitioner Initial Notification & Member Notification of Approvals (Notification May Be Oral and/or Electronic / Written)**	**Written/Electronic Notification of <u>Denial</u> to Practitioner and Member**
Translation Requests for Non-Standard Vital Documents 1. Urgent (e.g., pre-service pend or denial notifications with immediate medical necessity) 2. Non-Urgent (e.g., post-service pend or denial notifications)	**<u>LAP Services Not Delegated:</u>** All requests are forwarded to the contracted health plan. 1. Request forwarded within one (1) business day of member's request 2. Request forwarded within two (2) business days of member's request		**<u>LAP Services Delegated/Health Plan:</u>** All requested Non-Standard Vital Documents are translated and returned to member within 21 calendar days.
Prescription Drugs CA Health & Safety Code Section 1367.241 (CA SB 282; 2015-2016) **Exigent circumstances" exist when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function **OR** when an insured is undergoing a current course of treatment using a non-formulary drug.*	▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request	<u>Practitioner:</u> ▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request ***Note:** CA SB282 does not specify timeframes for member notification. To ensure compliance with regulatory and accreditation standards, refer to the urgent and non-urgent pre-service sections above for member notification timeframes.*	<u>Practitioner:</u> ▪ **Non-urgent:** Within 72 hours of receipt of request ▪ **Urgent request or exigent circumstances*:** Within 24 hours of receipt of request ***Note:** CA SB282 does not specify timeframes for member notification. To ensure compliance with regulatory and accreditation standards, refer to the urgent and non-urgent pre-service sections above for member notification timeframes.*

UM Decision Timeliness Standards – Centers for Medicare & Medicaid Services (CMS)

Decisions should be made in the least time needed based on member's condition.

Web Portal Notification/Provider

If a practitioner web portal is used to provide electronic denial notifications, the entity must:

- Inform practitioners of the notification mechanism and their responsibility to check the portal regularly.
- Document the date and time when the information was posted in the portal.
- Provide alternative notification method for practitioners who do not have web portal access.
- Ensure a process is in place for notifying a practitioner of a denial notification via the web portal.

Web Portal Notification/Member

The organization must document the member's agreement to receive electronic notifications via the portal. The entity must:

- Document the date and time when the information was posted in the portal.
- Provide members notification that a new document or update is available in the portal and when it was posted.
- Provide alternative notification method for members who do not have access to the web portal access or do not agree to receive notifications via the web portal.
- Ensure a process is in place for notifying a member of a denial notification via the web portal.

Type of Request	Decision	Notification Timeframes
Standard Initial Organization Determination (Pre-Service) - If No Extension Requested or Needed	As soon as medically indicated, within a maximum of 14 calendar days after receipt of request.	Within 14 calendar days after receipt of request. ▪ Use the Notice of Denial of Medical Coverage (NDMC) template for written notification of denial decision.
Standard Part B Drug Requests	Within 72 hours after receipt of request (includes weekends & holidays). No extension	Within 72 hours after receipt of request (includes weekends & holidays). No extension
Standard Initial Organization Determination (Pre-Service) - If Extension Requested or Needed	May extend up to 14 calendar days. ***Note:*** Extension allowed only if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions must not be used to pend organization determinations while waiting for medical records from contracted providers.	▪ Use the MA-Extension: Standard & Expedited to notify member and provider of an extension. **Extension Notice:** ▪ Give notice in writing within 14 calendar days of receipt of request. The extension notice must include: 1) The reasons for the delay 2) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. ***Note:*** The Health Plan must respond to an expedited grievance within 24 hours of receipt. Decision Notification After an Extension: ▪ Must occur no later than expiration of extension. Use NDMC template for written notification of denial decision.

UM Decision Timeliness Standards – Centers for Medicare & Medicaid Services (CMS) *(cont'd.)*

Type of Request	Decision	Notification Timeframes
Expedited Initial Organization Determination - If Expedited Criteria are not met	Promptly decide whether to expedite – determine if: 1) Applying the standard timeframe could seriously jeopardize the life or health of the member or the member's ability to regain maximum function, or 2) If a physician (contracted or non-contracted) is requesting an expedited decision (oral or written) or is supporting a member's request for an expedited decision. If submitted as expedited but determined not to be expedited, then standard initial organization determination timeframe applies: ▪ Automatically transfer the request to the standard timeframe. The 14-day period begins with the day the request was received for an expedited determination.	If request is not deemed to be expedited, give the member prompt (within 72 hours) oral notice of the denial of expedited status including the member's rights followed by written notice within 3 calendar days of the oral notice. ▪ Use the MA Expedited Criteria Not Met template to provide written notice. The written notice must include: 1) Explain that the Health Plan will automatically transfer and process the request using the 14-day timeframe for standard determinations; 2) Inform the member of the right to file an expedited grievance if he/she disagrees with the organization's decision not to expedite the determination; 3) Inform the member of the right to resubmit a request for an expedited determination and that if the member gets any physician's support indicating that applying the standard timeframe for making determinations could seriously jeopardize the life or health of the member, or the member's ability to regain maximum function, the request will be expedited automatically; and Provide instructions about the expedited grievance process and its timeframes.
Expedited Initial Organization Determination **- If No Extension Requested or Needed** (See footnote)[1]	As soon as medically necessary, within 72 hours after receipt of request (includes weekends & holidays).	Within 72 hours after receipt of request. Approvals – Oral or written notice must be given to member and provider within 72 hours of receipt of request. – Document date and time oral notice is given. – If written notice only is given, it must be received by member and provider within 72 hours of receipt of request. Denials – When oral notice is given, it must occur within 72 hours of receipt of request and must be followed by written notice within 3 calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be received by member and provider within 72 hours of receipt of request. Use NDMC template for written notification of a denial decision.
Expedited Part B Drug Requests	Within 24 hours after receipt of request. No extension.	Within 24 hours after receipt of request. No extension.

[1] Note: Health Plans may have referral requirements that may impact timelines. When processing expedited requests, groups must factor in the time it may take to refer the request to the health plan in the total 72 hours to ensure that expedited requests are handled timely.

UM Decision Timeliness Standards – Centers for Medicare & Medicaid Services (CMS) *(cont'd.)*

Type of Request	Decision	Notification Timeframes
Expedited Initial Organization Determination - If Extension Requested or Needed	May extend up to 14 calendar days. ***Note:*** Extension allowed **only** if member requests or the provider / organization justifies a need for additional information and is able to demonstrate how the delay is in the interest of the member (for example, the receipt of additional medical evidence from non-contracted providers may change a decision to deny). Extensions **must not** be used to pend organization determinations while waiting for medical records from contracted providers. When requesting additional information from non-contracted providers, the organization must make an attempt to obtain the information within 24 hours of receipt of the request. This attempt may be verbal, fax or electronic. The Extension Notice may be used to satisfy this requirement if it is delivered within 24 hours (e.g., fax or e-mail to provider). The attempt must be documented in the request file (e.g., copy of e-mail, confirmation of fax, or date/time of verbal request). Documentation of the attempt within 24 hours does not replace the requirement to send the written Extension Notice within 72 hours if requested information is not received timely.	▪ Use the MA-Extension: Standard & Expedited template to notify member and provider of an extension. **Extension Notice:** Give notice **in writing**, within 72 hours of receipt of request. The extension notice must include: The reasons for the delay 1) The right to file an expedited grievance (oral or written) if they disagree with the decision to grant an extension. ***Note:*** The Health Plan must respond to an expedited grievance within 24 hours of receipt. **Decision Notification After an Extension:** **Approvals** – Oral or written notice must be given to member and provider no later than upon expiration of extension. – Document date and time oral notice is given. – If written notice only is given, it must be received by member and provider no later than upon expiration of the extension. **Denials** – When oral notice is given, it must occur no later than upon expiration of extension and must be followed by written notice within 3 calendar days of the oral notice. – Document date and time of oral notice. – If only written notice is given, it must be received by member and provider no later than upon expiration of extension. Use NDMC template for written notification of a denial decision.

UM Decision Timeliness Standards – Centers for Medicare & Medicaid Services (CMS) *(cont'd.)*

Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
Hospital Discharge Appeal Notices (Concurrent)	Attending physician must concur with discharge decision from inpatient hospital to any other level of care or care setting. Continue coverage of inpatient care until physician concurrence obtained. Hospitals are responsible for valid delivery of the revised Important Message from Medicare (IM): 1) within 2 calendar days of admission to a hospital inpatient setting. 2) not more than 2 calendar days prior to discharge from a hospital inpatient setting. Health Plans or delegates are responsible for delivery of the Detailed Notice of Discharge (DND) when a member appeals a discharge decision. DND must be delivered as soon as possible but no later than noon of the day after notification by the QIO (Quality Improvement Organization).	Hospitals must issue the IM within 2 calendar days of admission, obtain the signature of the member or representative and provide a copy of the IM at that time. Hospitals must issue a follow up IM not more than 2 calendar days prior to discharge from an inpatient hospital. ***Note:*** Follow up copy of IM is not required: ▪ If initial delivery and signing of the IM took place within 2 calendar days of discharge. ▪ When member is being transferred from inpatient-to-inpatient hospital setting. ▪ For exhaustion of Part A days, when applicable. If IM is given on day of discharge due to unexpected physician order for discharge, member must be given adequate time (at least several hours) to consider their right to request a QIO review.	Upon notification by the QIO that a member or representative has requested an appeal, the Health Plan or delegate must issue the DND to both the member and QIO as soon as possible but no later than noon of the day after notification by the QIO. **The DND must include:** ▪ A detailed explanation of why services are either no longer reasonable and necessary or are no longer covered. ▪ A description of any applicable Medicare coverage rules, instructions, or other Medicare policy, including information about how the member may obtain a copy of the Medicare policy from the MA organization. ▪ Any applicable Medicare health plan policy, contract provision, or rationale upon which the discharge determination was based. ▪ Facts specific to the member and relevant to the coverage determination sufficient to advise the member of the applicability of the coverage rule or policy to the member's case. ▪ Any other information required by CMS.

