Table of Contents

5.1 Utilization Management

Section 5: Medical Care Solutions

5.1 Utilization Management *(cont'd.)*

5.2 Quality Management Programs

5.2 Quality Management Programs *(cont'd.)*

Section 5: Medical Care Solutions

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Introduction

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

Delegation

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

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

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

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

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

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

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

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

Delegation *(cont'd.)*

To ensure initial and ongoing compliance, Blue Shield will:

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

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

Delegation Oversight

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

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

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

Delegation of Utilization Management (UM)

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

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

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

5.1 Utilization Management

UM Criteria and Guidelines

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

Medical necessity reviews (for both authorizations and non-authorizations) made by Blue Shield use a hierarchy of criteria. (The specific hierarchy can be found in the Utilization Management Program Description.) These criteria consist of internal medical policies established by the Blue Shield Medical Policy Committee, nationally recognized evidence-based criteria, Milliman Care Guidelines (MCG), National Imaging Associates (NIA) Radiology Clinical Guidelines, Advisory Committee on Immunization Practices (ACIP), and Medication Policies (for non-self-administered drugs such as Injectable and Implantable drugs) established by the Blue Shield Pharmacy & Therapeutics Committee (these criteria and guidelines are adopted with input from network physicians and are regularly reviewed for clinical appropriateness). Where applicable, criteria established by the Center for Medicare & Medicaid Services (CMS) and DME coverage criteria are utilized. IPA/medical groups must use the most current version of the policies and manage updates to their UM review processes. These policies may be found on Provider Connection at blueshieldca.com/provider and may be updated quarterly as needed.

For fully-insured products, Mental Health and Substance Use Disorder medical necessity reviews utilize the American Society of Addiction Medicine (ASAM) criteria, Level of Care Utilization System (LOCUS) guidelines, Child and Adolescent Level of Care Utilization System (CALOCUS) guidelines and Early Childhood Service Intensity Instrument (ECSII) guidelines. and World Professional Association for Transgender Health (WPATH) guidelines. Additional MH/SUD guidelines may be added as they become available from non-profit professional associations in accordance with California law. MH/SUD reviews are the responsibility of the IPA/medical group.

Medical Necessity

Medical Necessity (Medically Necessary)*

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

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

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

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

Medical Necessity (Medically Necessary)**

Benefits are provided only for services which are medically necessary.

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

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

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

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

Medical Necessity *(cont'd.)*

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

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

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

Physician Reviews

Physician Review Process - Participants

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

Physician Review

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

Blue Shield Medical & Medication Policies

Medical and medication policies are general statements of coverage for Blue Shield as a company. Unless a specific regulatory requirement (state or federal) or a plan-specific benefit or limitation applies, medical and medication policies are applied to individuals covered by Blue Shield.

The emergence of new technologies and pharmaceuticals (or new uses for existing technologies and pharmaceuticals) is monitored on an ongoing basis to ensure timely availability of appropriate policies.

Medical Policy

The Blue Shield Medical Policy Committee reviews technologies (devices and/or procedures) for medical and behavioral health indications that are new or emerging, and new applications for existing technologies. The Committee meets at least four times per year. Experts are consulted and invited on an as-needed basis to the Committee.

The primary sources of the technology evaluations are derived from the Blue Cross Blue Shield Association (BCBSA) Evidence Street, the Blue Cross Blue Shield Association Medical Policy Reference Panel (BCBSA MPP), and the California Technology Assessment Forum (CTAF).

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

Medical Policy *(cont'd.)*

For a recommended technology to be considered eligible for coverage, that technology must meet all of the Technology Assessment (TA) Criteria:

1. The medical technology must have final approval from the appropriate government regulatory bodies.
2. The scientific evidence must permit conclusions concerning the effectiveness of the technology on health outcomes.
3. The technology must improve the net health outcome.
4. The technology must be as beneficial as established alternatives.
5. The improvement must be attainable outside investigational settings.

Medication Policy

The Blue Shield Pharmacy and Therapeutics (P&T) Committee reviews pharmaceuticals.

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

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

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

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

Note: Benefit and eligibility criteria supersede medical necessity determinations.

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

For Blue Shield Medicare HMO and PPO Members, Blue Shield follows Medicare national and local coverage guidelines. For Blue Shield Medicare PPO Plans, Blue Shield Medication Policies and Step Therapy requirements may also apply for select medications.

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

Medication Policy *(cont'd.)*

If Blue Shield determines that a previously rendered service is not medically necessary, or does not qualify for coverage, the provider will not be paid for the service and will not be able to collect payment from the member without a signed notice of non-coverage. If questions arise about Blue Shield Medical Policy or IPA/medical groups require specific guidelines, please contact Provider Information & Enrollment at (800) 258-3091.

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

Ambulance Services

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

Emergency Ambulance

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

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

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

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

For Commercial Members

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

For Blue Shield Medicare Advantage Plan Members

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

Ambulance Services *(cont'd.)*

Non-Emergency Ambulance

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

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

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

Providers needing to schedule ambulance services should go to Provider Connection at blueshieldca.com/provider and click on *Guidelines & resources, Patient care resources,* then *Ancillary provider rosters* to view a list of contracted ambulance providers or call Provider Information & Enrollment at (800) 258-3091 for information on contracted options.

Ambulatory Surgeries/Procedures

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

Office-based procedures should be performed in a physician-office setting, unless it is medically necessary that they be performed in a facility setting on either an outpatient or inpatient basis.

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

Facility-Based Ambulatory Surgeries/Procedures

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

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

Office-Based Ambulatory Surgeries/Procedures

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

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

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

For Commercial Members

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

For Blue Shield Medicare Advantage Plan Members

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

UM Authorization Reporting Process ("Authorization Logs")

Approval/Denial Data File Requirements

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

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

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

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

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

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

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

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

Clinical Trials for Cancer or Life-Threatening Conditions

For Commercial Members

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

An approved clinical trial is limited to a trial that:

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

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

Benefit Coverage

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

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

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

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

Examples of Non-Covered Services

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

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

Financial Responsibility

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

Experimental/Investigational Treatments

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

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

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

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

Experimental or investigational services are defined as:

- Any treatment, therapy, procedure, drug or drug usage, facility or facility usage, equipment or equipment usage, device or device usage, or supplies that are not recognized, in accordance with generally-accepted professional medical standards, as being safe and effective for use in the treatment of an illness, injury, or condition at issue.
- Services which require approval by the federal government or any agency thereof, or by any State government agency, prior to use and where such approval has not been granted at the time the services or supplies were rendered.
- Services or supplies which themselves are not approved or recognized, in accordance with accepted professional medical standards, but nevertheless are authorized by law or by a government agency for use in testing, trials, or other studies on human patients.

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

For Commercial Members

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

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

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

For Commercial Members *(cont'd.)*

Life-threatening means either or both of the following:

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

Seriously debilitating means diseases or conditions that cause irreversible morbidity.

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

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

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

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

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

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

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

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

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

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

For Commercial Members *(cont'd.)*

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

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

For Blue Shield Medicare Advantage Plan Members

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

Follow-Up Care in a Non-Contracting Hospital

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

Home Health Care

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

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

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

Home Health Care *(cont'd.)*

For Commercial Members

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

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

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

For Blue Shield Medicare Advantage Plan Members

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

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

Home health care services include:

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

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

Home Health Care *(cont'd.)*

Enteral and Parenteral Nutritional Therapies, Supplies, and Supplements

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

Enteral nutritional therapy is patient feeding via tubes that empty directly into the esophagus, stomach, or intestines. This method is used when the patient's lower gastrointestinal tract is functioning, allowing for adequate digestion and absorption. Enteral nutritional therapy that is not administered through a feeding tube will be denied for coverage.

Parenteral nutritional therapy, also known as Total Parenteral Nutrition (TPN), is intravenous (IV) feeding with a solution rich in nutrients. Patients receiving TPN may have a gastrointestinal dysfunction.

Enteral nutrition and parenteral nutritional therapies, including associated supplies and nutritional solutions, are covered under the home infusion benefit.

For Blue Shield Medicare Advantage plan members, these therapies are covered according to Medicare national and local coverage guidelines. For questions regarding coverage, please contact Medicare Medical Care Solutions.

Hospice Care

Hospice services are specialized interdisciplinary health care services designed to provide palliative care, to alleviate the physical, emotional, social, and spiritual discomforts of an enrollee who is experiencing the last phases of life due the existence of a terminal disease, to provide supportive care to the primary care giver and the family of the hospice member, and which meet all of the following criteria:

- Considers the member and the member's family as the unit of care.
- Utilizes an interdisciplinary team to assess the physical, medical, psychological, social, and spiritual needs of the member and the member's family.
- Requires the interdisciplinary team to develop an overall plan of care and to provide coordinated care, which emphasizes supportive services, including, but not limited to, home care, pain control, and short-term inpatient services. Short-term inpatient services are intended to promote both continuity of care and appropriateness of services for those members who cannot be managed at home because of acute complications or the temporary absence of a capable primary caregiver.

For Commercial Members

Hospice services are covered through a Participating Hospice Agency for individual and group members with a terminal illness (expected prognosis of one year or less to live), as certified by their physician.

The member's admission into a Hospice Program by a Participating Hospice Agency requires prior authorization by the IPA/medical group. The Participating Hospice Agency will be requesting the prior authorization from the IPA/medical group directly. A primary care physician authorization is not required for hospice services. IPA/medical groups must notify Blue Shield of authorizations for hospice care and any changes in the levels of hospice care.

Hospice Care *(cont'd.)*

For Commercial Members *(cont'd.)*

Covered services are available on a 24-hour basis to the extent necessary to meet the needs of the member for care that is reasonable and necessary for the palliation and management of the terminal illness and related conditions. Members can receive care for two 90-day periods followed by an unlimited number of 60-day periods. The care continues if the physician re-certifies the member as terminally ill. A member is allowed to change their participating hospice agency only once during each period of care.

> *Note: Members with a terminal illness who have not elected to enroll in a Hospice Program can receive a pre-hospice consultative visit from a Participating Hospice Agency.*

All of the following services must be received from a Participating Hospice Agency:

- Pre-hospice consultative visit regarding pain and symptom management, hospice and other care options including care planning. (Members do not have to be enrolled in the Hospice Program to receive this benefit.)
- Interdisciplinary team care with development and maintenance of an appropriate plan of care and management of terminal illness and related conditions.
- Skilled nursing services, certified health aide services and homemaker services under the supervision of a qualified registered nurse.
- Bereavement services.
- Social services/counseling services with medical social services provided by a qualified social worker. Dietary counseling, by a qualified provider, when needed.
- Medical direction from the medical director for meeting the general medical needs of the members with a terminal illness when these needs are not met by the primary care physician.
- Volunteer services.
- Short-term inpatient care arrangements.
- Pharmaceuticals, medical equipment, and supplies that are reasonable and necessary for the palliation and management of terminal illness and related conditions.
- Physical therapy, occupational therapy, and speech-language pathology services for purposes of symptom control, or to enable the enrollee to maintain activities of daily living and basic functional skills.
- Nursing care services may be provided to maintain a member at home and achieve palliation or management of acute medical symptoms. Hospitalization is covered when the interdisciplinary team makes the determination that skilled nursing care is required at a level that can't be provided in the home. Either homemaker services or home health aide services or both may be covered on a 24-hour continuous basis during periods of crisis, but the care provided during these periods must be predominantly nursing care.
- Occasional respite care services (no more than five consecutive days at a time). Respite Care Services are short-term inpatient care provided to the member only when necessary to relieve the family members or other persons caring for the member.

