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# Section 1: Introduction

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## Purpose of the Hospital and Facility Guidelines

The *Hospital and Facility Guidelines* describe the Blue Shield of California (Blue Shield) administrative guidelines, policies, and procedures for hospitals and ancillary facilities that have signed an agreement with Blue Shield to participate as a network facility.

Section 6: Capitated Hospital Requirements contains information applicable to only capitated hospitals (i.e., those hospitals that have Blue Shield capitated payment arrangements).

This *Hospital and Facility Guidelines* replaces and supersedes all previous versions of the manual that may have been received or viewed online before this issue date.

## Manual Orders and Updates

Go to Provider Connection at [blueshieldca.com/provider](https://blueshieldca.com/provider) and click on *Guidelines & resources*, then *Provider manuals* to view and download a copy of the *Hospital and Facility Guidelines*.

To request that a PDF version of the manual be emailed to you or mailed to you in CD format, email [providermanuals@blueshieldca.com](mailto:providermanuals@blueshieldca.com) or contact Provider Information & Enrollment at (800) 258-3091.

This manual is updated at least annually, in January.

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## Enrollment and Eligibility

For routine eligibility verification, the provider may:

- Log onto Provider Connection at [blueshieldca.com/provider](https://blueshieldca.com/provider) for current and historical eligibility and benefit information that is updated daily.
- Use the Member Services toll-free number listed on the member's ID card.

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

The provider may use his/her own office form or Blue Shield's Acknowledgment of Financial Responsibility Form for this purpose. A copy of this form can be found on Provider Connection at [blueshieldca.com/provider](https://blueshieldca.com/provider) under *Guidelines & resources, Forms*, then *Patient care forms*.

## Premium Payment Policy

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

- Ryan White HIV/AIDS programs under Title XXVI of the Public Health Services Act;
- Indian tribes, tribal organizations or urban Indian organizations;
- A lawful local, state, or federal government program, including a grantee directed by a government program to make payments on its behalf; and
- Bona fide charitable organizations and organizations related to the member (*e.g.*, church or employer) when all of the following criteria are met: payment of premiums is guaranteed for the entire plan year; assistance is provided based on defined financial status criteria and health status is not considered; the organization is unaffiliated with a healthcare provider; and the organization has no financial interest in the payment of a health plan claim. (Financially interested institutions/organizations include institutions/organizations that receive the majority of their funding from entities with a financial interest in the payment of health insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a financial interest in the payment of health insurance claims.)

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

## **Enrollment and Eligibility** *(cont'd.)*

### **Blue Shield Enrollment Responsibilities to Members on the Exchange**

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

### **Retroactive Cancellation/Ineligible Member**

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

If the hospital or facility fails to verify the patient's eligibility in accordance with this manual, Blue Shield shall have no obligation to compensate the hospital or facility for any services provided to patients who are not members at the time such services are rendered.

This provision does not apply to BlueCard Host, Medicare Advantage, and the Federal Employee Program.

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## Member Rights and Responsibilities

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

### Statement of Member Rights

Blue Shield health plan members have the right to:

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

## Member Rights and Responsibilities *(cont'd.)*

### Statement of Member Responsibilities

Blue Shield health plan members have the responsibility to:

1. Carefully read all Blue Shield health plan materials immediately after they are enrolled so they understand how to use their benefits and how to minimize their out-of-pocket costs. Ask questions when necessary. They have the responsibility to follow the provisions of their Blue Shield health plan membership as explained in the *Evidence of Coverage* or *Health Service Agreement*.
2. Maintain their good health and prevent illness by making positive health choices and seeking appropriate care when it is needed.
3. Provide, to the extent possible, information that their physician, and/or the plan need to provide appropriate care for them.
4. Understand their health problems and take an active role in developing treatment goals with their medical care provider, whenever possible.
5. Follow the treatment plans and instructions they and their physician have agreed to and consider the potential consequences if they refuse to comply with treatment plans or recommendations.
6. Ask questions about their medical condition and make certain that they understand the explanations and instructions they are given.
7. Make and keep medical appointments and inform the plan physician ahead of time when they must cancel.
8. Communicate openly with the primary care physician they choose so they can develop a strong partnership based on trust and cooperation.
9. Offer suggestions to improve the Blue Shield health plan.
10. Help Blue Shield to maintain accurate and current medical records by providing timely information regarding changes in address, family status, and other health plan coverage.
11. Notify Blue Shield as soon as possible if they are billed inappropriately or if they have any complaints.
12. Select a primary care physician for their newborn before birth, when possible, and notify Blue Shield as soon as they have made this selection.
13. Treat all plan personnel respectfully and courteously as partners in good health care.
14. Pay their dues, copayments, and charges for non-covered services on time.
15. For all mental health and substance use disorder services, follow the treatment plans and instructions agreed to by them and Blue Shield's mental health services administrator (MHSA) and obtain prior authorization as required by the applicable plans *Evidence of Coverage* or *Health Service Agreement* for all non-emergency mental health and substance use disorder services. Medical services for the treatment of gender dysphoria, eating disorder, or substance use disorder are the responsibility of Blue Shield.

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## Member Grievance Process

Blue Shield administers the investigation of member grievances. This process follows a standard set of policies and procedures for the resolution of member grievances. The process also encourages communication and collaboration on grievance issues among various Blue Shield departments and functional areas. Blue Shield requests that contracted hospitals and physicians become familiar with the member grievance process and suggest members use it.

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

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

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

- Access to Care/Potential Quality Issue (PQI)
- Appeal- Standard or Expedited
- Complaint



## Member Grievance Process *(cont'd.)*

### Definitions

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

- Access to Care
- Referral/Authorization Procedures
- Communication issues
- Provider/Staff Behavior
- Coordination of Care
- Technical Competence or Appropriateness
- Facility/Office Environment

Appeal – A request to the health plan for reconsideration of an initial determination resulting in a denial of service, benefit, or claim. Appeals may also include reduction of benefit, claim payment, redirection of service or benefits, delay of prospective authorization for service or benefits or eligibility related denials.

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

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

### Blue Shield Commercial Policy

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

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

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

When appropriate, Blue Shield will send copies of the member’s correspondence to the provider and request that he/she review and respond in writing to the Blue Shield Medical Director.

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## Member Grievance Process *(cont'd.)*

### Blue Shield Medicare Advantage Plan Policy

All Blue Shield Medicare Advantage plan<sup>1</sup> members receive in their *Evidence of Coverage* a Statement of Member Rights and Responsibilities. If a Blue Shield Medicare Advantage plan member asks about filing a grievance, complaint, or appeal, the member should be referred to Blue Shield Medicare Advantage Member Services.

The Blue Shield Medicare Advantage Appeals and Grievance Resolution Department will acknowledge receipt of the member's concern within five calendar days and provide the member with the name of the person working on their concern. The complaint will normally be resolved within 30 days of receipt. If not resolved, the member will be provided with a progress report every 31 days. Post service appeals (claims) are resolved within 60 days.

If the member is not satisfied with the initial resolution of the grievance or complaint, the member may file a written request for a grievance meeting. If the member is not satisfied with the proposed resolution after a grievance meeting, a formal grievance hearing may be requested and held within 31 days of receipt of written request. Contracted providers may be requested by the Blue Shield Medicare Advantage Appeals and Grievance Resolution Department to respond in writing to a member's issues.

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

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

### Standard Review Process

The standard review process for member grievances allows a 30-calendar day period of resolution from the date the grievance is received by Blue Shield to the time the member is informed of the decision. When the grievance is received, Blue Shield will acknowledge receipt of the member's grievance within 5 calendar days of receipt and provide the member with the name of a person to contact regarding their grievance. Generally, the member must participate in Blue Shield's grievance process for 30 calendar days before submitting a complaint to the DMHC or CDI. However, the DMHC or CDI can waive this requirement in "extraordinary and compelling cases." In these events, Blue Shield has five days to respond to the grievance. The Blue Shield grievance process allows members to file grievances within 180 days following any incident or action that is the subject of the enrollee's dissatisfaction.

