Section 6: Supplemental Direct Contracting HMO Administrative Procedures and Responsibilities

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Overview

The Blue Shield administrative procedures and responsibilities in this section apply specifically to physicians who have contracted directly with Blue Shield HMO for the delivery of care to Blue Shield Access+ HMO® members, Blue Shield Trio HMO members, Blue Shield Medicare Advantage plan members, Added Advantage POS℠ members (under the HMO option), and other Blue Shield HMO members.

Pursuant to the Blue Shield agreement, providers may be required to provide services directly to HMO members, in the absence of a Blue Shield-contracted HMO IPA or medical group. In the event such services are directly provided, reimbursement for medically-necessary HMO-covered services will be paid on a fee-for-service basis. Blue Shield will make payment at the allowances in effect at the time of service, based on Blue Shield's medical review allowance policies, as applicable. Blue Shield will notify providers when such a situation occurs.

> *Note: Providers affiliated with a Blue Shield-contracted IPA or medical group, please contact the IPA or medical group administrator for information regarding its internal policies and your responsibilities as a Blue Shield HMO provider. Blue Shield's HMO IPA/Medical Group Procedures Manual outlines expectations of Blue Shield contracted IPA or medical group network providers.*

The Medical Care Solutions Department within Blue Shield's Health Solutions division is established to provide oversight of the delivery of care to members. The Blue Shield Medical Care Solutions professional staff includes California-licensed physicians and nurses who monitor healthcare services delivered by contracted physicians and providers for timeliness, appropriateness, and quality of care.

Blue Shield's Medical Care Solutions Department is structured to ensure utilization management (UM) decision-making is based only on the appropriateness of care and service and existence of benefit coverage. The Medical Care Solutions Program ensures that contracting physicians are not penalized for authorizing appropriate medical care. Blue Shield does not specifically reward practitioners or providers or other individuals for issuing denials of coverage or service of care. Medical decisions are made by qualified individuals, without undue influence from management concerned with Blue Shield's fiscal operations. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.

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HMO Practitioner Responsibilities

Role of the Primary Care Provider (PCP)

For the HMO plan, the primary care provider (PCP) plays a critical role in managing and coordinating the care of the member. If a provider is selected as a PCP by a Blue Shield HMO member, the provider must understand the administrative responsibilities providers are required to follow, as well as the specific Blue Shield HMO procedures that apply to and affect HMO members.

Prior Authorizations and Referrals

In the absence of a Blue Shield-contracted IPA or medical group, the primary care provider works directly with Blue Shield's Medical Care Solutions Department to request prior authorization for specific services (refer to Section 3: Medical Care Solutions for prior authorization details). Providers can submit requests for authorization directly to Blue Shield for inpatient services, outpatient services, home health care/home infusion services, and DME/orthotic services. Simply go to Provider Connection at blueshieldca.com/provider and click on *Authorizations*. Enter necessary information and a response will appear in the message center advising providers of the status of the authorization request.

Except self-referrals to an OB/GYN or for Access+ *Specialist* visits, HMO members must obtain a specialty referral from their PCP for all specialty and ancillary services. PCPs may refer to in-network specialists without prior authorization in most cases. Medical necessity review by Blue Shield Medical Care Solutions may be required in certain geographic areas. For a referral to a specialist, the PCP should complete the prior authorization/referral form. Referrals to specialists not listed in the Blue Shield HMO provider directory require prior authorization.

> *Note: Blue Shield HMO Provider Directories may be obtained online at blueshieldca.com under Find a Doctor.*

An HMO member may self-refer directly to OB/GYN or family practice providers within the same Blue Shield defined network area as her PCP without a referral. However, services provided by an OB/GYN or family practice physician outside of the defined network area will not be covered under the plan.

HMO Provider Responsibilities *(cont'd.)*

Role of the HMO Specialist

The Blue Shield HMO specialist provides care in coordination with the member's primary care physician, except in those circumstances in which the HMO member is allowed to directly access a specialist (e.g., the Access+*Specialist* feature). Refer to Section 5 for details about this feature.

Generally, however, the member requires a referral from his or her PCP to receive care from a specialist.

Standing Specialist Referrals

Blue Shield maintains policies and procedures for standing referrals to specialists for members with a condition or disease, including but not limited to HIV and AIDS that requires specialized medical care over a prolonged period of time and is life-threatening, degenerative, or disabling. (Standing referral involves more than one appointment with a medical specialist.)

The Department of Managed Health Care (DMHC) issued a definition of an HIV/AIDS specialist which can be accessed at www.dmhc.ca.gov.

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 diagnosis or treatment of a condition requiring care by a physician with a specialized knowledge of HIV medicine, the primary care physician *must* refer the enrollee to an HIV/AIDS specialist.

Access to Care Monitoring for HMO Members

Blue Shield requires that Direct Contracted HMO providers provide access to health care services according to the applicable standards established by Blue Shield, Title 28 CCR 1300.67.2.2, and stipulated under Section 2 of this manual, Service Accessibility Standards.