Hospice Care *(cont'd.)*

Financial Responsibility

When the IPA/medical group is delegated, and Blue Shield has risk for these services, the in-network hospice will be reimbursed on a per diem basis after IPA/medical group authorization. Under Capitated Hospital arrangements, the Capitated Hospital will be responsible for reimbursing Medicare Certified Hospice Agencies directly for authorized services.

For Blue Shield Medicare Advantage Plan Members

Hospice services for Blue Shield Medicare Advantage plan members must be provided by a Medicare-certified provider. Hospice cases involving Blue Shield Medicare Advantage plan members must be reported to Blue Shield for Centers for Medicare & Medicaid Services (CMS) reporting requirements.

For Blue Shield Medicare Advantage plan members who elect hospice services, only prescriptions that are not related to the terminal illness and covered under the Part D benefit, may be covered. The IPA/medical group should work to coordinate with the Hospice provider to determine what drugs are covered under the Part A Hospice benefit, patient pay, and Part D.

When Blue Shield Medicare Advantage plan members require hospice benefits, the portion of the premium associated with the hospice-qualifying diagnosis and subsequent hospice care reverts to Medicare fee for service and is not the IPA/medical group's financial responsibility. All other medical care is still coordinated and provided through the IPA/medical group and is paid based on the IPA/medical group's agreement with Blue Shield. Refer to Section 6.4 for more information regarding Hospice Billing for Blue Shield Medicare Advantage plan members.

Medical Benefit Drugs

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

The Blue Shield Pharmacy and Therapeutics Committee (P&T) is the governing committee responsible for oversight and approval of medication coverage policies and requirements for drugs requiring prior authorization. Medication coverage policies for medical benefit drugs can be found on Provider Connection at blueshieldca.com/provider. Once you have logged on select *Authorizations*, *Clinical policies and guidelines*, then *Medical policies & procedures.*

When delegated for utilization management, Blue Shield requires the IPA/medical group to adhere to the Blue Shield's medication coverage policies for Blue Shield Commercial members when administering prior authorizations and follow step therapy and site of administration requirements. Refer to Section 2.8 - Pharmaceutical Benefits in this manual for more details. For Blue Shield Medicare Advantage plan members, Blue Shield follows Medicare guidelines for risk allocation, Medicare national and local coverage guidelines and Blue Shield Medication Policies where applicable. IPA/ medical groups may be subject to audit of medication coverage determinations according to Blue Shield medication policies by their Delegation Oversight Nurse in consultation with a Blue Shield pharmacist.

Medical benefit drugs are typically covered under capitation, unless contracted differently. Certain exceptions to capitation may be included according to financial risk allocation classifications, updated quarterly: (a) office-administered, (b) high-cost, (c) chemotherapy, and (d) chemotherapy and supportive/adjunctive injectable drugs. Please refer to your Division of Financial Responsibility (DOFR) for the classification(s) of drugs that are contractually carved out to Blue Shield. For Blue Shield Medicare Advantage plan members, Blue Shield follows Medicare guidelines for risk allocation and Medicare national and local coverage guidelines. If excluded from capitation, the medication will be subject to Blue Shield review for coverage according to Blue Shield Medication policy. IPA/medical group will be notified of coverage decisions.

High-cost medications including CAR-T and Gene Therapy are subject to Blue Shield review for coverage according to Blue Shield Medication Policy regardless if UM is delegated to the IPA/medical group. Refer to the Section 5.1 Prior Authorization.

Outpatient Prescription Drugs

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

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

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

Outpatient Prescription Drugs *(cont'd.)*

Commercial Plans

Pharmacy Benefit Medications. Providers can submit a prior authorization request electronically by utilizing one of our contracted electronic prior authorization (ePA) vendors, Surescripts or Cover My Meds. Providers also have the option to complete and fax the Prescription Drug Prior Authorization or Step Therapy Exception Request Form 61-211 (Revised 12/2016) to (888) 697-8122. This form is available on blueshieldca.com/provider under *Authorizations, Prior authorization forms and list,* then *Prior authorization forms*. Providers may also submit prior authorization requests online by going to blueshieldca.com/provider under *Authorizations* then *Request pharmacy authorization* or *Request pharmacy prior authorization electronically* to submit a request through an ePA vendor.

Providers have the alternate option to use AuthAccel to complete, submit, attach documentation, track status, and receive determinations for pharmacy prior authorizations. Registered users may access the tool, in the *Authorizations* section, after logging into Provider Connection at blueshieldca.com/provider. When providers submit requests via AuthAccel, it is not necessary for them to complete a separate California Prescription Drug Prior Authorization or Step Therapy Exception Request Form (61-211), as the required information is built into the tool.

Medicare Plans

The Centers for Medicare & Medicaid Services (CMS) compiles a "Preclusion List" of prescribers, individuals, and entities that fall within either of the following categories: (a) are currently revoked from Medicare, are under an active reenrollment bar, and CMS determines that the underlying conduct that led to the revocation is detrimental to the best interests of the Medicare program; or (b) have engaged in behavior for which CMS could have revoked the prescriber, individual, or entity to the extent applicable if they had been enrolled in Medicare, and CMS determines that the underlying conduct that would have led to the revocation is detrimental to the best interests of the Medicare program. CMS makes the Preclusion List available to Part D prescription drug plans and Medicare Advantage plans. Plans are required to deny payment for claims submitted by, or associated with, prescriptions written by prescribers and providers on the list. Full enforcement of the Part C and D prescriber exclusion list requirement began on January 1, 2019.

Providers can submit a prior authorization request electronically by utilizing one of our contracted electronic prior authorization (ePA) vendors, Surescripts or Cover My Meds. Providers also have the option to request a prior authorization or exception request by faxing a Medicare Coverage Determination Request Form (available at blueshieldca.com/provider) to (888) 697-8122 or via phone to (800) 535-9481 Monday through Friday, 8:00 a.m. until 6:00 p.m. PST, excluding holidays.

Providers can submit a prior authorization request electronically by utilizing one of our contracted electronic prior authorization (ePA) vendors, Surescripts or Cover My Meds. Providers also have the option to request a prior authorization or exception request by faxing a Medicare Coverage Determination Request Form (available at blueshieldca.com/provider) to (888) 697-8122 or via phone to (800) 535-9481 Monday through Friday, 8:00 a.m. until 6:00 p.m. PST, excluding holidays.

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

Outpatient Prescription Drugs *(cont'd.)*

Medicare Plans *(cont'd.)*

Once all required supporting information is received, a coverage decision, based upon medical necessity, is provided within the following timelines:

- Commercial plans within 24 hours for an urgent request and 72 hours for standard requests.
- Medicare Part D plans within 24 hours for an expedited review and 72 hours for standard requests.

Specialty Drugs are covered at a copayment or coinsurance and most require prior authorization for coverage. Specialty Drugs are available through a Blue Shield Network Specialty Pharmacy.

The most current version of Blue Shield formularies and other information about Blue Shield prescription drug benefits and pharmacies can be accessed on blueshieldca.com in the *Provider Connection* or *Pharmacy* sections or by calling (800) 535-9481.

Note: Different drug formularies apply depending on the member's plan.

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

Institutional Services

Generally, a primary care physician or specialist obtains an authorization for elective institutional services from his or her IPA/medical group, except for the authorization of services not delegated, such as transplant. The IPA/medical group reviews the request and coordinates the authorization with the Blue Shield Medical Care Solutions Department.

Depending on the HMO IPA/Medical Group's Blue Shield Agreement and delegation status, the IPA/medical group is required to request approval from Blue Shield for institutional services. When the IPA/medical group is delegated, and Blue Shield has risk for these services, these services may be reimbursed by Blue Shield under the Institutional Fund. Under capitated hospital arrangements, the capitated hospital will be responsible for reimbursing the providers directly for authorized services. Financial responsibility is further described in the Division of Financial Responsibility in the HMO IPA/Medical Group Agreement.

To facilitate timely authorizations of institutional services, IPA/medical groups should provide Blue Shield with the information outlined in the Authorization Approval and Denial Notifications Process section found above. Institutional services must meet medical necessity requirements as outlined below.

Preoperative Days/Testing

Whenever possible, preoperative testing should be done on an outpatient basis and patients should be admitted on the day of surgery.

Mental Health and Substance Use Disorder Services

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

The responsibility for authorizing mental health and substance use disorder services for Blue Shield Medicare Advantage plan members remains with the delegated IPA/medical group. If Medicare behavioral health utilization management is not delegated to the IPA/medical group, Blue Shield retains the responsibility for authorizing mental health and substance use disorder services. Mental Health services are covered in accordance with Medicare coverage guidelines.

Blue Shield provides coverage for the diagnosis and medically necessary treatment of mental health and substance use disorders. This includes conditions that fall under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the World Health Organization’s *International Statistical Classification of Diseases and Related Health Problems* or that are listed in the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). Blue Shield’s mental health service administrator (MHSA) for commercial HMO members is Human Affairs International of California (HAI-CA). For more detailed information about the services administered by the Blue Shield MHSA and the protocols developed to promote the integration of medical and behavioral health treatment, refer to the *Medical Interface Manual* on Provider Connection at www.blueshieldca.com/provider under *Guidelines & resources* and *Provider manuals*.

Members must utilize the Blue Shield MHSA provider network to access mental health and substance use disorder covered services. The MHSA participating provider must obtain prior authorization from the MHSA for services listed under the section Blue Shield Mental Health Service Administrator (MHSA) Covered Services and Financial Responsibility below. The MHSA only provides authorization for commercial and limited Group MAPD members, not for Individual MAPD members.

HMO IPA/medical groups are responsible for decisions related to delegated medical services. As such, medical services for the treatment of gender dysphoria, eating disorder, or substance use disorder are the responsibility of the IPA/medical group.

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

Member Self-Referral Number

Blue Shield members can self-refer for behavioral health services by calling the Customer Service or Mental Health Customer Service number on the back of their Blue Shield ID card.

Primary Care Physician Consultation Line

For Commercial and Group Medicare members, the Blue Shield MHSA offers a Primary Care Physician (PCP) Consultation Line at (877) 263-9870 to facilitate PCP discussion with a Board-Certified psychiatrist regarding mental health and substance use disorder issues, prescribing of psychotropic medication and coordination of care issues.

PCP Behavioral Health Toolkit

Primary care physicians and their staff members can access Blue Shield’s online PCP Behavioral Health Toolkit at any time by visiting blueshieldca.com/provider, selecting *Guidelines & resources*, *Patient care resources*, *Behavioral health resources,* then *PCP Behavioral Toolkit*. The website includes clinical consultation contacts, referral information, screening tools, patient education resources and more to help primary care physicians manage or refer patients to meet behavioral health care needs.