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<sup>1</sup> When the manual references Blue Shield Medicare Advantage plan, it refers to Blue Shield's Medicare Advantage plans; Blue Shield 65 Plus (HMO), Blue Shield Plus Choice Plan (HMO), Blue Shield Inspire (HMO), Blue Shield Vital (HMO), and Blue Shield Medicare (PPO).

## Member Grievance Process *(cont'd.)*

### Expedited Review

In keeping with the Knox Keene Act, Blue Shield provides an expedited review process in those circumstances where a member believes that his/her health or ability to function could be seriously harmed by waiting the 30 calendar days for a standard grievance. There are specific criteria that must be met in order for a grievance to be considered expedited. If there is a question as to whether a specific grievance qualifies for expedition, the member, member representative, or an attorney or provider on behalf of the member may contact Customer Services and request an expedited review. If the grievance meets the expedited criteria, the case will be handled within the expedited review process. If the grievance does not meet the criteria, the member will be informed of this decision and the review will be conducted under the standard review process guidelines. The expedited review process requires resolution and response to the member as soon as possible to accommodate the member's condition not to exceed 72 hours of the member's initial request. The member, his/her representative, attorney or physician on behalf of the member may file this request. The Blue Shield grievance process allows members to file grievances within 180 days following any incident or action that is the subject of the enrollee's dissatisfaction.

### External Review

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

### External Exception Review

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

### Contacting the Appeals and Grievance Department

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

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## 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 [blueshieldca.com](https://blueshieldca.com), click on the *About Blue Shield* link at the bottom, and then the *Preventing fraud*. 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](mailto:stopfraud@blueshieldca.com), or call Blue Shield's 24-hour Fraud hotline at the toll-free telephone number (855) 296-9092. Callers and emailers may remain anonymous, if desired.

## Provider Audits

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

Audits are also conducted to ensure compliance with:

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

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

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

Provider audits may result in a determination of overpayment and a request for refund.

## Fraud Prevention *(cont'd.)*

### Fraud, Waste, and Abuse

The Medicare Prescription Drug benefit was implemented by the Centers for Medicare & Medicaid Services (CMS) to allow all Medicare beneficiaries access to prescription drug coverage. In its effort to combat fraud in the Medicare prescription drug program, CMS has added several Medicare Drug Integrity 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 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 ID card.
  - Someone asks the beneficiary to get drugs or medical services for them using their Medicare ID card.
- The beneficiary feels a Medicare Advantage or standalone Part D plan has discriminated against them, including not letting them sign up for a specific plan because of their age, health, race, religion, or income.
  - The beneficiary was encouraged to disenroll from their current health plan.
  - The beneficiary was offered cash to sign up for a Medicare Advantage or standalone Part D plan.
  - The beneficiary was offered a gift worth more than \$15 to sign up for a Medicare Advantage or standalone Part D plan.
  - The beneficiary's pharmacy did not give them all of their drugs.
  - The beneficiary was billed for drugs or medical services that he/she didn't receive.
  - The beneficiary believes that he/she was charged more than once for their premium costs.
  - The beneficiary's Medicare Advantage or standalone Part D plan did not pay for covered drugs or services.
  - The beneficiary received a different 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](http://qlarant.com). Reports may also be submitted directly to Blue Shield of California's Special Investigations Unit at (855) 296-9092, via email at [stopfraud@blueshieldca.com](mailto:stopfraud@blueshieldca.com), or through the Medicare Compliance Department at (855) 296-9084.

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## Fraud Prevention *(cont'd.)*

### Medicare Compliance and Fraud, Waste, and Abuse Training Requirements

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

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

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

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

A statement of attestation is required annually by all IPAs, medical groups, and network pharmacies contracted with Blue Shield for the Medicare programs. The compliance statement of attestation indicates that the IPA, medical group or pharmacy staff, and downstream providers have completed the Medicare Compliance and Fraud, Waste, and Abuse training, equivalent training from another Plan Sponsor, or the CMS web-based compliance and FWA training that is accessible at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining>.

## 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 you or members of your staff have any other questions or require further assistance, please contact Provider Information & Enrollment at (800) 258-3091.