UM Decision Timeliness Standards – Centers for Medicare & Medicaid Services (CMS) *(cont'd.)*

Type of Request	Decision	Important Message from Medicare (IM)	Detailed Notice of Discharge (DND)
Termination of Provider Services: ▪ Skilled Nursing Facility (SNF) ▪ Home Health Agency (HHA) ▪ Comprehensive Outpatient Rehabilitation Facility (CORF) ***Note:*** This process does not apply to SNF Exhaustion of Benefits (100-day limit).	The Health Plan or delegate is responsible for making the decision to end services no later than two (2) calendar days or 2 visits before coverage ends: ▪ Discharge from SNF, HHA or CORF services OR ▪ A determination that such services are no longer medically necessary	The SNF, HHA or CORF is responsible for delivery of the NOMNC to the member or authorized representative ▪ The NOMNC must be delivered no later than 2 calendar days or 2 visits prior to the proposed termination of services and must include: member name, delivery date, date that coverage of services ends, and QIO contact information. ▪ The NOMNC may be delivered earlier if the date that coverage will end is known. ▪ If expected length of stay or service is 2 days or less, give notice on admission. ***Note:*** Check with Health Plan or delegate for delegated responsibility, as a Health Plan or delegate may choose to deliver the NOMNC instead of the provider.	Upon notification by the Quality Improvement Organization (QIO) that a member or authorized representative has requested an appeal: The Health Plan or delegate must issue the DENC to both the QIO and member no later than close of business of the day the QIO notifies the Health Plan of the appeal.

Note: Health plans may have referral requirements that may impact timelines. When processing expedited requests, groups must factor in the time it may take to refer the request to the health plan in the total 72 hours to ensure that expedited requests are handled timely.

UM Decision Timeliness Standards – Centers for Medicare & Medicaid Services (CMS) *(cont'd.)*

Review of Emergency Services

It is the expectation of Blue Shield that each entity provides emergency services to members in keeping with state and federal guidelines. These guidelines include:

- The entity approves emergency services necessary to screen and stabilize members without pre-authorization of emergency services in cases where a prudent layperson, acting reasonably, would have believed that an emergency medical condition exists.
- The entity approves emergency services if a practitioner or other representative acting through the IPA/medical group has authorized the provision of emergency services.
- The entity may utilize Blue Shield's Automatic Payment Emergency Diagnosis List (Autopay List) for approval, which is available for both Medicare and Commercial products, as part of the ER claim review process.

Medicare Expedited Initial Determination Process and Tracking

The Centers for Medicare & Medicaid Services (CMS) mandated an expedited review requirement effective August 1997 for Medicare members. If a request for expedited initial determination meets criteria, the determination must be made within a required 72 continuous hour time frame (including nights, weekends and holidays). If a request does not meet criterion for expedited review, the delegate will notify the member within the 72 hours and send written follow up. The time frame begins when the request to expedite the determination is received by Blue Shield Medicare or the IPA/medical group (not after all medical information has been obtained).

The entity may contact the health plan to request extensions to the 72-hour timeframe up to 14 additional calendar days if the extension benefits the beneficiary, such as allowing time for additional diagnostic testing or consultation with medical specialists; or if the beneficiary requests an extension to provide additional information. Failure of the entities to make an expedited initial determination within the time frame will result in the health plan making the determination on the entity's behalf.

- When Blue Shield receives a member request for an expedited initial organization determination, the health plan will notify the entities of the request via telephone. The 72 continuous hour decision time frame begins from the time the call is received by Blue Shield.
- The health plan will work with the entity to ensure that a decision is made within the required timeframe. Blue Shield will notify the member of the group's determination by telephone and by letter if the request is approved. The entity is responsible for issuing any applicable denial notices.
- The health plan may obtain a written approval from the member to extend the decision time frame for up to 14 days in order to make a more informed decision if the delay will benefit the member.

Denial Standards

Each entity shall provide evidence of use of approved denial letter language to communicate service denials (adverse initial determinations) to members and practitioners. The required denial letter language differs between Medicare and Commercial HMO products. The delegated entities must be certain their process allows for the selection and issuance of the correct denial letter format, given the product and the circumstances surrounding the denial.

The written notification of a denial must be sent to members and practitioners within specified notification timeframes, as appropriate, explaining the reason for the denial and must inform the member of the right to appeal, including their right to external review, and refer the member to the Blue Shield's appeal process.

Service Denial Letter Format Components

An approved service denial letter (written notification) format shall be created on the letterhead of the entity, and shall include the following elements:

- Member name and address.
- Subscriber ID number.
- Date.
- The service requested.
- Notification of the initial determination (review decision).
- The specific reasons for the denial, in easily understandable language.
- Reference to the member's evidence of coverage, if the service was not a covered benefit, or for additional language regarding coverage.
- A statement that members can obtain a copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request.
- Description of the benefit provisions, criteria, guidelines, protocol, or other similar criteria used (if any) and the clinical reasons for the medical necessity decision. In addition, reference to the particular criteria used. A copy of the scientific or clinical information must be provided upon request. Contact information and procedures to follow to obtain the information must be included in the denial letter.
- Suggestion for alternative treatment or services, if appropriate.
- Right to request an appeal (reconsideration) includes language with regard to members' right to submit written comments, documents or other information relevant to the appeal.
- An explanation of the appeal process, including members' rights to representation and appeal time frames.
- Right to request a 72-hour expedited appeal process from Blue Shield's Appeals and Grievance Department.
- Right to request an external review from the DMHC. Notification that expedited external review can occur concurrently with the internal appeals process for urgent care.
- Blue Shield Medicare Advantage plan denial letters must conform to CMS regulatory requirements.

Service Denial Letter Format Components *(cont'd.)*

- If member's employer is governed by the Employee Retirement Income Security Act ("ERISA"), include mandated ERISA statement in denial letter regarding the member's the right to bring a civil action under Section 502(a) of ERISA if all required reviews of the service/claim have been completed and the service/claim has not been approved. (Commercial only).
- Inclusion of the DMHC appeal process, address, Internet address and phone numbers. (Commercial only).
- Inclusion of Blue Shield's Notice of the Availability of Language Assistance Services with all denial letters to the member.
- Inclusion of Blue Shield's Notice Informing Individuals about Nondiscrimination and Accessibility Requirements.
- Appropriate Medicare appeal language for denial letters issued to Blue Shield Medicare Advantage plan members.
- Reference to any other reconsideration entity that the member may wish to access (e.g., CMS denial letters provide for reference to the quality improvement organization (QIO) authorized by Medicare (CMS) to review inpatient hospital services.).
- Reference to attachments appropriate to the subject of the letter.
- Notification letter to the physician or other provider must include the name and direct phone number or extension of the professional who is responsible for the decision, i.e., the Medical Director or behavioral health care provider.
- For Blue Shield Medicare Advantage plans, denial notification letters must be in keeping with the approved CMS format and content.
- For Blue Shield Medicare Advantage plans, facility denials must contain an acknowledgement page, which is signed by the member and witnessed by the staff issuing the letter.

Note: Appeals are <u>not</u> a delegated UM activity but may be delegated separately under Member Rights and Responsibilities to fully Knox-Keene licensed entities in the Commercial HMO.

Medicare Service Denial Letters

Blue Shield denial letter templates may be obtained by contacting a Blue Shield Delegation Oversight Nurse or by accessing the Health Industry Collaboration Effort (HICE) website at iceforhealth.org.

*Note: All initial determination/service denial letters sent to Medicare beneficiaries must be issued in **12-point font**.*

Should you have any questions regarding the use of CMS-approved service denial letter formats, please contact your Blue Shield Delegation Oversight Nurse.

Evaluation of Entities' Handling of Denials

Blue Shield's reporting requirements and audit process ensure simultaneous review of denials, which includes evaluating the appropriateness of the determination. In order to understand and provide oversight for the contracted IPA/medical group, Blue Shield requires that all denials, for both Commercial and Medicare services, be submitted at least monthly via a log unless otherwise specified (for fully Knox-Keene licensed entities). The entities will be evaluated at least annually for handling of UM denials (both Medicare and Commercial) including whether:

1. Time frames are met.
2. Medical Director/physician reviewer's reason for decision is documented in the denial file.
3. Adequate and appropriate information is gathered to make an appropriate initial denial decision.
4. Reasons for denial are clearly and concisely documented in terms the member will understand. The benefit provisions, criteria, guidelines, protocol, or other similar criteria used (if any) and the clinical reasons for the medical necessity decision are documented. *A copy of the scientific or clinical judgment must be provided upon request and the contact information and procedures to follow to obtain the information must be included in the denial letter*.
5. Alternate treatment plan is identified when medically indicated.
6. Appropriate denial letter language and protocol is used for members and practitioners.
7. Notification letter to the physician or other provider includes the name and direct phone number of the professional who is responsible for the decision, i.e., the Medical Director.
8. Upon member request, the identity of experts whose advice was obtained on behalf of Blue Shield in connection with an adverse determination must be provided without regard to whether the advice was relied upon to make the determination.