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

Telebehavioral Health Online Appointments

The Blue Shield MHSA offers real-time, two-way communication via online virtual appointments with a mental health or substance use disorder provider. Appointments are available for counseling services, psychotherapy, and medication management with participating therapists and psychiatrists contracted with Blue Shield's mental health service administrator (MHSA). To access Telebehavioral health providers, members can visit *Find a Doctor* on blueshieldca.com. Once on *Find a Doctor,* click on *Mental Health* to be directed to Blue Shield's MHSA website. Enter the required search criteria, hit search and on the next screen click on *Provider Search Telebehavioral* on the left of the screen.

Blue Shield Mental Health Service Administrator (MHSA) Covered Services and Financial Responsibility

For fully-insured products, the Blue Shield MHSA will utilize ASAM, LOCUS, CALOCUS, and ECSII for mental health and substance use disorder reviews. Additional MH/SUD guidelines may be added as they become available from non-profit professional associations in accordance with California law.

Blue Shield's MHSA is responsible for prior authorization and paying claims for the following services: *(Note: The MHSA only provides authorization for commercial and limited Group MAPD members, not for Individual MAPD members).*

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

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

IPA/Medical Group Covered Services and Financial Responsibility

The IPA/medical group remains responsible for the services listed below even when member's mental health and substance use disorder benefits are being managed by Blue Shield's MHSA:

- Outpatient radiology, laboratory, speech therapy, occupational therapy, and physical therapy services associated with a mental health and substance use disorder diagnosis.
- Medical consultations requested by the MHSA.
- Structured Pain Management Program.
- Nutritional counseling.
- Decisions related to delegated medical services. As such, medical services for the treatment of gender dysphoria, eating disorder, or substance use disorder are the responsibility of the IPA/medical group. In making utilization management decisions, the IPA/medical group will utilize ASAM, LOCUS, CALOCUS, and ECSII for mental health and substance use disorder reviews. Additional MH/SUD guidelines may be added as they become available from non-profit professional associations in accordance with California law.

Blue Shield Responsibility

Blue Shield remains responsible for the services below even when the member's mental health and substance use disorder benefits are being managed by Blue Shield's MHSA.

- Out-of-service area requests.
- Outpatient prescription medications.

Organ and Bone Marrow Transplants

Members referred for major organ and bone marrow transplants (excludes cornea, kidney-only, and skin) are evaluated within the Blue Shield Major Organ/Bone Marrow Transplant Network. Certain transplants are eligible for coverage within Blue Shield's transplant network, but only if specific criteria are met and prior written authorization is obtained from Blue Shield's Medical Care Solutions Transplant Team. Only the human organ and bone marrow transplants listed below are covered. For commercial HMO and PPO members, donor costs for a member are only covered when the recipient is also a Blue Shield member. Donor costs are paid in accordance with Medicare coverage guidelines for Blue Shield Medicare Advantage plan members.

All Major Organ/Bone Marrow transplant referrals must be to a California network transplant facility for benefits to be paid. Please contact the Blue Shield Transplant Team at (800) 637-2066, extension 8411130 for the listing of institutions selected to participate in this network and for coordination of referrals for evaluation. Members who are in a transplant treatment continuum must be cleared by the Blue Shield Medical Care Solutions Transplant Team for change of IPA. All requests should be sent via fax to the Transplant Medical Care Solutions Department in Rancho Cordova at (916) 350-8865. For members living in California, referrals to an out of state transplant facility must be at the referral of a Blue Shield's Major Organ/Bone Marrow Transplant Network facility approved for the specified type of transplant based upon medical necessity. For coverage, all referrals for medical necessity to an out-of-state provider must be pre-authorized by a Blue Shield Medical Director.

Organ and Bone Marrow Transplants *(cont'd.)*

Blue Shield Medicare Advantage Plan - Prior authorization for all Blue Shield Medicare Advantage plan evaluations and transplants is required and coverage subject to applicable Medicare coverage guidelines. These services must be performed at a Medicare-approved transplant facility for the specific transplant in question. The evaluation for Blue Shield Medicare Advantage plan members requires authorization by the IPA/medical group only.

> *Note: Charges incurred as a result of cadaver organ donor evaluation, donor maintenance and organ recovery are directly reimbursable by the Organ Procurement Organization (OPO) according to Federal law and therefore are not paid by Blue Shield. These charges may include but are not limited to extended hospital stay beyond the second death note, lab studies, ultrasound, maintaining oxygenation and circulation to vital organs, and the recovery surgery. Blue Shield will pay the appropriate organ acquisition fee at the time the organ is transplanted. For Blue Shield Medicare Advantage plan transplants, Blue Shield will pay in accordance with contractual or Medicare fee schedules in accordance with Medicare coverage guidelines.*

Commercial HMO - Both the transplant evaluation and the actual transplant procedure require prior authorization. The evaluation for HMO members requires authorization by the IPA/medical group or as otherwise specified. No self-referrals for transplant evaluations will be approved under the POS. All Blue Shield members are entitled to transplant evaluations at any Blue Shield transplant network facility approved for the specified organ, whether that facility has a contractual relationship with the IPA/medical group**.**

Transplant Authorizations

When the evaluation is completed, the transplant coordinator at the transplant facility will send the transplant request to Blue Shield's Medical Care Solutions Transplant Team for medical necessity review and authorization.

Authorizations for transplants are required from the Blue Shield Transplant Team for the following major organ and bone marrow transplant types:

- Bone marrow
- Stem cell
- CAR-T therapy
- Cord Blood
- Kidney and pancreas or kidney with another solid organ (for kidney only, see below)
- Heart
- Heart/lung
- Lung
- Liver
- Pancreas
- Small bowel with or without liver
- Multi-organ transplants (including kidney plus other organs)

Organ and Bone Marrow Transplants *(cont'd.)*

Transplant Authorizations *(cont'd.)*

The following transplants are also eligible for coverage but are handled as routine inpatient services by the designated Medical Care Solutions Prior Authorization Department for all members:

- Corneal
- Kidney only
- Skin

Requests for transplants must include the following:

- Subscriber ID, requesting MD and applicable procedure and diagnosis codes
- Letter of request, including protocol reference
- Patient Selection/Bone Marrow Transplant (BMT) Committee Minutes/Tumor Board Recommendation
- Transplant Consult (from diagnosis to current/chemosensitivity/lab/staging)
- Synopsis of psycho-social and caregiver evaluation
- Comprehensive psychiatric evaluation (history of serious/prolonged mental illness)
- Documented completion of substance use disorder program (current history of substance use)
- Complete Transplant evaluation and workup

Fax transplant authorization requests to (916) 350-8865 Attn: Transplant Team.

Other Alternate Care Providers

These services should be provided within the Blue Shield network of alternate care providers:

- Durable Medical Equipment (DME) rental or purchase
- Oxygen
- Prosthetics or orthotics over $50
- Colostomy and ostomy supplies

New technologies must be coordinated with Blue Shield Medical Care Solutions prior to IPA/medical group authorizations for shared risk/savings agreements. IPA/medical groups may contact Blue Shield Medical Care Solutions for questions or issues.

For the Blue Shield Medicare Advantage plan, depending on the IPA/medical group's contract and delegation status with Blue Shield, the IPA/medical group must coordinate authorization with the appropriate Blue Shield Medical Care Solutions Department when these services are required.

Other Alternate Care Providers *(cont'd.)*

Durable Medical Equipment (DME)

Delegated medical groups must refer to and abide by Blue Shield Utilization Management (UM) criteria for authorizations of durable medical equipment (DME). In the absence of any Blue Shield Medical Policy, it utilizes the Centers for Medicare & Medicaid Services (CMS) Coverage Issues Manual for Durable Medical Equipment (section 60). The manual can be found at cms.gov

Durable medical equipment is defined by the following standards:

- Designed for repeated use and is medically necessary to treat an illness or injury, to improve the functioning of a malformed body part, or to prevent further deterioration of the member's medical condition.
- Appropriate for use in the home.

Delivery charges are covered. Durable medical equipment rental is covered only up to the Blue Shield allowance for purchase of the item.

If an emergency room visit is covered, no additional authorization is needed for related DME given to the member in the emergency room. The DME must match services on the ER claim.

When requesting a tracking number for durable medical equipment rental or purchase, the IPA/medical group should specify the:

- Applicable Diagnosis Code
- IPA authorization number
- Specific Procedure Code
- Duration of need

Other Alternate Care Providers *(cont'd.)*

Oxygen

When authorizing a request for oxygen equipment, the IPA/medical group must specify the flow rate at rest, concentration and oxygen saturation.

Oxygen therapy includes professional respiratory therapy services to monitor use of oxygen in the home and supplies needed to administer oxygen.

Professional services associated with administration of oxygen in the home are covered under the Home Health Care benefit.

Apria Healthcare LLC is Blue Shield's Primary Preferred DME provider (including oxygen services) for HMO and PPO members. Apria should be considered the first option when DME services are ordered.

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

Orthotics and Prosthetics

Orthotics are materials such as an orthopedic appliance used to support, align, prevent, strengthen, or correct deformities or to improve the function of part of the human body. Prosthetics are artificial body parts, appliances, or devices used to replace an absent or missing part of the human body.

For Commercial Members

Financial responsibility is described in the Division of Financial Responsibility in the HMO IPA/Medical Group Agreement.

Orthotics and prosthetics that cost less than a contracted dollar amount (e.g. $50) are generally covered under professional capitation. Orthotics and prosthetics that have a Blue Shield allowed amount more than the contracted dollar amount (for a single item or cumulatively for all items required to make the orthotic or prosthetic) are generally covered as shared-risk under the Shared Risk/Shared Savings Fund, requiring IPA/medical group authorization and coordination with the Blue Shield Medical Care Solutions Department (see the Contact List in Appendix 1 in the back of this manual). Under Capitated Hospital arrangements, the Capitated Hospital will be responsible for reimbursing the providers directly for authorized services**.**

For Blue Shield Medicare Advantage Plan Members

Medicare coverage guidelines for orthotics and prosthetics are applicable for Blue Shield Medicare Advantage plan members. Financial responsibility is specified in the Division of Financial Responsibility in the HMO IPA/Medical Group Agreement with Blue Shield.

Out-of-Area Services

Services that are covered outside the member's primary care physician service area include:

- Non-emergency services referred out-of-area and authorized by the primary care physician/IPA/medical group and/or Blue Shield
- Emergency services (Refer to Emergency Services section)
- Urgent services (refer to the HMO Benefit Guidelines for urgent services benefit information)

Note: A covered exception for renal dialysis is described in the HMO Benefit Guidelines for out-of-area services.

Before approving out-of-area services, the IPA/medical group must confirm whether or not the provider is part of the Blue Shield HMO Provider Network by calling Blue Shield Provider Information & Enrollment at (800) 258-3091.

The IPA/medical group is responsible for all referred out-of-area professional fees and capitated services and for reporting all out-of-area professional referrals as encounter data. Blue Shield is generally responsible for payment of all fees related to out-of-area emergency or urgent care. Financial responsibility is described in the Division of Financial Responsibility in the HMO IPA/Medical Group Agreement with Blue Shield. The Blue Shield Medical Care Solutions Department works with the IPA/medical group to issue authorizations for all out-of-area institutional services. The IPA/medical group must notify the Blue Shield Medical Care Solutions Department of all institutional out-of-area referred services prior to providing those non-emergency services.

Out-of-Plan Services

Out-of-plan services are those services that are not available through the Blue Shield HMO Provider Network.