HMO Provider Responsibilities *(cont'd.)*

Office Review for HMO Providers

Site Evaluations

In adhering to accreditation standards for quality, Blue Shield requires that the offices of all providers meet appropriate office site quality standards. Upon receipt of one or more member complaints, Blue Shield may conduct site visits to review the quality of the office(s) where patient care is provided. Blue Shield staff, or a Blue Shield-contracted vendor may perform these office site evaluations. Areas covered in the evaluation may include but are not limited to physical accessibility (e.g., parking, handicap access), appearance, space adequacy (e.g., seating), medical record organization, record confidentiality (i.e., evidence that records are secured), and appointment availability (by type of care). Follow-up visits will be conducted (at least every six months) until deficient offices meet office site quality standards.

Medical Records Keeping Practices for HMO Providers

In alignment with regulatory and accrediting agencies, Blue Shield requires that providers maintain a centralized medical record for each member seen in his or her office and to comply with all applicable confidentiality requirements imposed by both federal and state law. Providers have an obligation to produce medical records to Blue Shield when requested for survey processes, quality improvement, and other provider relations activities.

A medical record keeping practices review, which may be conducted by Blue Shield or a Blue Shield-contracted vendor, looks at the quality, content, organization, and completeness of documentation. To ensure member confidentiality, Blue Shield may review "blinded" medical records or a model instead of the actual record. The review of medical record keeping practices does not have to include clinical elements.

HMO Member-Related Issues

Member-Initiated Primary Care Provider Change

Commercial HMO members may change their primary care provider or designated IPA/medical group by calling Blue Shield's Member Services Department. These changes are generally effective on the first day of the month following approval of the change by Blue Shield. Members receive an updated Blue Shield identification card that reflects the PCP or designated IPA/medical group change.

Once the PCP or designated IPA/medical group change is effective, all care must be provided or referred by the new PCP or designated IPA/medical group, except for the following:

1. Obstetrician/gynecologist (OB/GYN) services provided to a female member by an OB/GYN or family practice physician in the same IPA/medical group as the new PCP.

2. Services under the self-referral provisions of the Blue Shield Access+ *Specialist* benefit.

Voluntary IPA/medical group changes are not permitted during the third trimester of pregnancy or while admitted to a hospital. The effective date of the new IPA/medical group will be the first of the month following discharge from the hospital, or when pregnant, following the completion of post-partum care.

Additionally, changing primary care physicians or designating a new IPA/medical group during the course of treatment may interrupt the quality and continuity of care. For this reason, the effective date of the transfer when requested during the course of treatment or during an inpatient hospital stay will be the first of the month following the date it is medically appropriate to transfer the member's care to the new PCP or designated IPA/medical group, as determined by Blue Shield.

Note: Exceptions must be approved by the Blue Shield HMO Medical Director.

Blue Shield Medicare Advantage plan members may change their PCP by calling the Blue Shield Medicare Member Services Department

Provider Requests to Disenroll HMO Members

Blue Shield has established procedures for Blue Shield providers requesting to end their relationship with an HMO member for cause such as disruptive behavior or failure to follow treatment recommendations. Providers may not end a relationship with a member because of the member's medical condition or the cost and type of care that is required for treatment.

HMO Member-Related Issues *(cont'd.)*

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

Before requesting disenrollment for cause, providers must counsel the member in writing (via certified mail) about the problem. If the problem persists, providers may request disenrollment by sending all documentation, including the initial counseling letter, to Blue Shield's Member Services Department.

> *Note: For Provider requests to transfer or disenroll Blue Shield Medicare Advantage plan members, refer to Section 1 of this manual.*

Upon receipt of the documentation, Blue Shield will review the case and may:

- Decide not to disenroll the member
- Send a second counseling letter to the member
- Transfer the member to another provider
- Disenroll the member from the HMO with 31 days written notice

Providers will receive a written notice of Blue Shield's decision. When a member is transferred to another provider, the former provider must supply patient records, reports, and other documentation at no charge to Blue Shield, the new provider, or the member.

Providers are required to coordinate care for these members until their request for disenrollment has been reviewed and granted.

Blue Shield retains sole and final authority to review and act upon the requests from providers to transfer or terminate a member. Members will not be transferred against their will or terminated until Blue Shield has carefully reviewed the matter, determined that transfer or termination is appropriate, and confirms that Blue Shield's internal procedures have been followed.