   Note: Entities must comply with the additional UM standards in #8 above to align with the Employer Retirement Income Security Act (ERISA) upon the member's employer group enrollment or renewal. The additional UM requirements will apply to IFP members and any remaining members after 1/1/2003.
9. Appeal process is clearly explained in each denial letter. Letters for denial, modification, or delay of treatment or service, based on a decision that the service is not medically necessary, must include the external review process. Requests for external review are handled by the DMHC with submission of the request to an independent agency.
10. Explanation of appeal process clearly explains the members' right to submit written comments, documents or other information relevant to the appeal for all denials, whether they are based on a decision for benefits or medical necessity.
11. The member's right to an expedited appeal in compliance with the Expedited Review regulations is clearly explained in each denial letter. (Procedures for referring expedited appeals must be in place which allow for initiation of the appeal process by member or physician/practitioner. The entities must demonstrate knowledge of the member's and practitioner's appeal rights as well as ability to provide necessary information to the Health Plan within required response time frames.)
12. Inclusion of the mandatory DMHC language (Commercial only).
13. Inclusion of Blue Shield's Notice of the Availability of Language Assistance Services.
14. Inclusion of Blue Shield's Notice Informing Individuals about Nondiscrimination and Accessibility Requirements.

Evaluation of Entities' Handling of Denials *(cont'd.)*

15. Inclusion of the mandatory ERISA language, for members whose employers are governed by the Employee Retirement Income Security Act (ERISA), stating the right to bring a civil action under Section 502 (a) of ERISA if all required reviews of the service/claim have been completed and the service/claim has not been approved (Commercial only).
16. Entities must maintain a tracking system for all denials.

Standards for Personal and Health Information (Protected Health Information)

Entities are required to sign a Business Associate Agreement that includes, but is not limited to:

- A list of the permitted uses and disclosures of Protected Health Information (PHI).
- A description of information safeguards to preserve the confidentiality of and prevent inappropriate use or unauthorized disclosure.
- A stipulation that the delegate ensures that subdelegates have similar safeguards.
- A stipulation that the delegate will provide individuals (or individual's personal representative) with access to their protected health information.
- A stipulation that the delegate will inform Blue Shield of illegal, inadvertent, or wrongful disclosure or inappropriate uses of the information when it occurs.
- Upon termination of the delegation agreement, the delegate will return, destroy, or protect PHI within 30 days of the termination.

Standards for Evidence of Oversight for Any Delegated (Sub-Delegated) Activity, When Applicable

Entities that have a sub-delegated arrangement must have a mutually agreed upon delegation document defining the following:

- Describes the delegated activities and the responsibilities of the organization and the sub-delegated entity.
- Requires at least semiannual reporting by the sub-delegated entity to the organization.
- Describes the process by which the organization evaluates the sub-delegated entity's performance.
- Describes the process for providing member experience and clinical performance data to its sub-delegates when requested.
- Describes the remedies available to the organization if the sub-delegated entity does not fulfill its obligations, including revocation of the delegation agreement.

Standards for Personal and Health Information (Protected Health Information) *(cont'd.)*

Standards for Evidence of Oversight for Any Delegated (Sub-Delegated) Activity, When Applicable *(cont'd.)*

Additionally there must be evidence that the entities:

- Conduct an initial assessment prior to sub-delegation;
- Annually reviews the sub- delegates UM Program;
- Annually audits UM denials files against NCQA standards;
- Semi-annually evaluates required reports, and
- Annually evaluates sub-delegates performance.

If the entity sub-delegates and the delegation arrangement include the use of protected health information, the delegation document must also include the following provisions:

- A list of the allowed uses of protected health information.
- A description of delegate safeguards to protect the information from inappropriate use or further disclosure.
- A stipulation that the delegate will ensure that sub-delegates have similar safeguards.
- A stipulation that the delegate will provide individuals with access to their protected health information.
- A stipulation that the delegate will inform the entity if inappropriate uses of the information occur.
- A stipulation that the delegate will ensure protected health information is returned, destroyed or protected within 30 days if the delegation agreement ends.

The Blue Shield Delegation Oversight Nurse will review Policies and Procedures along with the annual site review, audit findings, Corrective Action Plan, and regular reports that the delegated entity receives from the sub-delegate.

Standards for Personal and Health Information (Protected Health Information) *(cont'd.)*

Member Experience and Clinical Performance Data

Blue Shield will proactively share member experience and clinical performance data with the delegate, and also if requested by the delegate. Blue Shield's policy is as follows:

- Blue Shield will provide member experience and clinical performance data to the delegate.
- Data will be provided at in-person meetings such as JOMs and/or by secure email.
- Data will be provided at least annually but may be provided as frequently as monthly if appropriate.
- Examples of data to be provided include utilization data from claims, Member Experience Survey Data and selected quality measures.
- Examples of member experience data include CAHPS survey results, or other data collected on experience with delegate services.
- Examples of Clinical performance data include HEDIS outcomes and other clinical data collected by Blue Shield/delegate.
- Blue Shield shall allow the delegate to collect data necessary to assess member experience and clinical performance, if applicable.
- If, for any reason, Blue Shield does not allow the delegate to collect data from members or practitioners directly, Blue Shield shall provide data to the delegate, when requested.

Clinical Data Collection and Analysis Standards

The entities must collect data for tracking, trending and education of the providers in the network and submit on their bi-annual report. Evidence to include health plan specific reports (12 months) containing supporting data which includes rate adherence to time frames for each category of request (i.e., urgent concurrent, urgent preservice, nonurgent preservice and post service.) If the organization is delegated for various line of business, then reports should be generated to reflect those differences. Some areas of review include:

- Inpatient Metrics
- Referral Metrics
- ER Metrics
- UM TAT Metrics (Turn-around time decision, notification and percent compliant for UM, BH and Pharmacy)
- Experience with the UM Process (Member and Provider)
- Over and Under Utilization Metrics

The entities must also document actions taken as a result of clinical data analysis, such as evidence of feedback to individual physicians/practitioners and use of data analysis in improvement of performance.

Standards for Personal and Health Information (Protected Health Information) *(cont'd.)*

Evaluation of Member and Practitioner Satisfaction with the UM Process Standards

The entities must evaluate member and practitioner satisfaction with the UM process as follows:

- Gather information from member and practitioners about their satisfaction with their UM process, at least annually.
- Address identified sources of dissatisfaction with corrective action within 30 days of receipt of information.
- Report satisfaction survey results and actions taken to address opportunities for improvement to Health Plan annually.

UM System Controls

IPA/medical groups are required to have policies and procedures describing system controls specific to UM denial notification dates that:

1. Define the date of receipt consistent with NCQA requirements.
2. Define the date of written notification consistent with NCQA requirements.
3. Describe the process for recording dates in systems.
4. Specify staff who are authorized to modify dates once initially recorded and circumstances when modification is appropriate.
5. Specify how the system tracks modified dates.
6. Describe system security controls in place to protect data from unauthorized modification.
7. Describe how the organization audits the processes and procedures in factors 1-6.

UM Systems Controls Compliance

At least annually, the organization demonstrates that it monitors compliance with its UM denials controls by:

1. Identifying all modifications to receipt and decision notification dates that did not meet the organization's policies and procedures for date modification.
2. Analyzing all instances of date modification that did not meet the organizations policies and procedures for date modification.
3. Acting on all findings and implementing a quarterly monitoring process until it demonstrates improvement for one finding over three consecutive quarters.

Commercial Required Reporting to Health Plan

Standards

Blue Shield requires regular activity reporting from its delegated groups. This reporting is used to facilitate Blue Shield's oversight and coordination of delegated activities. If Blue Shield identifies deficiencies, the delegate will develop a written action plan that includes specific time frames for resolution and demonstrates implementation of change and improvement in the delegated function.

For the purposes of reporting, the following grid outlines reports to be submitted and frequency along with the activity or function the report is demonstrating.

Note: For Blue Shield Medicare Advantage plan reporting requirements, refer to Section 6.5.