When providing an authorization for out-of-plan services, the IPA/medical group must contact the Blue Shield Medical Care Solutions Department for a letter of agreement.

The IPA/medical group is financially responsible for all referred out-of-plan professional capitated services and for reporting all out-of-plan professional services as encounter data.

If a letter of agreement for out-of-plan services is not obtained from Blue Shield, then the IPA/medical group is financially responsible for all fees associated to institutional services.

PKU-Related Formulas and Special Food Products

For Commercial Members

Benefits are provided for enteral formulas, related medical supplies, and special food products that are medically necessary for the treatment of phenylketonuria (PKU ICD-9 270.1, ICD-10-CM E70.0-E70.1) to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of PKU. These benefits must be prior-authorized by the IPA/medical group and must be prescribed or ordered by the appropriate healthcare professional. Refer to the member's EOC for benefit limitations.

5.1 Utilization Management

Prior Authorization

Except for emergency services, the following services may require prior authorization:

1. Ambulance
2. Colostomy and ostomy supplies
3. IV infusion therapy including high-cost medications such as CAR-T and Gene therapy
4. Facility-based outpatient surgeries/procedures
5. Home health care
6. Durable Medical Equipment (DME) – new technologies
7. Hospice care
8. Non-emergency inpatient hospital admissions
9. Inpatient rehabilitation
10. Skilled nursing facility admissions
11. Out-of-area services
12. Out-of-plan services
13. Oxygen
14. Prosthetics/orthotics – new technologies
15. Parenteral and enteral nutritional supplements
16. In-home physical therapy (PT), occupational therapy (OT), speech therapy (ST), and respiratory therapy (RT)
17. Organ transplants (Refer all transplants except kidney, skin and cornea to the Blue Shield Transplant Team)
18. Cancer clinical trial participation: not delegated to the IPA/medical group, refer to Blue Shield for authorization
19. Experimental/investigational procedures that are not delegated to the IPA/medical group
20. Medication administration at an outpatient hospital facility

Prior authorization for the services listed above is based on medical necessity and clinical criteria, which are guidelines for decisions about coverage of care. Prior authorization information is accessible through Provider Connection at https://www.blueshieldca.com/bsca/bsc/wcm/connect/provider/provider_content_en/authorizations/authorization_list#list. Blue Shield uses nationally recognized industry sources selected by Blue Shield, including CMS, Blue Shield Medical Policies, and Medication Policies (Injectable, Implantable, w/ DME) established by the Blue Shield Pharmacy & Therapeutics Committee.

For fully-insured products, the Blue Shield MHSA will utilize ASAM, LOCUS, CALOCUS, ECSII, and World Professional Association for Transgender Health (WPATH) for mental health and substance use disorder reviews. Additional MH/SUD guidelines may be added as they become available from non-profit professional associations in accordance with California law.

Prior Authorization *(cont'd.)*

For those services NOT delegated to the IPA/medical group:

- To obtain a service authorization, the IPA/medical group should call the Blue Shield Medical Care Solutions Department. Requests for service authorization should be made at least five business days in advance of service provision. Blue Shield will issue a determination. Services without an authorization that require an authorization will be denied.
- In addition to contacting Blue Shield by telephone or fax for medical authorizations, providers have the option to use AuthAccel, Blue Shield's online tool for submitting authorization requests. AuthAccel may only be used for services where the division of financial responsibility in the IPA/medical group's contract identifies Blue Shield as responsible for prior authorization. Providers may use AuthAccel to complete, submit, attach documentation, track status and receive determinations for applicable medical and pharmacy prior authorizations. Registered users at Provider Connection may access the tool, in the *Authorizations* section, after logging into the website at www.blueshieldca.com/provider.

To determine service authorizations, the IPA/medical group, in coordination with Blue Shield Medical Care Solutions Department:

- Verifies the patient's eligibility and contract benefits
- Checks the provider's status
- Applies appropriate medical necessity criteria
- Refers the request to a physician advisor or medical director, as appropriate
- Evaluates non-preferred home health care services and DME rentals/purchases

For those services delegated to the IPA/medical group:

- Delegated IPA/medical groups will issue a determination
- Delegated IPA/medical groups will contact the requesting provider(s) by telephone/fax within 24 hours of the decision to inform the physician(s) of the status of the authorization request

If a provider other than the primary care physician's IPA/medical group requests authorization, the provider will be directed to contact the IPA/medical group before the Blue Shield Medical Care Solutions Department reviews the authorization request.

Professional Services

Primary care physicians must follow their IPA/medical group's procedures when requesting authorizations for professional services and referrals.

When referring a member for specialty services, primary care physicians must follow their IPA/medical group's referral guidelines and should also:

- Note the referral in the patient's medical record
- Forward copies of medical records or test results to the specialist
- Coordinate with the attending physician when specialist consultations and services are needed during an inpatient stay

Rehabilitation Services

Rehabilitation services are covered as an inpatient or outpatient benefit when they are deemed medically necessary for the treatment of a single illness, injury or medical condition.

Rehabilitation and habilitation therapies are defined as:

Rehabilitation Therapies – Inpatient or outpatient care furnished primarily to restore an individual's ability to function as normally as possible after a disabling illness or injury. Rehabilitation services include physical therapy, occupational therapy, and/or respiratory therapy. Rehabilitation services will be authorized for an initial treatment period and for any additional medically necessary subsequent treatment periods.

Habilitation Therapies – Medically Necessary services and health care devices that assist an individual in partially or fully acquiring or improving skills and functioning and that are necessary to address a health care condition, to the maximum extent practical. These services address the skills and abilities needed for functioning in interaction with an individual's environment. Respite care, day care, recreational care, residential care, social services, custodial care, or education services of any kind are not considered Habilitative Services.

Occupational Therapy – Treatment under the direction of a physician and provided by a certified occupational therapist, utilizing arts, crafts, or specific training in daily living skills, to develop, improve and maintain a patient's ability to function.

Physical Therapy – Treatment provided by a physician or when provided by a licensed physical therapist for services diagnosed by a physician or licensed doctor of podiatric medicine. Treatment utilizes physical agents and therapeutic procedures such as ultrasound, heat, range of motion testing, and massage, to develop or improve a patient's musculoskeletal, neuromuscular and respiratory systems.

Respiratory Therapy – Treatment under the direction of a physician and provided by a certified respiratory therapist to develop, preserve or improve a patient's pulmonary function.

Inpatient Rehabilitation

Inpatient rehabilitation benefits will be provided for medically necessary inpatient days of care in an acute hospital rehabilitation unit or skilled nursing facility (SNF) rehabilitation unit.

Depending on the IPA/medical group's Blue Shield contract and delegation status, the primary care physician and/or the IPA/medical group should request authorization for inpatient rehabilitation service from the Blue Shield Medical Care Solutions Department when referring a member for admission or transfer to an inpatient rehabilitation unit or SNF. For Acute Rehabilitation, CMS guidelines should be applied in the absence of a specific Blue Shield medical policy or guideline. The Division of Financial Responsibility is specified in the HMO IPA/Medical Group Agreement.

For Blue Shield Medicare Advantage plan members, rehabilitation benefits are unlimited and are based on medical necessity. For more on Blue Shield Medicare Advantage plan inpatient rehabilitation benefits, see Section 6.

Rehabilitation Services *(cont'd.)*

Outpatient Rehabilitation

Outpatient rehabilitation therapy is covered for as long as continued treatment is medically necessary, pursuant to a written treatment plan and dependent on any EOC benefit limitations. Care must be rendered in the provider's office or outpatient department of a hospital.

A determination of medical necessity can include, but is not limited to, an evaluation of whether or not the member is a reasonable candidate for a rehabilitation program (i.e., the prognosis is such that there is reasonable expectation that rehabilitation efforts will affect greater functionality with respect to the activities of daily living).

Depending on the HMO IPA/Medical Group's Blue Shield Agreement and delegation status, the primary care physician and/or the IPA/medical group should request authorization for outpatient rehabilitation services from the Blue Shield Medical Care Solutions Department. Medically necessary services will be authorized for an initial treatment period and any additional subsequent medically necessary treatment periods. Medical necessity (as defined earlier in this section) is objectively assessed prior to therapy to establish treatment goals and objectives. The Division of Financial Responsibility is specified in the HMO IPA/Medical Group Agreement.

If rehabilitation services are rendered in the home, the visits will be applied to the 100-visits-per-calendar-year limit established for home health care services or according to the member's benefit limitations as shown in their EOC.

For Blue Shield Medicare Advantage plan members, rehabilitation services benefits are unlimited and are based on medical necessity. For more on Blue Shield Medicare Advantage plan outpatient rehabilitation benefits, see Section 6.

Skilled Nursing Facility (SNF) Admissions/Transfers

Note: For Blue Shield Medicare Advantage plan SNF benefit limits, see Section 6.

Blue Shield commercial HMO members may be admitted or transferred to a SNF from any environment. Depending on the HMO IPA/Medical Groups' Blue Shield Agreement and delegation status, IPA/medical groups may be required to obtain prior authorization for SNF admissions/transfers from the Blue Shield Medical Care Solutions Department.

Admission to a SNF is considered appropriate, and may be authorized for care provided by a licensed professional (both nurse and therapist), for the purpose of stabilization, assessment, or preventive care. Medically necessary skilled nursing services, including sub-acute care will be covered when provided in a skilled nursing facility when authorized. The IPA/medical group is required to perform concurrent review for medical necessity at least weekly on SNF patients, or more frequently as circumstances dictate.

Below are examples of services for which SNF admissions may be authorized:

1. Intravenous, intramuscular, or subcutaneous injections and or intravenous feeding.
2. Levine tube feedings and new gastrostomy tube feedings.
3. Nasopharyngeal and tracheostomy aspiration.
4. Insertion, sterile irrigation, and replacement of catheters.
5. Applications of dressings involving prescription medications and aseptic technique.
6. Treatment of extensive decubitus ulcers (stage II or greater) or other widespread skin disorders.
7. Heat treatments that require observation to adequately evaluate progress.
8. Initial phases of a regimen involving administration of medical gases.
9. Rehabilitation nursing procedures (e.g., the institution and supervision of bowel and bladder training programs, diabetic care).

   Note: For commercial members, the standard SNF benefit is limited to 100 days per calendar year, but SNF benefits may differ depending on HMO plan benefits.

Specialist Services

When providing healthcare services, specialists must:

- Render services only with appropriate authorization from the primary care physician or the IPA/medical group.
- Submit all claims for services rendered to the appropriate IPA/medical group affiliated with the referring primary care physician.
- Accept the IPA/medical group’s contracted rates as payment in full, minus applicable member co-payments.
- Provide the primary care physician with the results of any visits, tests, etc.

Specialist Services *(cont'd.)*

Standing Specialist Referrals

Each IPA/medical group must establish and maintain policies and procedures for standing referrals to specialists for members with a condition or disease, including but not limited to HIV and AIDS[2], which requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling. (A standing referral involves more than one appointment with a medical specialist.)

When authorizing a standing referral to a specialist for the purpose of diagnosis or treatment of a condition requiring care by a physician with specialized knowledge of HIV medicine, the delegated IPA/medical group must refer the member to a network HIV/AIDS specialist. A list of qualified HIV/AIDS specialists must be maintained by the IPA/medical group and accessible by the group's membership.

