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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.