ACTIVITY / FUNCTION	ENTITY's RESPONSIBILITIES	REPORTING FREQUENCY	SUBMIT TO
UM Program description and selected supporting policies and procedures as necessary to meet federal, state, NCQA and plan requirements.	Must be consistent with federal, state, NCQA and Blue Shield guidelines.	**Annually**	Delegation Oversight Nurse
UM Work Plan to include Commercial Reporting on: • Acute & SNF - Bed Days/1000 - Admits/1000 - Average LOS - Readmits/1000 • Total number of processed Referrals • Total number of Denials • Denial Rate • ER visit & Denial Rate • Turn Around Time (TAT) • Total # of decisions compliant with TAT & % compliant (UM, BH, Pharmacy) • Total # of notifications compliant with TAT & % compliant (UM, BH, Pharmacy) • % of Referrals that exceed TAT • Member and Provider Satisfaction Results • IRR results • Updates to UM Program	Must be consistent with federal, state, NCQA and Blue Shield guidelines. Maintain documentation of analysis and actions taken. Reports submitted must be Blue Shield specific.	**Semi-Annually**	Delegation Oversight Nurse
UM Annual Evaluation	Must be consistent with federal, state, NCQA and Blue Shield guidelines.	**Annually**	Delegation Oversight Nurse
UM Criteria and Guidelines	Must be consistent with federal, state, NCQA and Blue Shield guidelines.	**Annually** (can be reviewed at time of annual delegation audit)	Delegation Oversight Nurse
Behavioral Health Reporting • Assessment of under-and over-utilization of UM data related to behavioral health	Maintain documentation of analysis and actions taken.	**Annually**	Delegation Oversight Nurse

Commercial Required Reporting to Health Plan *(cont'd.)*

Standards *(cont'd.)*

ACTIVITY / FUNCTION	ENTITY's RESPONSIBILITIES	REPORTING FREQUENCY	SUBMIT TO
Behavioral Health Reporting • Total number of processed Referrals • Total number of Denials • Denial Rate • Turn Around Time (TAT) • Total # of decisions compliant with TAT & % compliant • Total # of notifications compliant with TAT & % compliant • % of Referrals that exceed TAT • Total # OON requests • Total # of OON approvals • Member and Provider Satisfaction Results • IRR results • Updates to UM Program	Must be consistent with federal, state, NCQA and Blue Shield guidelines. Maintain documentation of analysis and actions taken. Reports submitted must be Blue Shield specific	**Semi-annually**	Delegation Oversight Nurse
Encounter Data	Submit ALL Encounter Data to Blue Shield.	**Monthly**	Electronic submission
End Stage Renal Disease	Report of any new members initiated on dialysis with a diagnosis of End Stage Renal Disease.	**Monthly**	ESRD@blueshieldca.com
Changes in Key Management and/or Professional Staff, including Sub-Delegated changes		**Monthly**	Network Management

Commercial Required Reporting to Health Plan *(cont'd.)*

Standards *(cont'd.)*

ACTIVITY / FUNCTION	ENTITY's RESPONSIBILITIES	REPORTING FREQUENCY	SUBMIT TO
Commercial Shared Risk Authorizations (For groups with shared risk contracts ONLY)	Includes all services that entities approve and deny that are paid out of shared risk pool. These include: • Acute and skilled admits: med/surg/rehab/ detox/ MHSA-mental health and substance use disorder • DME • Home Health • Hospice Check your individual group shared risk matrix for additional details.	**Weekly** to Blue Shield Medical Care Solutions via Blue Shield secure email. Data must be delivered in a file format such as .xls,.xlsx .txt, or .csv to support auto-load into Blue Shield's system of record. Hardcopy, .pdf or .jpg formats will not be accepted by Blue Shield. Any file received which does not comply with the format, delivery or content requirements will be returned for correction and resubmission. Report should include: • Member name (last, first) • Member ID number • Date of Birth • Health Plan Type (Commercial vs. Medicare) • Type of Service (Inpatient, Outpatient, DME…) • Provider Name • Provider Tax ID # • Date of Service (start/end date; admit/discharge date) • Level of Care • Diagnosis (ICD-10-CM codes) • Procedure (CPT-4 codes) • # of units/visits • IPA/Medical Group Tracking/Reference # • Decision Outcome (if approval and denial decision s are combined on same file)	IPAAuths@blueshieldca.com

Commercial Required Reporting to Health Plan *(cont'd.)*

Standards *(cont'd.)*

ACTIVITY / FUNCTION	ENTITY's RESPONSIBILITIES	REPORTING FREQUENCY	SUBMIT TO
Commercial Contracted entity, Denial Logs Pre-Service/Concurrent/ Retrospective (ER, Claims)	Required to use Plan denial letter templates and required data elements for Commercial denials.	**Weekly** submission of denial logs showing 100% of all denials. Data must be delivered in a file format such as .xls,.xlsx .txt, or .csv to support auto-load into Blue Shield's system of record. Hardcopy, .pdf or .jpg formats will not be accepted by Blue Shield. Any file received which does not comply with the format, delivery or content requirements will be returned for correction and resubmission Report should include: • Member name (last, first) • Member ID number • Date of Birth • Health Plan Type (Commercial vs. Medicare) • Type of Service (Inpatient, Outpatient, DME…) • Provider Name • Provider Tax ID # • Date of Service (start/end date; admit/discharge date) • Level of Care • Diagnosis (ICD-10-CM codes) • Procedure (CPT-4 codes) • # of units/visits IPA/Medical Group Tracking/Reference #	IPAAuths@blueshieldca.com

Commercial Required Reporting to Health Plan *(cont'd.)*

Standards *(cont'd.)*

ACTIVITY / FUNCTION	ENTITY's RESPONSIBILITIES	REPORTING FREQUENCY	SUBMIT TO
Second Opinions for care from a specialist outside the member's IPA/medical group network (Commercial HMO only)	**NOT** DELEGATED Identify and report to Blue Shield	Forward to Plan **Immediately** for determination **Monthly** Report should include: • Member name Member ID number • Date of Birth • Provider Name • Date of Service • Diagnosis (ICD-10-CM codes) • Procedure (CPT-4 codes) • Denial Reason (medical necessity, not covered benefit, out of network) Type of Denial (urgent concurrent, retro)	Fax (844) 295-4637
Information on any denial or authorization which has been made. Including but not limited to the regulatory or appeals process.	Make available to Blue Shield all information requested on the denial.	**As needed**	Fax (844) 295-4637
Requests for Investigational/Experimental Services	**NOT** DELEGATED	Forward to Plan **Immediately** for determination	Fax (844) 807-8997
Request for Cancer Clinical Trials (Commercial HMO only) (Medicare Clinical Trials are handled by the Intermediary and not Blue Shield).	**NOT** DELEGATED	Forward to Plan **Immediately** for determination	Fax (844) 807-8997

Definitions of Delegation and Subdelegation

Delegation is defined by NCQA as:

> "…when an MCO gives another entity the authority to carry out a function that would otherwise be performed by the MCO. This authority includes the right to decide what to do and how to do it, within the parameters agreed upon by the MCO and the other entity. When referring to delegation, NCQA assumes the presence of a mutual agreement between and MCO and another entity in which the other entity performs specific functions that are related to the NCQA standards. Although the MCO does not directly perform the delegated functions, it is obligated to oversee these functions, i.e., to ensure that the functions are properly performed by the delegate. The MCO may reclaim the right to carry out the delegated functions at any time."

Sub-delegation is defined by NCQA as:

> "…when a delegate of an MCO gives a third entity the authority to carry out a function that has been delegated by the MCO. For example, an MCO may delegate UM activities to an IPA/medical group, which then delegates some credentialing functions to a hospital. The hospital, in this case, is the subdelegate."

"Documented process" refers to a written description that outlines your system of operation for implementing your organization's expectations. A "documented process" may include Policies and Procedures, process flow charts, protocols, and other methods that describe the actual process used by the organization. Policies and procedures are one type of documented process and typically indicate the plan for the course of action to be taken and the method in which the action will be carried out.

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Credentialing/Recredentialing Standards

The following standards apply to delegation of the credentialing/recredentialing process for Blue Shield of California (Blue Shield). The IPA and/or medical group (IPA/medical group) or other entities such as a Managed Behavioral Health Organization (MBHO) or Specialty Health Plan shall be able to show documented evidence of the following standards in order to be delegated or maintain delegation status. Credentialing/ recredentialing functions cannot be delegated separately. The delegate's failure to meet Blue Shield delegation requirements can result in the need to implement a corrective action plan, additional audits of compliance, and up to revocation of delegation status upon Blue Shield's determination of the entity not meeting the delegation requirements. Groups will be subject to all Blue Shield, NCQA, CDI, DMHC, and CMS standards and regulations.

A copy of the Credentialing/Recredentialing Tool used by Blue Shield during audits can be obtained by contacting your Blue Shield Credentialing Delegation Oversight Auditor or on the Industry Collaborative Effort (ICE) website at iceforhealth.org.

Blue Shield retains oversight and responsibility for the final decision regarding credentialing and recredentialing recommendations.

I. Credentialing and Recredentialing Policies and Procedures

A. The entities must have written policies and procedures for credentialing and recredentialing of licensed independent health care professionals whom they employ and with whom they contract. These policies and procedures must include the following elements and be reviewed and approved annually:

1. Scope of practitioners covered, which at a minimum include Medical Doctors, Osteopaths, oral surgeons, dentists (who provide care under the medical benefit plan e.g., outside dental benefits such as trauma surgery), podiatrists, chiropractors, telemedicine practitioner and allied behavioral health practitioners. Blue Shield will be assessing the following allied health professionals: doctoral and/or master's level licensed psychologists, licensed clinical social workers, marriage family therapists, qualified autism service professional, physician assistants, nurse practitioners, nurse midwives, licensed clinical nurse specialists, psychiatric nurse practitioners, speech pathologists, physical therapist, occupational therapist, acupuncturist, as well as covering physicians who have an independent relationship with the organization if they serve in the capacity for more than 90 days. Defined criteria to assess practitioner ability, and how each criterion is verified, including current unrestricted license to practice in the State of California, and a participant with Medicare, when providing care to Blue Shield Medicare Advantage plan members.
2. Specify verification sources it uses.
3. Establish criteria for credentialing and recredentialing.
4. Process for making credentialing and recredentialing decisions.
5. Process for notifying practitioners if information obtained during the credentialing process varies substantially from the information that they provided to the organization.
6. Process used to make decisions in a non-discriminatory manner (i.e., not based solely on an applicant's race, ethnicity/nationality, gender, age, sexual orientation, types of procedures or types of patients the practitioner specializes in), including receiving advice from participating practitioners and how decisions are made by a designated credentialing committee. Process to include processes for preventing and monitoring discriminatory practices. Monitoring must be conducted at least annually.
7. Process for making credentialing and recredentialing decisions.
8. Process for determination and approval of credentialing files that meet the organization's established criteria.