An IPA/medical group does not need to go outside its own network of providers when referring to HIV/AIDS specialists unless the IPA/medical group does not have the appropriate qualified physician, nurse practitioner, or physician assistant under the supervision of an HIV/AIDS provider, in its network.

There is no limitation to utilizing network providers, as long as an appropriate specialist is available within the network. If the IPA/medical group does not contract with a qualified HIV/AIDS provider as defined, the IPA/medical group is required to refer any members needing a standing referral to a physician outside the IPA/medical group's network at their own cost.

It is required that the member's primary care physician, in consultation with the specialist and the Medical Director of the IPA/medical group or designee, determine if the member needs continuing care from a specialist. If it is determined that access to a specialist is medically necessary, then the specialist must be allowed to see the member in his/her area of expertise in the same manner as the member's primary care physician. The IPA/medical group can simply approve the current standing referral order to a specialist or it can require a treatment plan. In the event that a treatment plan is required, all referrals must be made within four business days of the time that the treatment plan is submitted.

This law requires that patients receive a standing referral to an HIV/AIDS specialist when continued care is needed for the patient's HIV/AIDS condition. When authorizing a standing referral to a specialist for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, IPA/medical groups *must* refer the enrollee to an HIV/AIDS specialist.

[2] *Effective Date: January 16, 2003 (Commercial HMO)*

Specialist Services *(cont'd.)*

Standing Specialist Referrals *(cont'd.)*

The Department of Managed Health Care (DMHC) issued a definition of an HIV/AIDS specialist as follows:

(e) For the purposes of this section, an "HIV/AIDS specialist" means a physician who holds a valid, unrevoked and unsuspended certificate to practice medicine in the state of California and who meets any one of the following four criteria:
(1) Is credentialed as an "HIV specialist" by the American Academy of HIV Medicine; or
(2) Is board certified, or has earned a Certificate of Added Qualification, in the field of HIV medicine granted by a member board of the American Board of Medical Specialties, should a member board of that organization establish board certification, or a Certificate of Added Qualification, in the field of HIV medicine; or
(3) Is board certified in the field of infectious diseases by a member board of the American Board of Medical Specialties and meets the following qualifications:
(A) In the immediately preceding 12 months has clinically managed medical care to a minimum of 25 patients who are infected with HIV; and
(B) In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients, including a minimum of 5 hours related to antiretroviral therapy per year; or
(4) Meets the following qualifications:
(A) In the immediately preceding 24 months has clinically managed medical care to a minimum of 20 patients who are infected with HIV; and
(B) Has completed any of the following:
1. In the immediately preceding 12 months has obtained board certification or re-certification in the field of infectious diseases from a member board of the American Board of Medical Specialties; or
2. In the immediately preceding 12 months has successfully completed a minimum of 30 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients; or
3. In the immediately preceding 12 months has successfully completed a minimum of 15 hours of category 1 continuing medical education in the prevention of HIV infection, combined with diagnosis, treatment, or both, of HIV-infected patients and has successfully completed the HIV Medicine Competency Maintenance Examination administered by the American Academy of HIV medicine.

(f) When authorizing a standing referral to a specialist pursuant to Section 1374.16(a) of the Act for the purpose of the diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, a health care service plan must refer the enrollee to an HIV/AIDS specialist. When authorizing a standing referral to a specialist for purposes of having that specialist coordinate the enrollee's health care pursuant to Section 1374.16(b) of the Act for an enrollee who is infected with HIV, a health care service plan must refer the enrollee to an HIV/AIDS specialist. The HIV/AIDS specialist may utilize the services of a nurse practitioner or physician assistant if:
(1) The nurse practitioner or physician assistant is under the supervision of an HIV/AIDS specialist; and
(2) The nurse practitioner or physician assistant meets the qualifications specified in subsection (e)(4); and
(3) The nurse practitioner or physician assistant and that provider's supervising HIV/AIDS specialist have the capacity to see an additional patient.

Specialist Services *(cont'd.)*

Speech Therapy Services

Medically necessary Speech Therapy services are basic health care services under the Knox-Keene Health Care Service Plan Act of 1975. Health plans must arrange and cover speech therapy services for their enrollees when medically necessary. For the complete Speech Therapy Medical Policy, go to Provider Connection at blueshieldca.com/provider, click on *Authorizations, Clinical policies and guidelines*, then *Medical policies & procedures.*

Initial outpatient benefits for speech therapy are covered when diagnosed and ordered by a physician and services are delivered by a licensed speech-language pathologist that is licensed through the Department of Consumer Affairs, Speech-Language Pathology & Audiology & Hearing Aid Dispensers Board, and performs within the scope of practice pursuant to a written treatment plan, to:

(1) Correct or improve the speech abnormality, or

(2) Evaluate the effectiveness of treatment, and when rendered in the provider's office or outpatient department of a hospital.

Speech therapy is defined as therapy services, including diagnostic evaluation and therapeutic intervention, that are designed to improve, develop, correct, rehabilitate, or prevent the worsening of speech/language communication and swallowing disorders that have been lost, impaired or reduced as a result of acute or chronic medical conditions, congenital anomalies, or injuries.

Services are provided for the correction of, or clinically significant improvement of, speech abnormalities that are the likely result of a diagnosed and identifiable medical condition, illness, or injury to the nervous system or to the vocal, swallowing, or auditory organs.

Continued Outpatient Benefits will be provided for Medically Necessary Services as long as continued treatment is medically necessary, pursuant to the written treatment plan and likely to result in clinically significant progress as measured by objective and standardized tests and dependent on any limitations in the members EOC benefit plan. The provider's treatment plan and records must be reviewed periodically. When continued treatment is not Medically Necessary, pursuant to the treatment plan, is not likely to result in additional clinically significant improvement, or no longer requires skilled services of a licensed speech-language pathologist, the IPA/medical group must notify the member of this denial determination in writing and benefits will not be provided for services rendered after the date of written notification.

Specialist Services *(cont'd.)*

Speech Therapy Services *(cont'd.)*

The IPA/medical group shall send a denial notice to the member containing the following information:

- Member's name and name(s) of provider(s) who rendered services.
- Date and description of service.
- Clinical reason(s) for the denial.
- UM criteria, guideline, protocol or benefit provisions used in making the decision, including contact information and procedures to follow to obtain a copy.
- Alternative treatment options, as appropriate.
- For employer health plans governed by the Employee Retirement Income Security Act (ERISA), ERISA-required statement notifying member of the right to bring a civil action if all required reviews of the service/claim have been completed and the service/claim has not been approved.
- Appeal information, including the member's right to request an external, independent medical review through the DMHC (only Commercial members may appeal to DMHC, Blue Shield 65 Plus members must appeal directly to the health plan); the member's right to request expedited appeals; the member's right to submit written comments, documents, or other information relevant to the appeal; and the member's right to appeal to Blue Shield.

The IPA/medical group shall also send a copy of the member's denial notice to the member's primary care physician for follow-up regarding appropriate care. The denial letter to the treating provider shall also include the name, title and direct telephone number of the IPA/medical group's Medical Director who oversees the decision.

Note: The following conditions have been removed from Blue Shield's exclusions lists for speech therapy and therefore should not be automatically denied; however, these conditions are still subject to medical necessity review as described above:

- *Psycho-social speech delay including delayed language development*
- *Mental retardation or dyslexia*
- *Syndromes associated with diagnosed disorders attributed to perceptual and conceptual dysfunctions*
- *Developmental articulation and language disorders*

Urgent/Emergent Services

Urgent/emergent services are those services necessary to screen and stabilize members in cases where an enrollee reasonably believed he/she had an emergency medical or psychiatric condition given the enrollee's age, personality, education, background and other similar factors.

No Prior Authorization Required

State and federal law prohibits requiring prior authorization for emergency services. Blue Shield also does not require prior authorization for urgent services that meet the reasonable person definition.

Urgent or Emergency Services are covered automatically if an authorized Blue Shield representative or authorized representative of the member's assigned IPA/medical group has approved the provision of the urgent/emergent services. Authorized representatives may include, but are not limited to, Advice Nurses, Network Physicians, Physician Assistants, Nurse Practitioners, or Customer Service representatives.

When facing an urgent or emergency situation, the primary care physician should:

- Evaluate the medical necessity of a member's request for urgent or emergency services and determine the appropriate referral for these services, following reasonable person standards.
- If possible, direct out-of-area urgent or emergency services of a member to the IPA/medical group's service area.
- Notify the IPA/medical group or Blue Shield of urgent or emergency admissions.
- Document telephone conversations in the member's centralized medical record, whether the urgent or emergency service is approved or denied by the primary care physician.

For Blue Shield Medicare Advantage plan members, please contact the Blue Shield Medicare Medical Care Solutions Department for a copy of the Emergency Care Treatment Criteria Matrix, also known as the ER Matrix.

Urgent/Emergent Services *(cont'd.)*

Urgent or Emergency Services Denial

The IPA/medical group must adhere to the "reasonable person" standard prior to denying an urgent or emergency services claim.

If an IPA/medical group retrospectively denies an urgent or emergency service, it must document the following denial information and submit it to Blue Shield upon request.

The IPA/medical group shall provide Blue Shield with:

- A clinical reason for the denial based on the reasonable person standards.
- Proof of medical review by a physician.
- Verification that the primary care physician or his/her designee did not refer the member to the emergency room or urgent care provider.
- A copy of the claim with the member's denial notice.

The IPA/medical group shall send a denial notice to the member containing the following information:

- Member's name and name(s) of provider(s) who rendered services.
- Date and description of service.
- Clinical reason(s) for the denial.
- UM criteria, guideline, protocol or benefit provisions used in making the decision, including contact information and procedures to follow to obtain a copy.
- Alternative treatment options, as appropriate.
- For employer health plans governed by the Employee Retirement Income Security Act (ERISA), ERISA-required statement notifying the member of the right to bring a civil action if all required reviews of the service/claim have been completed and the service/claim has not been approved.
- Appeal information, including the member's right to request an external, independent medical review through the DMHC (only Commercial members may appeal to DMHC, Blue Shield Medicare Advantage plan members must appeal directly to the health plan.); the member's right to request an expedited appeal; the member's right to submit written comments, documents, and other information relevant to the appeal and the member's right to appeal to Blue Shield including representation by an attorney.
- The IPA/medical group shall also send a copy of the member's denial notice to the member's primary care physician for follow-up regarding appropriate care. The denial letter to the treating provider shall also include the name, title and direct telephone number of the IPA/medical group's Medical Director who oversees the decision.

Urgent/Emergent Services *(cont'd.)*

Appeal of Denied Urgent or Emergency Services

A Blue Shield Medical Director or physician designee reviews all appeals of denied emergency services.

Blue Shield may reverse the IPA/medical group's decision to deny urgent or emergency services. When this occurs, the Blue Shield Medical Care Solutions Department will coordinate the review of the denial with the IPA/medical group and notify the IPA/medical group and the member of the appeal determination.

Blue Shield retains the right to review and make determinations on appeals of all emergency services.

Urgent and Emergency Services Review

The Blue Shield Delegation Oversight and Appeals and Grievance Departments periodically evaluate an IPA/medical group's performance on urgent and emergency services review by monitoring the:

- Emergency room visits/1000 rate per IPA/medical group.
- Percentage of service denials reversed by Blue Shield based on member appeal.