Provider Status Changes

Primary Care Provider Termination Notification Requirements

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

1. Contracting IPA/medical groups must provide at least 90 days' advance written notice of a termination in accordance with Blue Shield's contractual requirements and the 1997 Balanced Budget Act (for Medicare Advantage members).
2. Notification to Blue Shield must include the following: termination reason (deceased, retirement from all practice, closed practice site, left IPA, etc)
   Terminating provider identifiers such as name and NPI or California license number
   When applicable, the name and NPI of the receiving PCP may be included for consideration in member reassignment.
3. Blue Shield provides affected members at least 60 calendar days' advance written notice of their primary care provider's termination which aligns with standard accreditation and regulatory requirements. The letter to the member includes notification of the PCP's termination, the termination date, their new PCP and/or IPA/medical group and the procedures for selecting another PCP by calling the Member Services toll free number.
4. In very limited circumstances the IPA/medical group may be unable to provide the required advance notice of a primary care physician termination,
   In these circumstances, the IPA/Medical group must work with the assigned Provider Relations Representative contact to facilitate the expedited transfer of impacted members to a new PCP
   In such cases where the IPA/medical group is not the source of a PCP termination, Blue Shield will notify and reassign members as outlined in section **Termination of Providers.**

Provider Status Changes *(cont'd.)*

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

The limited circumstances or exceptions referenced above include:

- Death
- Status change of medical license, or Medicare sanction and debarment, or any other sanction status which results in administrative termination due to the practitioner being ineligible to render care.
- A determination by Blue Shield's Credentialing or Legal Departments after an investigation of "Grossly unprofessional conduct", which includes any criminal or fraudulent acts (e.g., allegations of molestation or abuse).
- Relocation of practice out of the area without adequate notice.
- Practice closure without adequate notice.
- The physician is an employee of a medical group and resigns or is terminated effective immediately.

5. If an IPA/medical group is unable to provide Blue Shield with the required 90-day notice of a primary care provider termination due to one of the limited circumstances listed in number above, Blue Shield will automatically assign a PCP, IPA/medical group, and effective date for all affected members. Blue Shield's Commercial Membership Department will immediately notify each affected member, in writing, of their PCP's termination as well as their new PCP assignment and will send the member a new ID card. In instances where a member must access a PCP prior to receiving written notification from Blue Shield of his or her newly assigned PCP, the member is entitled to seek care by self-referring to a PCP within Blue Shield's HMO network (see number 3. of the policy). This does not apply to Blue Shield Medicare Advantage plan members.

6. In instances when a Medicare primary care provider terminates immediately, Medicare Member Services or Medicare Membership will attempt to contact each affected member via telephone (if possible) and/or via a member letter using a CMS-approved letter template to explain the situation and facilitate the member's assignment to a new PCP. During these calls, if any issues are identified that involve continuity of care (e.g., pending referrals, hospitalization, necessary immediate PCP visits, etc.), Medical Care Solutions will be notified. Blue Shield will send the member a new ID card and contact the IPA/medical group to facilitate transfer of all medical records.

Provider Status Changes *(cont'd.)*

Specialist/Specialty Group Termination Notification Requirements

Blue Shield recognizes the importance of timely member notification prior to the termination of a regularly seen specialist or specialty group. In accordance with accreditation standards of the National Committee for Quality Accreditation (NCQA), Blue Shield members are required to receive at least 30 days prior notice of an upcoming physician termination, including specialist or specialty group termination. Blue Shield does not assign members to specialist physicians/specialty groups, but members who have seen specialist still need to be notified of upcoming specialist terminations. The responsibility to notify the member of upcoming specialist terminations rests with Blue Shield and is based on the following requirements:

1. Blue Shield will notify members seen regularly by a specialist or specialty group whose contract is terminated **at least 30 days prior to the effective termination date**.

2. Ways Blue Shield identifies members seen regularly by a specialist or specialty group may include but are not limited to:

    - Number of visits within a specified time period such as two or more cardiac follow-up visits within one year.
    - Repeated referrals for the same type of care over a specified time period such as four referrals for the treatment of diabetes over a two-year period.
    - Receipt of periodic preventive care by the same specialist or specialty group such as a woman receiving an annual well woman exam by the same OB/GYN.

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HMO Claims Submission and Processing

Physicians (primary care providers and specialists) and other providers who are contracted and notified by Blue Shield to provide services directly to HMO members (i.e., no affiliated IPA/medical group involved) must submit their claims to the appropriate address listed in Appendix 4-E.

Refer to Section 4: Billing for complete instructions on submitting Blue Shield claims.

Specialist Claims

Specialists must receive a referral from the member's primary care provider to provide services, unless he/she is providing them under the Access+ *Specialist* feature or other circumstances in which a referral is not required (e.g., self-referral for OB/GYN care by a physician in the same defined network as the PCP).

When submitting a claim, specialists must include the primary care physician name in the referring physician's box (Form Locator 17a) of the CMS 1500 claim form.

Access+ *Specialist*℠ Claims Processing

If you have rendered services as an Access+*Specialist* (refer to Section 5: Blue Shield Health Plans for details about this feature), submit paper claims to Blue Shield at the address below, along with a copy of the Access+ *Specialist* card (if available), for reimbursement. Also write "Access+" on the claim and indicate that the copayment has been collected.

Blue Shield of California
Capitated Services Team
P.O. Box 629012
El Dorado Hills CA 95762-9012