9. Sub-delegation of any credentialing/recredentialing activities defined and the related oversight process described; sub-delegation is not permitted should the entity lose their delegation status.
10. Protection of practitioner rights, includes the right to review information obtained from outside sources used to evaluate their credentialing application, notification, of the status of the practitioner's credentialing or credentialing application, upon request and practitioners' right to correct erroneous information. Policy to include how practitioners are notification of these rights.
11. Medical Director or designated physician has direct responsibility, accountability, and participation in the credentialing process.
12. Clear statement of the confidential nature of the information obtained in the credentialing process, except as otherwise provided by law, and the mechanisms in place to protect this confidentiality.
13. Description of the process for facilitating that listings in practitioner directories and other materials for members are consistent with credentialing data, including education, training, certification, and specialty.
14. Credentialing System Controls policy to include:
    a. How primary source information is received, dated, and stored.
    b. How modified information is tracked and dated from its initial verification.
    c. Staff who are authorized to review, modify, and delete information to include circumstances when modifications or deletions are appropriate.
    d. The security controls in place to protect information from unauthorized modifications.
    e. How the organization audits the process and procedures in a-d. Audit process to include the audit method utilized to including sampling, the staff involved, frequency and oversight of the department responsible for the audit.

II. Credentialing Committee

1. Description of a Credentialing Committee designated to make recommendations regarding credentialing/recredentialing decisions.
    a. The Committee membership includes a range of participating network practitioners (primary care physicians and different types of specialists).
    b. A quorum is described and must be present to conduct a committee meeting.
    c. Identifies who has voting rights and voting members must be practitioners.
2. Meetings and decisions may take place in person or virtual meetings (i.e., through video conference or web conference with audio). Meetings may not be conducted through email.
3. May take all files to committee for review or establish and utilize a clean file process for practitioners that meet established criteria, however, committee must review credentials of practitioners who do not meet the established criteria thresholds for participation.
4. Ensures that practitioner files that meet established criteria are reviewed and approved by a medical director or designated physician. Evidence of review and approval is documented in the file via handwritten signature or initials, electronic identifier unique to the approver.
5. Description of the process to ensure that practitioners are notified of the credentialing decision or recredentialing denials within 60 calendar days of the Committee's decision.
6. Develop mechanisms to report serious quality deficiencies that could result in a practitioner's suspension or termination to appropriate authorities e.g. report to the Medical Board of California (MBC)/805/805.01 or the National Practitioner Data Bank (NPDB); includes review of who would be reported and under what circumstances.
7. Description of the appeal process and notification to practitioner of this process.

III. Ongoing Monitoring and Interventions

1. Must develop and implement policies and procedures for ongoing monitoring of practitioner sanctions, complaints, and quality issues between recredentialing cycles and taking appropriate action against practitioners when it identifies occurrences of poor quality. At a minimum, the Medical Group must collect and review the following:
   a. Medicare and Medicaid sanctions. (Must review within the thirty (30) calendar days of the report release date.)
   b. Sanctions or limitations on licensure. (Must review within the thirty (30) calendar days of the report release date.)
   c. Member complaints (Investigates practitioner-specific member complaints upon their receipt and evaluates the practitioner's history of complaints, if applicable. Evaluates the history of complaints for all practitioners at least every six months.
   d. Identified adverse events (monitors for adverse events at least every six months).
2. Report actions taken by the IPA/medical group to Blue Shield, as appropriate.

IV. Credentialing/Certification/Appointment Process

A. The entities must require a completed application for membership that is signed and dated. The application must include, at a minimum, statements regarding:

   1. Reasons for any inability to perform the essential functions of the positions, with or without accommodation;
   2. Lack of present illegal drug use;
   3. History of loss of license and or felony convictions;
   4. History of voluntary or involuntary loss or limitation of privileges or disciplinary action;
   5. Current malpractice insurance coverage; and
   6. An attestation to correctness/completeness of the application.

B. At a minimum, the entities must obtain and review verification of the following through appropriate means of primary sources during the 180-day period prior to a final determination:

   1. Current, active, and unrestricted California medical license or applicable health profession license;
   2. Clinical privileges in good standing at a contracted hospital affiliated with the practitioners IPA/medical group, 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);
   3. Valid DEA certificate to practice in California, as applicable;
   4. Work History (5 years);
   5. Current and adequate malpractice coverage; and
   6. Professional liability claims history.

C. In addition to the above six requirements, the entities must obtain and review verification through appropriate means of primary sources for:

   1. Graduation from medical school and completion of training, or board certification, as applicable. For dentists and non-physician behavioral health providers, there must be verification of education and training from a professional school. Board certification cannot be substituted for verification of education and training; however, board certification must be confirmed, as applicable. This requirement is exempt from the 180-day rule.

D. Prior to making a determination, the entities receive information on practitioners from the following designated agencies and the information is included in the practitioner credentialing file:

1. The National Practitioners Data Bank (NPDB).
2. Sanctions and restrictions on licensure, and/or limitations on scope of practice from the following agencies as applicable: Medical Board of California, Federation of State Medical Boards, Department of Professional Regulations, Osteopathic Medical Board of California or California Board of Chiropractic Examiners/Dental Board of California (as applicable); and for non-physician behavioral health providers, California Board of Registered Nursing, State Board of Psychology, or State Board of Behavioral Health Sciences (licensed clinical social workers and marriage/family therapists), and other licensing boards as appropriate.
3. The Medicare Opt-out List to assess participation in the Medicare Program when seeing Blue Shield Medicare Advantage plan members.

E. The entities implement appropriate interventions when occurrences of poor quality are identified and act on important quality and safety issues in a timely manner during the three-year interval between formal re-verification of credentials.

F. The entities shall submit, on a semi-annual basis, the list of providers who were reviewed for credentialing activity.

V. Office Site Visit and Medical Record Keeping Review

A. NOT DELEGATED.

1. When complaints are logged regarding a physician's office, Blue Shield will follow company procedure for follow-up and will not delegate this task to the IPA.

VI. Recredentialing

A. The entities must formally recredential practitioners at least every three years. There is no grace period beyond the 36-month allotted time.

B. The entities must conduct the same verification process, application/attestation requirements and NPDB query and Medicare and Medicaid Sanction, Medicare Opt-Out List review as described above in the Credentialing Sections I through II. The exception would be education and work history (5 years) do not need to be verified during recredentialing.

C. Performance monitoring data will be assessed by the entities for recredentialing on all practitioners. The review will include the following information, which must also be incorporated and documented in the recredentialing file:

1. Information regarding relevant member complaints and grievances:
   - Potential or actual trends
   - Complaints and grievances resulting in peer review
2. Identified adverse events.
3. Implementation of appropriate interventions when it identifies instances of poor quality. Examples include, but are not limited to, information from quality improvement activities, which may include:
   - Quality reviews; must include results from review of member complaints
   - Under- and over-utilization issues
   - Peer review
   - Potential or actual trends
   - Significant adverse sentinel events

VII. Organizational Provider Credentialing

A. Must develop and implement policies and procedures for evaluating/assessing an Organizational Provider/ Health Delivery Organization and specifies that prior to contracting with, and at least every three (3) years thereafter, it will confirm the following:
   1. In good standing with the state and federal regulatory bodies.
   2. That the provider has been reviewed and approved by an accrediting body.
   3. Conducts an onsite quality assessment, if the provider is not accredited (CMS or DHCS survey, may be utilized in lieu of a site visit and may not be more than three (3) years only at the time of approval.

B. Medical Providers include: Health delivery organizations (HDO) such as hospitals, home health agencies, skilled nursing facilities, and free-standing surgical centers.

C. Behavioral Health Providers include: Inpatient, Residential and Ambulatory.

D. Assess Medical Providers against requirements prior to contracting and at least every three (3) years.

E. Assess Behavioral Providers requirements prior to contracting and at least every three (3) years.

VIII. Sub-Delegated Credentialing/Recredentialing Activities

Note: Blue Shield considers the use of a CVO to verify credentialing information, as sub-delegation, which aligns with NCQA. Policy and procedures must be reviewed annually for NCQA Certified CVOs.

A. If the delegated entity sub-delegates any portion of the credentialing process, it must ensure that the following occur:

   1. Documentation of the agreement between the entity and sub-delegated organization is fully executed.
   2. Initial Evaluation of the sub-delegated organization prior to delegation;
   3. Sub-delegate submission of the list of providers who were reviewed for credentialing. (This list shall also be submitted quarterly or semi-annually to Blue Shield.);
   4. Annual Evaluation of the sub-delegated organization to include Policy and procedures, file review and evaluates performance against NCQA, state and federal Standards for delegated activities; and
   5. Documentation that the IPA/medical group retains the right of final determination over the sub-delegated organization in credentialing decisions.

B. Blue Shield will review oversight of Initial evaluation or annual review, audit findings, corrective action plan, and regular reports as well as the entities' evaluation of these reports. At a minimum, delegates must report on progress in conducting credentialing and recredentialing activities and on activities carried out to improve performance.