5.1 Utilization Management

Medical Care Solutions Contact List

Blue Shield Contact	Commercial HMO and Direct Contracted HMO*	Medicare HMO
Call Medical Care Solutions for questions about: • Request for authorization • Blue Shield Medical Policy • Information on referrals • Emergency services • Denials • Hospital admissions and/or discharges • DME/HME & Home Health • Chronic and catastrophic case management	**(800) 541-6652 Option 6** Urgent/ER Inpatient Admits: Fax (844) 295-4637 Prior Authorizations: Fax (844) 807-8997 Prior Authorizations for Office/Infusion/Home Health Administered Medications: Fax (844) 262-5611 *Mailing Address:* Blue Shield of California Medical Care Solutions P.O. Box 629005 El Dorado Hills, CA 95762-9005 To refer patients to a Blue Shield Case Management Program (877) 455-6777 *Direct Contracted HMO **-** Individual providers not affiliated with a Blue Shield HMO IPA/medical group and are contracted to provide benefits directly to HMO members.	**(800) 541-6652 Option 6** Urgent/ER Inpatient Admits: Fax (844) 696-0975 Prior Authorizations: Fax (844) 807-8997 Prior Authorizations for Office/Infusion/Home Health Administered Medications: Fax (844) 262-5611 *Mailing Address:* Blue Shield of California Medicare Medical Care Solutions P.O. Box 629005 El Dorado Hills, CA 95762-9005

Introduction

Blue Shield of California's mission is to ensure all Californians have access to high-quality healthcare at an affordable price. Blue Shield's Quality Management and Improvement Program was established in support of that mission and plays a key role in achieving the organization's goals to:

- Improve the quality and efficiency of health care
- Improve members' experience with services, care, and their own health outcomes
- Delivering an exceptional quality program across the organization

Superior care and service is the force driving the value equation. Blue Shield is committed to an objective, comprehensive, systematic, and multidisciplinary approach to managing and continuously improving the quality of care and service provided to members. Quality Improvement (QI) is an ongoing process of assessing, planning, organizing, directing, coordinating, monitoring, and evaluating the care and service provided to Blue Shield members. Blue Shield is dedicated and committed to the QI process and will strive to produce optimal outcomes by implementing interventions to address identified improvement opportunities to ensure that the quality of care delivered meets national best practice standards.

Quality Management and Improvement

Blue Shield's Clinical Quality Department, in collaboration with Blue Shield's Quality Committees, selects and oversees quality measurement and improvement activities to meet corporate strategic goals, accreditation, and regulatory requirements. Activities are conducted in all areas and dimensions of clinical and non-clinical member care and service, such as: Member Satisfaction, Access and Availability, Case Management, Continuity and Coordination of Care, Wellness, Preventive Health, and Healthcare Effectiveness Data and Information Set (HEDIS®) Measurement.

Blue Shield conducts ongoing systematic reviews of the health care and services provided to members. Care and services are coordinated and monitored in accordance with a variety of applicable accrediting standards, regulatory bodies, and statutes, including not but limited to:

- National Committee for Quality Assurance (NCQA)
- California Health and Safety Code
- California Department of Insurance (CDI)
- Department of Managed Health Care (DMHC)
- Department of Labor Employer Retirement Income Security Act (ERISA)
- Centers for Medicare & Medicaid Services (CMS)
- Centers for Disease Control (e.g., ACIP)
- Office of the Patient Advocate
- Covered California

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

Accreditation

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

Provider Responsibilities for Quality Management and Improvement

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

- Participation in QI Committees and collaborative QI activities
- Expert consultation for credentialing, peer review, and utilization management determinations
- Expert advisers for clinical QI workgroups
- Participation in focus groups
- Partnership in QI studies
- Investigation of member grievances and quality of care issues

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

In order to comply with NCQA accreditation requirements, Blue Shield collects and reports HEDIS data as it relates to Blue Shield members. Blue Shield HMO and PPO-contracted physicians and provider organizations are required to provide medical records requested for HEDIS data collection in a timely manner. HIPAA allows data collection for HEDIS reporting category thus no special patient consent or authorization is required to release this information.

Quality Management and peer review activities are considered privileged communication under California Health and Safety Code Section 1370 and California Evidence Code 1157. As such, neither the proceedings nor record of the review may be disclosed outside of the review process.

Quality Management and Improvement Program Requirements - Delegate Responsibilities

Blue Shield does not delegate Quality Improvement (QI) activities, however; the IPA/medical groups are required to maintain a QI Program that complies with Section 1370 of the California Health and Safety Code.

Each IPA/medical group shall:

- Have a written QI Program description that must be reviewed annually, updated as appropriate and approved by the IPA/medical group's Medical Director or appropriate review body. The program description shall include:
    - Program goals and objectives
    - Organizational structure including the role and function of the IPA/medical group's governing body, quality committees and subcommittees, the staff responsible for QI activities, and the frequency of their meetings
    - Scope and content of the QI Program to include the monitoring of quality of care and service
    - Frequency and method of QI Program evaluations
    - Development, implementation and annual evaluation of the QI work plan or schedule of activities, including objectives, scope and planned projects and activities for the year, and planned monitoring of identified issues and requirements according to Section 1370 of the California Health and Safety Code
- Specify a senior physician to be responsible for program implementation, oversight, and accountability
- Indicate the IPA/medical group Medical Director's involvement in QI activities and document the active participation of practicing providers in the quality committee meetings
- Maintain quality committee minutes so as to preserve their confidentiality and immunity from discovery according to Section 1370 of the California Health and Safety Code

Quality Management and Improvement Program Requirements - Delegate Responsibilities *(cont'd.)*

Quality Improvement

In compliance with these minimum program standards, the IPA/medical group shall:

- Provide adequate staff who have the knowledge, skills, and experience to perform quality improvement activities
- Work with Blue Shield to perform quality improvement activities and allow Blue Shield access to its members' medical records
- Develop a plan to evaluate and provide practice feedback to its physicians on:
    - Referral, clinical and utilization performance
    - Use of guidelines, protocols, and appropriate criteria applications/citations
    - Member satisfaction
    - Effective use of preventive screening and education
- Develop and share practice guidelines and explicit review criteria with providers affiliated with the IPA/medical group. These guidelines must be reviewed annually and updated as appropriate.
- Ensure that health services are available and accessible to Blue Shield members as needed and per regulatory/accreditation requirements.
- Take action to improve quality and routinely assess the effect of actions taken
- Evaluate the overall effectiveness of its quality improvement program on an annual basis
- Comply with applicable NCQA standards and guidelines

Quality of Care Activities

Blue Shield requires IPA/medical groups and their participating providers to work with Blue Shield in the following Quality of Care Activities, including, but not limited to:

- Access-to-care monitoring
- Coordination and continuity monitoring
- Investigation of member grievances and quality of care issues (see more below)
- Member satisfaction/disenrollment surveys
- Medical record review
- Office site review
- Healthcare Effectiveness Data and Information Set (HEDIS) data collection
- Disease management programs
- Quality improvement activities/initiatives/monitoring site visit for Utilization Management (UM) and Credentialing Evaluations

IPA/medical groups are responsible for providing copies of their Utilization Management (UM) and credentialing plans, including policies and procedures as necessary, to meet state, federal, NCQA, and Blue Shield requirements. IPA/medical groups must provide Blue Shield annually with information including, but not limited to:

- Process for referring complaints/grievances to Blue Shield
- Process for maintaining confidentiality of member's personal health information
- Nurse practitioner/physician assistant/pharmacist protocols (if applicable)

Quality of Care Reviews

Blue Shield has a comprehensive review system to address quality of care issues. A quality of care issue arising from a member grievance, or an internal department is forwarded to the Blue Shield Quality Management Department where a quality review nurse investigates and compiles a care summary from clinical documentation including, but not limited to, medical records and a provider written response, if available. The case may then be forwarded to a Blue Shield Medical Director for review and determination of any quality of care issues. A case review may also include a review of the care provided by a like-peer specialist and/or review by the Blue Shield Peer Review Committee.

During the review process, information is obtained from an IPA/medical group or directly from the involved provider. Upon review completion, dependent upon the severity of any quality findings identified, follow-up actions may be taken and can include a request for corrective action or an educational letter outlining opportunities for improvement. Patient safety concerns or patterns of poor care may be considered during Blue Shield recredentialing activities or reviewed in more detail by the Blue Shield Credentialing Committee and may result in termination from the Blue Shield network.

Blue Shield providers are obligated to participate in the quality of care review process and must provide documents, including medical records and corrective action plans upon request. Peer review activities are considered privileged communication under California Health and Safety Code Section 1370 and California Evidence Code 1157.

Medical Record Review

Consistent and complete documentation in the member's medical record is an essential component of quality patient care.

Primary care physicians are required to maintain a medical record for each member that must include patient records of care provided within the IPA/medical group, as well as care referred outside the IPA/medical group.

Blue Shield requires medical record reviews to assess both physician office records and institutional medical records, which are reviewed for quality, content, organization, confidentiality, and completeness of documentation.

Medical records are reviewed annually against Blue Shield's medical record standards. Records are sampled from those submitted for HEDIS review. Blue Shield requires that the physician's office medical records include the following:

- Identifying information on the member (patient ID on each page)
- Problem list noting significant illnesses and medical conditions
- Allergies and adverse reactions prominently noted
- Preventive Health Services
- Proof that baseline clinical exams were conducted, documented, and pertinent to the patient's presenting complaints
- Current summary sheets of medical history including past surgeries, accidents, illnesses/ past diagnoses and medications, and immunization history
- Consultation reports, hospital summaries, emergency room reports, and test reports that are easily accessible and in a uniform location
- Treatment plan consistent with diagnosis
- Evidence of medically appropriate treatment
- Continuity and coordination of care between primary and specialty physicians
- Prescribed medications, including dosages and dates of initial prescription or refills
- Evidence that the patient has not been placed at risk by a diagnostic or therapeutic procedure
- For Medicare Advantage members, evidence on presence or absence of Advance Directives, for adults over age 18 prominently located in the medical record

IPA/medical groups and physicians must also comply with all applicable confidentiality requirements for medical records as imposed by federal and state law. This includes the development of specific policies and procedures, when required by Blue Shield, to demonstrate compliance.

To assist Blue Shield in maintaining continuity of care for its members, IPA/medical groups are required to share medical records of services rendered to Blue Shield members. Members may also be entitled to obtain copies of their medical records, including copies of Emergency Department records, x-rays, CT scans, and MRIs. Upon the reassignment or transfer of a member, the physician or IPA/medical group must provide one copy of these materials, at no charge, to the member's new physician or IPA/medical group. Upon request, additional copies must be provided to Blue Shield at the IPA/medical group's reasonable and customary copying costs, as defined by California Health and Safety Code 123110.