## Privacy and Security

The Privacy Office provides oversight of Blue Shield's compliance with state, federal, and international 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 (HITECH) Act.

The Privacy Office accomplishes its mission of ensuring compliance with these laws and regulations via employee awareness and training programs, outreach, audits, policy development, incorporation of industry best practices, investigations, and through consultation and guidance provided to business units.

For additional information about confidentiality, privacy and security, please contact Blue Shield's Privacy Office Helpline at (888) 266-8080 or Hotline at (855) 296-9086.

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## Blue Shield's Code of Conduct and Corporate Compliance Program *(cont'd.)*

### Privacy and Security Risks of Medical Devices

There are several compliance risks associated with medical devices that can adversely affect healthcare organizations. Medical equipment and devices can contain electronic protected health information, which means any devices that are lost, stolen, or accessed by unauthorized individuals can result in privacy incidents that must be investigated, and potentially reported as breaches. Blue Shield suggests the following safeguards that hospitals can take to lower the risk of their medical devices being hacked:

1. Medical equipment should be assigned to hospital personnel. This provides accountability as well as ensuring software is routinely updated and missing equipment is reported immediately. The average hospital has 10 to 15 medical devices per hospital bed. With many devices operating 24/7, this creates countless entry point opportunities for hackers.
2. Medical equipment and devices that require a user name and password should be unique to each user. Some medical equipment and devices are installed with default user IDs and passwords. User names, passwords, and scannable badges should not be shared among personnel. Different passwords should be used for each piece of medical equipment that connects to the hospital's systems directly, using Wi-Fi, or other internet connection. Further, if a vendor controls the software upgrades, lists of authorized users, passwords, etc., require that the vendor keep the security software current and assigns different passwords for each piece of equipment. This will help prevent hacking all equipment if access is gained through one device.
3. Medical equipment and devices are not generally designed to be remotely managed. The timeframe for an idle user should be limited after sign-on, so that another person cannot access the device under the previous user's credentials.
4. Medical equipment and devices that are equipped with location capabilities should have those capabilities activated at all times. This will help locate lost or stolen equipment.
5. Medical equipment and devices with external USB ports should be covered if possible, to prevent the introduction of malware from an external storage device. In addition, hospital staff should refrain from sharing any Wi-Fi passwords with customers.

Hospital personnel who take these suggested actions will help lower the facility's risk for hacking through its medical equipment and devices.



## Blue Shield Medicare Advantage Program Overview

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

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

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

# Section 1: Introduction

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

## Blue Shield Medicare Advantage 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 functions 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 & Ethics 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

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

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

### Auditing and Monitoring

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

### Confirmation of Eligibility of Participation in the Medicare Program

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

- [https://www.oig.hhs.gov/exclusions/exclusions\\_list.asp](https://www.oig.hhs.gov/exclusions/exclusions_list.asp)
- <https://sam.gov/content/home>

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

## Healthcare Regulatory Agencies

### California Department of Insurance (CDI)

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

### California Department of Managed Health Care (DMHC)

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. If the member has a grievance against Blue Shield, the member should first telephone Blue Shield at the number provided in their *Evidence of Coverage* booklet to use the grievance process before contacting the 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 the DMHC for assistance. The member may also be eligible for an Independent Medical Review (IMR). If they are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by Blue Shield related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services.

Providers can reach the DMHC at (888) 466-2219, TDD line (877) 688-9891 for the hearing and speech impaired, or through [www.dmhc.ca.gov](http://www.dmhc.ca.gov), where complaint forms, IMR application forms, and instructions can be found.

### Centers for Medicare & Medicaid Services (CMS)

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

Blue Shield's stand-alone Medicare prescription drug plans are open to all individual Medicare beneficiaries who have Medicare Part A and/or Part B and permanently reside within the plan's service area. Additionally, Blue Shield offers a group Medicare prescription drug plan to Medicare beneficiaries retired from employer groups/unions who have selected the product as an option. Information about CMS or the Medicare program is available by calling (800)-MEDICARE [(800) 633-4227] and through the websites [www.medicare.gov](http://www.medicare.gov) and [www.cms.hhs.gov](http://www.cms.hhs.gov).

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