IX. Identification of Qualified HIV/AIDS Specialist (CA H&SC §1374.16; DMHC TAG (QM-004), DHCS MMCD All-Plan Letter 01001)

A. Policy and procedure describing the process that the organization identifies and reconfirms the appropriately qualified physicians who meet the definition of an HIV/AIDS specialist, according to California State regulations on an annual basis. The Department of Managed Health Care (DMHC) issued a definition of an HIV/AIDS specialist and criteria which can be accessed at dmhc.ca.gov.

B. Annually conducts screening of HIV/Aids Specialists to ensure qualifications and criteria of the DMHC are met.

C. Notify department responsible for authorizing standing referrals of its physician's that qualify as HIV/AIDS specialists according to DMHC regulations.

Credentialing and Recredentialing

The Plan evaluates several factors in credentialing and recredentialing for practitioners in the organization's network, such as:

- How fully the organization investigates each practitioner's qualifications and practice history before letting the practitioner into the network.
- How the organization assesses practitioners in its network on an ongoing basis.

Guidelines for Use

- When conducting file review for multiple Provider Organizations who are serviced by the same MSO, the Auditing Plan must determine whether all Provider Organizations use the same Credentials Committee:
  - If so, then the plan may pull one file sample across all contracted organizations and apply the same score for CR 3-4 for each organization.
  - If not, the plan should pull one file sample for each organization.
- Surveyors are to provide support for any deficiency, even if the score is 100 percent.
- Clarify any issues related to each element.
- For questions regarding evaluation of compliance with NCQA standards, go to ncqa.org
- For questions regarding posted results, send an email to the Health Plan auditor.

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Appendix for Section 6

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Medicare Managed Care Manual

Chapter 11 - Medicare Advantage Application Procedures and Contract Requirements

This Chapter Last Updated - (Rev. 83, 04/25/2007)

This appendix only references an excerpt from Chapter 11 of the *Medicare Managed Care Manual*. To view the full chapter, refer to the Centers for Medicare & Medicaid Services (CMS) website at cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs

100.4 - Provider and Supplier Contract Requirements

(Rev. 79, Issued 02-17-06, Effective Date 02-17-06)

Contracts or other written agreements between MA organizations and providers and suppliers of health care or health care-related services must contain the following provisions:

- Contracting providers agree to safeguard beneficiary privacy and confidentiality and assure accuracy of beneficiary health records;
- Contracts must specify a prompt payment requirement, the terms and conditions of which are developed and agreed to by the MA organization and its contracted providers and suppliers;
- Contracts must hold Medicare members harmless for payment of fees that are the legal obligation of the Medicare Advantage organization to fulfill. Such provision will apply, but will not be limited to insolvency of the MA organization, contract breach, and provider billing;
- Contracts must contain accountability provisions specifying:
    - That first tier and downstream entities must comply with Medicare laws, regulations, and CMS instructions (422.504(i)(4)(v)), and agree to audits and inspection by CMS and/or its designees and to cooperate, assist, and provide information as requested, and maintain records a minimum of 10 years;
    - That the MA organization oversees and is accountable to CMS for any functions and responsibilities described in the MA regulations (422.504(i)(4)(iii); and
    - That MA organizations that choose to delegate functions must adhere to the delegation requirements - including all provider contract requirements in these delegation requirements - described in the MA regulations (422.504(i)(3)(iii); 422.504(i)(4)(i)-(v));
    - Contracts must specify that providers agree to comply with the MA organization's policies and procedures;

100.4 - Provider and Supplier Contract Requirements *(cont'd.)*

In addition to the provisions mentioned above, MA organizations must include certain MA-related provisions in the policies and procedures that are distributed to providers and suppliers that constitute the organizations' health services delivery network. The following table summarizes these provisions:

CONTRACT REQUIREMENTS THROUGH POLICIES, STANDARDS & MANUALS	CFR REFERENCE
Safeguard privacy and maintain records accurately and timely	422.118
Permanent "out of area" members to receive benefits in continuation area	422.54(b)
Prohibition against discrimination based on health status	422.110(a)
Pay for emergency and urgently needed services	422.100(b)
Pay for renal dialysis for those temporarily out of a service area	422.100(b)(1)(iv)
Direct access to mammography and influenza vaccinations	422.100(g)(1)
No copay for influenza and pneumococcal vaccines	422.100(g)(2)
Agreements with providers to demonstrate "adequate" access	422.112(a)(1)
Direct access to women's specialists for routine and preventive services	422.112(a)(3)
Services available 24 hrs/day, 7 days/week	422.112(a)(7)
Adhere to CMS marketing provisions	422.80(a), (b), (c)
Ensure services are provided in a culturally competent manner	422.112(a)(8)
Maintain procedures to inform members of follow-up care or provide training in self-care as necessary	422.112(b)(5)
Document in a prominent place in medial record if individual has executed Advance directive	422.128(b)(1)(ii)(E)
Provide services in a manner consistent with professionally recognized standards of care	422.504(a)(3)(iii)
Continuation of benefits provisions (may be met in several ways, including contract provision)	422.504(g)(2)(i); 422.504(g)(2)(ii); 422.504(g)(3)
Payment and incentive arrangements specified	422.208
Subject to laws applicable to Federal funds	422.504(h)(2)
Disclose to CMS all information necessary to (1) Administer & evaluate the program (2) Establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services	422.64(a): 422.504(a)(4): 422.504(f)(2)
Must make good faith effort to notify all affected members of the termination of a provider contract *30 calendar days before the* termination by plan or provider	422.111(e)
Submission of encounter data, medical records and certify completeness and truthfulness	422.310(d)(3)-(4), 422.310(e), 422.504(d)-(e), 422.504(i)(3)-(4), 422.504(l)(3)
Comply with medical policy, QM and MM	422.202(b); 422.504(a)(5)
Disclose to CMS quality & performance indicators for plan benefits re: disenrollment rates for beneficiaries enrolled in the plan for the previous two years	422.504(f)(2)(iv)(A)

CONTRACT REQUIREMENTS THROUGH POLICIES, STANDARDS & MANUALS	CFR REFERENCE
Disclose to CMS quality & performance indicators for the benefits under the plan regarding enrollee satisfaction	422.504(f)(2)(iv)(B)
Disclose to CMS quality & performance indicators for the benefits under the plan regarding health outcomes	422.504(f)(2)(iv)(C)
Notify providers in writing for reason for denial, suspension & termination	422.202(c)(1)
Provide 60 days' notice (terminating contract without cause)	422.202(c)(4)
Comply with Federal laws and regulations to include, but not limited to: Federal criminal law, the False Claims Act (31 U.S.C. 3729 et. Seq.) and the anti-kickback statute (section 1128B(b) of the Act)	422.504(h)(1)
Prohibition of use of excluded practitioners	422.752(a)(8)
Adhere to appeals/grievance procedures	422.562(a)

100.5 - Administrative Contracting Requirements

(Rev.79, Issued: 02-17-06 Effective Date: 02-17-06)

The MA administrative contracting requirements apply both to first tier contracts and to downstream contracts in the manner specified for provider contracts, as described above. At the same time, the responsibility of the MA organization is to assure that its contractor and any downstream contractors have the information necessary to know how to comply with the requirements under the MA program.

These requirements do not apply to administrative contracts that do not directly relate to the MA organization's core functions under its contract with CMS. For example, a contract between the MA organization and a clerical support firm would not need to contain these provisions. Similarly, a contract between the MA organization and a real estate broker to identify rental properties for office space would not be required to address these areas. CMS would, however, view contracts for administration and management, marketing, utilization management, quality assurance, applications processing, enrollment and disenrollment functions, claims processing, adjudicating Medicare organization determinations, appeals and grievances, and credentialing to be administrative contracts subject to MA requirements as articulated in the MA regulation and related guidance.

The following provisions must be addressed in the administrative service contracts:

- The person or entity must agree to comply with all applicable Medicare laws, regulations, and CMS instructions;
- The person or entity must agree to comply with all State and Federal confidentiality requirements, including the requirements established by the MA organization and the MA program;
- The person or entity must agree to grant DHHS, the Comptroller General, or their designees the right to inspect any pertinent information related to the contract during the contract term, for up to 10 years from the final date of the contract period, and in certain instances described in the MA regulation, periods in excess of 10 years, as appropriate;
- The contract must clearly state the responsibilities of the administrative services provider and its reporting arrangements;

100.5 - Administrative Contracting Requirements *(cont'd.)*

- The contract must provide that the MA organization and any first tier and downstream entities has/have the right to revoke the contract if MA organizations do not perform the services satisfactorily, and if requisite reporting and disclosure requirements are not otherwise fully met in a timely manner;
- If the written arrangement provides for credentialing activities by a first-tier or downstream entity, the first-tier or downstream entity must meet all applicable MA credentialing requirements;
- If the written arrangement provides for the selection of providers by a first-tier or downstream entity, written arrangements must State that the MA organization retains the right to approve, suspend, or terminate any such arrangement;
    - Contracts between MA organizations and first tier entities, and first tier entities and downstream entities must contain provisions specifying MA delegation requirements specified at §422.504(i)(3)(iii) and §422.504(i)(4)(i)-(v). A written agreement specifies the delegated activities and reporting responsibilities of the entity and provides for revocation of the delegation or other remedies for inadequate performance. Contracts must indicate what functions have been delegated and must require the entity to comply with the requirements of these standards and of applicable law and regulations. When a function is only partially delegated, contract provisions must clearly delineate which responsibilities have been delegated and which remain with the organization. In the Quality Improvement area, for example, the organization might develop topics for projects in consultation with an affiliated medical group, but delegate the actual conduct of a specific project to the group. The agreement must specify how the delegate is to conduct Quality Improvement activities, at what points in the process decisions by the delegate (for example, on data collection methodologies) are subject to the organization's review, and how the delegate's activities will be integrated into the organization's overall Quality Improvement program (for example, through participation in an organization-wide committee).