Medical Record Review *(cont'd.)*

Medical Records Tools

Medical Records Tools (Health Maintenance Work Sheets) Make HEDIS Documentation Easier

As part of Blue Shield's commitment to supporting our practitioners, we offer valuable tools to assist you with your medical records documentation as well as HEDIS® compliance efforts. For the busy clinician, specialized flow sheets and quick disease screening tools are essential for timely comprehensive care, as well as meeting HEDIS documentation requirements. For example, the Child and Adolescent Flow Sheet can help you provide, record, and summarize years of pertinent clinical care. HEDIS audit requirements would be met for a diabetic patient with a photocopy of the Problem List, the Medication List, and the Diabetes Management Flow Sheet (to identify most recent test and results: HbA1C, dilated or retinal eyes exam, and urine microalbumin).

We encourage providers to use these forms. Using these forms and keeping them current can reduce HEDIS record submission to just a few pages. The HEDIS forms can be downloaded from Provider Connection at blueshieldca.com/provider. Once you have logged on, select *Guidelines & Resources, Guidelines and Standards,* and then *Medical Record Standards.*

Access to Records

The IPA/medical group and all sub-contracted practitioners and providers must maintain the medical records, books, charts, and papers relating to the provision of health care services and the cost of such services and payments received from members or others on their behalf, as well as make this information available to Blue Shield, the Department of Managed Health Care (DMHC), the Department of Health and Human Services (HHS), any Quality Improvement Organization (QIO) with which CMS contracts, the U.S. Controller General, their designees, and other governmental officials as required by law.

The above parties, for purposes of utilization management, quality improvement, and other administrative purposes, shall have access to, and copies of, medical records, books, charts, and papers (including claims) at a reasonable time upon request. All such records must be maintained for at least ten years from the final date of the contract period, or from the completion of any audit, whichever is later.

Note: Federal (HIPAA) law allows the plan to charge a reasonable cost-based fee for copying a designated record set, however, it is Blue Shield's policy to not charge a fee.

Delegation of Credentialing

The decision to delegate any function is based upon the IPA/medical group's demonstrated ability to successfully perform specific functions (i.e., Utilization Management, Credentialing, and Recredentialing). Initially, a pre-contractual or pre-delegation audit is conducted to determine if the IPA/medical group has the ability to perform the delegated function to the standards and requirements of Blue Shield and of the various applicable regulatory and/or accreditation agencies. After initial delegation, Blue Shield conducts an annual evaluation and oversight of the IPA/medical group based on the 12-month (no greater than 14th month) requirement set forth by NCQA. Blue Shield's oversight process is conducted through annual evaluation audits for each of the various delegated functions as well as semi-annual reports. The outcome of the evaluation determines if the delegation status will be continued as contracted or if a change in delegation status is indicated, up to, and including, revocation of delegation. Blue Shield may require more frequent or targeted audits or require a Corrective Action Plan in an effort to address any identified issues or deficiencies to avoid revocation of delegation. The delegation of this function will be granted only to those IPAs/medical groups that meet the standards outlined in the Blue Shield of California Credentialing/Recredentialing Delegation Standards (see Appendix 5-B in the back of this manual).

General Requirements for Credentialing/Recredentialing

Blue Shield is accountable for the credentialing and recredentialing of its practitioners. Blue Shield may delegate these activities but retains accountability for the oversight of the results to ensure that the same standards for participation are maintained throughout its practitioner network. Blue Shield retains the right to approve, suspend, or terminate any of the practitioners, providers, or sites of care.

Credentialing Oversight

Blue Shield will evaluate the IPA/medical group's credentialing program annually, per contractual line of business, based on the 12-month (no greater than 14-month) evaluation requirement set forth by the NCQA. The IPA/medical groups are expected to maintain their policies, procedures, programs and keep their processes up to date with the most current NCQA, DMHC, CMS, CDI, state and federal regulatory standards and Blue Shield requirements.

IPA/medical groups that are delegated for credentialing activities are required to credential and recredential practitioners/providers, mid-level practitioners/providers and non-physician practitioners/providers in accordance with the Blue Shield policies and procedures, NCQA, DMHC, CDI, CMS guidelines and applicable federal and state laws and regulations. Recredentialing is required at least every three (3) years.

Blue Shield retains ultimate responsibility and authority for all credentialing activities. Blue Shield will assess and monitor the IPA/medical group's delegated credentialing activities as follows:

1. The Credentialing Delegation Oversight Auditor will conduct pre-delegation and annual audits in accordance with the Delegated Oversight Policy and Procedure. The audit will include a review of the IPA/medical group's policies and procedures, Credentialing Committee functions and minutes, ongoing monitoring, organizational provider credentialing, sub-delegation oversight activities, quarterly reports, and the IPA/medical group's credentials files, as applicable. The Industry Collaborative Effort (ICE) standardized audit tool will be used to conduct an audit. The IPA/medical group will be required to submit a complete credentialing roster, with specialty, credentialing and recredentialing dates, and board certification name and expiration date, at least two (2) weeks prior to the scheduled audit date.

Delegation of Credentialing *(cont'd.)*

Credentialing Oversight *(cont'd.)*

2. Blue Shield will use one of the following techniques for the file review:
   a. The NCQA 8/30 file review methodology. Prior to the audit, the Blue Shield auditor will provide a list of 30 initial files and 30 recredentialed files to be reviewed at the audit to the IPA/medical group. The Blue Shield auditor will audit the files in the order indicated on the file pull list. If all eight (8) initial files are compliant with all the required elements, the remaining 22 reserve initial files will not have to be reviewed. If any of the first eight (8) files are scored non-compliant for any required element, then the auditor will need to review all 30 initial files.
   b. The NCQA's 5 % or 50 file review methodology of its files, whichever is less, to ensure that information is verified appropriately. At a minimum, the sample includes at least 10 credentialing files and 10 recredentialing files. If fewer than 10 practitioners were credentialed or recredentialed since the last annual audit, the organization audits the universe of files rather than a sample.
3. After completion of the initial file review, the auditor will follow the same procedure for the recredentialed files review and performance monitoring review (work history and education/training is not applicable at recredentialing).
4. The IPA/medical group will be required to sign and abide by the credentialing delegation agreement.
5. Results of the credentialing review of the Group's program will be forwarded to the Delegated Oversight Committee for action and approval in accordance with Health Plan policy.
6. To be delegated and to continue delegation for credentialing, the IPA/medical group must meet the minimum standards by scoring at least 95%. If the IPA/medical group scored below 95%, a corrective action plan (CAP) is required. The IPA/medical group must submit all deficiencies to Blue Shield Credentialing Delegation Oversight Department within 30 days of notification is received. After reviewing the CAP, the IPA/medical group will be sent a letter noting acceptance of the CAP or any outstanding deficiencies.
7. The Credentialing Delegation Oversight Department will ensure the CAP meets all regulatory requirements.
8. Failure to fulfill compliance with delegation standards or to meet expected business outcomes may result in full or partial de-delegation by Blue Shield. Corrective action will be required and may involve additional oversight or co-management of certain functions.
9. Delegated credentialing status may be terminated by Blue Shield at any time in which the integrity of the credentialing or recredentialing process is deemed to be out of compliance or inadequate.
10. Blue Shield may terminate this Agreement in the event that the IPA/medical group fails to perform Delegated Activities in accordance with Blue Shield's standards as described in this Agreement. Blue Shield will work with the IPA/medical group to correct the deficiencies. However, if the problem cannot be corrected, then Blue Shield may revoke the delegation status.

Peer Review Process

Peer Review is a physician review for the purposes of determining the existence of an actual or potential quality of care issue. This review process includes a review of the clinical and administrative information available. It is the evaluation or review of performance of colleagues by professionals with similar types and degrees of experience. Member complaints/grievances may identify potential quality of care cases. Results of determinations can improve performance levels when issues are identified.

Delegation of Credentialing *(cont'd.)*

Required Submissions/Notifications of Credentialing Program Activity

The IPA/medical group shall keep Blue Shield apprised of credentialing program activity through the following:

- The IPA/medical group will submit reports to Blue Shield twice a year listing those practitioners who have been credentialed, recredentialed, denied, and terminated by their credentialing committee and/or requested a fair hearing (including the outcomes of those determinations). Reports should also include the practitioners' quality improvement activities. The semi-annual reports must also include the practitioners' specialty and board certification status. (Reports may be submitted quarterly to align with other regulatory requirements such as DHCS.)

1st Semi-Annual	August 15th (January 1st – June 30th)	Credentialed Recredentialed Suspensions Resignations Terminations Organizational Providers QI Activities
1st Quarter	May 15th (January 1st – March 30th)	
2nd Quarter	August 15th (April 1st – June 30th)	
2nd Semi-Annual	February 15th (July 1st – December 31st)	
3rd Quarter	November 15th (July 1st – September 30th)	
4th Quarter	February 15th (October 1st – December 31st)	

- The IPA/medical group shall notify Blue Shield of practitioner terminations at least 30 calendar days prior to the effective date of the terminations.
- The IPA/medical group shall notify Blue Shield of changes in the credentialing staff and/or credentialing policies and procedures.
- The IPA/medical group will annually submit a copy of the group's current Credentialing/ Recredentialing Program and/or Policies and Procedures to bsc_cred.delegation@blueshieldca.com or the assigned auditor.

5.2 Quality Management Programs

Submission of Laboratory Results Data

All provider organizations (IPAs and medical groups) contracting with Blue Shield on a capitated basis are required to submit member-level laboratory results data as part of Blue Shield's Quality Management and Improvement initiatives. These data elements are used for HEDIS, Align Measure Perform (AMP) , disease management programs, and other similar activities. In lieu of direct submission, a contracting provider organization may cause its subcontracted laboratories to submit laboratory results data to Blue Shield in accordance with Blue Shield's specifications and requirements. Direct submission of results data by a laboratory on behalf of a provider organization does not relieve the provider organization of the obligation to ensure that complete, timely, and high-quality data are received by Blue Shield monthly.

Results for laboratory tests must be submitted using the current version of the CALINX lab data standard, which is based on the Health Level 7 (HL7) industry standard for exchange of laboratory results data. This standard may be obtained on the Integrated Healthcare Association's website at http://www.iha.org/calinx_lab_standards.html. Coding for analyses must use the LOINC coding system. Blue Shield subscriber and member identification numbers must be used in each record. Data must be submitted monthly using Blue Shield's secure data exchange procedures.

Contact Yuan Hong at (310) 744-2674 or yuan.hong@blueshieldca.com for additional details and requirements as well as to initiate required submissions of laboratory results data.

Practice Guidelines

Blue Shield is committed to improving health with optimal outcomes. Clinical practice and preventive health guidelines assist physicians by providing a summary of evidence-based recommendations for the evaluation and treatment of preventive aspects and select common acute and chronic conditions.

Blue Shield's Clinical Practice Guidelines focus on important aspects of care with recognized and measurable best practices for high-volume diagnoses. The basis of the Guidelines includes a variety of sources that are nationally recognized, or evidence-based, or are expert consensus documents. Additional points have been included where medical literature and expert opinion are noted. Network physician involvement is a crucial part of the guideline development as well as adoption for the organization after approval by Blue Shield of California Quality Committees.

Blue Shield's Clinical Practice Guidelines are available on Provider Connection at under *Guidelines and resources,* then *Guidelines and procedures.*

Service Accessibility Standards

Blue Shield requires that IPAs and medical groups, together with their contracted providers, provide access to health care services within the time periods as established by Blue Shield and Title 28 CCR Section 1300.67.2.2 as specified in this manual.

