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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.