100.6 - Implementation of Written Policies With Respect to the Enrollee Rights

(Rev. 79, Issued 02-17-06, Effective Date 02-17-06)

The organization must articulate enrollees' rights, promote the exercise of those rights, ensure that its staff and affiliated providers are familiar with enrollee rights, and treat enrollees accordingly. While most of the standards in this domain address basic procedural protections for enrollees, they are closely related to quality of care. Interpersonal aspects of care are highly important to most patients. Enrollees' interactions with the organization and its providers can have an important bearing on their willingness and ability to understand and comply with recommended treatments, and hence, on outcomes and costs. Policies are communicated to enrollees in the enrollee statement furnished in accordance with Chapter 2 of this manual, and to the organization's staff and affiliated providers, at the time of initial employment or affiliation, and annually thereafter.

Material on enrollee rights must be included in provider contracts or provider manuals, and in staff handbooks or other training materials.

Advance Directives

Federal law mandates requirements for specific Medicare and Medi-Cal providers related to patient self-determination – the right of individuals to make medical treatment decisions and to make advance directives, such as Living Wills and Durable Power of Attorney for health care. A summary of the requirements is as follows:

Every hospital, nursing facility, home health agency, hospice, and health maintenance organization (HMO) that receives funds under Medicare or Medi-Cal must:

1. Provide written information to each adult individual, as required, about the right to make decisions concerning medical care, including the right to accept, or refuse, medical or surgical treatment, and the right, under California law, to formulate advance directives.

2. Maintain and provide to individuals written information about their policies respecting the implementation of such rights.

3. Document in the individual's medical record whether or not the individual has executed an advance directive.

4. Not condition the provision of care, or otherwise discriminate based on whether or not the individual has executed an advance directive.

5. Ensure compliance with state law regarding medical treatment, decision making and advance directives.

6. Provide education to staff and the community on issues concerning advance directives. (Providers can demonstrate compliance with this Medi-Cal requirement by conducting educational campaigns, including newsletters, articles in the local newspapers, local news reports, or commercials.)

7. Revise and disseminate their informational materials when they receive information from the Department of Health Care Services (DHCS) regarding changes in state law which affect patients' rights related to patient self-determination. Materials must be revised as soon as possible, but no later than 90 days from the effective date of the change in state law.

8. Furnish written description of legal rights that includes a statement that the resident may file a complaint with their local Licensing and Certification district office, concerning non-compliance with their advance directives, resident abuse, neglect or misappropriation of resident property in the facility.

Advance Directives *(cont'd.)*

In addition to the above requirements, facilities *may*:

- Contract with other entities to furnish information concerning advance directive requirements and patients' rights to accept or refuse medical or surgical treatment. Despite the availability of information from other sources, providers are still legally responsible for ensuring that the statutory requirements are met, i.e., providers must, at a minimum, still provide the required brochure entitled "Your Right to Make Decisions About Medical Treatment".

- Provide information about advance directives to family members, or a representative, when an adult individual is incapacitated at the time of admission and is unable to receive information (due to the incapacitating condition or mental disorder), or articulate whether or not he or she has executed an advance directive. If the individual regains his/her capacity, the facility is obligated to provide this information to the individual.

The information required in 1 and 2 above must be provided to adult individuals as follows:

- A hospital must give information at the time of the individual's admission to inpatient.

- A nursing facility must give information at the time of the individual's admission as a resident.

- A provider of home health care or personal care service must give information to the individual in advance of the individual's coming under the care of the provider.

- A hospice program must give information at the time of initial receipt of hospice care by the individual.

- An HMO must give information at the time the individual enrolls with the organization, i.e., when the HMO enrolls or re-enrolls the individual.

To request copies of the California Advance Directive for Health Care, call Blue Shield Medicare Advantage Plan Member Services at (800) 776-4466 (TTY 711) 8 a.m. to 8 p.m., seven days a week, from October 1 through March 31, and 8 a.m. to 8 p.m., weekdays (8 a.m. to 5 p.m. Saturday and Sunday) from April 1 through September 30.

Disaster and Contingency Planning Guide

This quick reference chart is a tool for you to have available for addressing any natural disaster or systems failure. It is designed to be of assistance in assuring that members receive necessary care in the case of a disaster.

ISSUE	ACTION
Eligibility: You are unable to access the eligibility verification systems in place through your IPA/medical group.	Contact Provider Customer Services at (800) 541-6652, 8 a.m. to 5 p.m., Monday through Friday. Go to blueshieldca.com/provider and click on *Eligibility & benefits*.
Access-to-Care and Continuity of Care/Medical Records: Your office is without power or damaged by a disaster. Each provider is required to maintain his or her own medical records. In case of a disaster, access to patient records from impacted provider may become impaired.	Emergency and urgently needed services should be appropriately directed to the nearest emergency room or urgent care facility. Routine care should be triaged, as appropriate, to other providers in your IPA/medical group. For extended disasters or where your IPA/medical group physicians are not available, members are entitled to appropriate access to care and may be routed to other providers to assure necessary care is provided. Should a provider office be damaged and records inaccessible, care should be provided as medically indicated.
Referral Authorizations: Your IPA/medical group office is without power or damaged by a disaster and you cannot obtain either a written or verbal approval for necessary care.	Members who need urgent or emergency medical care should be referred as medically indicated. For routine referrals, should your IPA/medical group remain unavailable for more than 48 hours, contact the following for assistance in obtaining approval: Contact Provider Customer Services at (800) 541-6652, 8 a.m. to 5 p.m., Monday through Friday. Go to blueshieldca.com/provider and click on *Authorizations.*
Capitation Payments: Blue Shield experiences a major interruption.	Should a disaster occur, Blue Shield is committed to making payments based on current membership or estimated payments based on the prior month's membership.

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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.

Enhancements to build on the acknowledgment of receipt in the case of a refusal to sign:

- Often, a verbal notice of a planned discharge occurs prior to delivery of the actual written notice. Although not required, if a verbal notice occurs, it can be easily noted on the Acknowledgment of Receipt page prior to delivery of the notice to the member. By noting the verbal notice on the acknowledgment of receipt, the case documentation is enhanced, should an issue be subsequently appealed. NOTE: Verbal notice does not meet the requirements for valid notice. Verbal notice can only be used to enhance the case documentation related to the actual delivery of a valid notice with a signed acknowledgement of receipt.

Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

Guardians and Incompetent Patients

A Notice is not valid if delivered knowingly to an incompetent patient. Having a patient being discharged from skilled nursing care with a diagnosis of dementia is not likely to hold as a valid notice on appeal unless there are documented attempts to also deliver the Notice of Non-Coverage (NONC) to and secure a signed acknowledgment from any legal guardian or other family members.

Legal guardians include court appointed guardians, family members with Durable Power of Attorney for Health Care, or appropriate legal counsel/attorney representation. Additionally, it is also recognized that, as a practical matter, there are circumstances when appointment documentation cannot be obtained in a timely manner. If a member is not competent or is physically unable to sign the statement, and the representative is the spouse or next of kin, the notice acknowledgement that is signed by a default representative should be clearly documented by the facility as to the applicability of a state allowable person to be a default representative. In the event there is any controversy related to such default representation, only a representative as determined by the appropriate state court would be accepted.

If verbal or telephonic notice is provided to a representative, this is only as back up to the actual signed acknowledgement of written notice. The member officially receives notice when the written notice is delivered and a signed acknowledgement obtained or a clearly documented refusal to sign the acknowledgement occurs.

We are challenged when a guardian is unwilling to sign the acknowledgment of receipt of the notice and direct hand delivery is not viable. In such cases, document all attempts to both verbally inform and to physically deliver the notice carefully. If delivery of the notice to a guardian for an incompetent patient is via mail, keep all receipts from the courier service or certified mail (return receipt required) to demonstrate delivery of the notice. In such cases, the signed courier service or other confirmation of delivery can be submitted as valid acknowledgement of receipt.

- The patient's chart should document any verbal notice
- Document attempted delivery to member and guardian
- Obtain signed acknowledgement of receipt or document (and preferably witness) actual delivery of the notice, where there is a refusal to sign

Note: In cases where care must be coordinated through an offsite guardian, provide adequate time for delivery of a valid notice. (A courier service delivery will delay notice and potentially discharge by only one day if they are able to deliver to the guardian. U.S. Certified mail is not as predictable.)

Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

Regulatory Changes and the Centers for Medicare & Medicaid Services

Important Notice: The Grijalva Final Rule 42 C.F.R. § 422.620 contains provisions required under the settlement agreement in the Grijalva v. Shalala litigation concerning appeal rights under the Medicare managed care program to Medicare Advantage (MA) enrollees at the time of discharge from an inpatient hospital stay. For the Grijalva portion, which relates to SNF, Home Health and CORF discharges, the effective date was January 1, 2004. The current requirement still in effect for IPAs is to deliver the Notice of Non-Coverage (NONC) within one day prior to the effective date of the discharge.