Blue Shield uses the Consumer Assessment of Health Plans Survey (CAHPS), the Patient Assessment Survey (PAS), Provider Satisfaction Survey, Appointment Availability Survey results, and member appeals and grievances to measure compliance with the applicable access standards. While all of the previously mentioned surveys will be used to demonstrate compliance, an overall rate of compliance by the IPA/medical group will also be calculated based solely on the Provider Satisfaction Survey and Appointment Availability Survey results. Groups that are found non-compliant with the access standards may be required to submit a corrective action plan containing details on how the IPA/medical group will achieve and maintain compliance.

If it is not possible to grant a member an appointment within the timeframes indicated in the Access-to-Care table below, the wait time may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, has determined that a longer wait time will not have a detrimental impact on the health of the enrollee. Such provider must note, in the appropriate record, that it is clinically appropriate and within professionally recognized standards to extend the wait time.

If a member is unable to obtain a timely referral to an appropriate provider, the member, member representative, or an attorney or provider on the member's behalf, may file a grievance by contacting Blue Shield's Customer Service Department in writing, by telephone, or by submitting a completed Grievance Form online at blueshieldca.com. Blue Shield researches and investigates all grievances and, as appropriate, the Blue Shield Medical Director may review a grievance. For commercial members, call (800) 541-6652 and for Blue Shield Medicare Advantage plan call (800) 776-4466.

Members or providers on the member's behalf may also contact the applicable state regulator to file a complaint at the following toll-free numbers if they are unable to obtain a timely referral to an appropriate provider.

- California Department of Insurance (CDI): (800) 927-HELP (4357) or TTY (800) 482-4833
- Department of Managed Health Care (DMHC): (888) 466-2219 or TDD (877) 688-9891
- The Centers for Medicare & Medicaid Services (CMS): (800)-MEDICARE [(800) 633-4227] or TTY/TTD (877) 486-2048

Service Accessibility Standards for Commercial and Medicare

ACCESS-TO-CARE	STANDARD
Preventive Care Appointments Access to preventive care with a PCP, Nurse Practitioner, or Physician Assistant at the same office site as a member's assigned PCP.	Within 30 calendar days
Regular and routine care PCP Access to routine, non-urgent symptomatic care appointments with a member's assigned PCP. The time standards must be met unless: the referring, treating, or health professional providing triage services determines that a longer waiting time will not have a detrimental impact on the enrollee or the appointment request is for preventive care services.	Within 10 business days
Regular and routine care SPC Access to routine, non-urgent symptomatic care appointments with a specialist. The time standards must be met unless: the referring, treating, or health professional providing triage services determines that a longer waiting time will not have a detrimental impact on the enrollee or the appointment request is for preventive care services.	Within 15 business days
Urgent Care Appointment Access to urgent symptomatic care appointments that do not require prior authorization with the PCP, specialist, covering physician, or urgent care provider. The time standards must be met unless the referring, treating, or health professional providing triage services determines that a longer wait time will not have a detrimental impact on the enrollee.	Within 48 hours
Urgent Care Appointment Access to urgent symptomatic care appointments requiring prior authorization. When a Practitioner refers a member (e.g., a referral to a specialist by a PCP or another specialist) for an urgent care need to a specialist and an authorization is required, the member must be seen within 96 hours or sooner as appropriate from the time the referral was first authorized. The time standards must be met unless the referring, treating, or health professional providing triage services determines that a longer wait time will not have a detrimental impact on the enrollee.	Within 96 hours
Ancillary Care Appointments Access to non-urgent appointments for ancillary services for the diagnosis or treatment of injury, illness, or other health condition. The time standards must be met unless the referring, treating, or health professional providing triage services determines that a longer wait time will not have a detrimental impact on the enrollee or the appointment request is for preventive care services.	Within 15 business days

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

ACCESS-TO-CARE	STANDARD
Rescheduling of Appointments and Authorizations When it is necessary to reschedule an appointment or authorization it must be promptly rescheduled, in line with the health care needs of the patient, and consistent with professional standards. Interpreter services will be coordinated with scheduled appointments to ensure the provision of interpreter services at the time of the appointment.	As determined by licensed healthcare professional
After Hours PCP Access *See "After Hours Requirements" below for more details on this requirement.*	PCP or covering physician available 24 hours a day, 7 days a week
Emergency Care	Immediate
After Hours Emergency Instructions (telephone answering service or machine) *See "After Hours Requirements" below for more details on this requirement.*	Specific instructions for obtaining emergency care such as directing the member to call 911 or to go to the nearest emergency room.
In-office Wait Time **Recommendation:** In the absence of emergencies, medical offices should seek to limit wait time to 15 minutes after patient's scheduled appointment.	Member care will not be adversely affected by excessive in-office wait time.
Hours of Operation	All providers will maintain sufficient hours of operation so as not to cause member-reported access and availability problems with an adverse effect on the quality of care or medical outcome.

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

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

Behavioral Health Appointment Access Standards

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

Behavioral Health Geographic Access Standards

CATEGORY	ACCESS STANDARD	COMPLIANCE TARGET
Geographic Distribution of Behavioral Health including: Psychiatrists Psychologists Licensed Clinical Social Workers Substance Abuse and Addiction Specialists	Urban: 1 within 10 miles of each member Suburban: 1 within 20 miles of each member Rural: 1 within 30 miles of each member	Urban: 90% Suburban: 85% Rural: 75%
Geographic Distribution of Behavioral Health including: Inpatient Facility Residential & OP Treatment Facility	Urban: 1 within 15 miles of each member Suburban: 1 within 30 miles of each member Rural: 1 within 60 miles of each member	Urban: 90% Suburban: 85% Rural: 75%
Behavioral Health Member Ratio including: Top 3 HVS Substance Abuse practitioner	1 provider: 20,000 members	Urban100% Suburban: 100% Rural: 100%

After Hours Requirements for Commercial and Medicare Members

IPA/medical groups should abide by the following standards for after-hours emergency instructions and after-hours access to care guidelines.

After Hours Emergency Instructions

Note: The IPA/medical group must ensure that its contracted physicians leave emergency instructions that are compliant when contacted by telephone. A list of compliant and non-compliant responses is listed below.

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

After Hours Access-to-Care Guidelines

Note: The IPA/medical group should ensure that its contracted physicians or health care professionals respond to non-emergent After Hours calls within 30 minutes of a patient trying to reach the physician. A list of compliant and non-compliant responses from a physician or a health care professional is furnished below:

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

Provider Availability Standards for Commercial Products

Blue Shield has provider availability standards to ensure a network of established primary care physicians and high-volume specialty practitioners that is sufficient in number and geographic distribution for applicable commercial products. Please refer to the provider availability standards below.

Geographic Distribution

CATEGORY	PRODUCT TYPE*	STANDARD
Geographic Distribution (PCPs)	HMO/POS PPO – DOI & DMHC IFP ePPO CCSB HMO/PPO	One PCP within 15 miles or 30 minutes of each member
Geographic Distribution (SPCs)	HMO/POS PPO – DOI & DMHC IFP ePPO CCSB HMO/PPO	One of each type of High Volume and High Impact Specialists and OB/GYN (commercial only) within 30 miles of each member
PCP To Member Assignment Ratio	HMO	Maximum of 2,000 members assigned per PCP
SPC to Member Ratio	HMO PPO – DMHC IFP ePPO	1 OB/GYN to 10,000 (commercial members only) 1 HVS to 20,000 members
Geographic Distribution (Acupuncturist)	PPO	Urban/Suburban: 1 of each specialty within 20 miles of each member's residence or workplace or equivalent to 30 minutes. Rural: 1 of each specialty within 45 miles of each member's residence or workplace or equivalent to 60 minutes.
Provider to Member Ratio (Acupuncturist)	PPO	1 Acupuncturist per 5,000 members
Ethnic/Cultural and Language Needs	HMO/PPO	1 PCP speaking a threshold language to 1,200 members speaking a threshold language**
Geographic Distribution Hospitals	HMO/POS PPO – DOI & DMHC IFP ePPO CCSB HMO/PPO	One hospital within 15 miles of each member
Availability of Ancillary Care Providers	HMO/POS PPO – DOI & DMHC IFP ePPO CCSB HMO/PPO	Pharmacy: 1 in 15 miles DME: 1 in 15 miles Radiology/Lab/ASC/SNF: 1 in 30 miles Urgent Care/Dialysis: Urban 1 in 15 miles, Suburban 1 in 20 miles, Rural 1 in 30 miles

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

Geographic Distribution *(cont'd.)*

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

*PPO plans are both Blue Shield PPO – DMHC and PPO – CDI plans. PPO membership excludes ASO/self-insured business.
** Threshold languages are Spanish, Chinese - Traditional, and Vietnamese.

Provider Availability Standards for Medicare Advantage Products

Facility Time and Distance Requirements as required by CMS

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

Provider Time and Distance Requirements as required by CMS

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

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

Provider Minimum Number Requirements

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

*Minimum number of providers required is based upon the (minimum provider to beneficiary ratio) multiplied by the (95th percentile of the average health plan market share times the total Medicare beneficiaries residing in a county)

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

IPA/medical groups are required to be in compliance with the standards stipulated by CMS. If any IPA/medical group is unable to provide primary or specialty care services according to the requirements of CMS outlined above, the IPA/medical group is required to do one of the following to meet compliance:

1. Have a Medicare fee-for-service provider who meets both the driving time and driving distance requirements render services to the member, or

2. Contact Blue Shield and utilize one of Blue Shield's PPO providers who is also contracted for the Medicare line of business and meets both the driving time and driving distance requirements render services.

In selecting either one of the options, the financial responsibility for professional services rendered under this circumstance will rest with the IPA/medical group.

Linguistic and Cultural Requirements

MEASURE	STANDARD	COMPLIANCE TARGET
Ethnic/ Cultural and Language Needs	1 PCP speaking a threshold language to 1,200 members speaking a threshold language	100%

The top 4 Medicare threshold languages are Spanish, Chinese, Korean, and Japanese.

Additional Measurements for Multidimensional Analysis for Commercial Products

METRICS	PRODUCT	STANDARD	FREQUENCY
Access related member complaints and grievances	HMO/POS PPO	Rate of complains/grievances ≤1 per thousand members per month (non-Medicare) Rate of complains/grievances ≤5 per thousand members per month (Medicare)	Assessed Semi-Annually against Standard
Availability-related PCP Transfers	HMO	Rate of PCP transfers 1.68 per thousand members per month (Medicare)	Assessed Quarterly against Standard
PCP, Specialist and Hospital Network Change Analysis	IFP ePPO	10% (change)	Assessed Quarterly against Standard
PCP to Member Ratio	IFP ePPO	1:2000	Quarterly
Top HVS Turnover	HMO/PPO/ CDI/ SHOP HMO/PPO	10%	Assessed Quarterly against Standard
Hospital Turnover	HMO/PPO	5%	Ad hoc for Block Transfer Filings and 10% Change Analysis
Open PCP Panel	HMO/POS Directly Contracted HMO	85%	Assessed Semi-Annually against Standard
Member Satisfaction	HMO/POS PPO	HMO – Patient Assessment Survey at IPA/MG level HMO/PPO – CAHPS at Health Plan level	Annual

Additional Measurements for Multidimensional Analysis for Medicare Advantage Products

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