The Final Rule Requires:

- The right to an immediate review of a Medicare Advantage Organization (MAO) discharge decision by an independent review body if the enrollee believes services should continue.
- Advanced written notice to all MA enrollees **at least two days before** the termination of certain services (before planned termination of Medicare coverage of their skilled nursing facility (SNF), home health agency (HHA) or comprehensive outpatient rehabilitation facility (CORF) services), with instructions on how to obtain a detailed notice and file an appeal.
- Upon request, a specific and detailed explanation of why services are either no longer medically necessary or are no longer covered by the health plan. The health plan also needs to describe any applicable Medicare coverage rule, MA policy, contract provision or rationale upon which the termination decision was based.

In addition, the final rule requires MAOs to provide detailed discharge notices only in those situations where enrollees indicate dissatisfaction with the health plan's decision. All Medicare beneficiaries who are treated in a hospital will continue to receive generic notices upon admission that will inform them of their appeal rights, but only those beneficiaries that disagree with the decision to be discharged must be issued a detailed written notice of non-coverage one day before their hospital coverage ends. If an appeal is filed, beneficiaries remain entitled to continuation of coverage for their hospital stay until the quality improvement organization renders a decision.

Enrollees then may request an independent review of the MA organization's decision to end coverage of SNF, HHA or CORF services. In the event of a timely appeal request, an MA organization must issue a second, detailed notice that explains the reasons why Medicare coverage should end.

CMS has designated Quality Improvement Organizations (QIOs) to conduct these fast-track reviews. QIOs are suitable for the fast-track appeals process in light of their experience in performing similar, immediate reviews of inpatient hospital discharges. The QIO that has an agreement with the SNF, HHA, or CORF providing the enrollee's services will process the appeal. The MA organization must provide the second, detailed notice to both the QIO and the enrollee.

Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

Regulatory Changes & the Centers for Medicare & Medicaid Services *(cont'd.)*

Provider Notification of Termination. An important feature of the final rule provisions is that Medicare would charge providers with the actual delivery of the required notices. CMS believes that the providers themselves are in the best position to deliver the notices to enrollees, and that it would be placing an unreasonable burden on MAO's to require that they deliver the notices to affected enrollees. The MA organization would retain ultimate responsibility for the decision to terminate services and for financial coverage of the services, however. The services would remain covered until four calendar days after an enrollee receives the termination notice, or if the Independent Review Entity reviews the decision, until noon on the day after an Independent Review Entity decision upholding the MAO's decision. CMS believes that the requirement that providers issue these notices, in effect on behalf of MAO's, best ensures that beneficiaries receive these notices in a timely manner. To facilitate implementation of this policy, we are proposing under §422.502(I) that all contracts between MAO's and their providers must specify that the providers will comply with the notice and appeal provisions in subpart M of the federal requirements.

Timing of Notices. Section 422.624(b)(1) addresses the timing of the required notices. In general, the provider would notify the enrollee of the MAO's decision to terminate covered services two calendar days before the scheduled termination. Again, the current requirement still in effect is within one day of the date of discharge. If the provider services are expected to be furnished to an enrollee for a time span of fewer than two calendar days in duration, the enrollee should be given the notice upon admission to the provider (or at the beginning of the service period if there is no official ''admission'' to a non-institutional provider, such as in an HHA setting). The notice must be given in all situations, regardless of whether an enrollee agrees with the decision that his or her services should end.

CMS would allow providers a full working ''day'' within which to deliver the termination notice, with any notification delivered during normal business hours on a given day serving to initiate the four-day standard on that day, even if the timing of the delivery of the notice resulted in fewer than 24 hours to ask for an Independent Review Entity appeal, and fewer than 96 hours between notification and the proposed termination of services. That is, a notice delivered to a member at 2 p.m., Monday, would indicate that the member has until noon, Tuesday, to appeal to the Independent Review Entity, with termination of services scheduled for noon, Friday.

Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

Regulatory Changes & the Centers for Medicare & Medicaid Services *(cont'd.)*

Delivery of Notices. §422.624(c) specifies that ''delivery'' of a notice is valid only if a member has signed and dated the notice to indicate that he or she both received the notice and can comprehend its contents. This policy is consistent with our requirements governing delivery of similar notices, such as the requirements set forth in HCFA Program Memoranda A-02-018 for HHA Advanced Beneficiary Notices. Under this concept, a member who is comatose, confused, or otherwise unable to understand or act on his or her rights could not validly ''receive'' the notice, necessitating the presence of an authorized representative for purposes of receiving the notice. Similarly, presenting the standardized notice to a person who is illiterate, blind, or unable to understand English would not constitute successful ''delivery'' of the notice. Such situations could be remedied either through use of an authorized representative if that person has no barriers to receiving the notice or through other steps (such as use of a translator or language accessible version of the notice) that overcome the difficulties associated with notification.

Note: CMS would not interpret the requirement for successful delivery to permit an enrollee to extend coverage indefinitely by refusing to sign a notice of termination. If an enrollee refuses to sign a notice, the provider would annotate its copy of the notice to indicate the refusal, and the date of the refusal would be considered the date of receipt of the notice. Paragraph (c) describes what constitutes an effective delivery of a termination notice. The notice would have to be delivered timely, using standardized format and language, and include all of the elements required under §422.624(b)(2).

BLUE SHIELD OF CALIFORNIA
APPEAL PROCESS FOR NOTICE OF NON-COVERAGE HHA, SNF, CORF

#	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

Blue Shield Medicare Advantage Plan
Required Billing Elements

#	Responsible Party	Activity	Time Requirement
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
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

#	Responsible Party	Activity	Time Requirement
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
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.

- **Will SNFs, HHAs, and CORFs be required to retain copies of NOMNCs in patients' medical records? Will the MA organization need to obtain a copy?**
  The provider should retain a copy of the NOMNC as part of the patient's medical record; however, MAO's and providers should determine how and where the notices should be maintained to meet medical records' retention policies.

Skilled Nursing Facility Discharges (SNF or TCU) *(cont'd.)*

Contractual & Billing Requirements *(cont'd.)*

- **If a provider is discontinuing a previously authorized, discrete increment of services, e.g., the MA organization authorized 12 skilled nursing visits by an HHA nurse, does the provider still have to issue a NOMNC if the provider is planning to discharge the patient as scheduled on the last visit? Why?**
  Yes. The provider must deliver the NOMNC no later than the next-to-last visit in this example. Providing a notice to the enrollee not only conveys when the services are going to end, but also informs the enrollee of the right to appeal if the enrollee disagrees, and transfers liability to the enrollee if the enrollee continues to receive non-covered services.

- **Can you please clarify if whether the fast-track appeals process also includes psychiatric home health services?**
  Yes, the fast-track appeals process applies to psychiatric home health services.

- **How will providers know what their responsibilities are under the new fast-track appeals process?**
  CMS provides information to providers on their responsibilities under this new appeals process through CMS' Medlearn website, CMS' "list serve" of participating providers, outreach to provider trade associations, and CMS open door forums. In addition, we are instructing our fiscal intermediaries and carriers to include an article about the process in their next provider bulletins. QIOs also are required to provide education and training to the providers with whom they have agreements. MAO's must also do their part to ensure that their providers are educated about their responsibilities under the fast-track appeals process.

- **Will CMS release the NOMNC to providers, or will MAO's be required to distribute the notices to the providers directly?**
  The notices are available online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices. MAO's should work with their providers to determine whether direct distribution is necessary. The provider education material that we have distributed refers providers to the "appeals" website.

Blue Shield Medicare Advantage Plan
Required Billing Elements

CMS Model Letters:

- **DETAILED NOTICE OF DISCHARGE (Attachment A)**
- **NOTICE OF MEDICARE NON-COVERAGE (Attachment B)**

(Attachment A – CMS Model Letter – **SAMPLE -** Must be 12 point font)

Patient Name: **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)

(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

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

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			
Call patient's representative the day letter is issued. (Date of conversation is the date of the receipt of the NONMC). ID self and give organization, contact name and number, purpose of call (right to file an appeal) and describe the appeal right being discussed (e.g., QIO vs. expedited).					
Inform representative that skilled services will no longer be covered beginning on: (date) _____ and financial responsibility starts on (date) _____					
Advise representative of appeal rights. (You must read directly from the letter)					
Advise representative that an appeal must be phoned to HSAG by 12:00 p.m. the following day of receipt of the NOMNC or phone call.					
Provide the representative with the QIO name (HSAG) and phone number listed in the appeal section of the letter. Provide address, fax or other method of communication needed by representative for QIO to receive appeal in a timely fashion.					
Inform representative how to get a detailed notice describing why the enrollee's services are not being covered					
Provide at least one phone number of an advocacy organization or 1-800-MEDICARE					
Confirm the telephone contact by written notice mailed same day.					
If direct phone contact cannot be made, including leaving voice mail, mail the notice to the representative, certified mail, return receipt requested. (If the **Medical Group** is sending the certified mail, the Facility must notify the Medical Group immediately that certified mail is required.) (If the **Facility** sent the certified mail, and HSAG is processing an appeal, the certified returned receipt must be submitted to HSAG. If not submitted, the appeal may be decided in favor of the member solely due to lack of the receipt which is the evidence of timely notification.)					
Document that representative understands the information provided.					